Healthcare Interpreting Education: Are We Putting the Cart Before the Horse?

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An article in the November/December 2000 *ATA Chronicle* entitled "Interpreting Pedagogy: A Bridge Long Overdue" (Angelelli, 2000) discussed the relationship between theory, research, and practice. It noted the risks involved in any domain when research and practice are not synchronized, when a field does not turn to research to inform practices, or when practices do not set directions for research to help the field move ahead. It also argued for an interdisciplinary approach for interpreting pedagogy and stated the risks of staying within the confines of a closed circle, wherein a field draws only from the knowledge of its own experts and practitioners, thereby developing new ideas and strategies from within one limited perspective.

In his seminal work in pedagogy, D. Brown claimed that, "by perceiving and internalizing connections between practice (choices made in the classroom) and theory (principles derived from research), teaching is likely to be enlightened [emphasis in the original]" (Brown, 54). This statement can certainly be applied to the teaching of all types of interpreting, since the divorce between research and practice to which Brown alerted us not only occurs in the teaching of healthcare interpreting, but also still occurs to some extent in interpreter education in general. This article aims to continue that discussion, although due to editorial constraints, it will focus specifically on the pedagogy of healthcare interpreting.

Healthcare interpreting (sometimes called medical or community interpreting) has gained significant attention in the U.S. since 1964, when Title VI of the Civil Rights Act established the need for competent interpreters in order to ensure meaningful access to healthcare for patients with limited English proficiency. Such attention, unfortunately, did not center on the availability (or lack thereof) of educational opportunities for those individuals who wish to pursue them. Title VI called for the need of the professionalism of cross-linguistic communicators. During the last decade of the 20th century, medical interpreter organizations (e.g., the California Healthcare Interpreting Association and Massachusetts Medical Interpreters Association) were duly constituted and later published codes of ethics (CHIA, 2002; MMIA, 1995). They are currently discussing certification efforts (CHIA, 2005). Once again, in this discussion of professionalism, the issue of education, which is at the basis of any profession, has been overlooked.

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Funding agencies have also participated in this discussion by either encouraging and supporting research in the healthcare interpreting field, or by channeling efforts toward professionalization. Two examples of agencies that have supported the issue of linguistic minorities in the healthcare setting are The California Endowment (TCE) and Robert Wood Johnson Foundation (RWJF). TCE has generously supported CHIA for the writing and publishing of the Code of Ethics and Standards of Practice. Additionally, TCE funded dissemination of the CHIA Code through limited professional development opportunities, such as the training programs for healthcare interpreters offered by San Francisco City College and Mount San Antonio College. TCE also organized research symposia at the national level, and it partially funded the development of national standards of practice and a code of ethics that built on previous efforts at the state level. Exploring the link between empirical research in healthcare interpreting (Angelelli, 2001, 2003, and 2004a; Davidson, 2001 and 2002; Meztger, 1999) and assessment, TCE supported the development of the first empirical tests for healthcare interpreting in Cantonese, Hmong, and Spanish (Angelelli, 2003 and 2005), as well as the corresponding reliability studies. In 2001, the RWJF funded Hablamos Juntos, a national initiative to improve patient-provider communication for Latinos in the United States. The national project called for 10 sites to develop affordable models for healthcare organizations to offer language services in Spanish, with a focus in the areas of signage, written, and oral communication. Only one of those projects has directly targeted education (cf. with professional development or "training") and pedagogy for healthcare interpreting.

As a result of Title VI, government-funded programs for healthcare institutions have been mandated to provide interpreting services to limited-English-speaking patients (Allen, 2000). Additionally, legislation banning the use of children in healthcare institutions (Yee, Diaz, and Spitzer, 2003) and publications denouncing the use of bilingual janitors and untrained interpreters (Allen, 2000; Cambridge, 1999; Marcus, 2003) have fueled the debate on the quality of access to healthcare available

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From Now On: The Educational Technology Journal, Vol. 10/No 5, February 2001
(accessed on September 22, 2005 at www.fno.org/feb01/horsecart.html)

to speakers of non-societal languages in a multilingual society. Quality of access definitely assumes professional healthcare interpreting. As a result, healthcare organizations as well as individuals who want to use their talents to serve the needs of linguistic minorities are grappling with various important questions, including: How does one become a professional healthcare interpreter? Where do individuals who want to serve the needs of linguistic minorities in the healthcare setting get their education? Where can one find professional healthcare interpreters? What makes one a professional healthcare interpreter? Is it simply experience in the field? What is the difference between a gifted bilingual and a professional interpreter? Is it education in the field, or is it just membership in a professional organization? Can passing a test guarantee professionalism? Or is a professional an individual with a degree who can demand higher fees?

Up until the 1990s, healthcare interpreting was perceived as a less prestigious variety of interpreting, practiced mostly by *ad hoc* interpreters. The fees charged by healthcare interpreters were (and are) significantly lower than those received by conference and court interpreters. Certainly this perception was not linked to the field's lack of complexity (cf. Angelelli, 2001, 2003, and 2004a; Bolden, 2000; Cambridge, 1999; Davidson, 1998, 2000, and 2001; Kaufert and Putsch, 1997; Metzger, 1999; Prince, 1986; Wadensjö, 1995 and 1998), but perhaps to the fact that the practice lacked standards and was not recognized as an academic field. While there were opportunities for conference and court interpreters to further their education (e.g., Monterey Institute of International Studies and the University of South Carolina at Charleston, respectively), up until recently (see Jacobson: in Kennen, 2005), there was no graduate program (not even an undergraduate one) that would allow students to pursue an education in healthcare interpreting. Consequently, individuals practicing in the medical field could not show evidence of an advanced degree (which generally guarantees higher pay), and therefore the laws of supply and demand ruled.

I have argued elsewhere (Angelelli, 2004a and b) that standards and regulations applicable to one type of interpreting cannot be blindly transferred to others, since there are significant differences among the settings where interpreting is performed. However, there is one element common to all: the need for education. Conference interpreting identified this need in 1953. By the following decade, conference interpreters, who used to consist mostly of graduates of university linguistics programs, had graduated from university interpreting programs in their field (Seleskovitch, 1962). In the U.S., when discussing professionalism and meeting minorities' linguistic needs, the issue of education, which, as I mentioned earlier, is the basis of any profession, has been almost overlooked.

A characteristic of a profession is the access to a body of knowledge shared by its members. This body of knowledge is constituted by theories and research that, in turn, inform pedagogy. In the interdisciplinary field of healthcare communication, healthcare interpreting falls at the intersection of cross-linguistic/cultural healthcare. Students gain access to this body of

knowledge through education, since, as noted by Gile (1995), only a few individuals can perform interpreting tasks without education.

At present, most of the courses offered by institutions (e.g., universities, community colleges) or organizations (hospitals, community agencies) devoted to the teaching of interpreters for any setting in the U.S. do not focus as much on the education of the individuals who facilitate communication across cultures as they do on the training of how to interpret. Regardless of the length (from a 40-hour to a one-semester course) or mode (face–to-face, online, via telephone) of instruction, the truth is that courses are limited and, for the most part, of a pragmatic nature. The focus is not on educating well-rounded interpreters as much as it is on training in specific areas, such as information processing skills or terminology. Education is confused with "training." But how did this happen? And, most importantly, is there a difference between education and training?

In the early days (immediately after World War II), the education of interpreters was triggered by the need to ensure communication between heads of state or delegates of international organizations. Since the need was urgent, no research preceded implementation and no theory guided the practice. Consequently, many of the curricular decisions were made on the basis of trial and error. The picture is not very different from what we see today. Immigration waves, economic forces, or new legislation result in imminent needs on the part of linguistic minorities who have limited proficiency in the societal language to access healthcare. By definition, linguistic minorities do not share equal or similar socioeconomic status with speakers of the societal language. Differences between speakers who belong to different speech communities (Angelelli, 2000) result in interactions where power differentials are extremely salient, such as those we observe in bilingual hospital encounters (and court cases, or teacher-parent conferences). Research questions about this practice, its practitioners, and their education, which are essential to guiding pedagogy and to understand the underlying complexities of the interpreted communicative event in a medical setting (Angelelli, 2000; Metzger, 1999; Roy, 1989 and 2000), are deferred to the market need of practitioners.

Logistical questions directed to conducting training take priority over questions that are designed to understand what a well-rounded education of interpreters may look like and how it would account for the differences in settings where interpreters work. For example, as a result of personal experiences and opinions, many courses on healthcare interpreting are limited to the teaching of terminology related to the field. While it would be pointless to argue that terminology is not relevant, it is not sufficient and should definitely not drive the curriculum. A focus on de-contextualized terminology, a bilingual list of terms stripped from the discourse in which it was embedded, may mislead students. Terminology and glossaries derive from ways of speaking in a contextualized setting. They need to be studied in this way and should not constitute the centerpiece of any curriculum. Once again, education gets confused with training.

While education is the act or process of imparting or acquiring general knowledge of a field or particular knowledge or skills for a trade or profession, developing the powers of reasoning and judgment, and generally of preparing oneself or others intellectually for such a profession, training implies practical learning to do, or practice, usually under some type of supervision. Reducing the education of healthcare interpreters (or any type of interpreter for that matter) to training: 1) assumes that their knowledge of the field is sufficient enough for them to contextualize the newly acquired information; and 2) provides a limited opportunity to focus specifically on an objective (e.g., tips on how to use portable equipment). But then again, why could this be a problem?

Let's imagine the case of specific learners, such as circumstantial or elective bilinguals (Valdés and Figueroa, 1994) who have had experiences in facilitating communication for their friends and family. Existing programs vary significantly in what they offer students, from a quick overview of healthcare interpreting ethics, to medical terminology, to exposure to a few interpreting exercises in the form of scenarios, to a full-fledged graduate program on healthcare interpreting at the master's degree level. According to Jacobson (in Kennen, 2005:30), "programs available vary widely from 240-plus-hour classes complete with role playing and practicum to six-hour crash courses of dubious value." If the bilinguals of our example are not provided with a broader education and, instead, only have access to a course on ethics, they probably will exit the course with a good grasp on the behaviors that are considered ethical, but they may still not know how to put their bilingual talents to work for this specific job. They will not have the opportunity to reflect on how language for communication differs from language for work (Angelelli and Degueldre, 2002), nor will they acquire note-taking or active listening strategies, learn about ⇒

anatomy or physiology, or about the ways of speaking to patients and providers. The same would happen if a course only exposes them to medical terminology.

While all of these elements are important, they are only specific pieces of a puzzle, the solution to which may not be as simple as just having access to a master's program in healthcare interpreting. (Of course, such a program is not only desirable, but would also guarantee the recognition and professionalism of the field, which would definitely materialize into higher fees). Since healthcare interpreters could be "crossovers" from other settings (individuals with academic careers in other areas, such as conference interpreting, nursing, or social work), education for healthcare interpreters needs to be flexible enough to accommodate competent bilingual individuals who may already possess a background in healthcare, interpreting, or other areas of applied linguistics.

With meaningful testing in language proficiency and specific healthcare interpreting skills (similar to the TCE testing project), these individuals could complete graduate coursework in their areas of need to complement the education they already possess. So, for example, students who have completed courses on the skills and strategies of interpreting (e.g., crossing over from conference or court interpreting programs) or coursework in other related fields would benefit from courses on interpersonal relations or social psychology. These subjects would expose interpreting students to the types of interactions in which they will eventually be participating (the contextualization of interpreting). Courses in sociolinguistics and discourse analysis would empower students to problematize meaning and how it gets co-constructed by the parties. Problematizing the co-construction of meaning, rather than teaching students that there is only one meaning which is automatically constructed, would not only groom students to be more analytical and critical, but it would also raise awareness about the crucial role played by interpreters in this construction. Courses in dialectology, the varieties of language, and language register would help students contextualize language use and language users. Courses on issues specific to the healthcare setting in which medical interpreters work (e.g., power imbalance, institutional cultures, protocol, or ethics) would enhance student preparation.

Regardless of whether a student crosses over to healthcare interpreting from a related field or if this is the starting point for his or her education, an individual characterized as a professional in this field needs to have been educated in at least six different areas: 1) information processing; 2) interpersonal; 3) linguistic; 4) professional; 5) setting-specific; and 6) socio-cultural. If an individual only gets some "training," that person will be holding pieces of the puzzle, but may not be able to solve it. For example, attending short courses may provide students access to terminology or the ethics of the profession, but they may not have time to learn about information processing skills. Longer programs may focus on information processing and linguistic skills (such as active listening or memory, or language enhancement and register), but may not cover the specifics of the medical setting and the interpersonal role of the healthcare interpreter.

Students must become aware of the power they have as interpreters, how to use their skills effectively, and the responsibilities and duties that arise from their charge. For example, healthcare interpreters, like interpreters in general, are co-participants who share responsibility for effective communication (Roy, 2000). This responsibility needs to be made explicit to students. The professional education area informs professionals-to-be on matters such as ethics for the job, testing processes, and the rules and regulations upheld by professional associations. Students need to learn as much as possible about the discourse community they will eventually be working in. This may mean studying anatomy and physiology, understanding a medical interview, as well as mastering the most frequent expressions and terms that occur during a specific speech event (Hymes, 1974) or interview (e.g., a doctor's consultation with a patient prior to surgery). Finally, at the socio-cultural level, healthcare interpreting students need to be aware of the impact that both the institution and society have on the interaction they broker, and to realize its constraints and cultures.

If these six areas discussed above are either present in one program, or are offered as pieces of various programs, we can clearly see how we move from the narrow concept of training to the education of well-rounded professionals who will be respected and compensated as any other professionals with an acquired expertise.

Since this broader conceptualization of education is essential to all providers in the bilingual medical encounter, a word must be said about healthcare providers (HCPs). Since HCPs practice in a multicultural environment, it is essential that they be educated about cross-cultural issues, including how to work effectively

with an interpreter. Therefore the education of HCPs should include aspects of speaking with, to, and through an interpreter. As we look at ways in which HCPs can enhance their education to include the presence of the interpreter as a key player in a bilingual interview, we may also look at course offerings and successful pedagogies in medical schools that could be included in healthcare interpreting programs.

One of the most successful pedagogies in healthcare educational settings is problem-based learning, a pedagogical strategy in which students are confronted with significant, contextualized, real world situations. Students are provided with the resources, the guidance, and instructions to solve the problem. By doing this, they develop both content knowledge and problem-solving skills (Mayo, Donnelly, Nash, and Schwartz, 1993). Students also work together to study the issues of a problem as they strive to create viable solutions. Students also assume greater responsibility for their own learning (Bridges and Hallinger, 1991). In problem-based learning, the information is processed by the students; it is not imparted by faculty (Vernon and Blake, 1993). The instructor's role remains very important as he encourages student participation, provides appropriate information when needed to keep students on track, avoids negative feedback, and assumes the role of a fellow learner (Aspy et al., 1993).

Problem-based learning can be an important part of the education of interpreters. Although we may argue that in many interpreting courses today students are presented with a problem to solve, in general it is carefully structured and it is confined to the safe environment of the classroom. Oftentimes there is only one (or a very limited number of) right answer(s), and the focus is on solving the problem, not on working through the process. However, real (professional) life problems seldom parallel those discussed in the classroom. They are generally more complex and can be addressed through a variety of approaches. It is equally important that students be guided to reach both the objectives involved in solving the problem and the objectives related to the process. In the field of interpreting studies, many times the discussions on pedagogy characterize some of the skills and strategies that students need to acquire to adequately solve problems they will face on the job. Teachers of interpreting would find that problem-based learning can prove to be a useful tool when conceptualizing curriculum.

In short, this comprehensive education plan would also affect how student interpreters are assessed and certified. Currently, the interpreter certification process for other settings (e.g., the court) measures interpreters' ability to interpret consecutively and simultaneously and to sight translate. Certification also tests memory and terminology in both languages for which the interpreter is seeking certification. The underlying assumption is that the only skills that are worth testing are linguistic and information processing. Certification procedures should not overlook the fact that interpreting is an interaction (Wadensjö, 1998) as well as a discourse process (Roy, 2000). The interpersonal role of the interpreter needs to be integrated in the assessment of the profession. Issues of alignment, affect, trust, and respect should be present in the certification and assessment of interpreters, rather than simply ignored (Angelelli, 2004a). This broader view of assessment, aligned with integral education, would result in healthcare interpreting professionals who are better prepared to serve the communicative needs of individuals at all levels of society. However, the implementation of a comprehensive assessment program cannot afford to ignore education. It should be firmly rooted in a comprehensive education that would provide student interpreters with opportunities to hone their existing skills.

Conclusion

It is evident that a serious discussion on healthcare interpreting education is long overdue. Confusing education with training will not take us far. The laws of economics are quite clear: it is difficult to imagine professional recognition (and, thus, adequate monetary rewards) without formal education. A profession cannot be characterized as such without an education. Confusing training with education, encouraging interpreters to demand professional fees without offering them access to educational opportunities, or taking a leap to certification without educating for the intricacies of the field may result in putting the cart before the horse. Hopefully we know better.

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