

# Bridging the *Language* G A P

## *How to Meet the Need for Interpreters in Minnesota*

This report addresses one major question:  
How can we ensure access to public services—  
beginning with health care—for Minnesotans  
who speak little or no English?

A Report from the Working Group of the Minnesota Interpreter Standards Advisory Committee

**How can we bridge the language gap?**

How can we ensure access to public services--beginning with health care--for Minnesotans who speak little or no English? In other words: how can we bridge the language gap? This report addresses these questions.

It consists of recommendations to the Interpreter Standards Advisory Committee about training, certification, and use of foreign language interpreters in Minnesota. The report's recommendations focus on interpreters working in health care settings, but they are intended to be applicable to interpreters in other settings as well.

**The Interpreter Standards Advisory Committee**

Members represent education, health care, government, business, law, advocacy, community and interpreter organizations, linked by their interest in spoken language interpreting.

**What does the report say?**

The report covers these key questions:

- Why are foreign language interpreters required in Minnesota? (See *The Challenge*, page 3)
- What professional standards should interpreters meet? (See *Professional Standards Recommendations*, page 11)
- How should interpreters be trained? (See *Training Recommendations*, page 16 )
- How can the skills of interpreters be assessed? (See *Proof of Skills Recommendations*, page 19)
- How can professional interpreters be used more often in health care and other community settings? (See *Action Steps*, page 23 )

## How was this report developed?

This report is the work of the Interpreter Standards Advisory Committee's Working Group. The Advisory Committee consists of 75 individuals representing academia, health care, government, business, law, advocacy, community and interpreter organizations.

In June, 1998, the Advisory Committee deputized a 14-member Working Group (listed opposite) to research, debate, and come to consensus on the answers to key questions. Members of the Working Group met frequently for six months, reviewing local, national and international models for professionalizing interpreters.

## How were interpreters involved?

The concerns of working interpreters were carefully heeded during the Working Group's deliberations. Three of the Working Group members are professional interpreters; three others manage interpreter services for public and private organizations. In addition, the working group sought feedback and endorsement from a wider pool of interpreters at a special meeting attended by over 120 working interpreters. (A summary of that meeting is reprinted in Appendix 4.)

Observers were also invited to participate in the Working Group's process, either by attending meetings or by commenting on drafts of the recommendations as they emerged and were posted on a Web site ([www.umn.edu/ccch](http://www.umn.edu/ccch)).

## What comes next?

Now that the Working Group has answered the questions posed to it, the real work of creating a training and certification program for interpreters must begin. The recommendations in this report will require concerted, collaborative effort from everyone who has a stake in this process.

## WORKING GROUP MEMBERS

- **Liza Anderson-Gonzalez and Kari Mink** Interpreter Coordinators Neighborhood Health Care Network (651) 603-6040
- **Karen Clark**, Representative Minnesota Legislature (651) 296-0294
- **Bruce Downing**, Director Program in Translation & Interpreting University of Minnesota (612) 624-6552
- **Larry Edmonson**, Manager Interpreter Services, Olmsted County Health Department (507) 281-7364
- **Natasha Geilman**, Interpreter Hennepin County Medical Center (612) 566-4312
- **Jose L. Gonzalez**, Program Analyst, Minneapolis Department of Health and Family Support (612) 673-3815
- **Vinodh Kutty**, Director Center for Cross-Cultural Health (612) 624-6930
- **Manuel Lopez**, Associate Chancellor, MN State Colleges and Universities (651) 297-5264
- **Gretchen Musicant**, Vice President Minnesota Hospital and Healthcare Partnership (651) 641-1121
- **Colette Namyst-Goldberg**, Manager Language & Cultural Services Department Mayo Medical Center (507) 266-4161
- **Ellen Rau**, Interpreter Services Specialist, Hennepin County Medical Center (612) 347-2248
- **Guergana Savova**, Cultural and Linguistic Coordinator, Minnesota Department of Health (651) 215-1307
- **Cher Vang**, Community Liaison Children's Hospital, St. Paul (651) 220-6075

## COORDINATORS

- Patricia Ohmans and Barbara Babbitt Health Advocates Consulting (651) 489-4238

**Serving all Minnesotans**

Minnesota, like the rest of the United States, was built by people who did not speak English as their first language. Our state--once peopled by speakers of Lakota and Ojibway--was later settled by immigrants who spoke Norwegian, German, Spanish and Swedish, as well as English. Today we welcome new peoples, speaking Hmong, Somali, Russian, or Vietnamese. Tomorrow, others will come, speaking different languages.

There are few hard numbers when it comes to counting the limited-English speakers among us. The 1990 Census, now nearly ten years old, says there are 80,000 people in Minnesota whose English proficiency is limited. Since 1990, the number of children in the state's public schools who do not speak English well has nearly doubled, from 20,000 in 1990 to 38,000 in 1995, according to the Minnesota Department of Children, Families and Learning.

**Many Minnesotans speak limited English.**

Extrapolating from those facts, we can assume that there has been a very large increase in the total number of children and adults who are "limited English proficient," or LEP. Surely we are talking about at least 200,000 people, or one out of every twenty Minnesotans.

This growth mirrors the trend in other parts of the nation, where in five states (California, Texas, New Mexico, New York and Hawaii), more than one in ten people have limited English skills.

The largest numbers of non-English speakers are in Minnesota's Hmong and Spanish-speaking communities, but groups speaking African and Eastern European languages are also growing rapidly.

**Where They Come From**

The majority of refugees to Minnesota in 1997 came from the former Soviet Union, Bosnia and Somalia. Other refugee groups included Cubans, Bulgarians, Kurds, and Liberians.

--Office of Refugee Health, Minnesota Department of Health

Immigrants and refugees have settled primarily in urban areas, but many communities in rural Minnesota have been transformed by recent influxes of newcomers, speaking Spanish, Somali, Vietnamese and Russian.

**Laws guarantee access to public services.**

Newcomers to the United States and to Minnesota know they must learn English, the United States' language of education and commerce. But learning a new language takes time, especially for adult immigrants struggling to adjust to a new home.

In the meantime, residents or new citizens whose proficiency in English is limited are entitled to access the same health care and social services as those who speak English fluently. Not only that, according to federal law, they are entitled to the same quality of service, including unimpeded communication with the service provider.

Title VI of the Civil Rights Act of 1964 prohibits discrimination against any person on the basis of race, color or national origin in any program receiving federal assistance. Title VI has repeatedly been interpreted by the federal Office of Civil Rights to mean that trained and qualified interpreters must be provided in health care and other settings.

In 1997 the Minnesota legislature directed the Commissioner of Human Services to ensure that the state is in compliance with Title VI, and to develop a plan to serve public assistance recipients and recipients who have limited English skills.

Both federal and state laws repeatedly recognize the rights of limited English speakers. But too often, these rights are overlooked. In health care, especially, this neglect can have serious consequences.

**Title VI of the Civil Rights Act of 1964**

"No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal assistance."

**Minnesota Statutes 1995 15.441)**

"Every state agency that is directly involved in furnishing information or rendering services to the public and that serves a substantial number of non-English-speaking people shall employ enough qualified bilingual persons in public contact positions, or enough interpreters to assist those in these positions to ensure provision of information and service..."

**Professional Health Care Interpreters**

The need for clarity and understanding is paramount in any setting where people seek services. But in a hospital or clinic, life-and-death-decisions hinge on immediate, accurate communication. The consequences of poor communication can be devastating. Inaccurate history-taking, unnecessary testing, and misdiagnosis are just a few of the risks.

Federal law recognizes these potential risks to health care consumers by mandating "linguistic accessibility to health care" under Title VI of the Civil Rights Act. Minnesota law also requires public health care institutions to provide services to people with limited English proficiency.

In addition, health care accreditation systems have adopted standards that underscore the need for language access. The Joint Commission on Accreditation of Healthcare Organizations requires hospitals to "have a way of providing for effective communication for each patient served," while the National Committee for Quality Assurance, which accredits managed care organizations, has stipulated that the provision of medical interpreters is essential to overcome the communication gap between providers and non-English-speaking patients.

**Minnesota has not met the requirement for access, particularly in health care.**

Minnesotans with limited English skills have trouble gaining access to our state's health care system. Bilingual health care providers are few. For example, although there are nearly 50,000 Hmong people living in Minnesota, the state has only six Hmong-speaking physicians. There are no Somali-speaking physicians licensed to serve the state's estimated 12,000 Somali refugees. Hundreds of Spanish-speaking patients are served each year by Madelia Community Hospital in southern Minnesota, which in spring of 1998 had one bilingual nurse, and no trained interpreters.

**Federal Laws on Language Access in Health Care**

Title VI of the Civil Rights Act Hill-Burton Act  
Medicare  
Medicaid  
Categorical Grant Programs

Emergency Medical Treatment and Active Labor Act

**Minnesota Laws on Language Access in Health Care**

"Bilingual Services Act "1995 (MN Statutes 15.441, Subd. 1)

Metropolitan hospitals such as Hennepin County Medical Center, Regions Hospital and Mayo Medical Center have attempted to comply with state and national laws by hiring full time foreign language interpreters; for example, Mayo Medical Center has 80 interpreters on the payroll.

But the demand far outstrips current supply. Facilities which have hired interpreters find themselves virtually overwhelmed with the demand for their services: Hennepin County Medical Center's 46 interpreters (31 full-time, 15 on-call) made over 54,000 individual patient visits in 1997, serving patients who spoke Spanish, Somali, Russian, Amharic, Chinese, and 34 other languages.

When interpreters are not available, providers will often resort to using family and friends. The use of untrained, "volunteer" interpreters is rife with hazards: in one study of recorded ad hoc interpreter-assisted encounters, 25% to 50% of the words and phrases were incorrectly relayed. Using family members and friends as interpreters undermines patient confidentiality and privacy and in many instances is completely inappropriate, violating family roles and boundaries. According to the U.S. Office of Civil Rights, the use of children as interpreters or requiring patients to provide their own interpreters is a civil rights violation.

### **Better access benefits health care systems.**

Equal access for limited English-speakers is the law. Beyond complying with a legal mandate, however, community and health systems should have many other reasons for wanting improved access for LEP clients and patients. Minnesota's legal system has already recognized the benefits of providing interpreters in the court room, and mandates the use of trained interpreters in all state courtrooms.

### **Children Are Not Suitable Interpreters**

In one widely cited incident, a seven-year old girl was asked to tell her mother what an ultrasound examination had revealed: that the woman's fetus was dead in utero.

A teenager incorrectly interpreted a Minneapolis physician's directive for x-rays, and told his mother that she was going to be microwaved.

Health care systems have been slower in recognizing that better access leads to:

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### **Better health outcomes**

It's common sense that clear communication can ensure more accurate diagnosis and follow-through with medications and treatment regimens. An interpreter can help a physician avoid costly, unnecessary diagnostic tests, which are inconvenient at best, and at worst expose a patient to the risks of false-positive results.

### **Ethical patient care**

Direct communication with a patient through a trained interpreter, not a family member, reduces the likelihood of misunderstanding and helps ensure informed consent. Informed consent and respect for the expressed wishes of the individual are the hallmarks of patient autonomy--a basic ethical principle in Western medical practice.

### **Better quality care**

Health care providers can respond more promptly and sensitively and can understand the health needs, goals and desires of their patients if the language barrier is removed.

### **Money and time saved**

Providers lose time trying to communicate with a patient through untrained intermediaries. Encounters can take longer, and expensive tests may be required. Systems lose money if frustrated patients take their business elsewhere, or if they cannot understand what they are told about the billing process. Patients whose medical problems go undetected and untreated as a result of miscommunication often show up later in the Emergency Room with much more serious complaints.

### **Legal action prevented**

Misdiagnosis and miscommunication regarding treatment can, of course, lead to costly lawsuits.

**"The result of language barriers is often poor compliance, inappropriate follow-up and patient dissatisfaction."**

--Language Barriers in Medicine, Woloshin, et al, 1995 Journal of the American Medical Association

**"Courts have held that a physician's failure to overcome language barriers in treatment can establish a lack of informed consent."**

--Ensuring Linguistic Access in Health Care Settings, Kaiser Foundation report

Courts in various states have ruled in favor of plaintiffs who were unable to understand what a health care provider was trying to communicate to them, and have ruled that it is the provider's professional responsibility to overcome any language barrier.

**Greater use of interpreters benefits many community services.**

The benefits that accrue to health systems using properly trained foreign language interpreters have corollaries in other community services.

Teachers and parents can further the educational goals of a child they care about only if they can communicate freely. Protecting the rights of both crime victims and suspects relies upon accurate, detailed information. Tenants' and landlords' rights and responsibilities can be fully understood only if the language gap is bridged.

This report focuses on the problem created when the health care system ignores the language gap, but its proposed solutions can apply to many other facets of our community life.

**"Courts have construed professional standards of care to find that in cases where a language barrier exists between a physician and a patient, the doctor has a duty to take adequate steps to be certain that he fully understands the patient's complaints."**

Ensuring Linguistic Access in Health Care  
Kaiser Foundation Report

**DEFINING QUALIFIED INTERPRETERS**

Interpreters in health care and other community settings assume professional responsibilities. Like all professionals, they must be qualified, i.e., they must adhere to a set of standards of competence and ethics; receive appropriate training; and be able to demonstrate their skills.

Interpreters for the deaf in Minnesota undergo rigorous training, subscribe to a national code of ethics and standards, and must be certified.

In contrast, only language interpreters working in Minnesota's legal system are required to undergo any training at all. To be hired in the state court system, interpreters must pass an ethics examination and attend a two-day training session. To demonstrate that they are fully qualified, legal interpreters must then pass a difficult certification exam. As certification tests are developed for more languages, the state courts will be required to use only interpreters who meet this certification.

Standards and requirements for foreign language interpreters working in any community setting should at least match those of interpreters working in the courts.

The next part of this report consists of the Working Group's recommendations for standards, training and proof of skills for foreign language interpreters.

**"Medical interpreting as a profession is in its infancy...By simultaneously setting clear, high standards of performance and creating rigorous training and academic programs, a marked increase in the quality of interpreting in the health care arena will follow."**

--Medical Interpreting Standards of Practice, Massachusetts Medical Interpreters Association

**BACKGROUND**

The essential role of the interpreter is to make it possible for two or more individuals who do not share a common language to communicate directly with each other as if they did.

**Interpreting calls upon multiple skills.**

Many people speak more than one language, but simple bilingualism is only the beginning of interpretation. Skills central to the interpretation process include:

- a broad knowledge of both languages and cultures in which they are spoken;
- the ability to grasp readily and completely what others say in either language;
- the ability to speak in either language so as to be readily understood;
- a good memory for what is said;
- the ability to find equivalent means of expression in each language even when there are no equivalent words; and
- a knowledge of specialized vocabulary and concepts in areas such as medicine and law.

Quality interpreting also requires that the interpreter understands a set of core competencies, and adheres to a code of ethics. These are outlined on the next three pages.

**"Standards are needed to give interpreters and translators professional status in hospitals. Many hospitals consider medical interpreters clerical or temporary help."**

--John Nicosz, president of the Massachusetts Medical Interpreters Association

**RECOMMENDATIONS**

**Core Competencies**

Any job can be broken down into separate tasks, each requiring different skills, or competencies. Core competencies are those skills which interpreters must master in order to carry out their professional role.

The Working Group recommends the following ten core competencies for interpreters.

**The competent interpreter:**

**1. Introduces self and explains role.**

Ideally, the interpreter consults first with the provider to learn the goals of the medical encounter, and with the patient to assess language requirements. Then, if this is their first meeting, the interpreter explains his role to both the patient and the provider. The interpreter must emphasize the professional obligation to transmit everything that is said in the encounter to the other party and to maintain confidentiality.

**2. Positions self to facilitate communication.**

The interpreter should be seen and heard by both parties, but should position herself in the place that is least disruptive to direct communication between provider and patient, and most respectful of the patient's physical privacy.

**3. Accurately and completely relays the message between patient and provider.**

The interpreter converts oral messages expressed in one language into their equivalent in the other, so that the interpreted message can elicit the same response as the original. The interpreter does not alter or edit statements from either party, or comment on their content. The goal is for the patient and the provider to feel as if they are communicating directly with one another.

**Core Competencies Have Wide Application**

These competencies are written to apply to health care interpreting, but with few exceptions, can apply to the job of interpreting in social service or other community settings.

**4. Uses the interpretation mode that best enhances comprehension.** Page 12

The interpreter encourages direct communication between patient and provider, using whatever modes are appropriate. Usually, the best mode will be to use "I..." in reference to the speaker, rather than "he said that..." or "she said that..." and to interpret for the patient and the provider alternately (known as consecutive interpreting.)

**5. Reflects the style and vocabulary of the speaker.**

The interpreter attempts to preserve the register (special vocabulary and level of formality) as well as the emphasis and degree of emotion expressed by the speaker.

**6. Ensures that the interpreter understands the message to be transmitted.**

The interpreter asks for clarification or repetition if the message from either party is unclear.

**7. Remains neutral.**

In situations where there is conflict between patient and provider, the interpreter continues interpreting completely, lets the parties speak for themselves, and does not take sides.

**8. Identifies and separates personal belief from those of the other parties.**

The interpreter does not project his own values into the discussion.

**9. Identifies and corrects own mistakes.**

The interpreter checks the accuracy of her own interpretation.

**10. Addresses culturally based miscommunication, when necessary.**

The interpreter identifies instances in which cultural differences between provider and patient have the potential to seriously impair their communication. In those instances, the interpreter shares cultural information with both parties that may be relevant, or assists the speaker in developing an explanation that can be understood by the listener.

**Competencies Are Based on National Standards**

This list of core competencies is based on the "Massachusetts Medical Interpreters' Association Standards of Practice," a document developed in 1995 by the Massachusetts Medical Interpreters Association and Educational Development Center, Inc.

Those standards were endorsed in 1998 by the National Council on Interpretation in Health Care.

Codes of ethics are guidelines that help interpreters maintain professional relationships with colleagues and clients. The Working Group recommends the following set of professional ethics standards for interpreters.

**An ethical interpreter:**

**1. Maintains confidentiality.**

Information divulged in any interpreted exchange--for example, between a patient and a health care provider--is private. The interpreter does not intentionally reveal confidential information.

**2. Interprets accurately and completely.**

The interpreter is committed to transmitting the content and spirit of the original message into the other language without omitting, modifying, condensing or adding.

**3. Maintains impartiality.**

The interpreter withdraws from assignments where personal ties or beliefs may affect impartiality, and refrains from interjecting personal opinions or biases into the exchange.

**4. Maintains professional distance.**

The interpreter understands the boundaries of the professional role and monitors her own personal agenda, refraining from becoming personally involved in a patient's life.

**5. Knows own limits.**

The interpreter declines to interpret beyond his training, level of experience and skills. In addition, he avoids situations that may represent a conflict of interest or may lead to personal or professional gain.

**6. Demonstrates professionalism.**

The interpreter clearly understands her role and refrains from delivering services that are not part of that role. The interpreter conducts herself in dress, posture and speech in a manner appropriate to the situation, and is respectful, courteous and honest.

**A National Template**

These ethical standards are also based on the Massachusetts Medical Interpreters' Association Standards of Practice.

**BACKGROUND**

**Good interpreters are trained, not born.**

Comprehensive training is needed for a bilingual person to become an effective interpreter. Ideally, such training should take months, or even years. A recent survey of U.S. and Canadian interpreter training described programs as brief as six hours, and as long as three years.

Minnesota's courts have recognized the need for trained interpreters, and have begun requiring court interpreters to pass a certification test. The state is part of a 12-state consortium working on national standards for the certification of court interpreters. In contrast, only Washington state insists on training and certification for medical interpreters.

Health care and social service facilities often provide on-the-job or short term training for staff who are recruited as interpreters. For example, the Neighborhood Health Care Network offers training for interpreters they provide to Minneapolis and St. Paul community clinics. But very few interpreters working in Minnesota have such training. Only 50 individuals have passed through all of the introductory and intermediate level courses of the Program in Translation and Interpreting at the University of Minnesota, the only such program in the state.

**"Training enables the trained interpreter to perform his task with accuracy and confidence, the clinician to trust an indispensable tool, and the non-English speaking patient to be provided with reliable diagnosis and quality care."**

--New York City Hospitals and Health Care Corporation, 1986

**There are few training programs for interpreters.**

In 1996, the Legislature directed the Minnesota State Colleges and Universities (MnSCU) to develop a statewide model instruction program in interpreting and translation. Although such a plan was developed, based on the University of Minnesota's existing courses in interpreting, the plan lacked an implementation structure, and it was never funded.

Minnesota still needs a comprehensive training curriculum that is accessible statewide to anyone wishing to become a spoken-language interpreter. Currently, there is no such program, although a partial program exists at the University of Minnesota. (See Appendix 5 for a description of the program.)

A complete training curriculum would require basic language proficiency in two languages as a starting point. Would-be interpreters should then be able to gain basic skills, qualifying them for some kinds of community interpreting work. If they choose, they can continue to develop advanced and specialized competencies, enabling them to work as legal or medical interpreters.

Interpreter training programs should address the unique skill of the interpreter--the ability to relay accurately in another language the meaning expressed by another person. The training should stress interactive skills, such as making introductions and asking for clarification, and technical skills, like note-taking. Interpreters should learn both simultaneous and consecutive modes of interpretation, and to translate written documents orally, on sight.

In addition, interpreters should be taught how to conduct themselves in a professional and ethical manner. Finally, providers and consumers must themselves learn how to make the best use of a trained interpreter's services.

**RECOMMENDATIONS**

The Working Group agreed on recommended parameters for a multi-site, statewide, two-year pilot training program for interpreters in health care and other community settings. These are outlined below.

**Goal**

In the first year of training: to develop general interpreting skills.

After a second year of training: to acquire the knowledge and skills necessary to work as an interpreter in specialized arenas such as health care or law.

**Target Population**

Individuals with demonstrated bilingual proficiency and interest in the field, with priority given to those who speak languages that are in demand for interpretation in Minnesota. Minimum size of each year's training cohort: 64 enrollees total in three sites.

**"We need training! Medical terminology classes, skills classes, etc."**

--Comment written by a Minnesota interpreter attending the September 24 Working Group meeting for interpreters

**Level**

An accredited university and/or community college. The University of Minnesota provides coordination, lead instructors, course materials and instructors' manuals. Course credits should be transferable.

**Teaching Sites**

Three proposed pilot sites:

Primary site: University of Minnesota-Twin Cities, possibly paired with Century College or the St. Paul Technical Vocational Institute.

Second site: University Center-Rochester, in collaboration with the Mayo Clinic in Rochester.

Third site: to be determined (site in southwest or northwest Minnesota strongly recommended).

**Curriculum**

All courses beyond the first course would include laboratory sessions supervised by bilingual instructors. Courses uniform in content and transferable.

*Basic courses:*

Two courses: an introduction to interpreting and intermediate interpreting. The courses would emphasize the role, ethics and skills needed to interpret, and offer lab instruction.

*Fundamentals course:*

Fundamentals course in health care or law, as a bridge to specialized courses.

*Specialized courses:*

One course in interpretation for legal or medical settings, plus a practicum in either setting.

**Length**

Courses taught in sequence, usually one course per semester, requiring two to two-and-a-half years for completion.

*Basic courses :*

Two semesters or 90 classroom hours.

*Fundamentals course :*

One semester or 45 classroom hours.

*Specialized courses :*

One semester or 45 classroom hours, plus practicum hours.

**Prerequisites**

*Basic courses :*

Bilingual proficiency, as established by examination.

*Specialized courses :*

Completion of first year and fundamentals of health care or legal system course.

**Instructors**

Experienced in interpreting. Lead instructor position requires bachelor's degree. Assistant instructors with bachelor's degree preferred. Instructors' manual with texts and materials available for each course.

**Recommended Training Sites**

1. The University of Minnesota campus, Mpls/St Paul
2. University Center-Rochester
3. A community college in southwest or northwest Minnesota

**BACKGROUND**

Individuals seeking to establish a record of their skills and training as professional interpreters have no common system of certification or validation in Minnesota. Employers seeking to assess the skill level of would-be interpreters also have a difficult time. What is needed is a simple, consistent way to establish an interpreter's skill level.

**Certification ensures minimal competence.**

The skill level of a trained interpreter can be certified by others who are capable of assessing their professional competence. Such assessment or even certification provides a measurable standard which allows employers to know whether the interpreters they hire meet at least minimal competence criteria.

Certification can be provided by an educational institution, by a state agency or by a professional association. The Association of State and Territorial Health Organizations has recommended that state health agencies set and enforce quality standards for medical interpreters.

**States have begun to monitor interpreters.**

To date in the U.S., however, only Washington state has instituted a certification program for medical and social service interpreters. It requires interpreters hired by agencies with state contracts to pass an examination administered by the Washington Department of Health and Human Services.

In Minnesota, the Department of Administration is in the process of producing a list of interpreter services which will be approved for contracts with state agencies.

**"It is difficult from the standpoint of an agency to determine the qualifications of interpreters. It would be to everyone's benefit to have a test to follow."**

--A Minnesota interpreter agency owner, at the September 24 Working Group meeting for interpreters

**RECOMMENDATIONS**

The Working Group recommends a two-tiered system of assessing the proficiency of interpreters. Tier 1 establishes a minimum level of testable skills and recommends basic training for all interpreters; Tier 2 establishes recommended levels of skill and training for interpreters in specialized settings, such as health care.

**TIER 1: Minimum level of testable skills and training for all interpreters**

**Bilingual proficiency**

*Recommended* : All individuals hired to perform interpreting services should, at minimum, be able to demonstrate oral proficiency in each language through a test developed by the American Council of Teachers of Foreign Languages (ACTFL). An ACTFL score of "advanced-mid" level is recommended. (See Appendix 3 for more information on this test.)

**Basic understanding of professional ethics**

*Recommended* : All individuals hired to perform interpreting services should, at minimum, pass a test of comprehension of ethical standards. This test will be developed, based on the ethics standards endorsed by the Working Group.

**Basic interpreting training**

*Recommended* : In addition, it is recommended that all individuals hired to perform interpreting services complete basic courses in interpreter training offered through the University of Minnesota/ MNSCU system (Introduction to Interpreting and Intermediate Interpreting.)

**TRAINING  
basic courses  
in training  
program**

-----  
**SKILLS  
bilingual proficiency  
(ACTFL test)  
ethical understanding  
(ethics test)**

**TIER 1**

**General Interpreting:  
testable skills and training**

**TIER 2: For interpreting in specialized settings, for example, health care.**

**Specialized skills**

*Recommended* :All individuals hired to serve as health care interpreters in Minnesota should pass a state health care interpreter certification test. This is an oral test to be developed, modeled on the Court Interpreter test now offered in Minnesota and on other certification exams. This test should establish a testee's bilingual proficiency as equivalent to the ACTFL "Superior" level. (For more information on the ACTFL test, see Appendix 3)

**Specialized training**

*Recommended* :All individuals hired to serve as health care interpreters in Minnesota should complete the basic courses as previously outlined, plus the courses in medical interpreting, to be offered through the UM/MNSCU program. (Fundamentals of Health Care for Interpreters; Interpreting in Health Care Settings; and a practicum.) Training, though not required for certification, will benefit even those interpreters who pass the certification test.

**Advanced interpreting skills and training**

*Recommended* :Individuals who have passed the health care interpreting certification test (to be developed); have significant experience as a medical interpreter and have received advanced training in medical interpreting can be considered to possess advanced medical interpreting skills. Continuing education for interpreters should be made available through employers, professional associations and educational institutions.

**TRAINING  
specialized courses**

- - - - -

**SKILLS  
specialized interpreting  
(certification test)**

**TIER 2  
Specialized interpreting:  
testable skills and training**

**BACKGROUND**

Increased training, higher professional standards and greater utilization of health care and community interpreters will greatly benefit Minnesota's social service and health care systems. But few benefits are truly free. For Minnesota residents to enjoy equal access to health and social services that all are promised, regardless of the language they speak, we will have to manage the costs implicit in keeping that promise.

**Professional interpreter services are more costly.**

A comprehensive statewide training program for medical interpreters will cost money, as will a new system of certification for the interpreting profession. Using trained professional interpreters will cost health care and social service agencies more than relying inappropriately on untrained friends and family members.

**But consider the cost of the status quo.**

The hidden costs of the status quo must be acknowledged as well, in any cost-benefit inventory.

What is the health cost of denying full access to care to a significant proportion of Minnesotans?

What is the potential liability faced by institutions whose patients or clients feel they are denied access?

In its deliberations, the Working Group made an effort to estimate the costs of improving interpreter services statewide, for a two-year pilot period. A budget for this period appears on the next page.

**Consider the Costs**

To adequately serve its growing LEP population in 1997, Hennepin County Medical Center spent over \$1,000,000 in costs related to interpreter services.

**Consider the Benefits**

What benefits accrue to social service and health care providers who bridge the language gap between themselves and their newest patients?

## The Budget

### Recommended

This budget is for a two-year pilot period, beginning in 1999. Staff coordination is needed for the following tasks:

- disseminating the professional standards to working interpreters, their employers and other agencies that serve Minnesotans with limited English
- guiding the development of training programs at three pilot sites
- promulgating a system to test professional skills

### Funding Sources

Funding should come from a public-private partnership, including state agencies, the state colleges and universities, the legislature, private foundations and businesses. Interpreters will also bear some of the cost of their own training, through tuition fees.

### Two Year Pilot Program Budget: 1999-2000

<u>Task/line item</u>	<u>Estimated Cost</u>
Coordinating	192,000
Disseminating standards	30,000
Developing training program	530,000
• curriculum development	
• site development	
Promulgating standards	35,000
<u>Evaluation</u>	<u>13,000</u>
TOTAL	\$800,000

**RECOMMENDED**

Below are just a few ways in which every stakeholder reading this report can act on the recommendations in it. You can contact any member of the Working Group to express your interest.

**If you are an academic**

- collect data on needs of LEP populations.
- research the benefits and costs of increased use of professional interpreters.

**If you are an advocacy community member**

- monitor health and community organizations' use of interpreters; protest the use of family members and unqualified interpreters.

**If you are the administrator of a health care facility**

- hire and contract with interpreters who meet the standards outlined in this report.
- require training for providers on working with interpreters.

**If you are a health care provider**

- insist on working with trained professional interpreters who meet the standards outlined in this report.

**If you are an interpreter**

- seek appropriate training.
- help form a statewide organization of foreign language interpreters.

**If you are a legal advocate**

- promote the enforcement of rights guarantees in existing laws.

**If you work in a state Medicaid agency**

- make Medicaid provider contract guidelines comply with OCR requirements.

**To Be Continued...**

As of November, 1998, the Working Group of the Interpreter Standards Advisory Committee has been funded for three months to begin implementing the recommendations in this report.

**Follow the Working Group's progress or get involved:** consult the Web site at [www.umn.edu/ccch](http://www.umn.edu/ccch) (click "Interpreter Standards") or call coordinators Barbara Babbitt and Patricia Ohmans at (651) 489-4238.

# Appendix 1

## GLOSSARY

**interpreting:** enabling the communication between two or more individuals who do not speak a common language. An interpreter re-expresses a spoken message accurately, in another language.

**translation:** providing an accurate written version of a source text, in a different language.

**lay interpreter:** an untrained person who is called upon to interpret, such as a child interpreting for her parents.

**ad hoc interpreter:** a bilingual staff person who is called away from his or her regular responsibilities to interpret as needed.

**professional interpreter:** an individual with appropriate training and experience who is able to interpret with consistency and accuracy and who adheres to a code of professional ethics.

**certified interpreter:** a professional interpreter who is certified as competent by a professional organization or government agency through rigorous testing based on consistent criteria.

## Key Concepts

Many of the concepts and terms used in this report are drawn from the work of Bruce Downing, Ph.D., Director of the Program in Translation and Interpreting, University of Minnesota.

## Appendix 2

### APPLICABLE LAWS

#### **Title VI of the Civil Rights Act of 1964**

"No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal assistance."

Title VI Prohibition Against Discrimination on the Basis of National Origin—Persons with Limited English Proficiency (Guidance Memorandum from the Office of Civil Rights, January 1998)

"Because of these language barriers, LEP persons are often excluded from programs or experience delays or denials of services from recipients of Federal assistance. Such exclusions, delays or denials may constitute discrimination on the basis of national origin, in violation of Title VI..."

*full text on Internet Office of Civil Rights Homepage at [www.hhs.gov/progrorg/ocr/lepfinal.html](http://www.hhs.gov/progrorg/ocr/lepfinal.html)*

#### **Minnesota Bilingual Services Act, 1995**

Minnesota Statutes 15.441, Subdivision 1  
"Every state agency that is directly involved in furnishing information or rendering services to the public and that serves a substantial number of non-English-speaking people shall employ enough qualified bilingual persons in public contact positions, or enough interpreters to assist those in these positions to ensure provision of information and service..."

#### **Minnesota Statutes 1996, Section 256.01**

amended in 1998 to charge the Commissioner of Human Services with the "implementation of a procedure for public assistance applicants and recipients to identify a language preference other than English. ..(and to)...develop a plan to serve recipients who have limited English proficiency that ensures the state is in compliance with Title VI of the Civil Rights Act..."

**"States, health care providers and managed care organizations are largely unfamiliar with the numerous federal and state civil rights laws that protect limited English speakers against discrimination in the delivery of health care."**

--Ensuring Linguistic Access in Health Care Settings, Kaiser Foundation Report

#### **For a Comprehensive Review**

Language access responsibilities under federal and state laws and managed care guidelines are reviewed thoroughly in "Ensuring Linguistic Access In Health Care Settings: Legal Rights and Responsibilities," Henry J. Kaiser Family Foundation, January 1998

The report is available on the Internet at [www.healthlaw.org](http://www.healthlaw.org)

## Appendix 3

### TESTING LANGUAGE PROFICIENCY: THE ACTFL TEST

The American Council on the Teaching of Foreign Languages has developed a widely used test of spoken language proficiency, known as the ACTFL test. Through 15-30 minute tape recorded interviews, ACTFL testers establish a speaker's level of consistent functional ability and limitations of competence, ranging them on a scale from "Superior" to "Novice."

In the U.S., the ACTFL test is administered by Language Testing International, Inc. This report recommends that all interpreters be required to demonstrate oral proficiency of at least "advanced-mid" level, and further recommends a ranking of "superior" for all medical interpreters.

#### **Speakers at the Advanced-mid level can:**

- handle with ease and confidence a large number of communicative tasks;
- handle the linguistic challenges presented by a complication or unexpected turn of events
- combine and link sentences into connected discourse of paragraph length or longer; and
- be readily understood by native speakers unaccustomed to dealing with non-natives.

#### **Speakers at the Superior level can:**

- participate fully and effectively in conversations on concrete and abstract topics;
- provide detailed descriptions and narrations in all but the most complex time frames and aspects;
- explain and defend opinions and develop effective hypotheses;
- maintain discourse with a high degree of linguistic accuracy; and
- satisfy the linguistic demands of professional and/or scholarly life.

#### **For More Information Contact**

Language Testing International, 235  
Mamaroneck Avenue, Suite 103 White  
Plains, NY 10605  
(914) 948-5100

The Mayo Medical Center in Rochester  
requires ACTFL test screening of all  
medical interpreters on the payroll.

# Appendix 4

## INTERPRETERS MEETING SUMMARY

The meeting's discussion raised many important and valid concerns. Interpreters and other participants had an hour to question members of the working group, and also wrote comments and questions on notecards. All of these comments are summarized below, following the categories of the recommendations themselves-- professional standards, training, and certification.

The effort to form a statewide organization of professional interpreters received solid endorsement at the meeting. Many participants signed up for more information on this effort, which is being spearheaded by Working Group member Natasha Geilman, among others. Geilman distributed a sign-up sheet; others who are interested can contact her at (612) 566-4312.

### **1. Professional standards**

Several attendees spoke out in favor of consistent professional standards, particularly for medical interpreters. Interpreters who are aware of their professional responsibilities ultimately benefit the patients they serve, speakers asserted repeatedly.

Debate regarding standards centered chiefly around the question of whether the interpreter has an obligation to serve as a "cultural broker" as well as a linguistic intermediary. Feelings were strong about this issue: several speakers advocated clear and strict boundaries so that an interpreter would not feel obliged to explain (and possibly misinterpret) a patient's culturally-based behavior to a provider. "We don't have the expertise," said one speaker.

But a vocal minority felt that some cultural brokering was not only useful, but necessary to prevent miscommunication. "One cannot justify separating language from culture! They are inseparable in the mind of a well-trained interpreter," wrote one participant.

At least one participant felt called to befriend interpreting clients on occasion, citing the clients' apparent need for emotional support.

## **Interpreter Responses**

Over 120 Minnesota interpreters attended a special meeting hosted by the Interpreter Standards Advisory Committee's Working Group on September 24, 1998 in St. Paul. The meeting was designed to familiarize working interpreters with the draft recommendations on statewide standards, training and certification for interpreters.

Other written and spoken comments on the recommendations regarding professional competencies and ethical standards included these ideas:

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- modification of a patient or provider's exact wording is sometimes necessary, for clarity's sake;
- "underage kids" should not be hired by interpreter agencies; widely promulgated standards will help stop this practice;
- interpreters daily face very difficult ethical situations;
- the medical interpreter ethics should be very consistent with those promoted by the State Court Interpreter Program.

"How do I know I will be hired any more often after I complete training?" asked one speaker.

## 2. Training

The expansion of training options for interpreters was enthusiastically endorsed by participants in the meeting. ("How can we as interpreters be willing to be paid a professional wage if we are not willing to take professional training?" said one interpreter.) However, several speakers had reservations and comments about existing training programs and their possible expansion.

Chief among these was the concern that would-be interpreters might invest in training courses without any certainty of full-time after they graduate. Several participants asked about possible funding, such as loans or scholarships for trainees.

Another frequent request was for more flexible training options. Lower cost, more sites, weekend and evening hours, and shorter courses were all endorsed. Two speakers raised the specter of unqualified trainers, and wondered how high-quality trainers might be secured, especially for languages spoken by few people, locally or even world-wide. "I speak Tibetan," wrote one participant. "Dialects are many, Tibetans are few. (It will) cost more to teach me than all the income I will make in interpreting."

"Who will enforce the standards and do the testing?" asked another speaker.

One speaker felt that a training program ought to include an aptitude screening component at the very beginning. Another recommendation was for regular continuing education offerings for interpreters.

No one at the meeting spoke against the idea that interpreters should have to demonstrate their competence in some way. But many participants wondered about the logistics of such "certification," and endorsed some kind of flexibility in its implementation.

Particularly in rural areas, where interpreters are fewer, immediate enforcement of unrealistic competency standards may backfire, warned one writer.

Most questions centered around the idea that working interpreters with a certain amount of experience should be able to "test out" of any training requirement. "Experience is just as good or better than training," said one speaker. Another advocated that training be required only for interpreters who weren't able to pass a competency-based examination. Interpreters of languages with few local native speakers worried about the competency of future examiners; one speaker suggested that "outside experts" could be used, if the local community was too small in numbers to provide examiners.

Participants felt that proof of skill, if required, should be required universally. "What certification do the phone line interpreters at AT&T provide?" one speaker wondered. One writer asked whether reading and writing, as well as speaking skills, would be tested.

### 4. Implementation

Although the draft recommendations did not include any suggestions for implementing them (these will be drafted in October by the Working Group) comments made at the meeting raised several relevant questions:

"If federal law requires interpreters, why doesn't state law require competent, credentialed interpreters in these same situations?" asked one interpreter.

Are health care providers and their organizations committed to the idea of using (i.e. hiring) professional trained interpreters?

Can the recommendations be required in some way? "It would be really great if this can be a statewide thing so that no facilities can take advantage of their bilingual staff (by deploying them as interpreters, without training)" wrote a participant.

What legislation, if any, is needed to make these recommendations a reality?

# Appendix 5

## UNIVERSITY OF MINNESOTA TRAINING PROGRAM IN TRANSLATION AND INTERPRETING

### Basic courses

INTRODUCTION TO  
INTERPRETING\* 45 classroom hours

INTERMEDIATE INTERPRETING\*  
45 classroom hours

### Specialized courses

FUNDAMENTALS OF HEALTH  
CARE FOR INTERPRETERS  
45 classroom hours

INTERPRETING IN HEALTH CARE  
SETTINGS 45 classroom hours

PRACTICUM IN HEALTH CARE  
INTERPRETING 45 classroom hours

(OR)

FUNDAMENTALS OF AMERICAN  
LAW FOR INTERPRETERS 45  
classroom hours

INTERPRETING IN LEGAL  
SETTINGS 45 classroom hours

PRACTICUM IN LEGAL  
INTERPRETING 45 classroom hours

Courses marked with an asterisk (\*) are already offered at the University of Minnesota. Other courses would have to be developed.

This outline shows one way the courses could be sequenced.

## **Appendix 6**

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# Acknowledgments

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Coordination: Patricia Ohmans, MPH and Barbara Babbitt, RN, MA

Health Advocates Community Health  
Consultants  
843 Van Buren Avenue  
Saint Paul, MN 55104  
(651) 489-4238

Editing and report design: Patricia Ohmans  
Cover design by Anthony Schmitz, Frogtown Times

## **For limited additional copies, contact**

Sally Sabathier  
Minnesota Department of Health  
(651) 215-1305