NCIHC Open Call
January 28, 2005
9:30 – 11:00 PST

Topic:
Review of the Draft Standards of Practice for Interpreters in Health Care

The NCIHC Open Calls are held quarterly, as a means of encouraging exchange among professionals working in the field of language access and soliciting input from practitioners in the field to inform NCIHC policy making.

Introduction
The open call began with a short introduction. Cornelia Brown, from the NCIHC Advisory Committee, reviewed the mechanics of the call and then introduced this month's topic.

This month's call focused on providing feedback to the NCIHC Standards, Training and Certification Committee referent to the draft Standards of Practice for Interpreters in Health Care. Before signing onto this call, participants had been requested to complete a survey referent to the draft standards that had been posted to the NCIHC website. The focus of this call was to discuss certain parts of the survey in more depth. The input from this call will be used by the STC committee, along with the survey results, to revise the draft standards.

Dr. Brown then introduced Karin Ruschke and Shiva Bidar-Sielaff, Co-chairs of the Standards, Training and Certification Committee of the NCIHC, who gave a background presentation.

Background presentation
The NCIHC has received a grant from the Commonwealth Fund and The California Endowment to develop national standards of practice for interpreters in health care. As part of this process, the NCIHC has conducted an environmental scan (posted on the NCIHC website), and has developed a draft standards document. The STC committee is now looking for feedback on the

standards, from administrators, interpreter-trainers, and interpreters of all language pairs, all health venues, all contractual arrangements, and all cultural groups.

A participant on the call raised the concern that no set of standards of practice can be applied across all cultures, making these "standards" simply guidelines, not rules.

Participant discussion
The participants were then directed to certain of the questions on the survey and asked to share their thinking about a particular standard, whether they agreed with it, and why.

Survey question 6, regarding the stipulation that interpreters should maintain register when interpreting.

- Speaker felt that interpreters should maintain register.
- Speaker felt that interpreters could not always maintain register because there is no equivalency of register or terminology between some language pairs.
- Speaker felt that interpreters should maintain register – there are tools that can be used when there is no equivalency.
- Speaker felt that interpreters should maintain register, because the provider needs to hear the patient's own words, and the interpreter should not assume that the patient doesn't understand the doctor's register. The interpreter can check on understanding if unsure as to whether the patient understood.
- Speaker felt that maintaining register depends on a number of factors. Patients are already at a disadvantage being LEP and in unfamiliar place. By preserving provider register, we leave patients bewildered and at a greater disadvantage.
- Speaker felt that interpreters should not maintain register. Some terms need to be simplified. Providers use jargon, and interpreters must simplify because high register terms (if they even exist in the target language) will not be understood. Interpreting tone and style, however, is not as important, as patient is present and can discern tone and style for herself.
- Speaker felt that interpreters should maintain register. However we should add language to the standard dealing with how to handle a lack of linguistic equivalence at the same register.
- Speaker felt that interpreters should not maintain register. Doctors may use high register that won't be understood. Interpreter can check for understanding. Standard should add this option so it is clear that interpreters need to be concerned about understanding.
- Speaker pointed out that "incremental intervention" is only one model of viewing the interpreter's role. The standards should be more universal and should not be based on one model alone.
- Speaker felt that the issue of lack of linguistic equivalence MUST be addressed in the standards.
- Speaker felt that register, style and tone can at times be contradictory. The standards should specify which is most important to preserve.

* Speaker liked how the standard is worded and felt that it is helpful. We know there is variety in how standards are applied, so we should add the phrase "whenever possible." We don't want interpreters polishing or simplifying terms. The speaker was concerned about stereotyping of patients.
* Speaker pointed out that the intent of preserving register is to preserve fidelity, one of the canons of the Code of Ethics.

Survey question 14, regarding the stipulation that interpreters can share confidential information within the "treating team" and "as required by law":

* Speaker felt that this standard needed to clarify what is meant by "required by law."
* Speaker felt that there are problems with defining "child abuse, elder abuse, etc." because of cultural backgrounds. This needs to be defined further.
* Speaker felt that the inclusion of the "treating team" concept is helpful. However, we need to clarify the phrase "required by law."
* Speaker felt that the inclusion of the concept off the "treating team" is not helpful. Some hospitals consider interpreters part of the "treating team," but others feel that interpreters are more neutral. The inclusion in the "treating team" is especially unclear for on-call interpreters. Interpreters should be free to be more neutral and not be compelled to disclose by law.
* Speaker felt the language was useful, but asked for clarification. Could the interpreter disclose information across encounters? Or only within the same encounter?
* Speaker pointed out that the concept of confidentiality is not common in some cultures, and so it is very important to insist on this in the standards. There needs to be additional clarification of the phrase "required by law."
* Speaker felt the language was clear and he supported the standard.
* Speaker felt that patients should have a right to change or edit what they say, to lie if they wish. Therefore, interpreters should not share information learned in other interpreted sessions. On the other hand, if something is being done that might hurt the patient, the interpreter should ask the patient for permission to share the information from the other appointment.
* Speaker felt that the language is clear, expect the phrase "required by law."
* Speaker felt we should check with legal counsel about the legality under HIPAA of sharing information between encounters.
* Speaker felt we should add examples regarding the need not to disclose immigration status.
* Speaker expressed concern that Homeland Security laws may make "as required by law" become a catch-all that requires interpreters to give up confidentiality.

Survey questions 29/31, regarding the stipulation that dual-role interpreters perform only role at a time.

- Speaker felt that this section needs clarification – does this refer to a nurse doing nursing and interpreting at the same time, or does it refer to a nurse providing nursing services to a patient during other parts of the encounter?
- Speaker felt that the standard is clear, but that it's a training issue. We need to make interpreting more professional and so we shouldn't encourage the use of dual role interpreters by including this standard at all.
- Speaker also felt we should not support dual role interpreting by including this standard.
- Speaker felt that the reality is that there will be dual-role interpreters, so we need to have a standard that addresses their work. However, we need to clarify that they can't do two roles AT ONCE.
- Speaker is torn between a desire to professionalize (ie. no dual role) and reality (yes dual role). Some languages do not present enough demand to warrant the use of dedicated interpreters or staff interpreters, so bilingual staff will be used to interpret. But should we even call "dual role" interpreters "interpreters?" Should they have standards? Same or different? Or do we customize?
- Speaker felt that low demand does not warrant use of dual-role interpreters, because dedicated interpreters from agencies can be used.
- Speaker felt that dual-role interpreters should adhere to this standard only when actually interpreting, not when providing his/her own service.
- Speaker felt that dual-role interpreters are a fact of life and that we need to have standards for them.
- Speaker felt that we should be wary whenever interpreters are assigned multiple roles – e.g. patient escort, educators. Therefore, the speaker supports the use of reported speech in interpreting, as he feels that it clarifies who is speaking.
- Speaker felt that the use of bilingual provider is the best; second best is having an interpreter. For dual role interpreters, it is hard to define boundaries of which role the person is engaged in at any given time.
- Speaker felt that this standard is good but that we should point out that we don't encourage people playing dual roles.
- Speaker felt that we need to emphasize that when a dual-role interpreter is interpreting , the goal is to make principle the relation between physician and patient.

Survey question 47 regarding the inclusion of advocacy as part of the interpreter's role.

- Speaker strongly supports this standard, but felt that we need to add a case scenario (also to 46) to help readers understand it better.
- Speaker disagree with the wording. The word "advocate" infers an adversarial relationship. Perhaps we should choose a term that is softer (for example, "systems broker") that doesn't infer adversarial work.
- Speaker agreed with this standard. Advocates can help get what patients what they are entitled to WITHOUT being adversarial. Interpreters have to work as advocates at times, even if that advocacy is limited to certain circumstances.

- Speaker felt that the role of the interpreter should be JUST interpreting and should not include advocating. Advocating should be done outside of the interpreted session. Interpreters should be certified. Training on cultural awareness and refugee communities is important for providers, especially non-clinical staff.
- Speaker felt that as a profession we need to spend more time on this issue. The interpreter's role will vary based on the circumstances: the contractual arrangement, whether the encounter is in primary/secondary/tertiary care, etc.
- Speaker felt that the interpreter should wait until interpreting is done and go back later to advocate. Advocacy does not have to be antagonistic.
- Speaker agreed with both 46 and 47 – intervening for the patient, intervening for the community.
- Speaker agreed wholeheartedly. Advocacy should be mostly education.
- Speaker felt that the role of advocate is complicated and hard for beginning interpreters. There needs to be more work on training and toward certification
- Speaker agreed wholeheartedly, offering an example about stepping in if a patient is to be injected with something to which they are allergic.
- Speaker agreed: interpreters advocate for both sides in the partnership – advocating for best outcomes.

Other issues:

- What are the teeth in the standards of practice? Will anyone enforce it?
  Answer from NCIHC: There is not centralized mechanism for enforcing the standards. Local institutions must choose to adopt and enforce them.
- Might the Standards be used as a basis for training without referring to other support documents? They could be misunderstood and taught incorrectly.
  Answer from NCIHC: This is a constant concern for which there is no ready answer except to train on the Standards as widely as possible.

Participants on this call:

On behalf of NCIHC
1. Cindy Roat
2. Cornelia Brown
3. Karin Ruschke
4. Shiva Bidar Sielaff

From the field:
5. Esther Diaz, Austin, TX
6. Adam Kinsey, CHIA, Sacramento, CA
7. Leon Reynes, Spanish Interpreter, Harborview Medical Center, Seattle, WA
8. Samira Causevic, Medical Interpreter, Newcomers Health Program-RMC/FHC, San Francisco

9. Paul Camarena, MA, CHES, RHEd, Supervisor, Spanish Interpreters, Pitt County Memorial Hospital of University Health Systems, Greenville, NC
10. Natalia Molina McKendry, Manager Multicultural/Limited English Proficiency Services, Temple University Health Systems, Philadelphia, PA
11. Ben Karlin, Licensed Interpreter, Missouri Dept. of Mental Health, St Louis
12. Sandra Marchi Chada, Spanish Translator, Interpreter, and Trainer, Austin, Texas
13. Lucy Schwartz, InSync Interpreters, Customer Relations, Salt Lake City, Utah
14. Julie Burns, Interpreter Training Program Manager, The Cross Cultural Health Care Program, Santa Rosa, CA
15. T. Bergen, Asian Health Services, Oakland, CA Spanish-Eng Interpreter
16. Linda Okahara, Community Services Director, Asian Health Services, Oakland, CA 94607
17. Anissa Carbajal-Diaz- Project Coordinator, Master's of Public Health Program in Health Interpreting and Health Applied Linguistics, School of Public Health, University of North Texas Health Science Center, Fort Worth, Texas
18. Priscilla Ortiz- Graduate Teaching Assistant, Master's of Public Health Program in Health Interpreting and Health Applied Linguistics, School of Public Health, University of North Texas Health Science Center, Fort Worth, Texas
19. Saverio Madeo, Director of Telecommunications, Queens Health Network
20. Aurora Ronquilllo, Staff Interpreter – Spanish, Queens Health Network/Elmhurst Hospital
21. Fongyen Lin, Project Coordinator, Interpreter Training Project, Queens Health Network
22. Stefanie Trice, Senior Associate Director, Office of Cultural and Linguistic Diversity Development, Queens Health Network