

NSW Health Care Interpreter Services (NSW HCIS)

Interpreting in healthcare

Guidelines for interpreters

2014

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1. Introduction

1.1 Aim of the guidelines

The guidelines are designed for healthcare interpreters, both beginners and experienced practitioners with a clear understanding of industry standards. The guidelines:

1. Describe the context in which healthcare interpreters operate and set out the boundaries that allow effective and professional interpreter service provision to take place;
2. Outline the expectations of the employer that is New South Wales Health Care Interpreter Services (NSW HCIS);
3. Describe the practical and specific aspects of the interpreter's role in healthcare, including a number of potential challenges, and suggest useful strategies.

The guidelines aim to assist healthcare interpreters in navigating through ethical challenges and decision making processes. Interpreters can also use the guidelines as a tool in reflecting on their practice, self-evaluating performance and identifying their own training needs.

In addition, the guidelines aim to inform healthcare providers about the defined role of healthcare interpreters and thus enable them to better communicate with clients of culturally and linguistically diverse (CALD) backgrounds through interpreters.

It is expected that the standards of practice set out in this document will contribute further to the ongoing professionalism of healthcare interpreting, increase uniformity of service provision in this specialised field and advance the recognition of the expertise of NSW HCIS.

1.2 About NSW Health Care Interpreter Services

NSW HCIS are specialist health interpreter agencies that provide interpreting and translation services to NSW Health public facilities and some non-government organisations.

There are two Health Care Interpreter Services in the Sydney Metropolitan area:

1. South Western Sydney Local Health District Health Language Services (HLS) covering Sydney LHD, South Western Sydney LHD, South Eastern Sydney LHD, St Vincent's Health Network and Sydney Children's Hospital at Randwick (part of Sydney Children's Hospital Network);
2. Western Sydney Local Health District HCIS covering Western Sydney LHD, Nepean Blue Mountains LHD, Northern Sydney LHD, St Joseph's Hospital and Children's Hospital at Westmead (part of Sydney Children's Hospital Network).

In addition there are two regional/rural Health Care Interpreter Services in NSW as follows:

1. Hunter New England Local Health District HCIS covering Hunter New England LHD, Central Coast LHD, Mid North Coast LHD, Northern LHD, Far West LHD and Western LHD;
2. Illawarra Shoalhaven Local Health District (LHD) HCIS covering Illawarra Shoalhaven LHD, Murrumbidgee LHD and Southern NSW LHD.

The aim of the NSW HCIS is to assist clients/patients from culturally and linguistically diverse backgrounds to access health services by providing professional and confidential interpreting. NSW HCIS are the largest employer of staff and contract/sessional interpreters in Australia. Services are provided in over 140 languages including Australian Sign Language (Auslan).

NSW Government Policy requires that professional healthcare interpreters be used to facilitate communication between people who are not fluent in English, including people who are Deaf, and the staff of the NSW public health system. NSW Health has issued Standard Procedures for Working with Health Care Interpreters- Policy Directive PD2006_053 (NSW Health, 2006). The policy is mandatory for all providers of health care services in NSW Health facilities and funded services.

Interpreting services are free of charge for patients except for overseas visitors and workers compensation clients.

HCIS interpreters are highly-trained and accredited or recognised by the National Accreditation Authority for Translators and Interpreters (NAATI) except for some rare languages in which accreditation or recognition is not available in Australia. Interpreters are competent in medical terminology and are bound by the professional code of ethics, as prescribed by the Australian Institute of Interpreters and Translators (AUSIT) for spoken languages and the Australian Sign Language Interpreters Association (ASLIA) for Auslan interpreters. In addition, NSW HCIS provide a range of in-house professional development workshops for their interpreters under the auspices of the NSW HCIS Professional Development Committee (PDC). The PDC is comprised of the four NSW HCIS Managers, the NSW HCIS PDC Professional Development Coordinator as well as the Sydney and South Western Sydney LHD Interpreters, Research and Learning and Development Manager.

1.3 Guidelines development process

The guidelines are a result of years of discussions, professional development events and experience-sharing between NSW HCIS interpreters, managers and trainers. The guidelines were developed as a joint project of the four NSW HCIS, coordinated by the NSW HCIS Professional Development Committee (PDC).

The process was initiated in a focus group for NSW HCIS PDC members and senior staff interpreters in December 2009. The focus group discussed and documented particularly complex healthcare interpreting challenges. This led to the development of draft guidelines, co-written by the PDC Professional Development Coordinator and Sydney and South Western Sydney LHD Interpreters, Research and Learning and Development Manager. The guidelines also include many challenges described and strategies shared by NSW HCIS interpreters in professional development workshops, in particular Professional Update for Healthcare Interpreters (2011 and 2012), Group Interpreting Workshop (2005, 2009 and 2010) and Telephone Interpreting Workshop (2013). These are described and analysed in the context of current literature and research in community interpreting.

Prior to a wider consultation process, the guidelines were reviewed and approved by NSW HCIS Managers. Consultations involved NSW HCIS staff and contract/sessional interpreters as well as relevant industry stakeholders within Australia.

1.4. How to read this document

The guidelines are organised in five sections, which can be studied in sequence or referred to individually depending on the reader's area of interest.

Following the introduction, section Two describes the healthcare interpreting context including the facilities, services, patient-healthcare provider communication, healthcare interpreter role and ethics.

Section Three provides specific information about healthcare interpreting assignments including introductions and briefing prior to the assignment, professional interpreting skills and techniques, some interpreting procedures as well as debriefing following an assignment.

Section Four discusses ethical and other interpreting practice challenges in the medical setting. Ethical decision-making models as well as examples of specific professional and ethical challenges and useful practical strategies are offered.

Section Five focuses on the specifics of interpreting in specialist healthcare areas, i.e. speech pathology, mental health and neuropsychological assessment.

The guidelines describe practices that are common to all NSW HCIS. In addition to the guidelines, healthcare interpreters are encouraged to read their local HCIS policy and procedures manual for more detailed instructions on specific procedures applicable to their area.



2. The healthcare interpreting setting and the role of the interpreter

2.1 Healthcare interpreting settings

Healthcare interpreters work across a variety of medical settings within the NSW Health system. The facilities include public hospitals, community health centres, early childhood centres and some non-government organisations, e.g. NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors (STARTTS), medical services within NSW Correctional Centres and Blood Bank (part of Australian Red Cross Blood Services).

Within the hospital settings, healthcare interpreters interpret for both inpatients and outpatients in specialist clinics. The medical specialties range from obstetrics to gastroenterology, cardiology, oncology, paediatrics, geriatric medicine, dentistry, just to mention a few. Interpreters attend allied health appointments such as physiotherapy, neuropsychology and speech pathology. They also interpret in the mental health setting including mental health inquiries and tribunal hearings.

In addition, interpreters often go on home visits when a healthcare provider from a NSW Health facility visits a patient at home and requires the assistance of an interpreter.

2.2 Types of services

Healthcare interpreting is usually done face-to-face, i.e. the interpreter meets the healthcare provider and the patient at the health facility or the patient's home. However, healthcare interpreters also interpret over the telephone and sometimes via videoconference.

Most healthcare interpreting assignments are consultations with medical professionals attending to one patient who may sometimes be accompanied by a family member. Specific to the medical settings are also family conferences where a number of healthcare providers meet with the patient and his/her family to discuss the care plan. In family conferences special considerations apply in order to ensure that all the information is interpreted to the patient. Therefore, the meeting participants have to take care to speak one at a time and give the interpreter enough time to convey the messages in the patient's language.

Healthcare interpreters are also occasionally called upon to interpret in group settings. These are health education sessions where a health service provider addresses a group of CALD patients. In group assignments, interpreters address an audience and therefore require advanced preparation as well as public speaking skills. Interpreters need to prepare particularly thoroughly for group interpreting sessions and group talk facilitators are asked to provide relevant materials, including presentation slides and handouts, in advance of the session. Considerations and strategies specific to group interpreting are outlined in section 3.5.

2.3 Communication in healthcare

The goal of a medical consultation is to achieve the best health outcome for the patient and effective dialogue plays a central role in "patient-centered, sensitive healthcare" (Angelelli, 2004, p.29). A desirable doctor-patient therapeutic relationship is characterized by caring, concern, respect, compassion as well as support, empathy, and validation, which cannot be achieved without dialogue. Effective direct communication between the healthcare provider and the patient is crucial to:

1. Acquainting the physician with the patient's physical and emotional state, and making a correct diagnosis;
2. Developing rapport and trust; building a therapeutic relationship in counselling and mental health;
3. Determining appropriate treatment and achieving best clinical outcomes for the patient.

Healthcare interpreters play an important role in enabling direct dialogue between health service providers and patients who are not fluent in the English language. It is therefore essential for healthcare interpreters to understand the significance of effective direct doctor-patient communication. Professional interpreting techniques, interpreter role and ethics are

closely related to healthcare objectives. Interpreting techniques that enable direct doctor-patient communication are described in section 3.2.1.

It is important for healthcare interpreters to observe professional boundaries as outlined in section 2.6. Unnecessary interventions by the interpreter that interfere with the direct doctor-patient communication carry the following risks:

1. Impairing the doctor's ability to develop a therapeutic relationship with the patient by placing the interpreter at the centre of the medical encounter;
2. Creating a barrier rather than a bridge between the primary parties (Angelelli, 2004);
3. Marginalising the role of the healthcare provider resulting in loss of control over the interview;
4. Disempowering the patient, decreasing his/her autonomy and participation in the decision-making process; discouraging the patient from asking questions of the healthcare provider, expressing their viewpoint and concerns.

2.4 Healthcare interpreter ethics

Healthcare interpreting, a sub-category of community or public service interpreting, is an area where private and sensitive health matters relating to individual patients are discussed. Healthcare interpreters are entrusted with clients' highly intimate personal stories and assist in communicating significant every day issues. In the medical setting, unprofessional conduct can have serious consequences detrimental to the client's health. It is therefore essential that healthcare interpreters adhere to very high ethical standards, i.e. "the assurance that interpreters will abide by a strict code of ethics, which, among other things, ensures accuracy, confidentiality and impartiality, is important in being accorded such trust" (Hale, 2007, p. 26).

Codes of ethics typically set out standards of behaviour, protect the interests of clients, define expectations and provide a basis for making decisions (Hale, 2007; Napier, McKee & Goswell 2010). A Code of Ethics is defined as a "set of agreed upon values and principles that guide the work of members of a profession" (Cokely, 2000, p. 39).

Healthcare interpreters are bound by the AUSIT Code of Ethics (2012) for spoken languages and the ASLIA Code of Ethics (2007) for Auslan interpreters. The interpreter codes of ethics require practitioners to convey the message faithfully (accuracy), not to divulge information gained in the course of assignments to a third party (confidentiality) and to remain neutral (impartiality).

Healthcare interpreter conduct is also guided by the NSW Health Code of Conduct and the NSW Health Standard Procedures for Working with Health Care Interpreters-PD2006_053.

2.5 Interpreter role in the healthcare setting

The role of the interpreter is to facilitate communication between two parties who do not speak the same language and may represent different cultural backgrounds. In transferring messages, interpreters make appropriate linguistic and cultural decisions in order to convey all aspects of the message and produce the same impact on the listener as the original message would have (Mikkelsen 1995; Napier et al, 2010). At times, in addition to relaying messages, interpreters intervene to prevent misunderstandings and perform the task of coordinating or managing turn-taking in order to make the communication process flow smoothly and minimise disruptions (Mikkelsen 1995; Roy, 2000; Wadensjö, 1998, 2002).

The interpreter's role in the medical setting is best summarised under the direct approach framework as follows: "The interpreter renders each turn accurately from one speaker to another, leaving the decision making to the authors of the utterances" (Hale, 2007, p. 43). Ultimately, the health providers and patients are responsible for the resolution of the medical encounter.



In summary, the healthcare interpreter's role includes the following aspects:

- **Introducing oneself and explaining the interpreter's role to the clients (see 3.1.1);**
- **Facilitating communication;**
- **Providing cultural information relevant to the clinical and social needs of the individual patient for whom they are interpreting at the time (see 3.2.3);**
- **Managing the pace of communication and turn-taking (see 4.3.2);**
- **Sight translating documents essential to a specific patient consultation (see 3.2.4 D).**

Skills and strategies involved in carrying out the above aspects of the interpreter's role are outlined in section 3.

2.6 Role boundaries

Observing professional boundaries is essential in order to protect professional integrity, reduce the risk of liability, and maintain emotional well-being and physical safety (HIN, 2007). The importance of recognising professional role boundaries and maintaining professional relationships with clients is outlined in both the AUSIT and the ASLIA Codes of Ethics. Under Clarity of Role Boundaries (tenet 6), the AUSIT Code of Ethics states that interpreters focus on the message transfer and do not engage in advocacy, guidance or advice (AUSIT, 2012). In the Code of Conduct section, further explanation is offered, i.e. interpreters "assume responsibility for establishing and maintaining appropriate boundaries between themselves and the other parties in the communicative interaction" (AUSIT, 2012, p.21). Similarly, the ASLIA Code of Ethics (2007, p. 6) states that interpreters recognise "the difference between professional and social interactions" and "maintain appropriate boundaries between themselves and participants".

Overstepping professional boundaries involves risks for the interpreter in terms of potentially misleading clients, and can lead to adverse health outcomes for the patient. It can potentially lead to excessive emotional strain on the interpreter and even burnout. It also threatens direct communication between the health professional and the patient as described in section 2.3.

Determining where the professional boundaries lie can be challenging. It is a skill that comes with experience and continuous education. Below are some guidelines on recognising activities within and outside interpreter role boundaries.

While health care interpreters play a role in providing cultural information in an objective and professional manner, they do not:

- Advocate or speak on behalf of any party
- Provide advice to clients
- Make a judgement or express a personal opinion about client-related matters.

In some specialised settings, such as mental health, speech pathology and neuropsychology, interpreters may be asked to provide feedback about the patient's speech and/or language. This is a legitimate requirement given the types of assessment in these settings. See section 5 for more information.

Health Care Interpreter Services acknowledge that in some small yet linguistically diverse communities, there may be a limited number of practising professional interpreters. On occasion, healthcare interpreters may be called upon to interpret for someone who they are well acquainted with outside the professional environment. In these circumstances, interpreters are asked to notify the HCIS Booking Office that the client is a friend of theirs and HCIS will make every effort to book a different interpreter. In some instances this may not be possible. This fact shall be disclosed to the health professional for their consideration.



In addition, healthcare interpreters do not:

- **Assume the role of other health professionals**
- **Provide emotional support to patients**
- **Fill out forms on behalf of a client**
- **Explain medical terms to clients**
- **Interpret for their own relatives or friends.**

2.7 Duty of care and the interpreter

The interpreter's duty of care lies with communication facilitation and the responsibility to convey messages accurately. There is a foreseeable risk to the health of the patient when accuracy is not maintained or miscommunication occurs. Therefore, healthcare interpreters strive to maintain accuracy in terms of the content and intent of the source message (AUSIT, 2012), rectifying interpreting errors, and clarifying misunderstandings and unfamiliar terms as well as improving their competence through professional development. The duty of care for the clinical outcome lies primarily with the treating professional, and interpreters do not take responsibility for the health and wellbeing of the clients they interpret for.

However, in the medical field situations do arise where strict application of accuracy and impartiality may conflict with achieving the best health outcome for the patient. For example in cases involving potential harm to the client, determining the best course of action may require complex decision making on the part of the interpreter. The process involves analysing the underlying principles or core values, e.g. the overriding obligation to protect human life (Hoza, 2003). The teleological approach to ethics, with its focus on the context and the consequences of actions as well as possible outcomes of failure to act, can be particularly helpful in making a decision. For more information, see section 4.

2.8 Challenges in healthcare interpreting

A number of factors can contribute to creating challenges for healthcare interpreters in the course of their everyday duties. The medical setting is a dynamic work environment involving nuanced human interaction and requiring fast situational judgement. In such an environment, maintaining professional boundaries in providing ethical and accurate interpreting services is a constant demand placed upon interpreters (Dean, Pollard & English, 2004). Factors include proximity to the clients, power/status differences, misconceptions and competing demands related to the interpreter's role, as well as emotional impact.

2.8.1 Medical interpreting challenges/demands

In order to analyse, classify and reflect on interpreter challenges it is useful to apply the Demand-Control Schema Theory (D-CS) to interpreting (Dean & Pollard, 2001). D-CS is based on the theory of occupational stress. The term demand refers to the requirements of the job, which may include aspects of the environment, the task itself and other factors impacting on the participants in the interaction. This is what we usually call the professional challenges. The term control refers to the degree to which the individual

has the capacity to deal with the job demands in terms of decision making, skills and resources. In other words, these are the strategies available to the interpreter to effectively deal with the professional demands.

The demands or challenges are classified into four categories:

1. Interpersonal (relations between participants):

Clients' understanding of the interpreter role;
Power and authority dynamics;
Communication control, e.g. turn-taking;
Communication directed at the interpreter.

2. Intrapersonal (factors within the interpreter):

Emotional trauma/vicarious reactions;
Safety concerns;
Isolation;
Doubts about performance.

3. Linguistic/paralinguistic:

Client speech fluency, speed, clarity, volume;
Use of technical vocabulary.

4. Environmental:

Nature and setting of the assignment;
Seating arrangements;
Noise and visual distractions.

2.8.2 Challenges/demands for health care interpreters

NSW healthcare interpreters mostly report interpersonal challenges. These are followed by intrapersonal demands in the second place. Interpersonal demands arise due to the following factors:

- Physical proximity of the clients to each other and to the interpreter in dialogic interaction;
- Continuity of care when one interpreter is engaged to interpret for the same patient over a number of years and becomes familiar with the patient's medical history;
- Some healthcare providers' and patients' lack awareness of the interpreter role resulting in unrealistic expectations;
- Primary parties representing unequal social status and educational backgrounds

(Pöchhacker, 2004). It is common for patients to have a low health literacy level and find it hard to understand medical concepts or the health system in general. Healthcare providers, on the other hand, may not in the first instance be aware of this fact, thus creating a communication gap.

Interpersonal challenges reported by healthcare interpreters include:

- Managing communication in consultations involving multiple parties;
- Communication directed at the interpreter;
- Clients asking interpreters to perform tasks outside their role;
- Ethical decision making when aware of information not known to the treating healthcare provider;
- Temptation to explain when patients appear not to understand a procedure or treatment.

The above demands may lead to professional boundaries being challenged and ethical dilemmas for the interpreter. These are further described in section 4.1.

In addition, intrapersonal challenges are commonly reported by healthcare interpreters including emotional impact issues and safety concerns. Emotional demands arise predominantly around conveying terminal illness diagnosis, children's hospital appointments, grief and loss and victims of abuse and torture. Safety concerns crop up occasionally in some mental health appointments, on home visits and interviews involving aggressive patients and their relatives/partners. See section 4.1 for a more detailed description of intrapersonal challenges.

2.8.3 Strategies/controls for healthcare interpreters

The degree of job stress or satisfaction is related to the level of occupational demands and the corresponding control resources available to the individual worker (Dean & Pollard, 2001). Therefore, in interpreter education it is important to focus on strategies interpreters can put into place to deal with the practice demands.

These guidelines offer a number of strategies for dealing with medical interpreting demands. Specific examples of strategies for dealing effectively with both interpersonal and intrapersonal demands are included in section 4.

3. Medical interpreting assignments

3.1 Before the interpreting assignment

3.1.1 Introductions and educating clients on the role of the interpreter

Introductions and client education are very important to the success of an interpreting assignment. Interpreters introduce themselves to the patient as a matter of courtesy prior to the assignment.

Interpreters also explain their role to the clients in line with ethical principles (AUSIT, 2012). As described in the previous section, health providers and patients may have unrealistic expectations about the services that interpreters provide, which can be a barrier to effective communication. Educating clients about the interpreter's role is "an effective pro-active coping strategy to avoid confusion and lessen the occurrence of ethical dilemmas" (Dragoje & Ellam, 2007, p. 21).

The role description should be brief and include the following aspects:

- Communication through interpreters;
- Interpreter ethics, in particular confidentiality and accuracy;
- Professional boundaries.

3.1.2 Maintaining professional boundaries prior to the assignment

Avoiding unnecessary contact with clients outside an interpreting assignment is a useful strategy in maintaining professional boundaries (HIN, 2007). Having a private conversation with patients can create ethical dilemmas. Patients may disclose to the interpreter sensitive information related to their condition, e.g. thoughts of suicide or harming others. They also tend to ask personal questions of interpreters that may be uncomfortable to deal with.

Many outpatient units have separate waiting areas that can be utilised by the interpreter. It is recommended that interpreters take advantage of these whenever possible and avoid sitting with patients in the waiting area prior to the medical interview. In inpatient wards, interpreters wait in the nurses' station until the healthcare provider arrives. Offers to sit with the patient by their bedside to 'get to know them' are best politely declined.

However, a separate waiting area is not available everywhere and the interpreter may not be able to avoid sitting with the patient, particularly if they have met before. In such situations, interpreters ensure that the conversations "remain courteous but do not become personal" (AUSIT, 2012, p. 28). Interpreters can maintain professional distance by steering the conversation towards general topics not related to the personal life of the patient or the interpreter. This may be a good opportunity to educate the client about the role and professional boundaries of interpreters. If the patient starts talking about their condition, medical history or feelings, interpreters can advise that they are unable to repeat the information to the healthcare provider. This approach confirms the patient's right to choose what to say to healthcare providers and empowers them to make their own decisions. It also discourages patient dependence on the interpreter.

Occasionally, the patient may disclose information about their intention to harm themselves or others. Strategies for dealing with this situation are outlined in section 4.4.1.

3.1.3 Briefing with the health professional before the assignment

Establishing the context of the communicative event is required to determine the most effective interpreting strategies and/or behavioural decisions (Dean & Pollard, 2009). Therefore, it is desirable that all clinical and non-clinical staff who work with interpreters appropriately brief them prior to the assignment. As it does not always happen in reality, interpreters can take a proactive approach and ask that the healthcare provider briefs them. In order to ensure quality of their work, the AUSIT Code of Ethics (2012, p. 23) encourages interpreters to "request briefing and access to reference material and background information before their work commences".

Briefing with the health professional before the assignment where applicable should include:



- Describing the context of the consultation;
- Outlining the healthcare provider's objective for the consultation;
- Establishing the ground rules, mode of interpreting, seating arrangement, communication control strategies;
- Cultural background information;
- Assessment tools if used.

Briefing is particularly crucial in torture and trauma counselling, and in areas where formal cognitive assessment is performed such as neuropsychology, speech pathology and mental health.

3.2 During the interpreting assignment

3.2.1 Professional interpreting skills and techniques

Healthcare interpreters are aware of the importance of patient-centred care, enabling the primary parties to communicate directly and to develop rapport. Therefore, they encourage speakers to address each other directly (AUSIT, 2012). Professional interpreting techniques that enable direct communication between the patient and the healthcare provider include:

- Interpreting in the first person (direct speech) – Interpreters speak in the first person, i.e. in the same grammatical form as the speaker and say "I am unwell" instead of saying "The patient says that she is unwell". This minimises confusion, enhances accuracy in form and content as well as reinforcing the role of the interpreter as a neutral facilitator of communication.
- Seating arrangement – Interpreters arrange seating to facilitate direct communication between the primary parties. Spoken language interpreters usually sit next to the patient and a little bit behind. However, interpreter positioning depends on the contextual needs of the setting. For example, the interpreter may be asked to sit next

to the clinician in some counselling sessions where simultaneous interpreting is required as well as in some audiology assignments when the client needs to see both the audiologist and the interpreter to gain maximum visual information. Auslan interpreters, on the other hand, position themselves next to the healthcare provider as a rule. Special considerations apply to Auslan interpreter positioning during eye examinations and other physical treatments.

- Eye contact – Interpreters avoid engaging patients and health providers in direct eye contact and encourage them to look at each other instead of the interpreter. This does not apply to Auslan interpreters who need to maintain constant eye contact with their Deaf client due to the visual nature of sign language.
- Facial expressions – Interpreters are aware of their own body language and avoid facial expressions indicating opinion or judgement.
- Mode of interpreting – Healthcare interpreters work predominantly in the consecutive mode (with the exception of Auslan interpreters). This means that they wait for the person to finish speaking before reformulating the message in the target language. Some interpreters take notes to aid their memory. In some medical settings however, simultaneous interpreting is required, i.e. the interpreter interprets at the same time as the client is speaking. This mainly occurs in specialist areas such as mental health, counselling, or speech pathology when the client's speech is disturbed (see section 5).

3.2.2 Managing communication breakdowns

Interpreters play a role in discourse management and ensure that the communication flow is conducive to accurate interpretation. This includes managing the pace of communication, turn taking and overlapping speech. Specific strategies for managing communication are outlined in section 4.3.2

3.2.3 Providing cultural information

Interpreters have a role in bridging the cultural as well as the linguistic gap between clients and can offer insights into cultural aspects relevant to the treatment of individual patients. However, limitations apply and careful consideration is required in relation to when and how cultural information can be provided. Interpreters do not act as cultural brokers and take great care to avoid stereotyping. They generally provide cultural information at the healthcare provider's request or when the cultural gap is affecting communication during an interpreting assignment. Healthcare providers are encouraged to ask patients direct questions regarding any matters that they view as needing clarification, thus enabling patients to provide the information relevant to them as unique individuals.

Cultural issues are sometimes discussed prior to or following an interpreting assignment as initiated by the healthcare provider or by the interpreter. Occasionally in the course of an assignment cultural issues arise that may affect the communication process or even the patient's diagnosis and/or treatment. Examples include superstitions and religious references in mental health. In such cases, the interpreter asks the patient's permission to explain cultural references and makes the health professional aware of the issue, and all parties are kept informed about what is being said.

It is important for the interpreter and the healthcare provider to be mindful of variations in cultural practices within the same ethnic group due to factors such as: educational background, religion, traumatic experience in the country of origin or during migration, different experiences of the healthcare system, living conditions, etc. Interpreters accept that every client is an individual and are careful to avoid stereotyping, giving advice or volunteering unnecessary information.

The following phrase is a good way to introduce cultural information:

“It is possible that some people who come from this country may have these beliefs...” Interpreter statements beginning with “in my culture...” are generally unhelpful.

3.2.4 Interpreting procedures

The NSW Health Standard Procedures for Working with Health Care Interpreters-PD2006_053 (NSW Health, 2006) describe a number of specific procedures that healthcare interpreters follow in the course of their assignments. These include completion of patient medical records, consent procedures, completion of forms/questionnaires for patients and sight translating. This section describes the expectations of healthcare interpreters in respect of the above procedures. It also describes the safety procedures when interpreting in patients' homes.

3.2.4.1 Completion of patient medical records

Healthcare interpreters working in NSW Health facilities are required to sign and date the patient medical record in order to document their attendance at the interview.

When hard copy records are available, interpreters place an INTERPRETER sticker on the file and write a statement indicating the nature of the service provided after each session. The space for interpreters to write in is often limited. Wherever practicable, it is recommended that interpreters include the following information:

- Date and time of appointment
- Name and title of health care provider
- Reason for appointment (e.g. consent for surgery, birth, etc.)
- Name and signature of interpreter.

Occasionally, healthcare interpreters may be asked to enter this information on computerised systems or the healthcare provider may record the interpreters' presence in the electronic file on their behalf.

In case of phone interpreting, the health professional is required to note in the patient's file that the interview was interpreted over the telephone and may ask the interpreter's name for the record. As not all healthcare providers are aware of this requirement, it is good practice for the interpreter to state their name at the conclusion of a phone interpreting assignment so that it can be documented in the file.

3.2.4.2 Consent procedures

Strict guidelines apply to interpreting for healthcare providers obtaining patient consent for surgery, treatment or research. Interpreters observe the following procedures:

- The information provided by the healthcare provider and the patient's responses are interpreted.
- The healthcare provider reads the consent form to the patient and the interpreter interprets.
- If the healthcare provider requests it or has not read the consent to the patient, the consent is sight translated into the patient's language. The healthcare provider remains present during the sight translation process in order to answer questions from the patient.
- When the patient appears not to understand what is being said, the interpreter is required to inform the healthcare provider so that further explanations can be provided.
- The interpreter dates, signs and places an interpreter sticker in the designated area on the consent form once the consent form has been explained, interpreted and signed by the patient.
- If the consent form was sight translated, the interpreter includes a note that states "the form has been sight translated for the patient/client in the presence of a healthcare provider".
- In addition, the interpreter dates, signs and places the sticker in the patient's file together with a brief statement.
- If the patient refuses to sign the consent form, the interpreter does not sign it, and

notes this fact in the patient's file. (Example: Interpreted for Dr. X, appendectomy procedure explained to patient, patient did not sign the consent.)

- Some consultations prior to an operation take place in private specialist rooms where the consent is signed with the help of family members, while the surgery is performed at a public hospital. The consent has to be read out again and interpreted to the patient before a healthcare interpreter can sign it.

3.2.4.3 Completion of forms/questionnaires for patients

Many CALD patients are not able to read health related forms/questionnaires and/or to write their answers down in the English language. Some may be illiterate in their own language. However, interpreters do not fill out forms or questionnaires on behalf of the patient (NSW Health, 2006). Healthcare providers are therefore required to read the questions to the patient and the interpreter interprets them. Health staff may also be required to complete the form according to the patient's answers as conveyed by the interpreter.

Some healthcare providers may require further education on form completion with interpreters as this procedure has not been consistently implemented across all NSW Health facilities. Interpreters who experience difficulty in this area of practice are encouraged to consult with their HCIS team leaders.

3.2.4.4 Sight translations

Sight translation is "a transposition of a message written in one language into a message delivered orally in another language" (Lambert, 2004, p. 298). Healthcare interpreters provide sight translations of information written in English or other languages which are essential to the health care of an individual patient in the course of the interpreting assignments, e.g. consent forms, medical instructions or letters related to the patient's medical history. Sight translations take place in the presence of a healthcare provider.

Long and technically complex documents usually require extra time and resources, and therefore may not be suitable to be sight translated. Interpreters who are concerned about the length or technical nature of the document presented for sight translation can discuss the matter with the health care provider. Such documents may need to be referred for a written translation to a translation service or unit.

3.2.4.5 Home visits

Sometimes healthcare providers visit the patient at home and may require the assistance of an interpreter. The issues to consider when interpreting at a patient/client's private residence are the safety of the interpreter, the unpredictable nature of the situation, and

the environment. There is a tacit expectation that the health professional who organised the visit is responsible for informing the accompanying staff of any safety concerns. However, interpreters need to assume a degree of autonomy in taking steps to ensure their own safety and the safety of others in some situations.

The Work Health and Safety (WH&S) Policy prevents interpreters from entering the patient's residence without the healthcare provider. It is very important that all staff wear their ID badges and wait for each other outside before entering the client's home unless other arrangements have been made and stated when the booking is arranged. In the event of a healthcare provider not turning up, the interpreter rings the Interpreter Service and seeks further instructions.



Despite the above safety rules and precautions, interpreters need to be proactive in ensuring their own safety and exercise assertiveness in politely declining some suggestions from healthcare providers that may be unsafe. For example, when a patient refused to let the team enter the house, one healthcare provider asked the interpreter to put her foot in the door, which the patient had opened slightly, and to talk the client into agreeing to let the team in. The patient had a hot cup of coffee in his hand, splashed the hot drink onto interpreter's arms and closed the door. The interpreter suffered second degree burns to her forearms.

3.3 After the interpreting assignment

3.3.1 Debriefing

Debriefing with the health professional after an assignment is desirable and includes:

- Cultural issues
- Residual interpreting matters
- Assessment issues
- Lexical/grammatical/speech errors in speech pathology and neuropsychology.

It is also an opportunity for the interpreter to vent his/her feelings if needed. Interpreters can raise the need for debriefing even when it is not offered if they are emotionally affected by an interpreting assignment. Additional strategies for coping with the emotional impact of some assignments are offered in section 4.3.3.

3.4 Telephone Interpreting

Healthcare interpreters are often required to interpret over the telephone. Phone interpreting assignments in health are not usually pre-booked but requested as the need arises. This usually happens when a patient is in the doctor's surgery and a face-to-face interpreter has not been booked. Healthcare professionals and support staff also occasionally contact patients at home to discuss various aspects of treatment.

Specific procedures and protocols for telephone interpreting may differ from one HCIS to another. For example, in some HCIS all phone interpreting calls originate from and are coordinated by the booking office/call centre in a conference call. Others may pre-book some calls, and the healthcare provider calls the interpreter at the pre-arranged time. Interpreters apply the norms and processes determined by the HCIS they are interpreting for.

In general, telephone interpreting involves many of the skills and strategies outlined in the previous section. However, it is marked by the absence of the visual cues of face-to-face interpreting encounters. A range of useful strategies are outlined below that interpreters can choose from when dealing with phone interpreting demands. These are applicable in all NSW HCIS.

3.4.1 Phone interpreting briefing and introductions

Briefing before a phone interpreting assignment can alleviate many potential challenges. If the healthcare provider does not volunteer any briefing, interpreters are encouraged to request it. For example, when the doctor and the patient are in separate locations, the interpreter has the opportunity to ask for briefing before the patient is connected.

The health provider sets the context and introduces the participants. It is good practice for all the participants present to clearly identify themselves.

It is useful practice for the interpreter to establish the rules of communication and ensure that everyone can hear and understand each other. This enables ensuring that the patient and interpreter speak the same language before commencing interpretation in case the dialect has been mismatched. Following the above checks, the interpreter is able to confirm that she/he and the client understand each other and give the 'go ahead'.

3.4.2 The phone interview – dealing with specific challenges

Phone interpreting deprives interpreters of visual cues. Health providers can make up for this by explaining what is happening. For example, they can explain that they are writing and will be silent for a while (Wadensjö, 1999). Interpreters are encouraged to ask for clarification when there is no context or briefing.

3.4.2.1 Phone interpreting techniques

Efficient note-taking skills are useful when interpreting over the phone. It is good practice to have a notepad and a pen ready when accepting telephone interpreting assignments.

3.4.2.2 Use of direct speech (1st person) in phone interpreting

Similarly to face-to-face interpreting, direct speech (1st person interpreting) is the expected standard. However, when interpreting for more than one speaker in one language over the phone, use of the first person may at times create confusion as to who is talking. In order to minimise the confusion, interpreters can explicitly identify the speaker and then interpret in the first person. Occasionally, interpreters resort to interpreting some segments in the 3rd person for the sake of clarity.

3.4.2.3 Privacy issues

Interpreters are sometimes called to interpret over the phone when they are in a public place. However, due to confidentiality concerns, interpreting cannot go ahead over the phone where the public can hear. When faced with this challenge, interpreters have the choice to decline the job or move to a private area if possible.

3.4.2.4 Communication management

In phone interpreting encounters, service providers have less control over the communication process than in face-to-face, e.g. they have less capacity to interrupt the patient. Therefore, the interpreter takes on more of the communication management role. The following strategies may be helpful in managing the communication process:

- When there are many people present and they were not clearly identified at the beginning, interpreters ask the participants to identify themselves.
- When healthcare providers or patients speak continuously without stopping or talk at the same time (overlapping speech), the interpreter re-establishes the rules of communication and asks the speakers to speak one at a time and pause for the interpreter.

- When the patient and a relative are having a side conversation, the doctor takes the initiative to explain the situation or the interpreter asks for clarification of what is happening.
- When the patient's relatives speak English, the interpreter clarifies/negotiates what is to be interpreted or asks the service provider to summarise what has been said.

In mental health inquiries/tribunal hearings when the patient speaks some English, the interpreter is sometimes asked to periodically summarise the discussion between a number of English speaking participants instead of interpreting everything throughout the hearing. It is a useful strategy to ask a tribunal member to summarise what has been said and interpret the summary.

3.4.2.5 Silence, low speakers and other related demands

Silence is usually a sign of a problem. Interpreters can ask what is happening during a prolonged period of silence.

Sometimes the patient fails to respond. In this scenario, the interpreter can choose from the following strategies: raise his/her voice, inform the doctor, try again/repeat and then inform the patient that s/he is going to hang up.

When the patient speaks in a barely audible voice, the interpreter can ask him/her to speak louder. However, in some situations the patient may not be able to speak up and therefore the interview may need to be rescheduled with a face-to-face interpreter. Examples include some mental health interviews and counselling sessions involving issues of shame, depression, etc. In addition, clients with hearing impairment may not be able to be interpreted for over the telephone.

3.4.2.6 Technology issues

It is useful practice for interpreters to ask about the technology used at the other end. Speaker phones or dual headsets are preferable as they allow for smoother communication.

When an ordinary phone is used, some patients find it difficult to understand that the phone has to be passed to the doctor when they have finished speaking. Interpreters ask the patient to pass the phone back to the service provider. However, this request may need to be repeated in a number of different ways. It may be helpful for the interpreter to add "I'll come back to you" to reassure the patient that she/he will get another chance at speaking.

When reception is bad or the line drops, interpreters need to call the booking office/call centre for further instructions.

3.4.2.7 Time restrictions

Telephone interpreting assignments are booked for a specified period of time and interpreters frequently have other professional engagements afterwards. It is useful practice for interpreters to clearly specify the time limits and give a warning about the time running out.

It is important to acknowledge that the nature of a medical interpreter's work is unpredictable. Emergencies and serious medical conditions are often interpreted over the telephone. When a phone assignment has run over the booked time, there is room for interpreter discretion in terms of setting priorities depending on the nature of the subsequent appointment.

At the same time, appointments running over time, whether face-to-face or over the telephone, can be a challenge for interpreters and cause fatigue and stress. Interpreters can ask for a break if the level of fatigue is affecting their concentration and ability to interpret accurately.

3.4.2.8 Interpreting consent for surgery over the phone

Interpreters are sometimes required to assist with signing consent for surgery or treatment over the telephone. Best practice in this scenario is for the doctor to read the consent and for the interpreter to interpret.

3.4.3 Closing an interpreted telephone interview

Proper closure is required for telephone interpreting. Before hanging up, interpreters ensure that the interview is terminated and state their name so that the healthcare provider can document it in the patient's file.

Similarly to face-to-face interpreting, interpreters who have dealt with a particularly challenging or traumatic phone assignment are encouraged to seek post-assignment debriefing. Interpreter Coordinators are available for debriefing and are able to refer interpreters to professional counselling services if required.

3.5 Group Interpreting

From time to time healthcare interpreters are engaged to interpret at health education sessions delivered to a group of CALD patients. Topics may include antenatal classes, diabetes and diet, cancer, disease prevention, quitting smoking, etc. At some group interpreting sessions, most participants speak English and the interpreter interprets for one patient only. One example is an antenatal class where most participants speak English and the interpreter is interpreting for one client who does not.

Interpreting techniques used in a group talk are different from those used in a medical interview as the purpose of the session is different. In a medical interview,

the purpose is exploring the symptoms, making a diagnosis and deciding on the treatment. It is essential for the patient and the healthcare provider to build a rapport. The purpose of a group interpreting session, on the other hand, is to educate or inform the audience.

It is important to balance professional roles well in a group interpreting session. The role of the interpreter is to stay sufficiently in the background for the audience to understand that the English speaker is the presenter. At the same time, the interpreter needs to use effective presentation techniques such as voice projection and eye contact in order to enable the presenter to engage the audience.

3.5.1 Group interpreting preparation and briefing

In the group interpreting setting, it is particularly important for the interpreter to prepare thoroughly for the assignment. Interpreters who study the topic and ensure thorough understanding of the terminology and concepts are able to interpret fluently and confidently in front of an audience. It is helpful to research the topic and prepare a glossary of terms. The amount of preparation will depend on the complexity and the interpreter's familiarity with the topic.

NSW Health Care Interpreter Services request that group talk facilitators send their presentation to the interpreter to allow him/her to prepare. At the same time, interpreters are encouraged to take a proactive approach and obtain materials from the presenter if they have not been provided for them by the Interpreter Service.

On the day of the session, it is important for the interpreter to brief with the presenter and discuss the target audience, appropriate register, communication management, terminology issues and interpreting techniques, and to negotiate the length of segments to be interpreted. For example, the interpreter may agree with the presenter to pause and interpret after each concept.

3.5.2 Group interpreting techniques

Group interpreting requires the interpreter to have sound public speaking skills. The interpreting techniques used include short passage consecutive with noting down names, figures and lists or long passage consecutive with note taking. Some interpreters practise short passage consecutive interpreting without notes. Group interpreting sessions, where most participants speak English and the interpreter interprets for one patient only, involve whispering/simultaneous interpreting.

Group interpreting differs from interpreting for individual clients in relation to interpreter positioning and eye contact. In a group session, the interpreter stands at the front of the room, faces the audience and maintains eye contact with them. It is easier for the audience to follow the presentation if they can observe the interpreter's body language and lips. The interpreter's voice also carries better across the room when they are facing the audience.

Presentations tend to flow well with short and meaningful segments for interpretation as it helps maintain the audience's attention. An audience that does not understand English is likely to switch off with longer uninterrupted segments in English. However, if the segments are too short, e.g. 2 – 3 words, the message can get lost. Working with the presenter as a team is crucial in group interpreting. It is helpful to watch the presenter's body language for clues on when to start interpreting. When PowerPoint is used, the end of a slide may be a good point to start interpreting as the slide is still on the screen to prompt the interpreter's memory.

Taking notes may be helpful in aiding the interpreter's memory. Note taking will help with numbers, lists and names if the presenter is not using visuals/handouts and when the segments are too long to remember and interpret accurately.

In terms of interpreting delivery, the following aspects are particularly important in group interpreting:

- Fluency and speed;
- Accuracy in conveying paralinguistic features, e.g. stress, intonation, body language;
- Voice quality, good projection and clear enunciation – interpreters are expressive within the limits of the original speech as monotone can cause the audience to tune out;
- Posture and gestures – interpreters use body language appropriately. They maintain good posture and are aware of their gesturing. Moving around and waving hands excessively distracts the audience. Putting your hands in your pockets, on the other hand, appears disrespectful.

3.5.3 Communication management in group interpreting

The presenter plays the primary role in managing the audience. However, when things get out of hand and it becomes difficult to maintain accuracy, the interpreter may need to interrupt the session and re-establish the rules of communication if the presenter does not take the initiative. The interpreter alerts the presenter if she/he has not had the chance to interpret everything. The participants and the presenter will need to pause and allow the interpreter to finish before the session resumes.

Questions from the audience can be a challenge in group interpreting if they are not managed appropriately. It is helpful to agree with the presenter prior to the session on how they are going to be handled. Ideally questions are held until the end. Problems may arise when some members of the audience understand English and ask questions before the interpreter gets the chance to interpret the preceding presentation segment. Interpreters bring this to the attention of the presenter and ensure that everything is interpreted before the question can be answered.



4. Ethical challenges and strategies for interpreters in the medical setting

As described in section 2 on the healthcare interpreting setting, healthcare interpreters face a number of challenges in their professional practice. This section describes the challenges in more detail and offers some practical strategies for resolving them.

4.1 Challenges/demands reported by NSW healthcare interpreters

As outlined in section 2.7.2, interpersonal challenges are mostly reported by NSW HCIS interpreters followed by the intrapersonal demands.

Linguistic demands and environmental challenges tend to be reported less frequently. Healthcare interpreters undoubtedly experience these demands. However, they do not appear to be a major challenge for experienced interpreters who are fluent in medical terminology. It is therefore essential that interpreters who practise in the medical setting complete an approved medical terminology course and develop healthcare glossaries and strategies for dealing with new/unknown terminology, as well as preparing for all assignments.

Interpersonal demands reported by healthcare interpreters are mostly related to settings where more than one patient and/or healthcare provider are present, e.g. family conferences and mental health hearings. Challenges also frequently occur when interpersonal dynamics between the clients create pressures on the interpreter to act outside the strict boundaries of their professional role and/or the Code of Ethics.

Interpreting for multiple clients who share a common language, i.e. a number of English-speaking healthcare providers or relatives of the patient, leads to discourse management challenges for interpreters as clients who speak the same language tend to communicate directly with each other. This often results in one party being left out of the communication and puts pressure on the interpreter to interpret simultaneously or to manage turn-taking.

Other communication management challenges include:

- Communication directed at the interpreter, e.g. a patient asking an interpreter direct and personal questions in the presence of a healthcare provider;
- A patient with limited English attempting to communicate directly with the healthcare provider.

Challenges related to interpersonal dynamics that create pressures on the interpreter to act outside the Code of Ethics include:

1. Clients who are unfamiliar with the interpreter's role asking interpreters to perform tasks outside the role boundaries, e.g.:

- Healthcare providers asking interpreters to pass information to patients or persuade them to consent to treatment outside the medical interview;
- Patients asking interpreters not to interpret certain information, to take their side, or relatives asking interpreters about what happened during a clinical consultation.

2. Health/life-threatening situations – maintaining impartiality and confidentiality when the interpreter becomes aware of information not known to the treating healthcare provider, e.g.:

- Suspected elderly or child abuse, suicidal intentions, hearing voices, breaking fasting prior to operation, allergy to medication.

3. Prior knowledge of patient history and maintaining professional detachment or confidentiality, e.g.:

- Clients not understanding information from previous assignments, clients telling untruths.

4. Status and authority dynamics, e.g.:

- Temptation to explain to the patient directly, rather than alerting the health professional, when patients appear not to understand a procedure or treatment.

It is important to acknowledge that interpreters are at times affected by what they are required to interpret. Some patients or circumstances in particular may strike a vulnerable cord depending on the interpreter's background, beliefs and experiences. Intrapersonal challenges reported by healthcare interpreters include emotional and safety concerns as follows:

1. Emotional impact

- Conveying terminal illness diagnosis;
- Children's hospital appointments;
- Grief and loss, victims of abuse and torture.

2. Safety concerns

- Some mental health appointments;
- Aggressive patients and relatives/partners;
- Home visits.



Repeated exposure to traumatic events can lead to occupational stress or even vicarious trauma (Bontempo & Malcolm, 2012). It is important for interpreters to be able to acknowledge emotive reactions, recognise signs of stress, develop positive coping strategies and seek help when necessary.

4.2 Resolving ethical dilemmas and other professional challenges

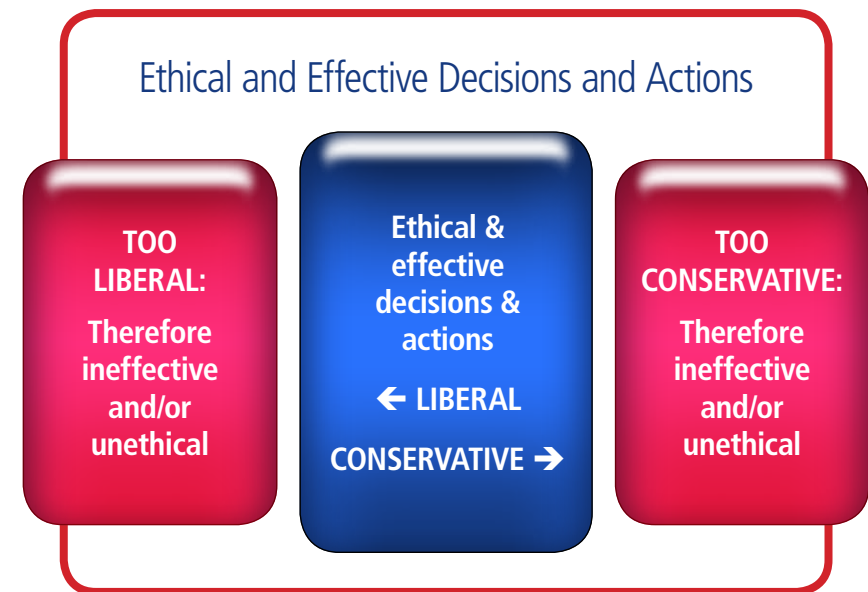
Many ethical and other professional practice challenges can be easily resolved by consulting the AUSIT/ASLIA Codes of Ethics, the NSW Health Code of Conduct or the NSW Health Standard Procedures for Working with Health Care Interpreters – PD2006_053. It is essential for interpreters to be well acquainted with the Code of Ethics (AUSIT or ASLIA as appropriate) as it is the first point of reference for dealing with professional dilemmas and guides interpreters in making professional decisions.

However, true ethical dilemmas involve complex decision-making processes and choosing between two or more possible courses of action. Consulting the Code of Ethics or the Code of Conduct does not always provide specific meaningful guidance. Therefore, it is also important for healthcare interpreters to understand their role with its limitations, to be well equipped with strategies to effectively deal with professional demands and to have sound problem-solving and decision-making skills.

Literature on community interpreting offers some models that may be helpful in analysing dilemmas, such as the Five step model for decision making (Fenton, 1988, in Napier et al, 2010). This model recommends the following procedure:

1. Define the problem
2. List the options for interpreter action
3. Visualise the consequences of each option
4. Act according to the option which gives the best match between professional ethics and personal ethics
5. Evaluate the decision.

It is important to understand that in some situations there is no one easy solution and a range of solutions may be applied. The Demand Control-Schema practice profession model of ethical reasoning (Dean & Pollard, 2005, p. 270) below is a graphic representation of the range of ethical and effective decisions and actions. Some decisions are outside the acceptable range as too liberal or too conservative and therefore ineffective.



The following sections describe some professional challenges in the medical setting and a range of possible solutions.

4.3 Strategies for resolving interpreting challenges

4.3.1 General strategies

Interpreters can anticipate and prevent many potential workplace problems. Preventative tactics can be classified into three categories: before, during and after the assignment. Some general proactive strategies are summarised below.

Pre-assignment controls:

Many challenges can be prevented from occurring with the following strategies:

- Preparing for assignments and developing glossaries;
- Educating clients about the role of the interpreter (see point 3.1.1);
- Maintaining professional distance, for example by avoiding waiting with the patient before the assignment (see point 3.1.2);
- Briefing with health professional before assignment (see point 3.1.3);
- Attending professional development workshops.

In preparing for assignments, it is good practice to consider the following specific questions:

- How to get to the location of the assignment and how long it takes to get there;
- Where interpreters can park;
- Who are the clients;
- What is the subject matter;
- What is the terminology in both languages;
- What preparation is required in terms of the concepts and terminology;
- What is the expected duration.

During-assignment controls:

Communication-related challenges arising during an assignment can be effectively prevented or dealt with using the following strategies:

- Introductions including explanation of interpreter role;
- Asking for clarification and clarifying misunderstandings;
- Managing communication when ordered turn-taking is not observed and overlapping speech occurs (see point 4.3.2);

- Whispering/simultaneous interpreting when a number of participants share a common language in order to keep all parties linguistically present;
- Strategically raising a concern when the patient appears not to understand;
- Remaining detached and interpreting everything – remembering that the interpreter is not the author of the utterances.

Post-assignment controls:

Interpreters are encouraged to continually aim to improve their practice in order to be able to deal more effectively with linguistic, ethical and role challenges by:

- Seeking guidance from HCIS Managers or team leaders when in doubt about the best course of action;
- Debriefing with and seeking feedback from healthcare professionals;
- Reflecting on professional practice and keeping a journal;
- Developing a personal toolbox of useful strategies.

4.3.2 Communication management strategies

4.3.2.1 Managing communication in multi-party interviews

During family conferences, in particular, interpreters may be required to manage the flow of communication. Typically in a family conference there are a number of healthcare providers and family members present. The English-speaking participants may talk at the same time, forget about the presence of the interpreter and make accurate interpretation for the patient challenging. Such circumstances raise concerns regarding interpreting quality. When multiple parties talk at the same time, the practical strategies available to the interpreter are:

- Verbally or non-verbally stopping the speakers and re-establishing the rules of communication;
- Holding a segment in memory if possible;
- Offering a turn to primary speakers;
- Ignoring some turns completely or momentarily in particularly challenging encounters (Roy, 2000).

Interpreters may need to decline the assignment when they are concerned about the quality of interpretation.

4.3.2.2 Communication directed at the interpreter

Patients are often interested in the interpreter and may ask personal questions relating to their place of birth, residence, marital status, earnings, religion and so on. Interpreters can avoid these questions by sitting in a separate waiting area prior to the interpreting assignment as described in point 3.1.2. However, sometimes patients direct questions of personal or other nature to the interpreter in the middle of a medical interview.

The following strategies are available to the interpreter in this situation:

- Providing a minimal response;
- Providing a longer response including an explanation of the interpreter role (Metzger, 2000 and 2005).

The above are the preferred strategies provided that the exchange is interpreted to the healthcare provider for the sake of accuracy and transparency.

The following strategies are also available, although not recommended in the health setting:

- Interpreting the question in the first person as if it was not intended for the interpreter;
- Ignoring the question (Metzger, 2000 and 2005).

Interpreting the question to the healthcare provider as if it were not directed to the interpreter is likely to create confusion.

Healthcare providers may also direct communication to the interpreter at times and the above strategies apply when this happens. It is particularly important to interpret all communication spoken in English into the patient's language. Patients tend to become anxious when the healthcare provider and the interpreter speak in English in front of them without interpreting what has been said. They are very likely to imagine that the conversation is related to their condition and may contain bad news.

4.3.2.3 Relay interpreting

Occasionally an incorrect dialect is booked and the interpreter is asked to assist in relay interpreting through a patient's relative. The recommended strategy is for the interpreter to decline the assignment and suggest that an appropriate interpreter be booked. In case of very rare dialects where no interpreters are available, the interpreter may proceed with relay interpreting after explaining accuracy considerations to the healthcare provider. The interpreter then makes a note in the patient's file stating that relay interpreting through a relative was performed.

4.3.3 Self-care strategies

The conference interpreting view of interpreters as mere translating machines has been long discarded in relation to the medical setting. Healthcare interpreters are humans as well as professionals doing their job and therefore are bound to be emotionally impacted by some assignments. Strategies for coping with intrapersonal demands on the organisational and personal levels are outlined below.

4.3.3.1 Organisational support

Following a particularly stressful assignment, e.g. in STARTS appointments or interpreting for terminally ill patients, etc., staff and contract/sessional interpreters have the following support mechanisms available to them:

- Debriefing with healthcare provider, colleague, team leader or a staff/Employee Assistance Program counsellor;
- Communicating with the immediate supervisor/manager to discuss further strategies after a particularly stressful case.

Interpreters are encouraged to recognise signs of stress and seek debriefing. It is a helpful self-care management strategy and not a sign of lack of professionalism or weakness.

4.3.3.2 Personal coping strategies

In order to cope effectively with the emotional strain of interpreting, interpreters are encouraged to develop their own positive action-oriented strategies. The following suggestions may be helpful (Bontempo & Malcolm, 2012):

- Self-care including: recreational activities (movies, concerts), spiritual practices, physical activities (massages, gardening, exercise);
- Peer/social support;
- Engaging in hobbies;
- Cognitive restructuring/reframing;
- Sharing feelings/debriefing;
- Journalling;
- Meditation, yoga.

A useful preventive tactic is developing a self-care plan that includes taking care of physical and emotional health, social, spiritual and financial needs.

4.4 Strategies for dealing with interpersonal demands with ethical implications

This section describes a range of strategies for dealing with specific ethical challenges and dilemmas in the healthcare setting.

4.4.1 Maintaining confidentiality

Interpreters are bound by confidentiality in all interpreting assignments unless mandated by law such as in the case of suspected child abuse (AUSIT, 2012). Confidentiality extends to the information exchanged with patients before, during and after the assignment.

However, the AUSIT Code of Ethics attributes special considerations to specific institutional settings such as healthcare. It states that in settings where duty of care regulates “the behaviour of all participants, such as health care (...), interpreters follow the relevant policies and procedures combining them with their interpreting code of ethics” (AUSIT, 2012, p. 29).

An example of applying the Code of Ethics in combination with the relevant policy is maintaining confidentiality in life-threatening situations. This may occur when a patient discloses to the interpreter in the waiting area that s/he is going to harm him/herself or others but does not share this intention with the treating healthcare provider.

In relation to patient suicide intentions, NSW Health employees have reporting responsibilities outlined in policy directive: PD2005_121 Suicidal Behaviour – Management of Patients with Possible Suicidal Behaviour, which requires them to raise concerns with the clinician responsible for the treatment of the patient. The policy says: “If any staff member in contact with a patient with possible suicidal behaviour does not personally provide services for the patient, the staff member should contact the appropriate team, service or clinician, and formally transfer ongoing responsibility for the patient” (NSW Health, 2005b, p. 5).

Strategies available to the interpreter in potentially life-threatening situations for the patient are:

- Waiting separately from the patient prior to assignments in order to avoid such dilemmas (refer to point 3.1.2 for more information);
- Recommending that the patient discuss his/her feelings or intentions with the healthcare provider. In cases of intended suicide, interpreters inform the patient of their obligation to disclose suicidal intentions to the clinician if the patient chooses not to do so.

- Requesting briefing with the healthcare provider to raise concern prior to the assignment;
- Raising concern about patient intentions during the assignment, if the patient does not volunteer the information;
- Debriefing with the health professional immediately after the assignment;
- Debriefing with HCIS team leader or manager in the case of concerns about potential harm to the patient or others. The manager may refer the interpreter to EAP counselling if appropriate and/or make a follow-up phone call to the healthcare professional.

4.4.2 Maintaining impartiality

Interpreters practise professional detachment and observe impartiality in the course of their work. They remain unbiased, convey the full intent of the communication and do not take responsibility for the content of the source messages (AUSIT, 2012).

Although the impartiality tenet appears clear in principle, it can be challenged in the medical environment as healthcare interpreters follow some patients over many years in a variety of clinical settings. They often become quite familiar with the patient’s medical condition and remember health information from previous assignments. This can create ethical dilemmas as demonstrated in the following examples.

A) Patient gives an answer that is in conflict with his/her medical history

AUSIT Code of Ethics clearly requires interpreters to convey untruths “in the same manner as presented” (AUSIT, 2012, p. 27) without any judgement or bias. However, healthcare interpreters may face dilemmas when they have prior knowledge of the patient’s medical history and the patient makes a statement that is in conflict with their history. For example, a client who is allergic to penicillin may say that he is not when he is about to be prescribed this medication. The interpreter may realise the mistake if he/she has been interpreting for the client at other medical appointments.

Primarily, it is the duty of care of the treating professional to ask additional questions and/or check the patient’s file, e.g. for known allergies as they are flagged in patient files. Patients in all doctor-patient encounters, including the monolingual, can make mistakes and tell untruths. They have the right to decide what they say and are responsible for the messages they choose to convey. In addition, interpreters cannot be certain that they remember the facts correctly.

However, conveying untruths impartially when they can have an impact on the patient's health may sit very uncomfortably with the interpreter. It is therefore important to make sure that the patient has heard correctly and understood the question. The strategies available to the interpreter in this scenario are:

- Asking the health professional's permission to repeat the question in order to ensure accurate communication;
- Debriefing with healthcare providers, HCIS team leaders or managers in cases of concerns about potential harm to the patient.

B) Situations that challenge interpreters' moral beliefs

Interpreters are bound by impartiality and do not "allow bias to influence their performance" (AUSIT, 2012, p. 11). However, some assignments can challenge interpreter impartiality due to personal experience or beliefs. Therefore, interpreters have the option not to accept or to withdraw from assignments in which impartiality may be difficult to maintain (AUSIT, 2012). Interpreting at an abortion clinic is an example of a medical setting that can challenge interpreters with strong moral beliefs related to termination of pregnancy or who have lost a child or are unable to conceive.

The strategies available to the interpreter in these situations are:

- Declining assignments in settings that can create impartiality conflicts if known at the time of the booking;
- Completing the assignment without allowing prejudice to interfere with professionalism when a controversial issue comes up in the course of the assignment;
- Avoiding discussions of personal beliefs with patients;
- Withdrawing from the assignment if impartiality cannot be maintained and professionalism is threatened.

4.4.3 Maintaining accuracy

Interpreters are bound to maintain accuracy in content and intent (AUSIT, 2012). Accuracy means conveying everything that is said by the parties present in the consultation room, not just what the healthcare provider and the patient say to each other. It includes interpreting side conversations between patients and their relatives/friends, or between two or more healthcare providers. When a client makes a side comment and asks the

interpreter not to interpret it, accuracy generally requires the interpreter to interpret both the comment and the request not to interpret it into the other language. The interpreter may choose to explain his/her role to the clients when this situation occurs.

Sometimes interpreting conversations between two healthcare providers to the patient may be challenging for the interpreter. This happens when they are using highly technical language that the interpreter is unable to follow despite his/her knowledge of medical terminology and is therefore unable to interpret accurately. A useful strategy is to inform the patient of this difficulty and interpret to the best of one's ability. The healthcare providers usually summarise their discussion in simpler terms to the patient and the interpreter interprets the summary.

In addition, interpreting without distortion or omission and not softening "the force of the message conveyed or language used" (AUSIT, 2012, p. 27) means faithfully conveying derogatory remarks and swearwords. These are all an important part of the message and may be relevant for the diagnosis and treatment. Developing glossaries of swearwords and practising saying them in private may be a useful strategy for interpreters who are not comfortable with swearing.

4.4.3.1 Maintaining register

Register is the stylistic level of language and it changes depending on the level of formality, familiarity between participants and the use of specialised jargon (Napier et al, 2010).

Accurate interpretation extends to maintaining register, including in circumstances where the terminology used by the healthcare provider is too technical and the patient is likely not to understand the message. When the register is altered by the interpreter, a wrong message is sent to the parties about the level of communication.

The onus is on healthcare providers to speak in plain language and adjust their register to that of the patient in the course of the consultation. It is also the doctor's role to explain unfamiliar terms to the patient and to check whether the patient understands. It is a very useful communication strategy for healthcare providers to ask the patient to repeat what has been said in their own language. In addition, patients who do not understand what is being said are expected to ask questions, which in reality does not always happen as outlined in point 4.4.3.2.



Strategies available to the interpreter are:

- Educating patients on working with interpreters and encouraging their independence – interpreters can suggest that patients ask questions when they do not understand what is being said;
- Maintaining professional development and expanding one's knowledge of medical terminology in order to be able to interpret accurately at different register levels – interpreters work towards maintaining register;
- Alerting the healthcare professional when the interpreter is not familiar with a term so that the register can be lowered appropriately.

Some languages lack the medical technical register, e.g. Auslan and many African languages. Interpreters in these languages have no access to equivalent terminology. It may be helpful to discuss this issue with the healthcare provider and make a joint decision on the register level and vocabulary choices in the source and the target language.

Further strategies for interpreters in situations where the patient does not understand the message are outlined in the following section.

4.4.3.2 Patient appears to lack understanding

Healthcare interpreters are occasionally faced with a dilemma when the patient appears not to understand what is being communicated but does not ask for clarification, and the healthcare provider does not notice the confusion. For example, certain medical terms such as 'fasting' may be misunderstood by the patient and require clarification.

Although healthcare providers are trained to observe the patient's body language and to check for understanding, they sometimes fail to recognise signs of incomprehension. Patients, on the other hand, often do not ask questions when they do not understand the message for fear of losing face or out of respect for the healthcare provider. This is a

challenging situation as the interpreter can never be certain that the patient has failed to understand the message and strives to avoid patronising the patient.

From the interpreter's perspective, it is important that the communication process is clear for both parties. The strategies available to the interpreter are:

- Asking the doctor to repeat in order to ensure correct interpretation and avoid embarrassing the patient;
- Clarifying whether the patient has understood the message with the health professional's permission, in a manner that is not patronising to the patient;
- Using the recommended expressions: "[May I] clarify the patient's understanding?", "[...] ensure that I have used the right language?", "[...] ensure that the correct term was used and understood by the patient?";
- Avoiding statements such as "I think the patient did not understand", as they can offend the patient when interpreted.

4.4.3.3 Interpreting patient body language

The patient's body language is visible, largely universal and often obvious to the treating health professional. Therefore, interpreters are not usually required to interpret/voice body language. Interpreters do not assess the congruency of the body language and the message content, e.g. the patient telling a lie.

However, culture specific gestures are interpreted. Also, interpreters may sometimes need to verbalise the patient's body language when the patient is pointing to body parts and the doctor is not looking at them. For example, when the patient is pointing to his right/left knee, the interpreter may be required to verbalise the action. The interpreter also seeks clarification when the patient's body language does not match what they are saying, for example when they point to their right eye and say "left eye".

As outlined in point 4.4.3.2, interpreters can ask for permission from the healthcare provider to clarify the patient's understanding when his/her body language indicates confusion.

5. Interpreting in specialist healthcare areas

Interpreting in specialist medical settings such as speech pathology, mental health and neuropsychology carries specific challenges. The most challenging aspect of interpreting in these areas is psychometric assessment where “incoherence, hesitations and unclear statements are maintained in the interpretation” (AUSIT, 2012, p. 27). In order to interpret successfully in these settings, interpreters require thorough contextual knowledge, an understanding of the purposes of assessment and the ability to work collaboratively with the healthcare provider. The following section includes some background information and specific strategies for interpreters working in these areas.

5.1 Interpreting in speech pathology

Speech therapy deals with deviations from natural language use: stuttering, slurring, unorthodox pronunciation patterns and confusion in syntax (Gentile, Ozolins & Vasilikakos, 1996). In speech pathology assessment, the patient’s speech and language are just as important as the message content. This is considerably different from other healthcare interpreting contexts where interpreting is mainly done to convey the speaker’s message – ‘what they are saying’. Speech pathologists, on the other hand, need to know ‘how things are being said’. This means that the focus of the task has shifted (Clark & Hand, Critical Link Conference, 2007). In speech pathology “diagnosis is based upon a range of verbal, vocal and paralinguistic behaviours that extends far beyond any normal understanding of a message to be passed from one party to another” (Gentile et al, 1996, p125).

Specific challenges for interpreters include:

a) Distorted communication

- The patient’s speech is often severely distorted. For example, in Broca’s aphasia discourse lacks significant grammatical markers, and Wernicke’s aphasia is characterised by seemingly fluent but incoherent and vague discourse.

- This discourse has to be conveyed faithfully in order to allow the therapist to make correct diagnosis based on the exact style of communication (Gentile et al, 1996).

b) Interpreting in assessment and testing

- There is a risk of changing the level of difficulty in translation.
- Translation into another language may miss the point of the test.
- It may be difficult or impossible to create on-the-spot equivalents.

c) Articulation, error analysis and jumps in discourse

Speech pathologists may rely on interpreters to be able to:

- Recognise deviations from the articulation norm and provide the information to the therapist;
- Describe patient’s responses in a form that will help the therapist analyse errors in performance in reading exercises;
- Identify a linguistic feature that has triggered a jump in discourse (Gentile et al, 1996).

Specific interpreting strategies in speech pathology include:

- Collaborating closely with the speech therapist including briefing and debriefing;
- Strategic interruptions (kept to a minimum);
- Learning about the purpose of particular test items;
- Conveying the discourse and style of expression, i.e. rendering into the target language what can be rendered (Gentile et al, 1996);
- Interpreting everything the client says including messages that do not make sense;
- Simultaneous interpreting when appropriate;
- Describing what cannot be rendered, e.g. error patterns in speech and language (Gentile et al, 1996; Clark & Hand, 2007);
- Alerting the therapist to problems with tense, syntax or semantics.

The following practices are unhelpful in speech pathology and may invalidate the assessment. It is particularly important for interpreters NOT to:

- Help the patient understand what is being said or prompt the patient if she/he has difficulty responding;
- Give clues to the client or hints about the ‘correct answer’;
- Give feedback to the patient about his/her performance;
- Polish up incoherent speech/make sense out of nonsense.

5.2 Interpreting in the mental health setting

Interpreting in the mental health setting is one of the most challenging areas in the healthcare interpreter's practice. Mental health clinicians are interested not only in what the patient is saying but also in how they are expressing their thoughts, including affect, intonation, tone of voice, speed, pitch and other prosodic features. Communication in mental health is often characterised by distorted speech patterns, e.g. dysfluency. Clinicians assess, diagnose and treat language dysfluency with the interpreter's assistance in languages that are different from their own (Pollard, 1997). For an interpreted mental health interview to be successful, interpreters must understand the purposes of psychiatric interviewing and therapy sessions, and the role communication plays in them (Gentile et al, 1996).

The role of the interpreter in this setting is to:

- Facilitate direct, clear communication and a rapport between the patient and the clinician;
- Give exact renditions of content and affect, i.e. the patient's feelings/emotions;
- Describe communicative features/aspects of speech that cannot be rendered into English.

Strategies include:

- Simultaneous interpreting;
- Describing communication features in addition to or instead of interpreting;
- Glossing, i.e. translating the individual words and phrases that the interpreter was able to understand without trying to make sense out of them (Pollard, 1997), when the patient's speech is not understandable or logical sentences cannot be constructed.

In the psychiatric setting interpreters DO NOT:

- Check/clarify with the patient what s/he wanted to say in cases of distorted speech/dysfluency;
- 'Clean up' very disturbed language by making understandable translations as this misleads the clinician (Pollard, 1997).

An additional challenge for the interpreter in the psychiatric setting is assisting in assessment using specific tests such as the mini-mental examination. These tests are often culture specific and the level of difficulty for the CALD patient may be increased. It is helpful to discuss assessment tools with the clinician prior to the interview and alert him/her to potential areas of difficulty. These may include different calendars and seasons in different countries as well as the use of proverbs or spelling activities. The clinician and the interpreter can agree on the best strategy to deal with these issues.

5.3 Interpreting in neuropsychology

Neuropsychology is another challenging area of healthcare interpreter practice. Similarly to the psychiatric setting, the interpreter needs to be aware of the format and purpose of assessment tools. The interpreter and the neuropsychologist are required to work closely together towards reliable and valid assessment of the patient.

Neuropsychological assessment investigates changes in thinking and memory in patients who have suffered from brain damage related to an accident or the aging process. It identifies the patient's strengths and difficulties in different cognitive areas. Standardised assessment tools are used in order to reliably compare the client's skills with those of the general population. There are strict instructions for administering and scoring, and any deviation may seriously affect the reliability of the test.

The additional challenge in neuropsychological assessment through an interpreter is that differences in languages may mean that the skill level changes. Examples include sentence structure in fixed word order (e.g. English) versus free word order languages (e.g. Polish) and differences in low/high frequency words across languages. For example, the word aquatic is a low frequency adjective in the English language, which may become a high frequency word when translated into another language. This changes the level of difficulty of the task as recognising a high frequency word is easier for the patient.

In order to achieve the best possible outcome for the client in neuropsychological assessment, interpreters DO:

- Interpret the clinician's information, instructions and feedback as close as possible to the way that they are said;
- Interpret everything the patient says accurately including:
 - A) Comments such as "I don't know what you mean"
 - B) Incorrect or incoherent answers
 - C) Mumbling to him/herself;
- Provide information about aspects of the client's speech that cannot be rendered into English.

When interpreting for neuropsychological assessment, interpreters DO NOT:

- Over-interpret the patient's incoherent response by trying to make sense out of it
- Add extra information;
- Give clues to the patient about the correct response;
- Change the wording without prior agreement with the clinician as it may give more or fewer clues than intended;

- Elaborate/expand on the clinician's spoken information or instructions;
- Make comments on the patient's performance;
- Ask questions about the patient's progress;
- Engage in a conversation with a patient.

The above actions by the interpreter can potentially invalidate the assessment.

Briefing before the session is very useful in this setting. In the briefing, the neuropsychologist may:

- Explain the assessment aims and process;
- Show the interpreter the tests;
- Discuss whether the tests are culturally and linguistically appropriate, e.g. proverbs and general knowledge tests;
- Ask to translate and write down lists of words;
- Ask to translate and write down a story;
- Discuss breaks in longer assessments.

In the post-assessment debriefing, the neuropsychologist may ask the interpreter questions regarding the patient's:

- Language/use of words
- Grammar
- Educational background and literacy
- Difficulties relating to cultural bias in the test.



6. Closing – A word on lifelong learning and consistent standards

In closing, it is important to emphasise that the guidelines do not aim to prescribe specific behaviours or provide an exhaustive list of instructions for dealing with challenging situations. Every situation encountered is different from the one before as the circumstances and the individuals involved are always unique. Above all, interpreters require effective decision-making skills based on sound training, and knowledge of the Code of Ethics and the specific context and the goal of each interaction. In order to minimise stress and potential problems, it is essential that interpreters continuously maintain and enhance their skills and that they prepare thoroughly for all assignments.

A lifelong learning philosophy and critical reflection are helpful in learning from experience, dealing with professional demands as they occur and preparing for future challenges. It is an ethical requirement for interpreters to continue professional development throughout their working life as follows:

1. **Professional Development:** "Interpreters and translators continue to develop their professional knowledge and skills (...) Practitioners commit themselves to lifelong learning, recognising that individuals, services and practices evolve and change over time." (AUSIT, 2012, p. 14)
2. **Ongoing Professional Development:** "Practitioners will aim to be self-directed learners, pursuing educational opportunities which are relevant to their professional practice." (ASLIA, 2007, p. 5)

Critical reflection skills, on the other hand, are believed to be essential for professionals and to distinguish professional from non-professional practice. Through 'reflection-on-action' in particular, the process which occurs after the interpreting assignment and which provides means for thinking about dilemmas, interpreters can become more skilled in handling similar demands in the future (Bergson & Sperlinger, 2003). Novice as well as experienced healthcare interpreters are strongly encouraged to develop reflective skills: "The fostering

of these processes that develop reflection-on-action should ensure that future knowledge-in-action and reflection-in-action could be more solidly grounded. This will encourage the development of a continuous cycle of improvement in interpreter practice and lead to higher quality interpreting service” (Bergson & Sperlinger, 2003, p. 21).



In order to continue to learn and improve as professionals, the following professional development and critical reflection methods are suggested for interpreters:

- Attending professional development workshops for healthcare interpreters;
- Researching new developments and the result of research in community interpreting;
- Sharing experiences and debating challenges with colleagues;
- Seeking new experiences and challenges, learning from mistakes and using others’ success as a source of learning;
- Taking breaks in interpreting to think about dilemmas that have arisen;
- Writing accounts of difficult situations in a reflective diary;
- Seeking feedback regarding specific areas of skill development.

Finally, the guidelines are an attempt at setting a clear direction in the healthcare interpreting industry. Inconsistent professional boundaries and variance in conduct create unrealistic expectations from clients and can tarnish interpreter reputation and client confidence in the services. The guidelines may be a helpful tool in self-assessing individual conduct and performance against the expected standards. Upholding professional standards, maintaining uniformity in conduct and a consistent approach among healthcare interpreters contribute to strengthening the healthcare interpreting profession, encourage client trust and respect of healthcare interpreters as professionals and improve working conditions for all interpreters practising in the medical field.

7. Glossary

Accredited Interpreter is an interpreter who has passed a NAATI accreditation exam and is certified to practise as a professional. Most healthcare interpreters are accredited at the professional or para-professional level.

AUSIT - The Australian Institute of Interpreters and Translators

ASLIA- Australian Sign Language Interpreters Association

Auslan– Australian Sign Language

CALD– Culturally and Linguistically Diverse

Clients – HCIS has two types of clients:

- a) healthcare providers, also referred to as health professionals or health providers
- b) patients, sometimes also referred to as clients

Community Interpreting (liaison/public service interpreting) is “Interpreting that takes place within one country’s community, and between residents of that country, as opposed to Conference Interpreting, which takes place between delegates who are residents of different countries, in the context of an international conference or meeting. (Hale, 2007, p.30)

Consecutive interpreting is a technique in which the speaker/signer delivers the message in chunks and pauses for the interpreter to convey it. (Napier et al, 2010)

Contract/sessional interpreters – Freelance interpreters contracted by HCIS to do specific jobs only according to demand, as opposed to staff interpreters who are employed on a permanent part–time or full-time basis.

Face-to-face or on-site interpreting - Interpreting done by an interpreter who is in the presence of the interpreting parties as opposed to remote (phone or videoconference) interpreting.

First person or direct speech interpreting - Interpreting in the first person demonstrated by

the use of “I” statements.

Interpreter Sticker– A bright coloured sticker issued by NSW HCIS for interpreters to place in patient files and record their attendance at the interview.

Interpreting is the process of transferring meaning between languages in the spoken or signed form. (Napier et al, 2010)

NSW HCIS – New South Wales Health Care Interpreter Services

NAATI – the National Accreditation Authority for Translators and Interpreters. NAATI is the national standards and accreditation body for translators and interpreters in Australia.

PDC – Professional Development Committee for interpreters in healthcare (NSW HCIS)

(NAATI) Recognition is an acknowledgement of interpreting experience without specifying the level of proficiency. It is granted in languages in which accreditation testing is not available on the basis of a direct application to NAATI and the required evidence (NAATI, 2012).

Register is the stylistic level of language, which changes depending on the level of formality, familiarity between participants and the use of specialised jargon. (Napier et al, 2010)

Sight translation is “a transposition of a message written in one language into a message delivered orally in another language” (Lambert, 2004, p. 298).

Simultaneous interpreting is a technique in which the speaker/signer talks without pausing and the interpreter conveys the message once they hear/see enough to understand. (Napier et al, 2010)

Translation is “the process of transferring meaning between languages in written or recorded texts” (Napier et al, 2010, p. 12)

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