



MODELS FOR THE PROVISION OF LANGUAGE ACCESS IN HEALTH CARE SETTINGS

by
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The National Council on Interpreting in Health Care

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INTRODUCTION

Scope and Purpose

The aim of this paper is to describe various approaches that have been taken or could be taken to avoid the linguistic incompatibility that impedes full and equal access to health care on the part of health care providers and their patients when they do not speak the same language.^{1, 2, 3, 4, 5}

For present purposes, we will assume that the common language of health care delivery is English, and that the language of the non-English-speaking individuals who seek health care is principally Spanish. Language access in settings other than health care will not be considered.

Approach

To maintain a focus on description and comparison of models, rather than evaluation or ranking of approaches, the paper is organized by categorizing the logically possible approaches into broad models of linguistic accommodation of which the more specific models are presented as subcategories. These individual models will be defined and discussed in terms of their inherent advantages and disadvantages. For each model, an effort is made not to focus on the shortcomings or successes of any actual implementations of a model, but rather on inherent characteristics of the model itself. Nevertheless, this paper also addresses practical limitations that may render a model inappropriate for some or even all practical applications.

The fundamental importance of language proficiency, interpreting skills and cultural competence.

Despite the variety of approaches to be described, one unavoidable element is common to all successful models of communication in health care. It is taken as given that communication and understanding between provider and patient are essential to the successful provision of health care. For this essential communication to take place, the two parties must share a common language. Regardless of differences in accent or dialect, range of vocabulary and levels of medical knowledge, the parties must be able to express themselves and understand each other sufficiently to arrive at mutual understanding. This means that when a bilingual provider communicates directly with a Spanish-speaking patient in Spanish, the provider must have a high level of competence in that language. It also means that Spanish-speaking patients should be expected to communicate their needs in English only if they have an adequate facility in English. Finally, it means that anyone serving as interpreter must be able to communicate adequately both in English, when speaking to an English-speaking provider, and in Spanish, when speaking with a Spanish-speaking patient or family member. This requirement holds whether the interpreter is a friend of the patient, an employee acting as interpreter, or a full-time staff interpreter. In the health care setting, linguistic competence in each language must include a strong command of health care vocabulary and the equivalence (or non-equivalence) of terms and concepts across languages. Otherwise, the aim of providing unimpeded access to health care will be compromised.

When the model includes the use of a linguistic intermediary – an interpreter – the requisite linguistic competence includes a set of skills specific to interpreting, including memory and note-taking skills, language transposition skills, etc., that go well beyond mere proficiency in speaking the languages in question. While language skills may be learned at home, in society or

through a general education, interpreting skills are primarily gained through specific training and are rarely developed through simple experience.

Finally, language and culture are inseparable. A patient and a provider who speak different primary languages will of necessity be of different cultures. Even patients and providers who do speak the same language may not share a cultural background. As a result, both providers and interpreters must be aware of the role that culture plays in communication and in health-related knowledge, attitudes and behavior, so that messages can be accurately rendered and comprehended in their own cultural context.

Any model of interlingual communication can be successful only to the extent that these basic skill requirements are satisfied.⁶

The necessity of multiple, complementary approaches

In this paper, a number of models are distinguished and described individually. In practice, however, in most if not all settings, a combination of models constituting a “multifaceted model” provides the best solution for eliminating linguistic barriers to health care. Even where most providers speak Spanish well enough to communicate in Spanish with their patients, interpreters will be needed when a patient must speak with a technician, admissions clerk, or replacement provider who speaks only English. Even when a hospital or clinic has dedicated interpreters on staff, a list of on-call interpreters may be needed to serve at times of high demand, after hours, etc. Telephonic interpreting may be needed when a provider communicates with a patient by phone even if face-to-face interpreters are generally preferred and available. It may be appropriate in some circumstances to rely on bilinguals engaged by the patient to interpret, but the use of such ad-hoc interpreters is risky unless interpreters with proven qualifications are available to monitor and if necessary replace the ad-hoc interpreter. The Spanish-English staff interpreter may need to be assisted by a Zapotec-Spanish interpreter when the patient speaks Spanish only haltingly, as his or her second language.

The models presented here as alternatives will therefore often need to be employed not as exclusive alternatives but as complementary parts of a comprehensive and flexible system facilitating communication between representatives of a health care system which predominately uses English and any patient whose language of preference is one other than English.

This paper will not distinguish face-to-face from telephonic interpreting as models. Rather they are seen as crosscutting means of implementing any of the models that require interpreting services. However, since telephonic interpreting and even video interpreting are becoming more popular, a short discussion of the implications of introducing such technology is included.

In what follows we will consider several models for communication in health care with LEP patients. Each model will be described and then discussed in terms of its inherent advantages and disadvantages and the circumstances in which the model seems most appropriate and most likely to succeed.

BILINGUAL PROVIDER MODELS

The ideal situation for any communication is one in which the parties are able to communicate directly with one another in a language that each speaks proficiently. In the U.S., English-speaking providers serve English-speaking patients in English. Ideally, also, Spanish-speaking providers and Spanish-speaking patients should be able to converse directly in Spanish. In this model, health care providers communicate directly with their patients in the patient's language, and written materials are likewise available in a language the literate patient readily understands. In such a setting, interpreters are unnecessary.

It is useful to distinguish two variants of this bilingual workforce model. (Other "work-force" models, one in which bilingual staff members interpret for others as needed, and one in which dedicated interpreters are employed as part of the workforce, are discussed separately below.)

Native Spanish-speakers as providers speaking Spanish

In this model the workforce is made up of bilinguals able to speak English in their contacts with the English-speaking world and Spanish in their contacts with Spanish-speaking patients and their families. The bilinguals speak Spanish by virtue of their ethnic heritage or national origin.

This model has several advantages. Most importantly, it satisfies the communicative ideal: health care services offered by providers able to communicate with each patient in the patient's language. It entails no interpreter costs and may require no special training programs. It approximates the services provided to English-speaking patients by English-speaking providers.

There are some disadvantages inherent in the model, however. Health care providers working in the U.S. must be proficient in English in order to function professionally in an English-dominant society. Many if not most of the books, articles, instructions, and charts, etc., that they read are in English. Often they received their professional education in English. Unless they have worked professionally in Spanish-speaking health care settings or received special training, their knowledge of Spanish may be limited to non-professional domains, such as family and community. They may be able to express their professional knowledge of health care better in English than in Spanish but to socialize more comfortably in Spanish than in English. In order to interact with patients in Spanish within the professional domain, they may need to work on developing the professional register of medical Spanish. In addition, their general proficiency in Spanish, their knowledge of dialects other than their own, etc. may be inadequate without special efforts devoted to extending their linguistic repertoire.⁷

There are some limitations on the venues in which such a model for language access will be effective. A Spanish-speaking doctor in private practice can insist that the nurse and the receptionist working in his or her office also speak Spanish. But in most communities in the U.S., it would be difficult or impossible to staff a large clinic or hospital entirely with individuals who are proficient enough in Spanish to provide all patient services in Spanish. Even if the medical and nursing staff is made up of Spanish-speakers, patients are likely to have contact with orderlies, scheduling clerks, lab technicians, or pharmacists who speak only English. For this reason, dependence on Spanish-speaking providers must often be complemented by the use of

interpreters. When the clinic or hospital serves multiple language groups, it becomes virtually impossible to guarantee that providers of all services will be able to speak all the languages required and so, again, other models must be used as well.

Native English-speakers providing services in Spanish

Like the previous model, this one focuses on providers communicating with Spanish-speaking patients in Spanish, without the need for interpreters. It emphasizes language instruction for providers (or future providers) who are not already proficient in Spanish, with the aim that all staff members will become bilingual and thus able to serve patients in their native language.

This model is again designed to promote the ideal of direct communication with patients in the patients' language, avoiding the need for interpreters. It goes beyond reliance on providers with native command of Spanish by promoting the idea that any health care provider, regardless of native language, can develop the capacity to serve Spanish-speaking clients in Spanish. Costs in this model are centered on the preparation and continuing development of the language skills of those who are or will become providers rather than the cost of developing interpreters and the ongoing cost of interpreter services. Essentially, one-time educational costs replace the expense of maintaining an interpreter service, while patients are better served through direct communication in their language.

Unfortunately, learning to speak a second language proficiently is a long and time-consuming process. Some individuals, regardless of their intellectual capacity or level of education, have little aptitude for language learning. Even for those with linguistic aptitude, classroom language instruction is poorly suited to developing the cultural understanding that must accompany language skills in order for real communication to take place. Even an undergraduate major in Spanish is generally insufficient for an individual to achieve the requisite native-like competence. A lengthy residence in a Spanish-speaking environment, along with formal language study, might be adequate preparation, but this is costly and may be impractical as a requirement for everyone who deals directly with patients, from doctors to lab technicians, pharmacists, nursing assistants, and clerical staff. Less extensive instruction in Spanish is valuable for anyone who serves Spanish-speaking patients, if only to enhance rapport and respect for the patients and their culture, but "a little Spanish" will not generally enable a doctor to take patient histories, or obtain informed consent, or discuss the pros and cons of treatment alternatives in the Spanish language.⁸

Before it is possible to expect most or all providers of health care services to communicate with their patients in Spanish, it may be necessary for American education to require the mastery of a second language as a normal part of education for all citizens, just as, for example, mastery of English or some other foreign language is expected of educated adults in Sweden, Germany and many other countries.

Under what circumstances can this model succeed then? This model offers a possible long-term solution to problems in providing health care access to Spanish-speakers, and in the short-term can may increase the number of providers able to communicate without the help of interpreters. Heavy reliance on this model, however, may require widespread, long-term systematic changes in the preparation of health professionals and perhaps in American education generally.

Training in medical Spanish, extended visits to Spanish-speaking countries, and courses on cultural health care beliefs and practices of Hispanic communities are always valuable, even for providers who must rely on interpreters. Targeted language training may bring individuals who already have a strong base of knowledge of Spanish to a level where they can communicate without an interpreter in at least some situations.

THE BILINGUAL PATIENT MODEL (The ESL Approach)

This model focuses on developing the capacity of patients to speak English, in order to express themselves and communicate with health-care providers in the dominant language of the health-care establishment and of the country in which they reside.

Like the previous models, this model aims for direct communication between providers and patients, making interpreters unnecessary. Given the dominance of English for most public purposes in the U. S., it seems desirable for all residents of the country to be able to communicate in English, not only in seeking health care but also in many domains of life. If Spanish-speaking individuals become bilingual in Spanish and English at a sufficiently high level, they will be able not only to communicate readily with any health-care provider but also to enjoy all the other benefits of speaking English in an English-dominant country.

However, while the American educational system is geared toward English language proficiency, and adult education courses in English are widely available, the system cannot make proficient English-speakers of the large number of Spanish-speakers who are recent immigrants from other countries or who have not been able to complete their educations in English-medium schools. Language mastery is time-consuming and often highly demanding for adult learners, and the difficulty increases with age. Many Spanish-speakers live in environments that provide little day-to-day contact with English-speakers. Existing English as a Second Language (ESL) programs for adults generally emphasize practical communication for survival and employment, but do not develop the higher-level language skills one needs to understand explanations of diseases and bodily processes or treatment alternatives. Adults who have families to support and care for generally do not have the time or the means necessary to develop mastery of a second language.⁹

As a long-term strategy, any effort to help Spanish-speaking residents of the U. S. develop their ability to communicate in English is clearly worthwhile. However, for older adults who do not already speak English well and especially for recent immigrants, this language-learning model, by itself, does not solve the immediate problem of communicating in health care settings for those who have not yet mastered English or are unable, for whatever reasons, to do so.

Clearly, instruction in medical English can be valuable for those who already have a basic understanding of English. However, individuals who need to develop their English in this area also need to develop other aspects of English proficiency for other purposes; they cannot afford to devote all their efforts to learning the register of the health care domain.

INTERPRETER MODELS

The third major category of approaches to providing language access is the interpreter models. If the provider cannot be taught to speak the language of the patient, and if the patient cannot be taught to speak the language of the provider, the only recourse is to engage a third party who speaks both languages to act as interpreter. We divide the interpreter models into two main groups: the ad-hoc models and the dedicated interpreter models.

Ad-hoc models

Ad-hoc models of interpreting depend on individuals whose main function in the health care setting is something other than interpreting. These individuals may work within health care or outside it. They provide interpreting services as a secondary function to their principal job.¹⁰

Bilingual Clinical Staff Model

This model depends on bilingual clinical staff, such as physicians, PAs, ARNPs, nurses, technicians etc. to provide interpreting services for patients being seen by other providers. They generally interpret in the same clinic or specialty area in which they provide their professional services and most often are asked to interpret as the need arises, without previous notice.

The advantages of this model lie in the immediate availability of the ‘interpreter’ and his or her knowledge of health care concepts and medical terminology, at least in English. Administrators may also perceive that interpreting is being provided at no additional cost to the institution.

The disadvantages of this model, however, are numerous. Primary among them and common to all ad-hoc models is that clinical staff members are rarely trained to interpret and so are likely to be ignorant of the ethics and techniques so essential to quality interpreting. While clinical staff members trained in the U.S. may be familiar with health care concepts in English, they are, as a rule, unfamiliar with the same terminology in their other language. It may be very difficult for patients to understand when this bilingual clinical staff person is acting in his or her professional role and when he or she is acting as an interpreter. This confusion of roles often leads the patient to speak to the ‘interpreter’ rather than to the provider that the ‘interpreter’ is supposed to be assisting, undermining the patient-provider relationship. Because these bilingual staff members have other professions, they often do not think of themselves as interpreters and very rarely strive to improve their interpreting skills or participate in continuing education in the field. Finally, being pulled from other duties to interpret lowers their productivity in the job for which they were hired, and with higher per-hour compensation rates, clinical staff make for very expensive interpreters.

For these reasons, using bilingual clinical staff to interpret is a questionable use of these highly trained individuals and is likely to result in poor-quality interpreting and confusion for the patient. In addition, in clinics with a variety of language needs, it would be very difficult to have enough bilingual staff to cover all the needs. To successfully employ this model, it is imperative to assure that the staff being asked to interpret meet the same criteria as any interpreter: demonstrated linguistic proficiency; training in health care interpreting ethics and techniques;

interpreting competency; and participation in continuing education for interpreters. In this way, at least some of the disadvantages of this model can be ameliorated.

Bilingual Non-Clinical Staff model

Related to the previous model and probably more common is the use of bilingual non-clinical staff to interpret.¹¹ This includes receptionists, medical assistants, janitorial and food services staff, and any clinic staff members who are asked to interpret outside their area of expertise. In this model, bilingual staff members are commonly asked to interpret anywhere within the medical facility on short notice. In most cases, bilingual staff members are not paid extra for this service.

The advantages of this model include rapid access to individuals who can be called upon to act as ‘interpreters.’ Like the previous model, this model is often perceived by administrators as an efficient use of bilingual personnel to provide language access at no extra cost to the institution.

The drawbacks to this model include some that impact interpreting and some that impact the functioning of the institution. Like bilingual clinical staff, non-clinical staff members usually have no training as interpreters. And unlike clinical staff, these individuals rarely have a working knowledge of health care issues and vocabulary in either of their languages. Unless special training is offered, these two attributes together usually lead to very poor quality interpreting. On the institutional side, pulling bilingual staff members from their regular work interrupts clinic functioning and often causes dissatisfaction among colleagues who must cover for the absent worker. Productivity is likely to go down. Anecdotal evidence suggests that bilingual staff members required to interpret often have very high turnover rates, incurring additional hidden costs for the institution.¹²

While this is one of the most widespread models currently in use in the U.S., in practice it has suffered from the drawbacks mentioned above and has been attempted mainly in institutions that serve one primary LEP group. For this model to be implemented effectively, staff members need to have their language skills screened and to be trained and assessed as interpreters. In addition, strong support needs to be developed among mid-level managers and line staff so that bilingual staff will not suffer from unwarranted consequences when called away to interpret. Some institutions have established an “Interpreter for a Day” program in which bilingual staff spend one day a week interpreting only. Others have instituted pay differentials for bilingual staff called to interpret, in recognition of the additional responsibilities and the training and skills those responsibilities require. Again, this model works best in clinics serving one primary LEP language group and where the non-clinical staff includes many who are highly proficient in two languages.

Community Service Agency staff model

In many cities around the country, community service agencies have taken on the responsibility of providing interpreters free of charge to accompany their clients to medical and social service appointments. Catholic Charities, Lutheran Social Services and other refugee resettlement agencies are among those who provide this service in many cities as a means of guaranteeing access for their clientele. In this model, the community service agency provides a bilingual staff

member, often a Case Manager, to accompany the client to the clinic and provide interpretation. These ‘interpreters’ are employees of the agency and are not paid by the medical center. For hospitals and clinics, this arrangement has many advantages, as it removes the language barrier for these patients with no cost or effort on the clinic’s part. The ‘interpreter’ is also commonly a Case Manager who has an on-going trusting relationship with the patient, leading to a higher level of trust with the provider. Finally, these encounters may seem to go very smoothly to the provider, as the Case Manager is able to explain history, provide additional information and take responsibility for all the necessary follow-up.

There are, however, disadvantages to this model. As in all ad-hoc models, Case Managers frequently have no training as interpreters and so may be unable to provide accurate interpretation. Case Managers are often drawn from the incoming refugee group, so, depending on the refugee group, the English spoken by the ‘interpreter’ may be little better than that of their clients. In addition, experience has shown that Case Managers, unless trained as interpreters, frequently take over and mediate the medical encounter, undermining the development of the patient-provider relationship and creating long-term dependence for the patient on the Case Manager. From a systemic point of view, hospitals and clinics which benefit from these services often perceive that their language access problem is solved, and they do not develop the internal systems necessary to serve other LEP patients who are not clients of the community service agency and so bring no accompanying interpreter. Exacerbating this problem, community service agencies funded to serve refugees may only be able to provide interpreters for the refugee’s initial resettlement period. The service provided by community service agencies may provide an immediate solution for their clientele, but it begs the question of the long-term responsibility of all recipients of federal funding to provide language access to all LEP patients. In addition, the community service agency may feel (rightly in some cases) that the health care or social service facilities are taking advantage of their commitment to the community by passing the responsibility for providing interpreting along to them.

There are steps that can be taken to improve the effectiveness of this model. As with all interpreters, Case Managers or others who interpret need to be screened for language proficiency, trained as interpreters, tested and monitored to assure quality in the interpretation. The basic conflict between the role of Case Manager and the role of the interpreter must be addressed. Efforts must be made to assure that the hospital or clinic does not depend exclusively on this service for its language access needs. In fact, many community service agencies have started to charge clinics for the interpreters’ services, placing fiscal responsibility back on the service provider, who may have a legal obligation to pay for interpreting under federal law (*see the Agency Model below*).

Family and Friends model

In this model, interpretation is provided by a patient’s family, friends, or even by other patients who are total strangers. In the best of scenarios, this situation arises because the patient insists on using a family member to interpret; in the worst cases, the provider requires the patient to bring someone to interpret. A common model in much of the country at one time, this practice has been discouraged by the Office for Civil Rights (DHHS) (see below, fn. 15) and has been largely discredited as an effective means of providing language access.

This model offers some apparent advantages. It does provide the LEP patient with someone to facilitate communication, at, of course, no cost to the health care institution. The special trust between family members may provide support to the patient, and some patients do not wish anyone outside their families to know about their health condition.

The disadvantages, however, are overwhelming. It is virtually impossible to screen family or friends for language skills or require them to be trained as interpreters, because the ‘interpreter’ could be anyone. There is ample documentation that the quality of interpreting is often abysmal: information is summarized or just deleted, messages are changed completely, the ‘interpreter’s’ views are added, information may deliberately be kept from the patient, and the family member often ends up dominating the encounter. Family and friends are rarely familiar with health care processes or medical terminology, compromising the quality of the interpretation even further. In addition, many patients are loath to disclose important personal information in the presence of a family member or friend. When other patients are used to interpret, this danger is compounded. There is often a hidden cost in that the family member or friend may be required to take time off from work in order to accompany the patient.

There are additional concerns when children are used to interpret. Children’s vocabulary is even more limited than an adult family member, and children are likely to be unaware of the purpose of the communication, leading to increased inaccuracies. Children can be traumatized by the responsibility of negotiating an elder’s health care and may feel responsible (or even be held responsible) for the outcome of the encounter. A child may be embarrassed by being asked to talk about intimate physical or sexual matters. In addition, the inversion of the power dynamics in the household, where adults – not children -- should be in control, can be damaging to the family structure as a whole.

Finally, the Office for Civil Rights (DHHS) has made it clear that the practice of “requiring, suggesting, or encouraging” a patient to bring his or her friends, minor children, or family members to serve as interpreter infringes on the patient’s civil rights under Title VI of the 1964 Civil Rights Act (see reference in fn. 15). This aspect of the Family and Friends model is simply illegal, at least when the provider institution is a recipient of federal funds.

The only circumstances under which the use of family or friends to interpret may be justified is at the direct request of the patient, and only after it has been made clear to the patient that a professional interpreter is readily available at no cost. In many cases, health care institutions are requiring the patient to sign a waiver in these cases to release the institution from liability. Others will allow family and friends to interpret only if a professional interpreter is present in the room to assure accuracy in the communication. By and large, however, this model is not conducive to meaningful language access.

Dedicated interpreter models

The previous models all depended on ‘interpreters’ whose principal function in the health care setting was something other than interpreting. A second set of models depends on interpreters whose sole function in the encounter is to interpret. These models are known as “dedicated interpreting models.”

Staff Interpreter Model

In the staff interpreter model, hospitals and clinics retain professional interpreters on staff to meet the institution's language access needs.¹³ Interpreters are usually recruited in the most common languages served and may be employed either part-time or full-time. In this model, interpreters are pre-scheduled when possible, but can also be paged for emergency or walk-in patients.

The advantages of this model lie in the quality of interpretation and the support for the smooth functioning of the clinic. Staff interpreters can be chosen specifically for their interpreting skills, so there is a good chance that the clinic can recruit professional interpreters with strong language skills, appropriate training and even certification where it is available. Staff interpreters come to know the patient and provider population, the vocabulary and processes in the clinic or hospital. They spend eight hours a day interpreting, gaining valuable experience and building skills rapidly. They have a clear and distinct role in the encounter, minimizing patient confusion. As they are focused on interpreting only, they are more likely to participate in basic training (if they don't already have it) and continuing education over time. The result is a much higher quality of interpreting and clearer communication between patients and providers.

Operationally, staff interpreters allow the clinic a high degree of flexibility both in scheduling and in responding to emergencies and walk-ins. This model makes it easy to centralize assignment of interpreters, for greater efficiency. If a scheduled patient does not come, the interpreter can be diverted to other language-oriented work. Some interpreters also do written translation and can provide these services in their down time. A dedicated interpreter model also frees bilingual staff from being called from their other duties and facilitates smooth functioning of the clinic.

There are some disadvantages to this model. While it may be less costly than other dedicated interpreter models, there is an expense involved in recruiting and maintaining staff. In addition, since it is rarely cost effective to employ interpreters in all language combinations, this model is usually augmented by another that covers less common languages. And finally, the model will function well only in so far as the interpreters have been screened, trained, and assessed.

While an interpreting staff will constitute a separate budget category, it will often be less expensive than the hidden cost of calling interpreters from other tasks, because of greater efficiency and competence. The amount of interpreting needed will be the same either way. Also, fewer individuals will be assigned interpreting duties in this model than when all bilinguals may be called upon to interpret, thus reducing screening and training costs.

Contract Interpreter Model

A close relative to the staff interpreter model is the contract interpreter model. In this model, interpreters are not employees of the health care institution but are contracted directly and paid per hour only for the time they interpret. Interpreters can be scheduled in advance but also contacted by pager on short notice when necessary. Contract interpreters are sometimes called "per diem" interpreters, "on-call" interpreters or "freelance" interpreters.

This model shares many advantages with the staff interpreter model, in that the interpreters can be carefully chosen and are more likely to be trained and assessed. The model also allows the institution to save on costs, especially where demand for a particular language is low or uneven, since the interpreters will be paid only when used. At the same time, these interpreters are free to work for various institutions and agencies, thereby working enough hours to make a living.

The greatest disadvantage to this model is that it requires the establishment of an interpreter services department in the institution to effectively coordinate the screening, contracting, dispatching and payment of interpreters. While the establishment of such a department is usually a positive step for an institution programmatically, it does represent a cost. Contract interpreters will be more expensive per hour than staff interpreters, but they are paid only when they interpret and do not receive benefits. In addition, the success of this model depends on the availability of well qualified interpreters who are willing to work on contract, and the presence of multiple health care institutions (or other venues) that in aggregate will provide the interpreter with enough work to stay in business. As a final consideration, if training is offered by the institution itself, this may put the institution's contractual relationship with the interpreter in jeopardy.

Agency Model

Interpreter agencies represent a third option for the provision of language access through dedicated interpreters. In this model, the hospital or clinic contracts with one or more language agencies, who in turn recruit, contract, and dispatch interpreters on demand. These agencies may be for-profit companies, "interpreter pools" supported by a coalition of user institutions, or not-for-profit community based organizations.

There are many advantages to a well-run agency model. Agencies can support an internal interpreter services department, or they may supplant such a department, taking responsibility for recruiting, screening, training, paying and monitoring interpreters. Because interpreting is usually their whole business, they are more apt to invest time in developing relationships with bilingual communities from which interpreters can be recruited. In addition, since they can have multiple and widespread contracts, large agencies can keep interpreters busy and so may have access to a greater number of interpreters (to meet peak demand) and a wider range of languages than a single institution could contract directly.

On the downside, language service agencies may be prone to contracting unqualified interpreters, just to fill appointments. An institution has little control over which interpreter the agency sends, and agency interpreters interpret in so many venues that they may never become familiar with the particular institution or the vocabulary used there. Agencies may cancel at the last minute, leaving patient and provider with no interpreter. And of the first three dedicated interpreter models, this is usually the most expensive, as the agency will charge overhead and possibly a profit mark-up in addition to the direct cost of the interpreter's time.

For the agency model to work well, agencies must have high standards for the interpreters they contract, demonstrable through their screening, training and monitoring processes. It should be possible to assure this through the contracting process; agencies must be required to demonstrate the competence of their interpreters. There must be a user-friendly systems in place for hospital

or clinic staff to either order an interpreter or to lodge a complaint. Someone in the clinic must also monitor response and cancellation rates. Agencies that specialize in specific venues (health, legal, conference) may do a better job responding to the institution's needs and providing interpreters that are familiar with industry specific vocabulary.

Volunteer Model

A few institutions around the country are using the volunteer model to provide interpreter services. This model closely resembles the contract interpreter model, except that the interpreters are not compensated in any way for their work. They may be immigrants, students or the spouses of such without work permits, or they may simply be good-hearted individuals who are willing to volunteer their time in service to their communities.

The volunteer model is a relatively cheap way to provide language access, aside from the costs involved in administering it. Aside from that, it has little to recommend it.

Although volunteers are usually well meaning, few are trained as interpreters and few know the vocabulary or techniques necessary to interpret accurately in health care settings. It is difficult to require extensive screening or training for them or to hold them to high standards, since they are, after all, working for free. In addition, volunteers as a group tend to have a high turnover rate, requiring continuous recruiting and training efforts. To cover a large language need, an institution needs a more extensive group of volunteers than it would if using paid interpreters, since the rate of refusal is so much higher. And finally, different cultures view volunteering in different lights, making it difficult to recruit volunteers at all for certain language groups.

The same standards should apply to interpreters who volunteer as to those who are paid; they must be screened, trained, assessed and monitored. Clear systems for dispatching interpreters (usually an interpreter services department) must be in place. Recruiting must be on-going, since turnover is high. This model works best in institutions that have a low demand for language services, or that are using volunteer interpreters as a back-up only. It also works best in areas with large number of well-educated bilinguals who are not working at other jobs, for example, university towns or areas with a heavy concentration of diplomats or foreign business people.

Face-to-face, telephonic and video interpreting

A great deal of attention is being paid these days to the increased use of telephonic and video technologies for interpreting. Any of the above models can be used to provide interpreting face-to-face, over the phone or through a video connection. Still, it is worthwhile to include a short discussion of the use of these differing modes of interpreting.

Face-to-face interpreting is by far the most common of these three modes of providing language access. In this mode, the interpreter is present in the room with the two interlocutors and provides interpreting, usually consecutively. The use of telephonic interpreters, however, has been increasing rapidly in the health care sector. In this mode, an interpreter is linked to the interlocutors over the phone, either through the use of dual headsets, a speakerphone, or by passing one handset back and forth. A few institutions are experimenting with video links, through which an interpreter who is not present in the room with the interlocutors can see them

through a small camera mounted in the room. Though there is limited research comparing these three modes of providing interpreter services, there are some questions that should be raised. One question is the role of non-verbal communication in understanding meaning. Face-to-face and video interpreters have the benefit of the speakers' non-verbal communication in addition to the verbal from which to garner the meaning that is interpreted. Does this make face-to-face interpreting more accurate? More research is needed to answer such questions.

A related issue is the scope of the interpreter's role. Face-to-face interpreters may provide additional services to patients that remote interpreters cannot, including culture-brokering, limited advocacy, guiding the patient around the health center, building patient confidence in a strange environment and increasing patient trust in the provider. There are, however, differences of opinion as to whether these roles should even be filled by interpreters, and there is no research that measures the impact on patient satisfaction of limiting these roles.

There seem to be some logistical advantages to telephonic interpreting, including being able to avoid wait times, traffic and parking costs and to maximize the productive use of the interpreter.¹⁴ As telephonic interpreters can work from any location, they can serve a wider public, meaning that interpreters of languages of limited diffusion may be able to get enough work to make a living in the field, gaining experience and expertise. On the other hand, these interpreters never become familiar with particular venues and do not have access to the visual information that a face-to-face interpreter has. Indeed, in some cases telephonic interpreters may be called upon to serve clients in multiple industries, making it difficult to master the vocabulary of all of them.

Finally, remote interpreting is often touted as cheaper, because the interpreting is charged by the minute, not by the hour. However, cost to the user depends entirely on the length of the interpretation and the fee per minute. The success of the interpretation also depends heavily on the nature and quality of the technology used and the appropriateness of the setting. Passing a handset back and forth may lead to summarizing instead of interpreting; use of a speaker-phone may be better, except where background noise makes it difficult for the interpreter to hear. If a health care center must upgrade its phones or install video equipment for video interpreting, this cost must be considered. If the health care center chooses to implement its own call center with staff telephonic interpreters, instead of contracting with a telephonic interpreting agency, the cost of implementation increases even more. In summary, many factors affect the cost of interpreting services, and so the claim that telephonic interpreting is less costly must be examined closely in each particular circumstance.

Conclusion

In its Guidance Memorandum on Language Access, published in 2000, the DHHS Office for Civil Rights¹⁵ emphasized that the requirement to provide linguistic access to programs supported by federal funds could be satisfied through any number of approaches. This paper has offered a general overview of various models implemented in the U.S. for provision of language access. Each is effective in certain circumstances; some are more effective than others. The systematic study of each of these models will provide the field greater insight into which approach should

be used when, by whom, and with what caveats in order to ensure truly equal access to health care for limited-English-speaking patients.

- ¹ A number of models and actual programs designed to address linguistic access are described in Riddick S. Improving access for limited English-speaking consumers: A review of strategies in health care settings. *Journal of Health Care for the Poor and Underserved* 1998; 9 Supplemental:S40-S61.
- ² Ginsberg C, Martin V, Andrulis D, Shaw-Taylor Y, and McGregor C. Interpretation and translation services in health care: A survey of U.S. public and private teaching hospitals. Washington, DC: National Public Health and Hospital Institute, 1995.
- ³ Woloshin S, Bickell NA, Schwartz LM, Gany F, and Welch HG. Language barriers in medicine in the United States. *JAMA* 1995 Mar 1;273(9):724-28.
- ⁴ Prince C. *Hablando con el doctor: Communication problems between doctors and their Spanish-speaking patients*. Ph.D. dissertation, Stanford University. Ann Arbor, Michigan: University Microfilms International, 1986. See especially Ch. 3, Cross-cultural communication for discussion of alternative models.
- ⁵ Downing [B]T. The use of bilingual/bicultural workers as providers and interpreters. *International Migration (Special issue: Migration and Health in the 1990s, H. Siem and P. Bollini, (Eds.))*, 30:121-29, 1992 discusses three distinct roles for bilinguals working in health care settings.
- ⁶ More general standards for communicating with members of linguistic minorities are detailed in U.S. Department of Health and Human Services, OPHS, Office of Minority Health. National standards for culturally and linguistically appropriate services in health care [“CLAS standards”] Executive summary. Washington, DC: March 2001.
- ⁷ Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K. Use and effectiveness of interpreters in an emergency department. *JAMA* Mar 13, 1996; 275(10): 783-788; see especially p. 784.
- ⁸ Prince D, Nelson M. Teaching Spanish to emergency medicine residents. *Acad Emerg Med* 1995 Jan; 2(1):32-6; discussion 36-7.
- ⁹ Tse L. “Why don’t they learn English?”: Separating fact from fallacy in the U.S. language debate. Willston, VT: Teachers College Press, 2001.
- ¹⁰ Various ad-hoc approaches to interpreting are described in Putsch RW III. Cross-cultural communication: The special case of interpreters in health care. *JAMA* 1985; 254(23): 3344-3348.
- ¹¹ Egli E. Bilingual workers. Mental health services for refugees. Refugee Mental Health Program, Public Health Service, U. S. Department of Health and Human Services, Washington, 1991, pp. 90-110.
- ¹² Difficulties for the interpreter/culture broker are discussed in Kaufert JM, Koolage WW. Role conflict among ‘culture brokers’: The experience of Native Canadian medical interpreters. *Social Science & Medicine* 1984; 18(3): 283-286.
- ¹³ A program employing professional staff interpreters is described in detail in Davidson B, *Interpreting medical discourse: A study of cross-linguistic communication in the hospital clinic*. Ph.D. diss., Stanford University. Ann Arbor, MI: University Dissertations International, 1998.
- ¹⁴ Hornberger JC, Gibson CD Jr, Wood W, Dequeldre C, Corso I, Palla B, Bloch DA. Eliminating language barriers for non-English-speaking patients. *Medical Care* 1996; 34(8): 845-856.
- ¹⁵ Office for Civil Rights at <http://www.hhs.gov/ocr/lep/guide.html>.

Appendix A: Models in Action

Introduction

The purpose of this appendix is to identify programs that are currently providing language access services using each of the models described in the body of this paper. As mentioned earlier, the most effective language access programs provide services through a combination of models and rarely through one model alone. However, the programs described here are effective examples of the model they employ.

Bilingual Provider Models

The bilingual provider model is one adopted primarily by clinic systems serving predominantly one language group. **SeaMar Community Health Centers** in Seattle is a good example of one such program.

SeaMar was founded in 1978 specifically to serve the Hispanic population of Puget Sound as a completely bilingual, full-service primary care clinic system. As such, SeaMar's commitment to a bilingual provider staff was built into the program from the beginning. Today SeaMar runs a number of clinics throughout Western Washington as well as a long-term care facility in Seattle. In most of the clinics, the overwhelming majority of patients are Spanish-speaking, although a few serve a significant number of English, Russian or Korean-speaking patients as well.

In order to serve this predominantly Spanish-speaking population, 90% of all clinic staff is bilingual, speaking both English and Spanish. About half the providers are native speakers of Spanish, while half are native English speakers who have learned Spanish as a second language. Bilingual Medical Assistants or nurses interpret for the small number of providers who do not speak English. In one clinic serving a growing number of Russian-speakers, bilingual Russian-speaking support staff is being hired to interpret. In another clinic, a multilingual Southeast Asian dentist provides care ½ day a week specifically for Southeast Asian patients. When LEP patients present who speak other languages, SeaMar contracts with a local language service agency for interpreter services.

Three questions are commonly asked of programs using bilingual providers: where do you get them, how do you keep them, and how do you assure the quality of the language skills?

SeaMar assures the quality of provider language skills through a variety of mechanisms. While there is no formal assessment of language skills, new providers are observed by the clinical directors and the medical director, all of whom are native speakers of Spanish. Providers who have learned Spanish as a second language are usually paired with nurses or MAs who are native speakers, and peer review is done both by providers and by other clinical staff. On client satisfaction surveys, done in Spanish, patients are specifically questioned about their experience with communication in the clinic. Finally, at least some of the clinic personnel who do interpret for the monolingual providers are certified as interpreters through the Washington State Department of Social and Health Services.

To recruit and retain its bilingual staff, SeaMar works hard both to attract bilingual professionals and to train bilingual individuals in health related professions.

For example, SeaMar has instituted training programs for Spanish-speaking dental assistants, chemical dependency professionals, medical records and billing staff. Students in these programs are paid a salary while being trained, and many elect to accept positions at SeaMar upon completing their studies.

SeaMar has also partnered with South Seattle Community College to create a program to train bilingual nursing professionals. At this time, the program has graduated three classes of Certified Nursing Assistants. Graduates will be eligible to enter into the programs for Medical Assistants, Licensed Practical Nurses and Registered Nurses that are currently being developed.

To find bilingual Registered Dietitians, SeaMar created a nationally accredited dietetic internship program that focuses on recruiting bilingual/bicultural interns. Unlike other such programs, SeaMar's internship application puts less emphasis on GPA and more on other criteria such as interest in community health, an approach that has proven to be highly successful.

In order to recruit bilingual medical staff, SeaMar has joined the Family Physician residency program at Swedish Medical Center, also focusing on recruiting bilinguals. Mentorship programs and outreach into high schools to encourage more bilingual youth to enter the health professions complete SeaMar's comprehensive recruitment strategy,

Even with such creative and outstanding programs in place, SeaMar reports that recruitment and retention are two major challenges in this approach to the provision of language services.

For more information, please contact Mary Bartolo (Development Director) or Carolina Lucero (Vice President of Long Term Care) at SeaMar Community Health Centers in Seattle, 206-763-5277.

The Bilingual Patient Model (ESL Model)

While countless programs to teach English as a second language are in place across the country, to our knowledge none are being used by health centers as a primary means of addressing language access issues.

Interpreter Models

Ad-hoc Models

Bilingual Clinical Staff used to interpret

Because of the cost involved in employing highly trained and paid bilingual clinical staff such as doctors, nurse practitioners, physicians assistants, registered nurses, therapists, etc, to interpret for other staff, we do not know of any program that uses this model exclusively to provide language access. At most, programs that even allow bilingual clinical staff to interpret will do so as a last resort and as a small part of a program based predominantly on another model.

Non clinical Staff used to interpret

A much more commonly used model for provision of language services is one in which bilingual support staff, such as Medical Assistants, receptionists, technicians, food service staff or maintenance staff are called upon to interpret. This is the model that dominates in part of **Kaiser Permanente Hayward/Fremont**.

Kaiser Permanente, a large HMO, recently merged two primary clinic systems in Hayward and Fremont in northern California. A third clinic in Union City also belongs to the group.

Located south of San Francisco in the Bay Area, these clinics serve a heavily Spanish-speaking population, as well as significant populations of Chinese and deaf/hard-of-hearing patients, as well as a growing number of Punjabi patients. A multilingual call center facilitates communication for patients calling in to the clinic. There are also about 400 requests for language assistance on site in the clinics per day. At the Fremont clinic, where about half of interpreter requests are for Spanish, about 40% of the Spanish appointments are covered by a dedicated Spanish interpreter, about 20% by bilingual providers and about 40% by bilingual support staff acting as interpreters. The Chinese-speaking patients are served completely by a dedicated interpreter of Cantonese/Mandarin and 4 bilingual providers. One full-time, one part-time and 10 contract interpreters serve patients who need ASL.

The Union City clinic, which provides 60% of the Spanish language appointments, began using bilingual support staff to interpret, but found the system disruptive as bilingual workers were constantly pulled off their other jobs to interpret. When the clinic moved into new quarters, speakerphones were installed in each exam room and the clinic switched to telephonic interpreting exclusively.

The Hayward Clinic, on the other hand, was strongly dedicated to the concept of hiring all bilingual staff. Since this clinic is located in a heavily Hispanic/Latino part of the Bay Area, the LEP patients being served were 80% Spanish speakers. The clinic brought on Spanish-speaking MAs and receptionists, and an effort was also made to recruit bilingual medical providers as well. This proved to be more difficult than expected, however, and the clinic today has no dedicated interpreters and very few bilingual providers. As a result, interpreting services are being provided almost exclusively by the bilingual support staff. Between 80-90% of these appointments are in Spanish.

At this point in time, few of the bilingual staff interpreting at Kaiser Hayward have been formally screened or trained as interpreters. However, the sister program at Kaiser Fremont has already trained 31 of its bilingual support staff in interpreting techniques through a 40-hour training. At Fremont all candidates for a posted bilingual position go through a formal language assessment, and all the dedicated and contract interpreters are trained and experienced. The ASL interpreters are all certified. Through a Culturally Competent Care Committee there are plans to spread these practices to the other clinics in the new merger. Forty-five bilingual support staff members are scheduled to attend the

forty-hour training this year. In-services are being given to providers on how to work effectively with interpreters, and wider policy issues are being addressed.

The model of depending heavily on bilingual staff has been a useful one for Kaiser Hayward/Fremont, especially where the staff called upon to interpret has been trained. However, there have been some challenges in implementing this model. As might be expected, recruiting bilingual support staff has required quite an effort. Managing staff flow has been difficult and training is needed for managers so that they better understand the implications of having staff pulled to interpret. As mentioned, the Union City clinic found these interruptions so disruptive that the clinic converted to telephonic interpreting only. Also, when a new language group begins to seek services in large numbers, such as the Punjabi patients in Fremont, the clinic is faced with a dilemma as to how to respond. As a result, as we have seen in so many cases, the clinic is moving toward a more integrated model of provision of language access.

For more information on this model, contact Maria Servín, Director of Member Relations at Kaiser Permanente Hayward/Fremont, at (510) 795-3259, maria.l.servin@kp.org.

Community Service Agency staff model

In a number of areas in the U.S., community service agencies such as refugee resettlement groups or ethnic community mutual assistance organizations, have taken on the responsibility of providing interpreter services free of charge to health and social service agencies that serve their clientele. **Mercy Medical Center**, in Des Moines, Iowa, is one program that uses this service to augment its own interpreter services and to stretch scarce resources.

Mercy Medical Center is a full service medical center, including inpatient and trauma care. About 10% of its patient population requires language assistance, and roughly half of these are refugees from Bosnia, the Sudan and Southeast Asia. Mercy does employ one full-time staff interpreter, who also coordinates the language access program, as well as contracting with about 30 individual interpreters and language agencies to cover a demand for over 40 languages. The medical center also contracts for telephonic interpreter services and provides limited translated materials. One resource the program counts on is the Iowa Bureau of Refugee Services in Des Moines, which provides interpreters for about 70% of the medical center's refugee patients, free of charge.

This collaboration grew up several years ago as Mercy initiated a program to upgrade its language access services. A bit earlier, the Bureau of Refugee Services had adopted a program to train its bilingual case workers as interpreters in order to assist refugee clients when they seek health and social services. Since Mercy had a history of depending on external interpreters, as opposed to bilingual staff, to provide interpreting services, the collaboration between the institutions was a natural one.

The Bureau of Refugee Services recruits interpreter/case managers from the communities it serves. While there is no formal language screening at this time, these bilingual recruits

do attend 40 hours of training as interpreters. The Bureau also opens these courses to community interpreters in non-refugee languages, resulting in improved interpreting for all language groups. The Bureau is now leading a collaborative of health and social service agencies, of which Mercy is a member, to develop a language assessment process to be used throughout the city.

While this model provides Mercy with trained interpreters for refugee populations and helps to stretch scarce resources for the language access program, it does present some challenges. For example, the staff of the Bureau of Refugee Services often find that their roles as interpreters and case managers conflict, a problem with most of the ad-hoc models. In addition, the Bureau of Refugee Services has no mechanism to provide interpreters after hours, and cannot guarantee an immediate response to a last minute request. As we see across the country, language access services require an integrated approach employing a variety of models in order to be comprehensive and effective.

For more information about the interpreter program at Mercy Medical Center, please contact David Jones, Coordinator of Interpretation/Translation Services, at (515) 643-2865, djones@mercydesmoines.org.

Family and Friends model

Due to the limitations of this model, there are no examples of its implementation that could be considered acceptable for providing language access.

Dedicated Interpreter Models

Staff, contract and agency interpreter models

A common model for the provision of language access services in large medical centers is a combination of staff, contract and agency interpreters. A highly documented example of this is sort of program is **Harborview Medical Center** in Seattle, WA.

Harborview is a full service medical center and level one trauma center, one of the safety net providers serving the highly linguistically diverse Puget Sound region and the principle trauma center for the entire northwest.

Harborview has been serving a highly diverse patient population since the 1970's and over time has assembled an impressive team of clinical interpreters. In addition, Harborview pioneered the celebrated "Housecalls" program which employs over five Interpreter/Case Managers (ICMs) to not only interpret but to do community outreach and provide assistance to families with special needs. Altogether the service has:

- 5.5 FTE ICMs;
- 4 full-time staff interpreters, who cover requests for Cambodian, Laotian, Cantonese, Chou-jo, Mandarin, Spanish and Somali;
- over 70 hourly contract interpreters;
- contracts with 3 interpreter agencies for face-to-face interpreting;
- a contract with one telephonic interpreter service;

-
- 3.5 FTE administrative staff (including a manager, a fiscal specialist, a data entry specialist, and a nurse and supervisor for the ICMs); and
 - three full time schedulers.

As a rule, bilingual clinical and non-clinical staff are not called upon to interpret at Harborview. The program provides about 105,000 hours of interpreting services annually in well over 60 languages, about 90% in the top 8 languages.

Staff and contract interpreters all go through an informal language screening process and all must take at least 40 hours of basic training within 6 months of starting or lose their contract. Certification by the Washington State Department of Social and Health Services is required, as are at least nine hours of continuing education per year. New interpreters must start by shadowing staff interpreters and being shadowed in turn. Agency interpreters are also expected to be trained and certified. In addition, staff and contract interpreters are periodically evaluated by the clinicians with whom they work.

How does Harborview manage to recruit and retain such a wide network of services? Harborview and other health care providers in the Puget Sound area have both helped to create and benefited from the presence of a large network of trained contract interpreters that has grown up over the past two decades. State funding and innovative leadership have supported this growth, as has the active involvement of the Office for Civil Rights and legal advocacy groups.

Such a complex program obviously has its challenges. Management and coordination is a daunting task, and the program requires a significant budget. It is clear that this program could not exist without the solid backing of the top administration and the clear mission of the medical center to serve this linguistically diverse community.

For more information about Harborview's program, please contact Mamae Teklemariam at 206-731-4468, or mamae@u.washington.edu.

Volunteer Interpreter Model

Though successful volunteer interpreter programs are rare, we have found two that have proven effective. They are the programs at **Yale New Haven Medical Center** in New Haven, Connecticut and Primary Children's Hospital in Salt Lake City, Utah.

Yale New Haven Medical Center is a 900-bed hospital with 70 attached clinics. The interpreting service operates 24/7 and receives about 34-55 requests a day for 64 languages, mostly Spanish. About two-thirds of these calls are for immediate or same-day appointments. The program employs one full time coordinator, one dispatcher, and one Spanish interpreter, as well as counting on two work-study students who provide logistical support in data input and analysis and interpret only occasionally. The program also uses a telephonic interpreting service as a backup. The mainstay of the program, however, is the 50-60 volunteer interpreters.

Who are these volunteers? Some are interested community members, others are work-study students. For languages other than Spanish, most are non-clinical bilingual staff who are not involved in patient care. Clinical staff are used to interpret only on their own units, so as not to disrupt patient care. Most of the rest are students, both undergraduate and graduate, at Yale, and about half of these are pre-med or medical students.

Volunteering to interpret is a significant commitment. Non-employee volunteers must go through a semi-formal language screening process and attend a 6-hour training on interpreting techniques. They receive the same health screening as employees at the medical center. Once accepted, volunteers must check in with interpreter services according to a schedule, receive a pager, and agree to stay for a four-hour shift. Since the hospital is attached to the medical school, many find a place to study while waiting to be paged. Even with these requirements, for the volunteers interested in health care, this experience gives them a close contact with clinical reality and allows them to observe medicine in action in a wide variety of settings. Recommendations from the interpreter program may also be a significant addition to a medical school application.

This model of provision of interpreter services has presented some challenges. Because so many of the volunteers are students at Yale, there are times of the year when they are not available. Some volunteers prove to be unreliable, but it is difficult to “fire” a volunteer. There is a sense that the program cannot require extensive training of volunteers, since their time is limited. The turnover rate is high, so recruitment, screening and training must be on going, which absorbs a lot of the program coordinator’s time. Finally, as in other institutions, this model must be complemented with a back-up interpreting system to accommodate immediate need and the large diversity of language groups served at the medical center.

For more information about this program, please contact Cathi Kroon at Yale new Haven Medical Center, at 203-688-7523, kroonca@ynhh.org.

A second volunteer program that has been highly successful is found at Primary Children’s Hospital in Salt Lake City, Utah, a part of Intermountain Health Care. This medical center provides all levels of care in pediatrics. About 80% of the LEP patients speak Spanish, although the interpreter service does receive requests for a variety of other languages.

In order to meet this need, the program does employ 5 full-time staff interpreters, who are native speakers of Spanish, who have received 40 hours of training as interpreters, and who have traveled to Washington State to be certified in medical interpreting by the Department of Social and Health Services there. The program uses one local agency and two telephonic interpreter services as a last resort. In addition, the program counts on 61 community volunteers. All of these have received 40 hours of training as interpreters before they can start interpreting. The 33 Spanish-speaking volunteers set their own schedule of when they will commit to coming to the hospital to be on call. Interpreters in languages with less demand commit to coming when called for a patient appointment.

Since Primary Children's is located on the campus of UU, it is easy for students to get to the hospital quickly when called.

This model was chosen for Primary Children's due to two factors: one was the lack of resources available to mount an all-paid service, and the second was the unique location of Primary Children's in Salt Lake City. As one of the centers of the Church of Jesus Christ of Latter Day Saints (LDS), Salt Lake City has a large number of returned LDS missionaries. Many are youth who are studying at the University of Utah or are working in the community. There is a strong motivation for community service in the church, and many returned missionaries wish to maintain the language skills they developed while out of the country. In addition, just as at Yale/New Haven, pre-med students at UU look at this as an opportunity to gain early clinical experience.

In order to recruit volunteers, then, Primary Children's turned to the Bennion Center at UU, a clearinghouse on campus for student volunteer opportunities. Once the program was registered with the Bennion Center, the volunteers started appearing. Native Spanish-speaking staff screen the language skills of Spanish-speaking volunteers; non-Spanish speakers receive no language screening. All volunteer, however, must attend a 40-hour training on interpreter skills before being allowed to interpret. This course is offered twice a year, to coincide with the recruitment drives. Feedback cards distributed to physicians and to Spanish-speaking families as an additional quality control.

This model has proven to be quite successful for Primary Children's. As always, however, there are some caveats. It is hard to imagine this model working so well in the absence of the linguistically diverse and service-oriented student base at the University of Utah and in Salt Lake City in general. Another concern is the quality of the language skills and the level of cultural understanding of the volunteer interpreters. Unlike most interpreter services, which depend heavily on foreign-born interpreters, Primary Children's program depends on volunteers of whom 90% are native speakers of English. Having gained their language skills in relatively short stays abroad, there could be concerns as to the degree of linguistic and cultural competency in the group, especially since there is no formal screening for either of these skill sets. Regardless, this model allows Primary Children's to serve a large LEP population at a relatively low cost.

For more information about the program at Primary Children's, please contact Lucy Cabal, Language Program Coordinator, at (801) 588-4083, plcabal@ihc.com