

# THE IMPORTANCE OF SPECIALIZED CERTIFICATION

The Importance of Specialized Certification in Healthcare Interpreting

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### **Abstract**

In recent years, stricter standards have been proposed for interpreters in healthcare settings, but evidence for these proposals has yet to be shown through research. This study begins with exploration of the current literature regarding interpreting in healthcare settings to determine if specialization would address issues, problems, and concerns identified in previous research. The author also collected data via pilot surveys among both the d/Deaf community and working ASL-English interpreters, with a total sample size of ten participants, to investigate where current opinions stand on the issue of healthcare specialization. Surveys reflected widespread agreement among d/Deaf participants that healthcare interpreting should require specialized certification, but opinion among working interpreters was more evenly divided. These results provide evidence that current interpreting standards in the medical field fall short of the ideal, and require action from professional organizations to provide better service to d/Deaf and hearing consumers. Before professional organizations establish guidelines, further research should be done to better understand current opinion and interpreter concerns.

### The Importance of Specialized Certification in Healthcare Interpreting

The need to seek out and participate in a healthcare system at some point in one's life is a common experience shared by most people around the world. The experience that most d/Deaf people have in the context of healthcare is profoundly different than the general population, due to the unique communication needs of working with interpreters in medical situations.

In the United States, the hospital environment is an extremely complex setting in terms of political hierarchies, emotional and social interactions, customs and norms, regulations and procedures. Since for most people, their health is critical to their well-being, there is often a high level of risk involved to patients in the medical setting to have positive outcomes. For d/Deaf patients, this means there is great importance in rendering accurate interpretations. The nature of the field also requires deep understanding of ethics, with an interpreter in this setting likely to encounter delicate or difficult situations requiring thoughtful interactions. All of this is in addition to the topic of medicine itself, in which in which an interpreter having background knowledge of human bodily systems, medical issues, complications, and treatments is useful in producing the best possible interpretation. This is the minefield that healthcare interpreters must walk through, and increased education, practice, training, and certification are their armor.

The healthcare field should be considered a highly specialized setting for interpreters and thus should require specialized certification. As will be further explored in the Literature Review, previous research shows that without proper training, experience, and oversight, d/Deaf patients are put at risk by well-meaning but unqualified interpreters. This conclusion is further supported by the data collected in this study.

### **Literature Review**

Currently in the field of ASL-English interpreting, legal work is generally seen as an area of specialization in which further education and experience is needed to interpret effectively. The Registry of Interpreters for the Deaf (RID, 2007) has taken the position that best practice includes a specialized certification for those interpreters wishing to work in legal settings, stating, “Legal interpreting requires highly skilled and trained specialists because of the significant consequences to the people involved in the event of a failed communication... A qualified interpreter will have a specific skill set to ensure that a deaf person’s right to be present and participate is not compromised.” (RID, 2000). Support for this assertion is found in a 2011 study published in the *Journal of Interpretation*, which found that interpreters with specialized training related to the legal setting were better able to navigate the complex dynamics and vocabulary of the courtroom. The study’s authors note, “One of the key implications from the review of data is that interpreting in legal settings is not appropriate for all interpreters... Interpreting in legal contexts requires not only specialized, focused training but also unique vocabulary and skill sets” (Roberson, Russell, & Shaw, 2011, p. 75). The authors discovered that legal interpreters used specific tools and techniques to manage the complexity of the situation, including frequent use of consecutive interpreting, working in teams with both hearing

interpreters and Certified Deaf Interpreters, using case materials to prepare before the assignment, and recording their interpretations for later review.

While legal settings often deal with a person's right to liberty, healthcare settings deal with a person's right to life. The consequences of inadequate access are similarly grave, and like the courtroom, medical settings also contain complex vocabulary and interpersonal dynamics. The arguments for a specialized legal certification are directly applicable to support a specialized healthcare certification as well.

Interpreting in healthcare settings carries with it many of the complexities of interpreting in legal settings, such as intricate social, linguistic, and procedural factors. Interpreters without adequate experience in a medical environment may fail to fully notice underlying meanings behind a message, the true role of each person in the interaction and their motivations, or how power differentials affect the interactions. A study by Davidson found that one hospital's culture of maximizing efficiency and reducing time spent with each patient influenced how much information was interpreted from the Spanish-speaking patients into English to the treatment provider. The researchers found that this external pressure resulted in the role of the interpreter being changed: "Analysis shows that, through variable patterns of how and when utterances are interpreted, the interpreter functions, not as an 'ally' of the patient nor as a neutral conveyor of propositions, but rather as a covert co-diagnostician and institutional gatekeeper" (Davidson, 2001, p. 1).

In many of the encounters collected, interpreters answered patient questions themselves or simply neglected to interpret them. As a result, the patients were perceived by the physician as uninterested in their own health, which affected the course of treatment even further. In a

Scandinavian study surveying the opinions of spoken language healthcare interpreters, respondents were in agreement that their role in the clinical encounter was fraught with uncertainty and conflict: “Some of the interpreters regarded themselves as closer to the [general practitioners]... The patient, on the other hand, usually looked upon the interpreter as some sort of counsellor” (Fatahi, Mattsson, Hasanpoor, & Skott, 2005, p. 162). Respondents in this same study also mention difficulty mediating between the healthcare culture of the doctor and the culture of the patient within the system’s time constraints. Though these studies focus on spoken language interpreting, their results are relevant to signed languages as well. In the field of healthcare, interpreters must be familiar with the unique sociolinguistic factors of the setting. They must incorporate far more than the actual utterances of the participants, including contextual information, implied meaning, emotional content conveyed by prosody, and much more. Furthermore, they must do so in a high-pressure, fast-paced environment.

Not only is the environment of healthcare a complex one, the vocabulary itself is technical enough to require additional education, especially for someone needing to know it in two languages. Medicine has an enormous amount of advanced vocabulary, with specialized terminology and implicitly conveyed information of anatomical systems, illnesses and treatments, complications, procedures and policies. Though interpreters cannot be expected to have in-depth knowledge of all medical concepts equivalent to a physician’s knowledge, a basic understanding of common healthcare language is essential to deliver adequate interpretations.

One study conducted in South Africa examined whether interpreters fully understood an informed consent form they were required to interpret and have the patient sign. All the participants were professional interpreters: one with no previous interpreting training and five

with interpreting training ranging from six weeks to two years. None of the interpreters felt that they understood the message enough to interpret it, some felt it was too long or complicated to accurately paraphrase to fit the time allotted to explain it, and none felt comfortable getting the patient to sign that they understood and consented to the treatment. Not only were the interpreters in this study asked to balance shifting roles in the interaction (by acting as members of the healthcare team as well as translators), they lacked the vocabulary and background knowledge to do even the primary job of interpreting. The researchers concluded that, “The interpreter needs to have a deep and thorough knowledge of the subject matter as well as the language used within that field... The ability to interpret accurately and completely is, to a large extent, dependent on how much background knowledge the interpreter has of the content and context of the communication” (Feinauer & Lesch, 2013, p. 121). Since even professionals cannot interpret what they do not understand, it is essential for healthcare interpreters to have basic extralinguistic knowledge of the specialized vocabulary in English as well as a good grasp on how to express those concepts in ASL.

Given the evidence of the multifaceted environment and language of healthcare, the frequency of unqualified interpreters accepting assignments in this field is cause for concern. A study by Walker and Shaw (2011) on specialized settings found that healthcare was the second most frequently worked setting for recent graduates of ASL-English interpreter training programs in the US, with interpreters deeming themselves “prepared” within 6 months to one year post-graduation. Ninety-three percent responded they would feel comfortable interpreting in “any” medical situation. Even more concerning is the finding that “some respondents confessed that they proceeded with healthcare interpreting because the work was available, despite the fact

that they felt unprepared” (2011, p. 6). These same respondents acknowledged the importance of background knowledge of medical concepts and a need for strong expressive skills in ASL.

These same respondents rated legal interpreting as the most common specialization they would not work, citing “a lack of procedural and terminology knowledge, ASL vocabulary deficiency, and the potential for added liability and responsibility” (Walker & Shaw, 2011, p. 7). The evidence indicates that interpreters need to examine the contradicting beliefs that legal interpreting is a highly specialized field but healthcare interpreting is not. Both are areas requiring specialized skills with the possibility for serious and profound consequences if mistakes are made.

The consequences of mistakes in medical interpreting have been demonstrated in the literature. One famous case of a tragic miscommunication happened in 1980, when an 18-year-old Spanish speaking male named Willie Ramirez presented to an emergency room (ER) in an unconscious state. The ER doctor relied on his rudimentary knowledge of the Spanish language in lieu of calling a professional interpreter to the scene. When the family used the Spanish word “intoxicado,” meaning an adverse reaction to something one eats or drinks, the doctor made a false fluency assumption and believed the patient to be intoxicated from a drug overdose. Ramirez’s brain hemorrhage went undiagnosed for over two days, resulting in him becoming quadriplegic. Later, the family admitted that they discussed amongst themselves that drugs were not even a possibility, but their cultural norms precluded them from contradicting or confronting the authority of the doctor. The interpreting mistake cost the hospital \$71 million in settlement money and damaged several lives: the patient’s, the family’s, and the doctor’s (Price-Wise, 2008). The presence of a professional interpreter with healthcare specific skills



could have changed this story, through an understanding of medical vocabulary, the subtleties of message equivalence, and cultural mediation.

However, research has also shown that professional interpreters make serious mistakes as well. In a study published in the journal *Pediatrics*, thirteen interpreted clinical encounters with Spanish patients were recorded and analyzed for errors (six of the encounters used professional interpreters employed by the hospital's interpreting department, seven used ad hoc interpreters with no interpreting training, such as nurses or family members). Of the encounters with a professional interpreter, linguistic analysis found an average error rate of 30 interpreting errors per encounter, most commonly errors of omission and false fluency. Many of the errors were attributed to lack of knowledge of medical terminology and lack of fluency with this vocabulary in Spanish. The study found that over half of the errors had potential clinical consequences, leading the authors to conclude that "most hospital interpreters do not receive adequate training at their institution" (Flores et al., 2003, p. 10). While it may not be possible to produce an error-free interpretation, given the fact that errors may have a significant effect on the patient's health, attempts should be made to reduce or limit the frequency of serious errors through increased specialized training and certification.

Many of the arguments for specialized healthcare certification focus on the interpreter, but it is also essential to consider the perspective of the d/Deaf consumer in the healthcare setting. A study by Meador and Zazove (2005) found that d/Deaf patients face several barriers to treatment, including inadequate linguistic accommodations, mistrust of healthcare providers, and being perceived to have low intellect. A later study conducted focus group interviews among Deaf communities in several American cities to gather information about participants'

experiences in the healthcare system. The interviews found that common issues included problems with communicating, fear about bad outcomes, feelings of mistrust, and low rates of self-advocacy. Analysis of the focus groups found that "...many participants reported that communication was best with medically experienced certified interpreters (Steinberg, Barnett, Meador, Wiggins, & Zazove, 2006, p. 261). These studies indicate that d/Deaf people struggle to receive adequate care or access to services. Awareness of the d/Deaf experience in healthcare settings can provide valuable insight when considering the need for increased training and specialized certification.

Finally, a component of the healthcare specialization that is less frequently discussed is the high-stress environment and its contribution to vicarious trauma, compassion fatigue, and burnout. Especially in settings such as hospitals and mental health clinics, interpreters may benefit from additional training on how to avoid burnout or vicarious trauma and tools to recognize and mitigate it when it happens. One study published in the *Journal of Interpretation* argued that interpreters are prone to vicarious trauma simply due to the nature of their work: by placing themselves in the first person to actively listen, visualize, reformulate, match affect, and retell traumatic events, interpreters make themselves vulnerable to being affected by the content of the message themselves (Anderson, 2011). The study also argued that the ethical tenets an interpreter must follow of objectivity and confidentiality may further remove them from awareness of how they are impacted by the work (Anderson, 2011). An earlier study found several other contributing factors to burnout and vicarious trauma: stressful working conditions, unreasonably high expectations for interpreters, differing opinions on the interpreter's role, sensitive and emotional situations with no opportunity to process them, a narrowly-defined

ability to help consumers, and “real or perceived skill inadequacies” (Dean & Pollard, 2001, p. 3).

All of these factors and more are present in the health care environment. However, research has indicated that receiving proper training about the risks of working in high-stress environments, about the factors involved in burnout and vicarious trauma, and about healthy coping skills can mitigate these risks. Bontempo and Malcolm (2012) examined the range of factors that contributed to vicarious trauma, including personality traits, characteristics of the interpreting profession, and positive and negative coping skills. They found that incorporating discussion on this topic into interpreter education programs would benefit interpreters when they face high stress situations: “Incorporating trait awareness into interpreter training and developing skills such as self-confidence, positive coping strategies, assertiveness, and resilience would also most certainly be useful...” (p. 129). Since interpreters face a heightened level of stress in healthcare settings specifically, it is likely that training and education in managing this stress may benefit their personal safety, health, and well-being.

### **Method**

This research consisted of pilot surveys of both the d/Deaf community and ASL-English interpreters currently working in the field. Each group had their own survey with questions directed to their experiences (see Appendices A and B for full questionnaires). Extensive demographic information of participants was not collected to protect anonymity and encourage participation; each group had a sample size of 5 participants. All d/Deaf participants used ASL as their primary language. For that group, questions were designed to elicit information about their experiences with interpreters in a healthcare setting and their opinions on the need for specialized

certification. Surveys were administered in-person on paper, and further clarification of the questions were provided by the researcher in ASL whenever it was requested by participants. All interpreter participants had several years of experience in the field of interpreting as well as experience in healthcare settings. Surveys sought to collect their opinions on the need for specialized certification and were administered online via email. Responses were analyzed both quantitatively and qualitatively for trends in the data, with written comments from participants included in the results section below.

### Results

All Deaf respondents felt that healthcare interpreting should require a specialized certificate comparable to legal certification. Additionally, all respondents felt they would be more trusting in the interpretation received by an interpreter with a certificate like this. A majority of the sample felt the healthcare setting was “high risk” or “very high risk.” Table 1 shows the data of Deaf participants by survey question and response.

**Table 1**

**Proportion of d/Deaf Participants’ Responses by Survey Question and Response**

Survey question	Response	
	Yes	No
Should healthcare interpreting should require specialized certification?	1.00	0.00
Have you had a negative healthcare experience with an underqualified interpreter?	0.40	0.60
Would you feel more trusting of interpreter with specialized certificate?	1.00	0.00
Would you consider an interpreter without medical background knowledge to be qualified?	0.00	1.00
	<b>High risk</b>	<b>Very high risk</b>
How “high-risk” is the healthcare setting? <sup>a</sup>	0.40	0.60

<sup>a</sup> None of Deaf respondents answered that the healthcare setting was “very low risk,” “low risk,” or “average risk.”

One additional finding was that of the three respondents who indicated they never had a negative experience with an interpreter, two specified that they had never requested a professional interpreter, opting to use pen and paper or family members instead. Two of the three respondents who had used interpreters in the past had at least one negative experience. One respondent also stated that his negative experience was with Video Remote Interpreting (VRI), in which interpretation was provided remotely through a computer: “VRI doesn’t allow reliable communication and there are often miscommunications.”

Perspectives among the interpreter sample were more varied, with a small majority believing healthcare interpreting should require specialized certification. Additionally, most of the interpreter respondents indicated they were unsure if they would pursue such a certification if it were offered. The perspectives among interpreters regarding risk level of healthcare settings was also more varied than Deaf respondents: the majority opinion was split between rating the setting as average/neutral risk or high risk, and a small minority felt it was a very high risk setting. Table 2 shows the data of interpreter participants by survey question and response.

**Table 2**

**Proportion of Interpreter Participants’ Responses by Survey Question and Response**

Survey question	Response		
	Not Sure	Yes	No
Should healthcare interpreting require specialized certification?		<b>0.40</b>	<b>0.60</b>
Is additional practice/mentoring necessary for healthcare interpreting?		<b>0.80</b>	<b>0.20</b>
If a specialized certificate for healthcare was offered, would you try to obtain it?	<b>0.80</b>	<b>0.20</b>	<b>0.00</b>
	<b>Average risk</b>	<b>High risk</b>	<b>Very high risk</b>

How “high-risk” is the healthcare setting? <sup>a</sup>	<b>0.40</b>	<b>0.40</b>	<b>0.20</b>
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<sup>a</sup> None of interpreter respondents answered that the healthcare setting was “very low risk” or “low risk.”

Additionally, the majority of respondents (80%) did feel additional practice or mentoring was necessary for interpreting in a healthcare setting, as well as specialized vocabulary in ASL and English (80%), knowledge of medical ethics (80%), a minimum level of background medical knowledge (100%), and an understanding of hospital culture (60%). Only 40% believed prior experience in a healthcare setting was necessary for healthcare interpreting.

One interpreter added a comment that “healthcare is such a wide subject that it’s a little hard to answer... In more than half of all healthcare interpreting appointments, there is very low risk. There are rare cases that are higher risk, but they are few and far between and usually the risk is more for the doctor than the interpreter.”

### **Discussion**

The majority opinion of Deaf participants surveyed in this study supports the notion that healthcare interpreting should require specialized certification. All Deaf participants rated the healthcare setting as high risk or very high risk, all felt an interpreter without background knowledge in healthcare would be unqualified to interpret, and all stated they would feel more comfortable with standards of practice that certification entails.

The opinions of working interpreters was somewhat more divided: The minority (40%) believed that healthcare assignments should require specialized certification, and the majority (80%) were not sure they would seek it out if it was offered. Despite the split opinions on certification, though, most interpreters did acknowledge the importance of additional practice

and/or mentoring, background knowledge of medical issues, specialized vocabulary, ethics, and healthcare culture. One potential reason for the variety of responses may be explained by one interpreter's comment that the healthcare field consists of such a wide range of situations of varying levels of risk that it is difficult to make generalized statements about the field. Other potential reasons may include a resistance to further credentialing, a lack of awareness in judging their own competence, or perhaps a belief that standardized specialization is not the appropriate response.

Additionally, it is worth noting that opinions between Deaf consumers and professional interpreters were quite divided. While most of the interpreters did not believe healthcare interpreting should require additional certification, most of the Deaf respondents who used interpreters in this setting reported negative experiences. This may indicate a disconnect between interpreter's perceptions of their work and the reality of consumers' experiences that is worth examining further. The divide may also reflect a difference in how important the encounter is for both parties; that is, while interpreters may understand the significance of being qualified and delivering a good interpretation, it is ultimately a job, with the professional distance a job affords. For the Deaf consumer, however, the situation is highly personal and they are the ones impacted if errors are made. While the interpreter is free to move on to the "next job," the Deaf consumer could continue to experience the consequences of a failed interpretation. This disparity may lead a d/Deaf participant to have stronger opinions about certification than an interpreter participant.

This pilot survey was designed to explore the current opinions regarding healthcare specialization of two populations with significant stake in the matter. As with all pilot studies,

however, it, has limited scope and leaves much opportunity for expansion. Since this study had a small sample size of 10 participants, repeating the surveys with a larger, more representative sample size would produce more reliable results. The surveys could also be lengthened to include the varied nature of healthcare interpreting: gathering opinion on how to balance low risk situations like routine checkups versus high risk situations like surgeries. Interviews could also be utilized in order to better understand the experiences of patients and the work performed by interpreters.

Being cautious about not creating too many barriers of entry to practice must also be part of the conversation. There are a number of difficult but critically important questions to be answered: Should everything with any healthcare element require certification, or only certain settings like inpatient or emergency rooms? If further research also showed a wide spectrum of opinions, it would be worth examining why: do interpreters truly consider the full complexity of healthcare, is risk difficult to predict accurately, is the trend toward specialization encountering resistance?

Another area of study closely related to this research would be VRI and its use in medical settings. The trend in hospitals seems to be moving towards VRI as a time- and cost-saving measure, in opposition to the trend in interpreting towards specialization. Research is needed to determine how d/Deaf patients are affected by VRI and how its use factors into evidence based practice. There is much work to be done to answer the question: what is truly the best conceptualization of interpreting in the healthcare setting, meeting the needs of consumers, and creating sustainable and realistic professional standards?



Further research can continue to guide the conversation regarding healthcare interpreting and specialization, but it is a conversation whose time has come. The interpreting profession must always strive to move towards high standards of work and evidence based practice. The research cited in this paper provides a strong argument that healthcare interpreting should be considered for specialized certification. In the final analysis, the complexity of the interactions, the advanced vocabulary, the high-stress situations, and the inherent risk of the setting demands the most qualified interpreters as well as a standard of assessment to determine this competency.

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## Appendix A

### Pilot Survey of Deaf Participants

1. Do you think healthcare interpreting should require a specialized certificate (comparable to legal certification)?
2. Have you ever had a negative experience with an underqualified interpreter in a healthcare setting?
3. Would knowing your interpreter has a specialized certificate make you feel more comfortable or trusting in the interpretation you receive?
4. Would you consider an interpreter without background knowledge of the medical setting to be qualified for that setting?
5. How “high-risk” is the setting of healthcare?
  - Very Low Risk
  - Low Risk
  - Average/Neutral Risk
  - High Risk
  - Very High Risk

## Appendix B

### Pilot Survey of Working Interpreters

1. Do you think healthcare interpreting should require a specialized certificate through RID (comparable to the legal certificate)?
2. In your opinion, which of the following are necessary in healthcare interpreting? (check all that apply)
  - A minimum level of medical background knowledge (e.g., basic anatomy, common illness, frequently occurring symptoms, etc)
  - Specialized vocabulary in both English and ASL
  - Prior experience in a healthcare setting (either as an interpreter or in another role)
  - Understanding of hospital culture
  - Knowledge of medical ethics
3. How “high-risk” is the setting of healthcare?
  - Very Low Risk
  - Low Risk
  - Average/Neutral Risk
  - High Risk
  - Very High Risk
4. Do you think additional practice and/or mentoring in a healthcare-specific setting is necessary to interpret in that environment effectively?
5. If a specialized certificate for healthcare interpreting was offered, would you try to obtain it?
  - Yes
  - No
  - Not sure