

*The National Council on Interpreting in Health Care  
Working Papers Series*



***GUIDE TO  
INITIAL ASSESSMENT OF  
INTERPRETER QUALIFICATIONS***

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**The National Council on Interpreting Health Care**

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## **General Background and Purpose**

### **The Field of Health Care Interpreting Today**

Language interpretation in health care and other community settings is essential in order for people with limited English proficiency to have access to health care and other public services. Interpretation is a complex and demanding task. Therefore, it is important to determine the qualifications of those called upon to interpret. How is this to be done? With the exception of organizations for signed interpretation, there is no national organization that certifies the competence of interpreters. Washington is the only state with formal certification or licensing of interpreters who work in health care settings. There even continues to be some disagreement about what counts as competent performance and what interpreters should be expected to do or not to do.

Meanwhile, those who employ, refer or contract with interpreters need a way to decide whom to hire. Thus they need a way to assess the qualifications of those who interpret for them or who are candidates for employment as interpreters.

### **Purpose of this Guide**

The *NCIHC Guide to Initial Assessment of Interpreter Qualifications* is intended to lay out an adequate and efficient strategy for initial assessment of interpreter qualifications in the absence of (or in conjunction with) certification by a government agency or professional organization. It can be used by organizations such as hospitals and clinics seeking to employ interpreters as well as by agencies that refer interpreters for assignments in health care settings. The guide outlines a recommended strategy for assessment and components of a comprehensive assessment that can be adapted to particular settings and purposes. It can be used by agencies within a community that choose to collaborate on designing and administering a single assessment instrument to identify a local pool of qualified interpreters that can be called upon to work in any of their facilities.

### **Development of this Guide**

This Guide to Initial Assessment of Interpreter Skills was developed by the Committee on Standards, Training, and Certification of the National Council on Interpreting in Health Care and reviewed and approved by the NCIHC Board of Directors.<sup>1</sup> Plans for preparation of the guide were developed during a meeting of the NCIHC at the University of Wisconsin-Madison in June 2000. A detailed outline was developed during a two-day meeting of the committee in Chicago, Illinois, in December 2000, and the guide itself was written and edited by the committee co-chairs and the full membership of the committee.

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<sup>1</sup> The individuals who jointly wrote this guide were Maria-Paz Beltrán Avery, Ann Chun, Bruce Downing, Marcia Maynard, and Karin Ruschke, (all members of the Standards, Training, and Certification Committee of the NCIHC), along with NCIHC Board Co-chairs Shiva Bidar-Sielaff and Cindy Roat. We wish to thank Margaret Malone of the Center for Applied Linguistics for generously sharing her expertise regarding oral skills testing and reading a draft of the guide. We also wish to thank Gaea Honeycutt, who edited a near final draft.

This guide is based upon widely accepted views of what constitute the basic skills of the health care interpreter. The sources we consulted include the Massachusetts Medical Interpreters Association's *Medical Interpreting Standards of Practice*, the *Standard Guide for Language Interpretation Services* developed by the American Society for Testing and Materials (ASTM), and the *Bridging the Language Gap* report written by Minnesota's Interpreter Standards Advisory Committee.

The authors drew upon two main sources in thinking about the make-up of an initial assessment process. One is a screening process used successfully over the past few years by a consortium of health care agencies that employ interpreters in Madison, Wisconsin. This group, which includes Shiva Bidar-Sielaff of the University of Wisconsin Hospital and Clinics, jointly developed an initial assessment process, which it offers on a regular basis to select interpreters qualified to work in any of the participating institutions. The second source is the formal certification process being developed by the Massachusetts Medical Interpreters Association under the leadership of Maria-Paz Beltrán Avery. Both Bidar-Sielaff and Avery contributed to the preparation of the present guide.

## Terms and Concepts in this Guide

### Interpreter

The interpreter assists two or more persons, speaking different languages, to communicate orally (or in a signed language) with one another. The interpreter does so by attending to what the speaker is saying, capturing the meaning of each utterance, and then repeating the message of that utterance in the language spoken by the other party or parties. (The terms ‘translation’ and ‘translator’ are reserved for the process of re-expressing the content of a written text in written form in another language.) An interpreter expects the parties to the conversation to speak to each other, not to the interpreter, so that the interpreter can work in “first-person” mode. For example, the interpreter would say “I” where the speaker says “I,” rather than something like “The doctor wants me to ask you ...” or “She says she has a bad headache.”

### Health care interpreters

Professionals who interpret bilingual conversations, which usually involve one or more health care providers (generally speaking English), a patient or client (speaking another language), and sometimes members of the patient or client’s family. Health care interpreters work in clinics and hospitals, in private medical and dental offices, during home health visits, and in health education. Health care interpreters usually work in the “consecutive mode,” giving the interpretation of what has been said after a speaker pauses or finishes speaking, rather than in “simultaneous mode,” in which the interpreter renders the interpretation as the speaker continues speaking.

### Assessment

In this guide, assessment refers to the process of determining a person’s qualifications for a particular type of employment—in the present case, employment as a health care interpreter.

*Initial assessment* is assessment of individuals’ qualifications at the point where they are either being hired or being admitted to a list of interpreters available for assignments as needed — an interpreter pool. Initial assessment is also referred to as employment screening. Initial assessment must be distinguished from at least two other types of assessment: “performance assessment” and formal assessment for “licensure” or “certification.”

*Performance assessment* is an on-going or periodic assessment of an interpreter’s performance on the job. In performance assessment there is less emphasis on the basic skills that have already been determined and more emphasis on the interpreter’s actual job performance and adherence to professional standards in his or her daily activities. The Massachusetts Medical Interpreters Association’s Standards of Practice are well designed for use in assessment of interpreter performance.

*Licensure* is the process by which an individual obtains an official license or authorization to perform a particular job. A candidate for licensure may be required to achieve a passing score on a formal assessment of skills, but in some cases licensure only requires completion of a course of training, or a knowledge-

based, rather than skill-based, assessment. Thus while a person who is licensed is *permitted* to interpret, their qualifications may not have been assessed.

*Certification* is the process by which a governmental or professional organization (sometimes a particular employer such as the Federal Courts) attests to or certifies that an individual is qualified to provide a particular service.

## Overview of Assessment

The assessment process can be used in either of two ways. When the purpose is to make a hiring decision, it may be used simply to select the best available candidate who demonstrates minimal qualifications. Alternatively, a passing score may be set and all those whose performance reaches this threshold will be admitted to the pool of qualified interpreters. In all cases the results of the assessment should be used to give feedback to those being assessed and to identify specific needs for training and personal development. The use of the assessment will obviously depend on whether it is intended to precede or follow training (more will be said about this below).

When an assessment process consists of several distinct components, as suggested here, it is always necessary and important to weigh each component in arriving at a total score. How this is done will again vary according to the setting. Generally, some kinds of knowledge and skill are more essential than others. As we will describe in this guide, it is possible for a person with essential basic skills to work successfully as an interpreter while other skills are being developed. The most important criterion is the ability to integrate one's knowledge and skills successfully in the process of actually interpreting.

An initial assessment of interpreter qualifications should, of course, be thought of as one stage in a process. Where interpreter training is to be offered, assessment may precede the training, or follow it, or both. When assessment precedes training, its purpose may be simply to provide a standard for accepting applicants. But, it may be used diagnostically to determine what knowledge, language skills and interpreting skills the candidate needs to further develop, and whether the person is ready for training and what training is needed.

When the assessment is given post-training, obviously one aim may be to find out to what extent the individual has benefited from the training. But, unlike the final exam in a formal course of training, we assume that initial assessment is also intended to assist in selecting individuals for employment as interpreters. Based on this assumption, one has to look at the purpose for which assessment is being conducted to select a single top candidate for employment or to identify a pool of qualified interpreters.

Setting a "passing threshold" is also the responsibility of those who use the assessment process. Consistent and accurate interpretation is extremely demanding. Certification exams such as those conducted by the federal courts and various state court systems frequently have a pass rate as low as five percent. There are few training programs that extend beyond a basic orientation for languages other than American Sign Language (ASL) and, in some localities, Spanish. It is also true that all candidates for employment in some languages are recent immigrants who are still developing proficiency in their second language. For these reasons, it may be necessary to accept candidates whose language skills or knowledge of specialized terminology is less than the ideal.

Once a candidate or candidates have been assessed and the successful one(s) selected, the need for evaluation does not disappear. It is essential that there be continuous monitoring and periodic assessment of work performance, and there may at some point be an additional assessment for promotion or certification.

## **About Certification**

Certification calls for formal assessment, using an instrument that has been tested for validity and reliability, so that the certifying body can confidently determine an individual's qualifications. Examples of formal certification include the Federal Court Interpreter Certification, State Court certification (available in 25 states at the time of this writing), the various certifications offered by the Registry of Interpreters for the Deaf (RID Inc.), and the certification of health care and social service interpreters offered by the State of Washington. The few certification programs developed through private industry are not available to the general public.

Apart from the Washington State program, there is presently no organization in the United States that specifically certifies interpreters to serve in health care settings. However, the Massachusetts Medical Interpreters Association (MMIA) is piloting an examination for certification of professional health care interpreters, and the California Health Interpreters Association (CHIA) has received substantial funding to develop a certification program in that state. Other local or regional efforts toward certification are in progress around the country. NCIHC is also exploring the development of a national certification process.

It is important to keep in mind that claims of certification found in some interpreters' resumé or reported in interviews may be ungrounded or misleading. Completion of a few hours of training or recognition as an interpreter by an interpreter referral agency without formal testing does not constitute certification. Even an official certificate or a college degree earned for completion of a program of professional interpreter education does not necessarily mean a candidate is certified. Formal screening of the skills required for satisfactory performance may not be required to obtain a certificate or diploma.

## Recommended Process for Assessment

The qualifications of the competent health care interpreter include a wide range of knowledge and skills. While it is essential that the interpreter be able to integrate his knowledge and skills in the process of interpreting, it is desirable in an initial assessment to isolate specific competencies, using a multi-part assessment process.

### Informal review and references

As in any hiring or screening process, one can begin by interviewing the applicant and reviewing her credentials. Background documentation might include:

- a letter of application
- a resumé
- letters of recommendation (from employers and, where appropriate, from members of the ethnic community for whom the interpreting will be provided)
- evidence of prior education and training

A normal employment interview will provide an opportunity to judge attitude, general communication skills and responsiveness.

### Elements of initial assessment of interpreter skills

The following six components together comprise a reasonably comprehensive process for initial assessment of qualifications for health care interpreting.

*Basic language skills.* General proficiency in speaking and understanding each of the languages in which the applicant would be expected to work. (If multiple languages are involved, it is essential that the applicant's ability in each language be assessed, especially those in which the applicant may have more limited proficiency.)

*Ethical case study.* Recognition of ethical issues, knowledge of ethical standards (a code of ethics) and ethical decision-making, assessed by obtaining the candidate's response to scenarios calling for ethical choices.

*Cultural issues.* Ability to anticipate and recognize misunderstandings that arise from the differing cultural assumptions and expectations of providers and patients and to respond to such issues appropriately.

*Health care terminology.* Knowledge of commonly used terms and concepts related to the human body; symptoms, illnesses, and medications; and health care specialties and treatments in each language, including the ability to interpret or explicate technical expressions.

*Integrated interpreting skills.* Ability to perform as required for employment, demonstrated by interpreting a simulated cross-linguistic interview with



acceptable accuracy and completeness while monitoring and helping to manage the interaction in the interest of better communication and understanding.

*Translation of simple instructions.* Ability to produce oral translations, or, where appropriate, brief written translations, of written texts such as application forms, signage, or medicinal labels.

### **Sequencing Assessment Components**

These components of an initial assessment can probably be administered in any order. Cost and efficiency considerations, however, may dictate a preferred sequence. For example, basic language skills are absolutely essential as a prerequisite to either training or service as an interpreter. Accordingly, if basic language skills are assessed first and those scoring below a threshold level identified, further testing of the low scorers will be unnecessary. Similarly, it may be unnecessary to administer the more expensive and time-consuming assessment of integrated interpreting skills of applicants who have performed poorly on the easily scored health care terminology assessment. For this reason, it might make sense to do the terminology assessment first. Where the assessment is intended to serve a *diagnostic* function, rather than simply a *screening* function, it may of course be desirable to administer all components of the assessment to each candidate.

In the following sections, guidelines are offered for each component of the assessment, including governing principles, content and procedures.

### **Basic Language Skills**

The most basic skill that an individual brings to interpreting is competence in speaking (or signing) and understanding the two languages to be interpreted. Every interpreter, even the most skilled, will need to expand his or her vocabulary through training and ongoing study. However, basic oral proficiency (speaking and understanding speech) in both languages is a prerequisite for anyone wishing to serve as an interpreter. The screening for oral proficiency is the first step in assessing the competence of an interpreter candidate.

#### *Assessment Components*

There is some disagreement over which language skills need to be evaluated when testing interpreter candidates. At a minimum, oral skills (speaking and understanding) in both of the languages candidates intend to interpret — their “working languages” — should certainly be included. This means testing the following.

- *English oral comprehension.* How well does the candidate understand spoken English? This does not include medical terminology or jargon, but only everyday speech.
- *English oral production.* How well does the candidate speak English?
- *Non-English language oral comprehension.* How well does the candidate understand the other working language(s)?
- *Non-English language oral production.* How well does the candidate speak the other working language(s)?

The population for whom the candidate will be interpreting should be kept in mind when conducting an oral proficiency language screening. For example, if the candidate's language pair is English-Spanish, and the clinic's patient population includes people from Cuba, it is important to know how well the interpreter understands Cuban Spanish, and how well he is understood by speakers of this dialect. If the language pair is English-Arabic, and the clinic's Arabic speakers are principally Iraqi, the question is how well the candidate understands Arabic as spoken in Iraq. Conversely, how well does the candidate understand English as it is commonly spoken in the clinic? Will the candidate's English be comprehensible to these health care workers? Regional differences in grammar, vocabulary, word meanings and accents may need to be taken into account.

Socioeconomic status may also be an issue, because the same language is used differently by different social groups with varying levels of education, types of employment, lifestyles, etc. If the patient population is made up mostly of Mexican farm workers, how well does the candidate understand the language typical of this group? Could a typical patient understand the candidate's speech? Although few formal assessments of basic language skills take these issues into account, they should nonetheless be considered.

Some argue that screening should include evaluation of the candidate's comprehension and production of written language (i.e., reading and writing). Interpreters are often called upon to orally translate short documents such as discharge instructions ("sight translation"), a task which requires understanding of written English. They may also be called upon to produce quick, on-the-spot written translations of instructions into the patient's language. (Whether these should be considered essential responsibilities for a health care interpreter is the subject of a separate position paper by NCIHC.)

With reference to initial assessment, however, we do not believe that reading and writing skills represent a testing priority. Interpreting is fundamentally an oral skill. Even candidates who do not read and write well can be excellent interpreters and should not be initially screened out based solely upon their lack of literacy. Indeed, in some refugee populations there may be very few interpreter candidates who have had the opportunity to study English formally and, therefore, few may read or write English well. Likewise, some languages have seldom or never been used as a medium of formal schooling. There are even language groups in which the written form of the language is relatively new and, even if the interpreter did write the language, the patient would likely be unable to read it. For these reasons we do not include formal assessment of written language skills as a part of the minimum screening necessary in an initial assessment, even though it may be a valid component of a certification program.

### *Testing Basic Oral Language Skills*

There exists a variety of models for assessing basic oral language skills, ranging from very informal and subjective to highly formal and more objective. All of these models are applied orally, whether in person, over the phone, or through a taped protocol.

The more informal approach usually takes the form of an unstructured oral interview between the candidate and an ad-hoc rater who speaks both of the candidate's working languages. After a brief conversation, the rater gives a broad subjective characterization of the candidate's language

skills (i.e., native, excellent, good, adequate, poor). This approach is usually faster, cheaper and easier to arrange than the more formal models, however, there are many drawbacks. Without a structured assessment, there is no way to measure tool validity (does it test what it claims to test?), consistency and reliability (does it give similar results with candidates of similar skill). If multiple raters are employed, it is impossible to tell if a score of “good” from one rater equals a score of “good” from another. And finally, it is hard to justify the results of such an assessment if the candidate challenges them.

A more formal approach still utilizes ad-hoc bilingual raters but includes training to help them conduct a semi-structured interview with clear criteria for scoring. For example, the rater might be trained to note down the frequency of vocabulary errors, grammatical errors, use of false cognates, and obvious attempts to paraphrase when the exact term is unknown. Those who develop this sort of assessment must be familiar with language testing procedures, etc. (in order, for example, to devise a scoring system that gives appropriate weight to errors, range of expression, etc.) This approach is much more standardized and defensible. Without a statistical review, of course, there is no proof that a given protocol is valid or reliable, but training and testing of raters can increase the rating consistency between raters (“inter-rater reliability”). This assessment approach’s drawback is the time required for development and rater training.

The most formal of the approaches is to conduct an official ACTFL Oral Proficiency Interview (OPI). This test includes a structured interview designed to ensure that candidates use a variety of language functions. By applying an internationally recognized scale of language proficiency, the ACTFL Proficiency Guidelines, a meaningful rating of oral proficiency can be assigned to each candidate. The ACTFL test is conducted as a live interview or in the form of taped responses to taped questions, a simulated oral proficiency interview (SOPI). Both types of tests require raters who have been trained and, usually, certified in the evaluation of the results. Usually, the session is recorded, even if the interview is conducted “live,” so that performance can be reviewed by repeated listening. The benefit of using a professionally designed OPI or SOPI model is in its validity and reliability. The drawbacks are in the cost involved and the limited number of languages for which the tests are available.

Many of these formal assessments are grounded in the ACTFL rating scale (a scale that defines characteristics and levels of language proficiency adopted by the American Council on the Teaching of Foreign Languages and other testing bodies). This scale has four main levels: Novice, Intermediate, Advanced and Superior, with “low,” “mid” and “high” subdivisions in each level except Superior. The final challenge to the screening organization is to decide what level of language proficiency will be acceptable. It is not unusual (or inappropriate) for different levels of proficiency to be required for different language groups, depending on the skill level of the available pool of candidates for each language.

#### *Exempting Candidates from Basic Skills Assessment*

A candidate’s non-native language skills should normally be assessed. What about their native language skills? Wouldn’t it make sense to exempt a candidate from testing in their native language? The answer is often not as simple as it appears. When the native language is not English, the candidate’s command of their “native” language is impacted by a multitude of factors:

- Was the language spoken in the dominant culture or only at home?
- If the language was spoken at home, was it spoken exclusively by everyone at home or only by certain family members?
- Was it the language in which the candidate was educated?
- If the candidate grew up outside the U.S., at what age did she arrive in the U.S.?
- How long has she been in the U.S.?
- To what extent has the candidate continued active use of the language, and in what contexts?

Because of the complexity of these situations, the NCIHC recommends that candidates be assessed in all languages in which they will be interpreting. Exceptions might be made in the two cases described below, provided the candidate has continued to actively use her languages.

Example 1:

Candidates with a college-level education earned in a particular language should not require testing in that language. For example, a candidate who has a college degree earned in Russia should not need to be screened in Russian. A degree from an American university with a major in Russian would not fulfill the necessary criteria, even if some time was spent studying abroad.

Example 2:

A native speaker of Somali, who grew up in Somalia, where everyone spoke Somali, where the candidate was educated in Somali, and who has only recently arrived in the U.S., probably speaks Somali well and will not need to be screened. Conversely, a native speaker of Spanish, who grew up in the U.S., in whose home only the grandparents spoke Spanish exclusively, who was educated in English, certainly should have his Spanish skills evaluated.

*Existing resources*

Many institutions use the informal and semi-formal approaches to assess basic language skills, but those tests are not scientifically constructed, and we know of none that are available commercially. There are, however, several commercially available sources of formal oral proficiency tests. We include two here as examples; the inclusion is not meant to imply official endorsement by the NCIHC.

*Language Testing International* in White Plains, NY, will provide formal oral language testing services over the telephone in 37 languages. The taped ACTFL oral proficiency interview, done in person or over the phone one-on-one), takes from 10-30 minutes and is conducted by a trained interviewer. The tape is rated first by the interviewer and then again by a second rater. At this time (January 2001), the cost for each administration of the test is \$139. For more information, contact Helen Hamlyn, Testing Director, at LTI (tel: 914-948-5100 or 800-486-8444, ext. 4; email: [testing@languagetesting.com](mailto:testing@languagetesting.com); website: <http://www.languagetesting.com>).

The *Center for Applied Linguistics* in Washington, D.C., conducts similar testing using a taped interview that is self-administered by the candidate with a master tape and a test booklet. Responses are recorded and evaluated by a trained reviewer using the same ACTFL guidelines. The test takes around 25-30 minutes and is currently available in 11 languages. CAL also has a program to prepare internal raters for any organization. With the purchase of a rater's kit, local raters can learn to administer the test. CAL will both train and certify these raters, or they can learn through the kit and be certified through a taped process. Rater kits are available in seven languages: Arabic, Chinese, French, German, Japanese, Spanish and Russian. Each kit costs \$150 per language, but the certified rater can then administer as many tests as he wishes at no additional charge. For more information, you can contact Laurel Winston at CAL (tel: 202-362-0700; email: [laurel@cal.org](mailto:laurel@cal.org); website: <http://www.cal.org>).

A number of oral proficiency tests are available for English for which there are no versions to test other languages. One is the *Test of English as a Foreign Language* (TOEFL), which includes a listening component. This test, however, has a strong literary and academic orientation and is not very suitable for testing the oral skills of interpreters. Another is the Test of Spoken English, which is administered by the same TOEFL organization. It could be used for initial assessment, but it is given only in certain locations on a fixed schedule. It currently costs \$125 per testee, and it may take several weeks to receive the scores. Information about these tests is available at the TOEFL website: <http://www.toefl.org>.

There is also the BEST test, intended for use in Basic English as a Second Language programs. Its limitation is that it does not discriminate higher levels of English required for language professionals.

Finally, there is the SPEAK test, an oral English test used in colleges and universities to test non-native instructors and teaching assistants. It can be administered locally. It has a definite academic focus but is sometimes used to test bilingual health care workers. A number of institutions of higher education have their own English language proficiency tests, including a spoken language component (speaking and listening). Such institutions may be willing to work with you to develop and administer an appropriate oral language proficiency test.

### **Ethics**

A competent interpreter needs to demonstrate an understanding of ethical principles and ethical decision-making. In every profession there is a set of guidelines, often referred to as a "code of ethics," that governs the behaviors of those in the profession. Although there is not currently a nationally recognized health care interpreter code of ethics, the growth of health care interpretation has sparked the development of numerous codes of ethics. These codes of ethics vary, but often contain the same basic elements as outlined under "Assessment Content" below.

For examples of health care interpreter codes of ethics, see *Bridging the Language Gap* (1998), which is available from the Program in Translation and Interpreting at the University of Minnesota at <http://cla.umn.edu/pti/downloads.htm>; *Bridging the Gap: A Basic Training for*

*Medical Interpreters* at <http://www.xculture.org>; and the MMIA code of ethics at <http://www.MMIA.org>. For an example of a national code of ethics see Registry of Interpreters for the Deaf at <http://www.rid.org>, or the code of ethics of the Australian Institute of Interpreters and Translators at <http://www.ausit.org>. The NCIHC is developing its own code of ethics which will be posted on its website at <http://www.ncihc.org>.

### *Assessing Ethics*

A written or oral scenario-based case study is the best tool for evaluating a candidate's understanding of ethical principles and choices. Use of a case study allows the assessor(s) to conduct a discussion to identify how the candidate would react when faced with an ethical dilemma, how well the candidate understands the code of ethics and, therefore, how well she understands her role as a health care interpreter.

### *Content*

The following is a listing of ethical principles that are common to various codes of ethics.

- *Confidentiality*. The interpreter must treat all information disclosed during interpretation as confidential.
- *Accuracy and completeness*. The interpreter conveys the entire message faithfully in a linguistically appropriate manner, without adding or omitting any information.
- *Impartiality*. The interpreter will remain objective and shall not give her personal opinion.
- *Respect and professionalism*. The interpreter will maintain professional integrity and treat both patient and provider with respect.
- *Conveying cultural information*. The interpreter should be prepared to intervene by providing information on cultural differences and practices to the provider or patient when such information is needed to avoid cultural misunderstanding and miscommunication.
- *Acceptance of assignments*. The interpreter will decline or withdraw from any assignment in which he cannot abide by any element of the Code of Ethics.

Whichever version of the code of ethics an institution adopts, it should be shared with health care interpreter candidates prior to the initial assessment to allow the candidates to prepare themselves for this section of the assessment.

### *Examples*

#### Example 1:

You just finished interpreting for a young woman. The doctor told her she is pregnant. You walk out of the exam room with the young woman. Her husband is sitting in the waiting room. He approaches you and says: "What did the doctor tell my wife?" What would you do? Why?

#### Example 2:

While waiting for the doctor, the patient tells you her husband is beating her and asks you for advice. What would you do? Why?

### *Scoring*

When scoring this section, consider the following:

1. Was the candidate able to persuasively justify her answer?
2. Was the candidate able to relate his answer to the code of ethics?

It is important to remember that in ethical situations there is rarely a black and white answer. Therefore, a range of answers may be acceptable as long as they demonstrate a good understanding of ethical decision-making and are well argued.

### **Cultural Understanding**

Language is not the only element at work in the interaction between providers and patients who speak different languages. Culturally based beliefs, values, and assumptions held by each underlie the messages that they communicate to one another. For the provider, the “culture of medicine” as practiced in the Western world frames the type of questions they ask, the inferences they draw from patient descriptions of symptoms, and the expectations they have about prevention, treatment, and compliance. For the patient, deeply held beliefs about the relationship between the body and the spirit and the causes of illness or well-being influence the presentation, course and outcomes of illness.

When the patient and the provider share similar assumptions about health and illness and the functions of the health care system, the interpreter may simply have to make the conversion from one linguistic system into the other. When the extent of cultural dissimilarity is great, however, the interpreter may have to assist both provider and patient in unmasking the discontinuity in understanding. An example of this occurs with “untranslatable” words, which represent concepts for which a comparable referent does not exist in the society of the target language (Seleskovitch, 1978). To convey the concept, the interpreter may have to use a metaphor that is understandable in the target language and serves to convey the meaning of the “untranslatable” word.

The interpreter, therefore, must be mindful of those occasions where unshared cultural beliefs and assumptions can create a barrier to effective communication. In these situations, the role of the interpreter is twofold: 1) to identify the possibility that a cultural misunderstanding is creating a barrier to communication; and 2) to assist both the provider and the patient in exploring with each other what this barrier may be.

### *Assessing Understanding of Cultural Issues*

The best way to evaluate a candidate’s understanding of the role of the interpreter with respect to cultural issues is through the presentation of scenarios that describe potential cultural barriers. Candidates are asked to respond to these scenarios by indicating the intervention they would make and how the intervention would be carried out. The scenarios and responses can be presented in written or oral form.

Ideally, these scenarios should highlight practices and beliefs associated with the particular cultural-linguistic group for whom the candidate will be interpreting. However, it is not always possible for the assessor to have culture-specific information about all the cultural-linguistic groups for which they may be testing. In such cases, it is possible to ask the candidate to identify a cultural belief or practice pertinent to the group for whom they will be interpreting and describe what they would do if it arose as an issue in an interpreter-assisted encounter.

### *Content*

An assessment of an interpreter's ability to address cultural issues should require the candidate to demonstrate:

- an understanding that differences in cultural beliefs and assumptions can lead to miscommunication;
- the ability to intervene appropriately in order to identify when a cultural barrier to communication may exist;
- the ability to frame questions to help the provider and the patient explore what this cultural barrier may be.

### *Examples*

#### Example 1 (culture-specific scenario):

The doctor is trying to determine whether and how well the patient is complying with the treatment regimen. You notice that the patient is answering "yes" to all the questions that the doctor asks. However, you also notice that the patient seems uncomfortable. At the same time, it is clear to you that the doctor is becoming more and more frustrated because the patient's symptoms don't seem to make sense if the patient has been following the treatment regimen. You know that in this patient's cultural group it is considered impolite to say "no." What do you say and do in this situation?

#### Example 2 (candidate-identified scenario):

Describe a cultural belief, value, or practice (way of doing things) that is important in the culture of the patients for whom you interpret that you think may cause misunderstandings with providers in the United States. What kinds of misunderstandings do you think these may cause? What would you do and say, as the interpreter, if you were faced with this situation? What would you say to the doctor? What would you say to the patient? Be as specific as you can.

### *Scoring*

When scoring this section, consider the following:

1. Did the candidate show an understanding of the influence of cultural issues in the described encounter?
2. Did the candidate intervene appropriately? Did the candidate indicate in some manner that she was now speaking for herself as opposed to interpreting the words of the patient? Did the candidate share his observation that there was some miscommunication going on and that he was prepared to assist the provider and the



patient in exploring where the barrier was? Or did the candidate take over by providing her own explanation?

### **Health Care Terminology**

Interpreting is a specialized skill that requires ongoing training and experience. In fact, many interpreters focus on a particular field of interpreting such as legal, social service or health care so that they can increase their effectiveness through the expansion of vocabulary and by becoming more familiar with the environment in which they interpret.

First and foremost, health care interpreters must have general proficiency in the selected working languages. Proficiency however, does not necessarily mean that the interpreter is familiar with health care terminology. Therefore, it is critical that health care interpreters be tested for their knowledge of basic medical vocabulary. Interpreters should be familiar with commonly used health care terms (such as *bladder, sprain, urine, diabetes*) in both languages, and be able to interpret such terms even if there are no exact equivalents in the other language. Ignorance of basic health care terms could result in misdiagnosis and poor health outcomes.

#### *Assessing Knowledge of Health Care Terms*

Assessing an interpreter's knowledge of health care terms can be accomplished through many different types of tests. Of course, the interpreter must demonstrate knowledge of terminology in both languages. The assessment therefore usually involves translating individual terms from one language into the other, in both directions, orally or in writing. Two alternative methods of testing, oral and written exams, are briefly described below.

#### Oral Exams

##### *Basic medical terms tested orally, face-to-face*

To test basic medical terms orally, a rater (interviewer) must be familiar with medical terms in both working languages, and should have experience interpreting in a health care setting. The exam can make use of a list of medical terms (please see Content section below) read aloud by the rater, which the candidate is asked to interpret as accurately as possible. For example, the rater reads "sharp pain" and the candidate will interpret the words into the target language either with an exact equivalent or if no exact equivalent exists, with a paraphrase that expresses the same meaning (e.g. "a pain that feels like being stabbed by a pin or a knife"). Testing orally, face-to-face has the advantage of being able to see how the candidates react to the test and to interact with them if necessary, for example, for the purpose of reducing their nervousness. A disadvantage is the cost of administering such exams, which may be higher than audiotaping or paper testing. Costs would include having one, or possibly two, bilingual staff members conduct exams.

##### *Basic medical terms tested orally through audiotaping*

The same exam described for a face-to-face oral exam can be used to test knowledge of basic medical terms orally through audiotaping. First, the medical terms should be read and taped in the working languages, leaving enough time in between the terms to allow for response from the candidate. If available, a

language lab (such as found in most educational institutions) would be an ideal setting because the tape can be played and the response recorded (on another track or another tape) for all candidates at the same time. Otherwise, two tape recorders may be necessary — one to play the recorded text and one to record the applicant's response. The advantage of audiotaping is that it is less time consuming, allowing the rater to listen to the audiotape at their convenience. The disadvantage is that the rater is not able to see and interact with the candidate.

#### *Role-play with medical terms in the text of the script*

Another way to test medical terms is through the use of scripts. Role-playing is a common tool for testing many aspects of an interpreter's skill. (See comprehensive skill testing below.) In this mode, the candidate is called upon to find the right equivalent for words used in context and must interpret whole utterances rather than isolated words. The inclusion of many different categories of medical terminology within the text of the script can not only assess the candidate's knowledge of medical terminology but also his ability to handle a situation when the interpreter does not know particular medical terms.

#### Written Exams

##### *Basic medical terms tested through written translation*

Written exams can be conducted using several different testing tools. Frequently used testing tools include multiple choice, fill-in-the-blanks, and matching, including identification of body parts by labeling elements of pictures and diagrams. The same list of medical terminology used for oral assessment can be used in written exams. Written tests have certain disadvantages. For example, the candidate's performance will depend on writing skills, which may or may not be a goal of the test, as well as her familiarity with testing protocols. With a written test, the rater will need clear guidelines as to whether or not to count spelling, or how "close" the answer must be to be considered correct. In addition, some languages do not have a written form in common use, which limits testing to oral exams. The benefit of written tests is that they are much less costly to apply, easier to grade, and less vulnerable to challenges.

#### *Content*

When assessing an interpreter's knowledge of medical terminology, it is important to include terms from all areas in the health care field. Listed below are recommendations for the areas to be tested, with sample lexical items:

- *Symptoms*: from provider as well as patient, including nauseated, shooting pain down my arm, head spinning
- *Anatomy*: bladder, gall bladder, ankle, thigh, tongue
- *Disease*: tumor, high blood pressure, diabetes, leukemia
- *Procedures/tests*: X-ray, glucose test, abortion, surgery
- *Equipment*: wheelchair, ultrasound, bed, cart, sterilizer, monitor, microscope
- *Specialists*: gynecologist, cardiologist, pediatrician, dermatologist
- *Treatment*: chemotherapy, physical therapy
- *Common medications*: aspirin, laxative, eye drops, insulin

- *Hospital departments/clinics*: radiology, primary care, in-patient, outpatient, intensive care unit

Notice that such lists of specialized terminology usually include only nouns. It is essential that knowledge of adjectives, verbs and possibly other parts of speech also be assessed because these words can also express technical concepts.

- *Verbs*: to examine, to elevate, to draw (blood), to intubate
- *Adjectives*: elevated (levels), throbbing (headaches), primary (symptoms), distended
- *Adverbs*: periodically, regularly, normally, intravenously, laterally.

In each of these areas there are basic terms that every interpreter needs to know. In addition there are many technical terms that are commonly used but that the speaker can explain if the interpreter does not know the technical term. (Basic terms include *bladder, kidney, surgery, sputum, oxygen*. Technical terms include *appendectomy, meningitis, laparoscopy, nocturnal, gastrointestinal, biopsy*.) The Massachusetts Medical Interpreters Association has compiled lists of the most commonly used words in various medical specialties. These lists may be found on the MMIA website at <http://www.MMIA.org>. A list of moderately technical terms that interpreting students are expected to master in a course on health care terminology at the University of Minnesota can be obtained by sending e-mail to [pti@umn.edu](mailto:pti@umn.edu).

### *Scoring*

Scoring to assess an interpreter's basic knowledge of medical terms can be more difficult than one may assume. Of course there are obvious equivalent terms in English and another language, such as *eye* which in Spanish is *ojo*. However, Spanish is a language spoken in many countries, each of which may have their own culture, different words for the same thing, or different meanings assigned to the same word. Also most words have multiple meanings depending upon the context. In addition, many languages such as Mien and Hmong may have very few words that exactly match Western medical terminology. For these reasons, scoring can become a very complex matter. We recommend that raters be flexible in deciding what to accept as a correct answer.

### **Integrated Interpreter Skills**

"Integrated interpreter skills" refers to the full complement of skills that a competent interpreter calls upon to ensure the accuracy and completeness of each "converted message." Thus, in addition to the central skill of oral language conversion, there are other auxiliary skills that a competent interpreter should have in order to ensure accuracy and completeness. Examples of key auxiliary skills are asking for pauses and clarification, using a variety of mnemonic devices to remember important information, and managing the flow of communication.

Assessing a potential candidate's ability to use such auxiliary skills is especially important for coordinators of interpreter services who are often faced with limited time to identify interpreters in a pool of candidates who are highly proficient in both working languages. By using these auxiliary skills as strategic interventions, a potential interpreter whose command of one of the languages is still somewhat basic may be able to maintain accuracy and completeness.

The purpose of this section, therefore, is to allow the candidate the opportunity to demonstrate their performance using all the skills they have in an integrated way. It also provides the assessor with a sense of how well the candidate is able to use these skills to maintain accuracy and completeness without detracting from the patient-provider relationship and the clinical goals of the encounter.

### *Assessment of Integrated Interpreter Skills*

The best way to assess integrated interpreting skills is through a role-play that simulates an interpreter-assisted clinical encounter. The role-play might consist of a 20-minute scripted dialogue between a patient and a provider. The candidate would function as the interpreter in this scripted dialogue. However, the dialogue can be constructed to include segments where the interpreter might be expected to intervene. Examples would be terminology the candidate did not understand, the speaker talking at great length, or cultural issues that might interfere with mutual understanding.

At a minimum, the role-play should be audiotaped. This provides a record of the candidate's performance on the role-play in the event that a dispute arises over the results of the assessment. If the raters will not be present during the recorded session, then videotaping may be advisable so that the raters can have a comprehensive view of the performance. Those who rate this segment of the screening must, of course, be proficient in the languages of the interview.

### *Content*

At a minimum, the scripted role-play should include the following elements:

- an opportunity for the candidate to introduce him or herself and briefly explain the role of interpreter;
- medical terminology as well as patient language, including dialectal expressions, colloquialisms, and uncommon medical terminology;
- cultural references; and
- varying lengths of utterances, from simple and short speech turns to long and complex ones.

### *Scoring*

This role-play should be designed to include specific items the interpretation of which will be tested. In the written copy of the script to be used for scoring, these so-called 'key points' should be clearly marked and numbered to match the order of those on the score sheet:

1. Did the candidate render accurate and complete conversions? Based on the key points in each message, the interpretation should be scored for accuracy, including mistakes, omissions, and additions. Accuracy refers to message conversions that are equivalent in both languages. Mistakes are message conversions that are different in meaning from the original. Omissions are key points that are not interpreted. Additions are any ideas expressed by the interpreter that were not in the original message.
2. How well did the candidate explain the role of interpreter and maintain this role throughout the role-play?
3. Did the candidate use the consecutive mode of interpreting?
4. Did the candidate position herself unobtrusively?

5. How well did the candidate use the auxiliary skills of managing the flow of communication, appropriately asking for pauses or clarifications when necessary, and using mnemonic devices? In using these skills, did the candidate's behavior support the patient-provider interaction or did it detract or obstruct it?
6. Did the candidate handle cultural references appropriately?
7. When the candidate intervened, did he do so in such a way that it was clear he was now speaking for himself?

### **Translation of Simple Text**

In the health care setting, information is not always presented in spoken form. Signage, notices, medical documents, questionnaires, registration forms, brochures, patient education materials, invoices, appointment cards, prescription labels, discharge instructions, and other written communications are common. Therefore, the interpreter may be asked to translate written messages into spoken messages (sight translation), or to translate short passages of written text into written form in another language. An interpreter who is capable of doing both will be better positioned to meet the needs of those who use the interpreter's services.

It is important to keep in mind, however, that an interpreter is not necessarily qualified as a translator and does not have the time, while interpreting, to perfect a written translation. Therefore, the interpreter's responsibility for providing written text is strictly limited to brief instructions for individual patients. (See *ASTM Standard Guide for Language Interpretation Services*, 11.2.3.8.1). Interpreters are never expected to take dictation (i.e., to translate spoken text into written form in any language).

It would be desirable if all health care interpreters had the skills to do both accurate sight translations and accurate on-site simple translations, but many interpreters do not. Therefore, it will be necessary to decide whether some or all applicants should be tested in these areas, and whether sight translation and short translations should be expected of some or all interpreters.

Information rendered orally is fleeting, its retention being dependent on the hearer's memory. Information in written form has a greater permanence and may be desired by patients who would like to reference the material at a later time. The patient's level of literacy must be considered in determining the mode by which information is delivered. If the interpreter is not literate in the patient's language, or if literacy in a particular language is limited or non-existent in general, skill in translation need not and should not be tested.

Assessment of an interpreter's ability to perform sight translation and to translate simple text will enable the evaluator to identify a candidate's proficiency level and limitations. As noted earlier, a candidate without written language skills may still provide a valuable service as a health care interpreter. Other methods can be used by the medical provider to change written information into a form (written or oral) that is accessible by the client or patient.

#### *Assessing "Sight Translation" and "Translation of Simple Text" Skills*

Keeping in mind the practical application of these skills, the best method of testing is to use actual text commonly encountered in medical settings. By choosing text that is graduated in difficulty, the evaluator can gain useful information about a candidate's abilities and limitations.

Testing requirements include a testing room without distractions, appropriate furniture, a facilitator/proctor to oversee the test, an audio or video recorder, testing documents, and writing tools. The use of audio or video equipment allows flexibility for the test to be scored by raters from a remote location. This is extremely helpful when working with languages for which there are no qualified local raters or when it is desirable to use raters unknown to the candidate. Also, as mentioned earlier, in the case of a dispute, a candidate's performance can be reviewed if captured on tape.

#### Sight Translation (Written to Oral)

Sight translation is the oral rendering in one language of text written in another. The candidate translates written text into the spoken form of the target language. In nearly all cases, this will mean an oral rendition in the patient's language of a text written in English.

#### Translation of Simple Text (Written to Written)

By "simple" we mean brief and uncomplicated. A simple text would generally be something that is presented in layman's terms and is translated into a written form that the patient can most readily understand. Interpreters should not be expected to translate more complex texts than these "on the spot." Text is presented in written form, in English. The candidate translates this text into the written form of the other language.

NOTE: *Testers should instruct the candidates to respond as if on an actual interpreting assignment (i.e., requesting clarification if needed).*

#### *Content*

Testing materials should include a sampling of common text from medical settings. The text can be graduated according to level of difficulty. The use of three levels of text with one or two samples at each level will provide a good base for evaluation. Texts well suited to "sight translation" include signage, notices, menus, registration forms, financial aid forms, brochures, flyers, questionnaires, letters, pre-procedural instructions, post-procedural instructions, discharge instructions, and some patient education materials. Texts well suited to simple written translation by an interpreter include appointment cards, brief discharge instructions, individualized directives for use of medicine, instructions for referral to another medical provider, directions for finding a facility location, and other simply-worded and brief documents (or portions of documents) that contain information a patient will most likely need to reference later.

NOTE: *We consider informed consent documents too complicated for sight translation or "on-the-spot" written translations by an interpreter. Materials of this complexity should be translated in advance by professional translators.*

#### *Examples*

Choose written samples that are not more than half a page in length. Use only samples that would be appropriate for an interpreter to sight translate or translate as simple text. Avoid documents that commonly need to be explained to the patient by the medical provider (e.g., complicated discharge instructions, wound care instructions).

### Sight Translation (Written to Oral)

1. *Signage*: Signs posted in a health care facility generally fall into one of three categories: directional, informational, or warnings. Examples:
  - In a hallway – “Second Floor: Outpatient Infusion Therapy, Diagnostic Imaging, and Laboratory.”
  - In a cafeteria – “Hours of operation: 6:00 a.m. to 9 a.m., 11:00 a.m. to 2:00 p.m., 5:00 p.m. to 8:00 p.m.”
  - In a cardiac unit – “Cellular telephones may interfere with medical equipment and must remain off at all times.”
  - In an emergency department waiting room – “Emergency patients: Check with nurse before eating or drinking.”
  - In an X-ray room – “If you are or might be pregnant, inform the technologist.”
2. *Brochures*: Simple descriptions of programs, services, or testing procedures.
3. *Discharge Instructions*: Choose carefully. Some are brief, of a routine nature, and easily sight-translated. Others are more complex and would need to be translated prior to use, not sight-translated.

### Translation of Simple Instructions (Written to Written)

1. *Appointment Cards*: “Your next appointment with Dr. Adams is on Tuesday, January 1, at 2 p.m.”
2. *Referrals to Another Facility*: “Follow-up with Dr. Hernandez at the Lake Grove Clinic on the corner of 1st Avenue and Main Street. Call 555-2121 for an appointment.”
3. *Medication Usage*: “Medication name: Erythromycin. Take two tablets, twice a day for ten days. Take all medicine as directed until it is gone.”
4. *Discharge Instructions* (Brief discharge instructions only.): “Keep leg elevated as much as possible for the next three days. Take the medicine as prescribed. If condition worsens, call your primary care physician or return to the emergency room.”

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### *Scoring*

When scoring this section, consider the following:

- Did the candidate translate exactly what was written? Render the meaning of the message accurately, without adding, deleting or changing anything?
- Did the candidate successfully deal with the style and contextual assumptions of the original?
- How did the candidate negotiate ambiguous terms?
- Did the candidate ask for clarification of any words or concepts that she did not understand?
- For spoken rendering of the message, was the candidate’s speech well paced, clear and understandable?
- For written rendering of the message, was the candidate’s handwriting legible? Were there spelling errors, and, if so, did they affect the meaning of the message?
- Does the candidate work with a language that lacks equivalents of Western medical terms, or with a community that is less likely to understand Western medical practices?

and technology? If so, how well did the interpreter convey the intended meaning of the source text?

## Conclusion

The content of this paper is based on the experience of interpreters and people who work with interpreters in the United States. Health care interpreting is a young profession, and individual readers may have encountered specific situations, which we have not contemplated, that will inform their use of techniques described here. An assessment of the interpreter's skills alone is not sufficient to ensure the quality of the interpreter's performance. On-the-job training and supervision are necessary in order for interpreters to hone their skills and enhance their understanding of the interpreter role.

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## Organizations referenced

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Language Testing International, <http://www.languagetesting.com>  
Massachusetts Medical Interpreters Association, <http://www.mmia.org>  
National Council on Interpreting in Health Care, <http://www.ncihc.org>  
Program in Translation and Interpreting, University of Minnesota, <http://cla.umn.edu/pti>  
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