STANDARDS OF PRACTICE
EXHIBIT "A"

The IMIA, the governing body of the interpreting trade has established standards of practice for our industry. These standards are founded on the premise that an interpreter's primary task is interpretation, that is, the relaying of a message expressed in a source language into its equivalent in a target language, so that the interpreted message has the potential for eliciting the same response in the listener as the original message. (Seleskovitch, 1978; Cokely, 1988; Downing and Swabey, 1992). To be able to do this, the interpreter must not only be fluent in both the source and target languages but must also have the skills and knowledge base to be able to comprehend the message quickly in the source language and just as quickly re-express it in the target language.

If all that the provider and patient need to achieve the goals of the clinical encounter is this linguistic conversion, then the interpreter's role is fulfilled simply by providing such a conversion. The standards, however, go beyond the skills of conversion and recognize the complexities of interpretation and the clinical interview. The medical encounter is a highly interactive process in which the provider uses language (the provider's and the patient's) as a powerful tool to understand, evaluate, and diagnose symptoms (Woloshin et al., 1995) and to mutually inform and instruct. The interpreter, therefore, cannot simply be a 'black box converter" but must know how to engage both provider and patient effectively and efficiently in accessing the nuances and hidden socio-cultural assumptions embedded in each other's language, which could lead to dangerous consequences if left unexplored.

These standards of practice also recognize the importance of the medical encounter in establishing a therapeutic connection between provider and patient. The formation of a therapeutic relationship is especially difficult when parties cannot communicate directly, and it becomes even more complex when different culturally based belief systems are involved. A competent interpreter can mediate these barriers by attending not only to the linguistic but also to the extra-linguistic aspects of communication.

The Medical Interpreting Standards of Practice are organized into three major task areas: (1) interpretation, (2) cultural interface, and (3) ethical behavior. Following is a brief explanation of each of these task areas

A. Interpretation

As noted earlier, the primary task of the interpreter is to interpret, that is, to convert a message uttered in a source language into an equivalent message in the target language so that the intended recipient of the message responds to it as if he or she had heard it in the original (Seleskovitch, 1978; Cokely, 1988; Downing and Swabey, 1992). The primary test of a competent interpreter, therefore, is the accuracy and completeness of the interpretation.

Although the main task of the interpreter is to interpret, there are other complementary skills that an interpreter must possess, although they are not necessarily used in every encounter. The standards of practice in this section focus on both the skills of straight interpreting and these complementary skills. The skills in this section can be organized around five subtasks:

1) ***Setting the stage****.* The role of the professional interpreter is still new and largely unknown in the medical setting. For this reason, it is important for interpreters to set clear expectations of their role at the very start of the triadic (provider-patient-interpreter) encounter, stressing in particular the elements of accuracy, completeness, and confidentiality. It is also important in the early moments of the triadic encounter for the interpreter to attend to other concerns, such as arranging the spatial configuration of the parties in the encounter, addressing any discomfort a patient or provider may have about the presence of an interpreter, or assessing the linguistic style of the patient, keeping in mind at all times the goal of establishing a direct relationship between the two main parties.

2) ***Interpreting****.* The most basic task of the interpreter is to transmit information accurately and completely. Therefore, interpreters must operate under a dual commitment: (1) to understand fully the message in the source language, and 2) to retain the essential elements of the communication in their conversion into the target language. Interpreters whose linguistic proficiency (in terms of breadth and depth) in both languages is very high and who have a solid working knowledge of the subject matter are more likely to be able to make the conversions from one language to another without needing to ask for much clarification Those whose linguistic proficiency is limited can use appropriate strategies to ensure that they themselves understand the message before they make the conversion and that all the pertinent information has been transmitted.

3) ***Managing the flow of communication.*** In the interest of accuracy and completeness, interpreters must be able to manage the flow of communication so that important information is not lost or miscommunicated. Interpreters may also have to attend to the dynamics of the interpersonal interaction between provider and patient, for example when tension or conflict arises. The role of the interpreter, however, is not to take responsibility for the actions of the two parties but rather to assist in establishing a communication process that allows the parties to work things out for themselves.

4) ***Managing the triadic relationship.*** The introduction of a third party into the medical encounter generates dynamics that are inherent in triadic interactions. A primary characteristic of a triadic, as opposed to a dyadic, relationship is the potential for the formation of an alliance between two of the three parties. Because the interpreter is the party to whom both provider and patient can relate most directly, both have a propensity to want to form an alliance with the interpreter. The provider and patient often exhibit this tendency by directing their remarks to the interpreter rather than to each other, which leads to the 'tell the patient/doctor' form of communication. Thus, the interpreter must work at encouraging the parties to address each other directly, both verbally and nonverbally. The natural tendency of both providers and patients is to perceive interpreters as an extension of either their own world or the other, rather than as partners in their own right, with their own role responsibilities and obligations. For patients, the desire to form an alliance with the interpreter is heightened because they are likely to perceive the interpreter as understanding not only their language but also their culture. This perceived cultural affinity often leads patients to act as if the interpreter were there as their friend and advocate. For providers, the danger lies in assuming that the interpreter is part of their world and therefore expecting that the interpreter can and should take on other functions, such as obtaining a medical history. On the other hand, when providers assume that interpreters are extensions of the patient's world, they tend to dismiss the importance of their role and ascribe inferior status to their work.

As professionals in their own right, in the interpreter-mediated encounter interpreters owe their allegiance to the therapeutic relationship and its goals of quality health care. Their commitment is to support the other two parties in their respective domains of expertise – the provider as the technical expert with the knowledge and skills in medicine and health care, and the patient as the expert on his or her symptoms, beliefs, and needs. The provider offers informed opinions and options, while the patient remains the ultimate decision maker in terms of treatment. The role of the interpreter is not to take control of the substance of the messages but rather to manage the process of communication.

5) ***Assisting in closure activities.*** The responsibility of the interpreter in the closing moments of the clinical encounter is to encourage the provider, when necessary, to provide follow-up instructions that the patient understands and will therefore be likely to follow. In addition, the role of the interpreter is to make sure that the patient is connected to the services required (including additional interpreter services) and to promote patient self-sufficiency, taking into consideration the social context of the patient.

B. Cultural Brokering

Language is not the only element at work in the interaction between providers and patients who speak different languages. The meaning inherent in the messages conveyed is rooted in culturally based beliefs, values, and assumptions. According to the linguists Whorf (1978) and Sapir (1956), language is an expression of culture and the way in which culture organizes reality. The interpreter, therefore, has the task not only of knowing the words that are being used but of understanding the underlying, culturally based propositions that give them meaning in the context in which they are spoken. Interpreting in the health care arena requires the interpreter to understand the ways in which culturally based beliefs affect the presentation, course, and outcomes of illness as well as perceptions of wellness and treatment.

If provider and patient share similar assumptions about medicine and its positivistic, scientific principles, it is more likely that the interaction will go as smoothly as if they were speaking the same language. In such a case, the interpreter simply has to make the conversion from one linguistic system into the other; the layers of meaning will automatically be understood.

As the dissimilarities between providers' and patients' assumptions increase, however, literal interpretations become inadequate, even dangerous. In such cases, to convey the intent of the message accurately and completely, the interpreter may have to articulate the hidden assumptions or unstated propositions contained within the discourse. Here the role of the interpreter is to assist in uncovering these hidden assumptions and, in doing so, to empower both patient and provider with a broader understanding of each other's culture.

Another major cultural linguistic problem occurs when a speaker uses 'untranslatable' words. 'Untranslatable' words represent concepts for which a comparable referent does not exist in the society of the target language (Seleskovitch, 1978). For example, the concept of bacteria, a living physical organism that is not visible to the naked eye, is a concept that has no equivalent in many rural, non-literate societies. To get the concept across, the interpreter may have to work with the provider to find ways to transmit the essential information underlying this concept.

Interpreters, therefore, have the task of identifying those occasions when unshared cultural assumptions create barriers to understanding or message equivalence. Their role in such situations is not to 'give the answer' but rather to help both provider and patient to investigate the intercultural interface that may be creating the communication problem. Interpreters must keep in mind that no matter how much 'factual' information they have about the beliefs, values, norms, and customs of a particular culture, they have no way of knowing where the individual facing them in that specific situation stands along a continuum from close adherence to the norms of a culture to acculturation into a new culture. Cultural patterns, after all, are generalized abstractions that do not define the individual nor predict what an individual believes or does. They are simply hypotheses that may be more likely to occur in a member of that culture than in someone who is not a member (Avery, 1992).

C. Ethical Behavior

The role of interpreter, on the surface, appears to be straightforward and uncomplicated. The interpreter is present to convert a message uttered in one language into another. Professional interpreters, however, understand the profound complexities of what appears to be a simple task. In fact, even in the simplest of encounters, the interpreter may need to recognize and address a series of dilemmas.

In face-to-face, interpreter-assisted, medical encounters, the very presence of the interpreter changes the power dynamic of the original dyadic relationship between patient and provider. In a very significant way, the interpreter holds tremendous power, often being the only one present in the encounter who understands both languages involved. In addition, the interpreter enters the interaction as an independent entity with individual

beliefs and feelings. Both the patient and the provider have to be able to trust that the interpreter will not abuse this power. They need to trust that the interpreter will transmit faithfully what it is they have to convey to each other and not the interpreter's own thoughts. They also need to trust that the interpreter will uphold the private and confidential nature of the clinician-patient relationship. "It is the function of a code of ethics to guide the interpreter on how to wield that power" (Edwards, 1988, p.22). A code of ethics provides guidelines and standards to follow, creating consistency and lessening arbitrariness in the choices interpreters make in solving the dilemmas they face (Gonzalez et. al. 1991).

Adhering to this code of ethics also includes arriving early for your appointments and following through until the end of the appointment and never appearing to have to "rush" to get to your next assignment.