



# NATIONAL STANDARDS

*for*

## Healthcare Interpreter Training Programs

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## COMMITTEE

### PREPARED BY THE NCIHC STANDARDS, TRAINING AND CERTIFICATION COMMITTEE

#### *Co-chairs*

Karin Ruschke, MA  
President, International Language Services, Inc.  
Interpreter Trainer, Program Development Consultant

Shiva Bidar-Sielaff, MA (through May 2010)  
Director of Interpreter Services and Community Partnerships  
University of Wisconsin Hospital and Clinics

Cynthia E. Roat, MPH (May 2010–May 2011)  
National Consultant on Language Access in Health Care

#### *Members*

Maria-Paz Beltran Avery, PhD  
Managing Director, Education Development Center, Inc.

Julie Burns, MEd  
State of California Workers Compensation Certified Medical Interpreter English/Spanish  
American Translators Association-Certified Translator Spanish into English  
Certification Commission for Healthcare Interpreters – Certified Healthcare Interpreter™

Adelya Carlson, MEd  
Director, Training and Outreach  
Northern Virginia Area Health Education Center

Bruce Downing, PhD  
Associate Professor Emeritus, Linguistics  
Former Director, Program in Translation and Interpreting  
University of Minnesota

Carola E. Green  
Federal Court Certified Interpreter  
Coordinator for Court Interpreting Testing Services and Operations, Research  
National Center for State Courts

Katherine Langan, PhD  
Interpreter/Translator III, Trainer  
Mercy Medical Center, Des Moines, Iowa

Orlin Márquez, RN, BSN, MBA  
Practice Manager—Physiatry/Rehabilitation  
Children's Healthcare of Atlanta at Scottish Rite  
Immediate Past President, Medical Interpreter Network of Georgia (MING)

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### REVIEWED AND APPROVED BY THE NCIHC BOARD OF DIRECTORS, APRIL 2011

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Doreena Wong, JD, Co-chair, Policy and Research Committee  
Cynthia E. Roat, MPH, Interim Co-chair, Standards, Training and Certification Committee  
Karin Ruschke, MA, Co-chair, Standards, Training and Certification Committee  
  
Gem P. Daus, MA, Executive Director

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### **Project Advisory Committee**

Marjory Bancroft, MA  
 Eduardo Berinstein, FCCI  
 Agustín de la Mora, FCCI  
 Nora Goodfriend-Koven, MPH  
 Marilyn Mochel, RN  
 Elizabeth Anh-Dao Nguyen, MA, AHI  
 Robert Pollard, PhD  
 Laurie Swabey, PhD  
 Amy Wilson-Stronks, MPP, CPHQ

### **Expert Consultants**

Robyn Dean, MA, CI/CT  
 Gregory Figaro  
 Catherine Ingold, PhD

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## **National Standards for Healthcare Interpreter Training Programs**

### **INTRODUCTION**

Over the past decade, formal training opportunities for interpreters in health care have increased significantly across the United States. In 1994, when the group that would become the National Council on Interpreting in Health Care (NCIHC) first met, both the practice of healthcare interpreting and formal preparation of healthcare interpreters were in their infancy. To raise the quality of healthcare interpreting and to standardize and advance the profession, the NCIHC embarked on the following five-step strategy:

- Document the national dialogue on the role of the healthcare interpreter.
- Develop a nationally vetted code of ethics for healthcare interpreters.
- Develop nationally vetted standards of practice for healthcare interpreters.
- Develop nationally vetted standards for healthcare interpreter training.
- Establish a national certification process.

In 2001, NCIHC published a conceptual paper summarizing the national dialogue on the complex role of the healthcare interpreter as it had evolved since the early 1990s. The National Code of Ethics for Interpreters in Health Care was published in 2004 and the National Standards of Practice for Interpreters in Health Care were published in 2005. In 2007, work began on developing national standards for training programs. At about the same time, a separate effort to certify healthcare interpreters was launched, supported by the NCIHC and other organizations.

Understanding that programs to equip potential interpreters with both key knowledge and foundational skills would need to be available to raise the quality of healthcare interpreting, the NCIHC focused its work on developing national training program standards. While by 2007 the formal preparation of healthcare interpreters had improved significantly in many parts of the country, vast differences in the quality and comprehensiveness of programs still characterized the training landscape. It was hoped that the availability of carefully crafted and nationally vetted standards would help to both standardize and increase the quality of training for interpreter candidates across the country.

This document presents standards for the formal preparation of bilingual or multilingual individuals who wish to enter the healthcare interpreting profession. The standards are intended to serve as a guide for the development and ongoing review of “entry-into-practice” healthcare interpreter training programs—that is, programs designed for individuals who wish to acquire the background knowledge and foundational skills that every healthcare interpreter needs to demonstrate in order to function independently. The standards are built on the best knowledge and expert opinion available to date about what every interpreter needs to know and be able to do and the most effective instructional methods for helping interpreter candidates master these knowledge and skill areas. We anticipate that as the profession of healthcare interpreting matures, these standards will need to be reevaluated. Until then, they are intended to provide a common and consistent base for healthcare interpreter training programs in the United States.

The document is organized into the following sections:

- **Section I: Background and Context.** This section presents the background and context in which the standards for healthcare interpreter training programs were developed.
- **Section II: The National Standards for Healthcare Interpreter Training Programs.** This section presents the standards themselves.
- **Glossary:** The glossary defines specialized terms used in this document.

## SECTION I: BACKGROUND AND CONTEXT

### Why Standards for Training Programs?

Although the formal preparation of healthcare interpreters has progressed significantly since the early 1990s, vast differences still exist in the rigor and comprehensiveness of programs.

Trainings may last anywhere from 2 hours to 200 or more hours. Some cover only the Code of Ethics, while others focus principally on medical terminology, and still others incorporate both interpreting theory and skill-building. The languages chosen for instruction or skill-building also vary considerably. Some programs are taught only in English, others are taught in English with varying amounts of bilingual skill-building practice in the trainees' languages, and still others are taught bilingually for specific language pairs. Classes meet in person, over the telephone, or over the Internet. Some programs screen potential students for linguistic proficiency in English, others screen for proficiency in the other language(s) used in interpreting, and some require no language screening at all. Some have clearly defined performance expectations for those who complete the programs while others simply acknowledge student attendance.

Recognizing that the advent of national certification presupposes that quality training programs should be available and that foundational knowledge and skills for healthcare interpreters should be standardized, these standards set minimum requirements for what needs to be taught and, more importantly, learned before a candidate can practice as a professional healthcare interpreter.

### Development Process

The NCIHC Standards, Training and Certification (STC) Committee developed these standards using the following process.

1. *Review of existing knowledge.* Before actually drafting standards, the STC conducted a body of background research. First, the STC reviewed training standards in other fields in order to learn how related disciplines have approached this challenge. At the same time, the committee commissioned a background paper that included a literature review on effective methods for training interpreters and an analysis of 10 documented interpreter training curricula representing diverse settings and duration. The goal of the literature review was to identify what is already known about training interpreters; the



goal of the program review was to identify the breadth of topics and teaching techniques currently being used in a representative sample of healthcare interpreter courses being implemented in the U.S. today. The committee had also planned to conduct a job analysis that identified the core knowledge, skills, and abilities of working healthcare interpreters; however, this became unnecessary when the Certification Commission for Healthcare Interpreters (CCHI) allowed NCIHC access to the job task analysis it had already conducted along with its Body of Knowledge study as background for its national certification exam. In addition, a series of 10 focus groups were conducted across the country.

2. *Consultation with an expert advisory committee.* A Project Advisory Committee was formed, comprising individuals with extensive experience in fields relevant to interpreter training, such as curriculum development, training practices, and linguistics. Many committee members were also experienced and respected healthcare interpreters and trainers. Establishing such a committee was seen as essential to developing the standards because systematic research on or evaluation of healthcare training programs was lacking. The Project Advisory Committee first met in April 2010 to review the background research and advise the STC Committee on the content and structure of the draft standards.
3. *Development of draft standards:* An initial draft of the standards was developed, informed by reviews of existing knowledge and guidance from the Project Advisory Committee and feedback from two national online surveys.
4. *Feedback from interpreters, trainers, and administrators:* Two national online surveys—one for interpreters and another for trainers—provided feedback on the draft standards. In addition, the Project Advisory Committee met a second time in November 2010 to review feedback on the draft standards and make recommendations on their final form and content.
5. *Finalizing the standards:* Feedback from the online surveys and focus groups and comments from Project Advisory Committee members were carefully reviewed and considered to develop the final set of standards.

This document, which resulted from this 2-year process, presents standards for introductory spoken-language healthcare interpreter training programs, whether based in community, private, or academic settings.

## Organization of the Standards

The standards are divided into three major areas:

1. *Program content standards:* The content standards identify the background knowledge and foundational skills in which every professional interpreter should demonstrate competency or understanding before assuming full responsibility for interpreting between English-speaking providers of health care and individuals with limited English proficiency (LEP). The premise of the content standards, based on a general understanding in the field, is that every healthcare interpreter, including a novice, needs to be competent in certain core skills—such as consecutive conversion skills—in order to practice independently, while other more advanced skills—such as fluid simultaneous interpretation—can be developed after an interpreter starts working.
2. *Instructional methods standards:* The instructional methods standards draw on principles of adult learning and recognize that interpreting is a skill-based profession. These standards, based on research in other fields of interpreting and on the collective experience, practice, and expertise of healthcare interpreter trainers, present a consensus on best instructional practices for preparing healthcare interpreters, with a strong emphasis on skills development supported by an understanding of why and how these skills are best applied.
3. *Programmatic standards:* The programmatic standards set out operational practices and policies that contribute to a quality formal training program and include recommendations on instructor qualifications and requirements for entry into interpreter training programs. Some flexibility in implementing these programmatic standards will, however, be required in order to address the unique circumstances and characteristics of potential candidates from diverse languages, cultures, national histories, and histories of immigration and internal migration in the United States.

## Audience

These National Standards for Healthcare Interpreter Training Programs provide guidance to training program developers as well as program administrators, trainers, interpreter candidates, consumers of interpreter services, and others concerned with the competence of interpreters and the quality of interpreter services.

1. *Program developers and training program administrators* can use the standards to evaluate and improve the comprehensiveness of existing programs, expand existing programs, or design new programs. Compliance with these standards increases a program's credibility.
2. *Trainers* can use the standards to assess their choice of instructional practices and content, keeping in mind the goal of developing their students' ability to apply their knowledge and demonstrate competency in the foundational skills.
3. *Interpreter candidates* can use the standards as a guide to assessing the quality of training programs they are considering or the adequacy of programs they have completed. In addition, the standards help inform interpreter candidates about the knowledge and skills they must acquire to practice as competent professionals and to prepare for certification.
4. *Consumers of interpreter services*, especially employers, can use the standards as a reference for what they can expect from interpreters who have completed entry-into-practice training.

## Scope of Application of the Standards

The National Standards for Healthcare Interpreter Training Programs recognize that many programs are currently not designed or able to cover every component in the standards. The standards are presented as a goal to aspire to as the field of healthcare interpreter training evolves. Thus, the standards are intended to apply to all training programs regardless of their duration or sponsorship—whether training dedicated staff interpreters, dual-role interpreters with other job responsibilities, or freelance interpreters. Likewise, the standards apply equally to

programs preparing interpreters to work face to face as well as programs preparing them to work remotely. Whatever the nature of an interpreter's employment relationship, the principal goal of a competent interpreter is always the same: bridging the linguistic barrier in the service of communication between provider and patient. All healthcare interpreter training programs must keep this goal in mind.

Particular attention should be paid to how to apply these standards to training interpreters in languages of lesser diffusion, a task which poses unique challenges. As mentioned earlier, these standards are intended to describe what is considered essential; at the same time, the complexities inherent in training speakers of languages of lesser diffusion—especially those persons who are recent arrivals in the United States—need to be recognized and addressed by implementing the standards with some flexibility. For example, training programs may need to reconsider such programmatic standards as those addressing the prerequisites for entry into training. Potential students may come from countries with a history of interrupted schooling or may lack formal educational credentials but show a high level of maturity and understanding of the world. For some linguistic groups, certain content areas may present unique challenges. For example, healthcare concepts in one language may not have lexical equivalents in another. In situations where literacy is not widespread in the culture, dictionaries and other instructional tools may not exist and teaching methods requiring the use of the written word may be ineffective.

At the same time, programs must seek creative solutions to these challenges. For example, when assessing linguistic proficiency in languages other than English, the lack of standardized proficiency assessment in a particular language is not a valid excuse to forgo language screening altogether. There are many ways to determine a candidate's level of proficiency against community standards set by speakers of a particular language. Protocols for assessing the proficiency of speakers of languages of lesser diffusion can be developed based on the consensus of multiple members of the language community. This option demonstrates how creative thinking can address a training standard that might otherwise appear unreachable.

## **Length of Training**

By design, this document does not specifically recommend how long introductory training programs should be. The class hours needed to learn the content identified in the standards will

depend on a number of factors, including the training program's resources and the characteristics of the pool of potential students, including their prior interpreting experience, specialized knowledge of health care, and general level of education. *The standards focus on the elements of training needed to ensure that interpreters are prepared to interpret competently in their initial professional encounters.* If, for practical reasons—for example, the lack of instructors, limited resources, or time constraints—a specific instructional program cannot address all elements of the standards, it should not be considered deficient or unsatisfactory. It may simply need to provide additional training before trainees are ready to interpret on their own.

At the end of such training, candidates should be given a “road map” that clearly identifies the competencies they have acquired to date, the additional competencies they need, and, whenever possible, how those competencies can be acquired. The end point of training is determined not by the clock but by the trainee's readiness for independent professional service. Therefore, preparatory training can be considered complete when a trainee has developed all the competencies essential for independent performance in the role of healthcare interpreter. For this reason, the standards refer to programs of study (possibly including a series of trainings or courses) rather than to individual training programs.

## Summary

The standards that follow represent the careful thought of a large community intimately involved with preparing healthcare interpreters. As mentioned earlier, it is to be expected that the expertise in this nascent field will grow over time and research will provide more concrete data on which to base recommendations. NCIHC hopes that this document will provide both a set of unifying standards for the present and a point of departure for future discussions in this field, with the constant goal of improving the quality of healthcare interpreting to the benefit of limited-English-proficient patients and the healthcare providers who serve them.

## **SECTION II: STANDARDS**

### **I. Program Content Standards**

#### **Introduction**

As discussed in the general introduction, these standards reflect broad agreement on the knowledge and skills any interpreter will need before entering into practice, that is, before interpreting independently. Some topics included in this program content section may seem more advanced than would be expected in a basic training. However, in the focus groups and online surveys conducted during the design of these standards, many working interpreters stated that they seldom can choose to interpret only in certain specialties or for “easy” cases—they must be prepared for whatever presents itself in any healthcare encounter. So, for example, while most interpreter training assumes that beginning interpreters must be competent in the consecutive mode, these standards recognize that they will also need at least basic knowledge of and skill in the simultaneous mode. Interpreters will be called upon to do sight translation, already taught in most interpreter training, but also some short translations (such as discharge instructions). They will need a broad range of healthcare terminology and the associated concepts found in varied specialties. And all interpreters should be expected to know something of the legal and social context of their work. As a result, the scope of topics included in these standards may be somewhat broader than expected.

At the same time, certain less common and more demanding areas of healthcare interpreting have been omitted here since they can be addressed in advanced/specialized courses or continuing education. These include interpreting for mental health, speech therapy, pediatric specialties, pharmacy, social work, financial services, palliative care, diet and nutrition, smoking cessation, support groups, Emergency Department/trauma, and care conferences. Other topics to be covered in specialized workshops are business practices for freelance interpreters, demographic and socio-historical information regarding patients’ country of origin, as well as migration history and settlement patterns of particular linguistic groups. Local circumstances may determine whether interpreters just entering practice need these or other specific knowledge and skill areas.

This section has been divided into two parts: content related to knowledge and content related to skills. Knowledge about a topic gives the interpreter background and context and often answers the question why: Why do interpreters maintain confidentiality? Why do they use the first person? Skills are demonstrable behaviors that often take practice to learn and perfect, such as accurate conversion skills. While the two sections have been addressed separately to highlight the importance of each, they are best taught in an integrated fashion. So, a lesson on the pre-session would include both knowledge (the reasons for doing a pre-session, the content addressed in a pre-session) and skills (practice doing a pre-session). Regardless of the length of a class or course, it is critical to include both knowledge and skills.

Reading this section may raise the question of how one can know if a standard has been met. How much training on the history of healthcare interpreting is enough? How many hours are sufficient to teach accuracy in consecutive interpreting? The standards in this section were not designed to be measured in this way, primarily because no research has been done to establish benchmarks in these areas. These should be seen as initial guidelines. As the field grows and develops, and as more research is done, quantifiable goals can be established and be more defensible. For the present, simply identifying the scope of the content to be included in initial interpreter training is a step forward.

## **Program Content Standards**

**A. Knowledge:** *The basic program of study exposes the student to the essential body of knowledge that serves as the context for the healthcare interpreting profession.*

1. **The healthcare interpreting profession:** A basic program of study introduces the student to healthcare interpreting as a profession.
  - a. The definition of interpreting as contrasted with bilingualism and translation
  - b. Fields of interpreting (e.g., diplomatic interpreting, liaison interpreting, business interpreting, and community interpreting, including judicial, healthcare, social service, law enforcement, and educational interpreting)
  - c. Ways in which interpreters are employed (dedicated vs. dual-role interpreters, contract or freelance interpreters)
  - d. Overview of the history of healthcare interpreting in the United States
  - e. The purpose and functions/responsibilities of the healthcare interpreter

- f. Modes of interpreting in health care (consecutive, simultaneous, and sight translation)
  - g. Media of interpreting (e.g., face to face or remote (telephonic or video))
  - h. Laws, standards, and regulations relevant to healthcare interpreting (e.g., Title VI of the 1964 Civil Rights Act [Section 601],<sup>1</sup> Department of Health and Human Services [DHHS] Standards for Culturally and Linguistically Appropriate Services [CLAS],<sup>2</sup> The Health Insurance Portability and Accountability Act of 1996 [HIPAA],<sup>3</sup> The Joint Commission,<sup>4</sup> the Americans with Disability Act,<sup>5</sup> and relevant state laws and local policies).
  - i. Liability insurance (e.g., Errors and Omissions)
  - j. Availability, purpose, and limitations of certification
2. **Language and communication:** A basic program of study introduces the student to different aspects of language and communication dynamics as they impact interpreting.
- a. Language elements (e.g., regional and social dialects, style, register, and discourse; literal and figurative language; use of idioms and frozen language; literalness vs. meaning accuracy; paraphrasing; and conversation vs. interviewing)
  - b. Communication elements (e.g., power dynamics and negotiation of meaning)
  - c. Cultural elements of language (e.g., forms of address, politeness markers, turn-taking and interruptions, and body language)
3. **Professional practice:** A basic program of study introduces the student to ethics in the healthcare profession as well as the ethical principles and standards of professional interpreter practice.

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<sup>1</sup> Information on Title VI can be found at Limited English Proficiency, A Federal Interagency Website, <http://www.lep.gov/>.

<sup>2</sup> Information on the CLAS standards is found on the Office of Minority Health website at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>.

<sup>3</sup> Information on HIPPA can be found on the Health and Human Services website at <http://www.hhs.gov/ocr/privacy/>

<sup>4</sup> Information on The Joint Commission can be found at [www.jointcommission.org](http://www.jointcommission.org).

<sup>5</sup> Information on language access for the deaf/hard of hearing is available at [http://www.ada.gov/reachingout/hospcombr\(lesson2\).html](http://www.ada.gov/reachingout/hospcombr(lesson2).html).



- a. The general concept of ethics and its application to interpreting in health care
  - b. Ethical principles and standards of practice consistent with the National Code of Ethics<sup>6,7</sup> and National Standards of Practice for Interpreters in Health Care<sup>8</sup>
  - c. Self-care (including physical safety and emotional well-being and preparing for high-stress situations)
4. **Health system:** A basic program of study introduces the student to the key concepts, beliefs, and common terms relevant to the U.S. healthcare system.
- a. Overview of the U.S. healthcare system (e.g., venues, insurance, primary and specialty care, types of hospital services, categories of healthcare workers, and legal concepts and terms)
  - b. Concepts and relevant terminology in biomedicine (e.g., anatomy and physiology, symptoms, common diseases, diagnostic procedures, common medications, treatments, and apparatus)
  - c. Overview of common healthcare interview routines and medical decision-making (e.g., the medical interview, process of diagnosis, referral process, and physical exam)
5. **Culture:** A basic program of study introduces the student to culture and its impact on health and health care.
- a. Overview of culture—what it is and how it impacts health and health care
  - b. Concepts and relevant terminology from the patient's perspective (e.g., understanding of the human body and its functioning, descriptions of symptoms, common diseases and treatments, expectations around insurance, origins of illness, and complementary and alternative medicine)

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<sup>6</sup> National Council on Interpreting in Health Care. (2004). *A National Code of Ethics for Interpreters in Health Care*. Working Papers Series, July.

<sup>7</sup> Other comparable ethical standards have been developed by the California Healthcare Interpreting Association (CHIA) (<http://www.chiaonline.org/>) and the International Medical Interpreters Association (IMIA) (<http://www.imiaweb.org/default.asp>).

<sup>8</sup> National Council on Interpreting in Health Care. (2005). *National Standards of Practice for Interpreters in Health Care*. September.  
<http://data.memberclicks.com/site/ncihc/NCIHC%20National%20Standards%20of%20Practice.pdf>

- c. The culture of biomedicine (e.g., the biomedical view of origins of illness, doctor-patient relationships, hierarchies, and decision-making)
  - d. Cultural awareness and sensitivity
6. **Resources:** A basic program of study introduces the student to where to find and how to manage resources for further study for both knowledge and skill areas.

**B. Interpreting Skills:** *A basic program of study provides the student with models of effective practice and opportunities to develop the foundational skills of healthcare interpreting*

1. **Message conversion:** A basic program of study gives the student opportunities to practice converting messages accurately and completely from a source language to a target language and includes the following components.
  - a. Active listening
  - b. Message (discourse) analysis
  - c. Target language equivalence (e.g., figurative language, expletives, idioms, and colloquialisms)
  - d. Managing regional dialects
  - e. Maintaining / changing register
  - f. Memory skills (e.g., chunking, prediction, visualization, and note-taking)
  - g. Self monitoring and self-assessment
2. **Modes of interpreting:** A basic program of study demonstrates and gives the student practice in the various modes of interpreting. It focuses on developing consecutive interpreting skills as the default mode used in healthcare interpreting.
  - a. Consecutive
  - b. Simultaneous (exposure to)
  - c. Sight translation<sup>9</sup>

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<sup>9</sup> A discussion of sight translation is included in National Council on Interpreting in Health Care. (2010). *Sight Translation and Written Translation: Guidelines for Healthcare Interpreters*, March. <http://data.memberclicks.com/site/ncihc/Translation%20Guidelines%20for%20Interpreters%20REVISED%2031710.pdf>.

3. **Interpreting protocols:** A basic program of study demonstrates and gives the student practice in interpreting protocols based on understanding the rationale for these protocols and their appropriate use.
  - a. Introducing and explaining the role of the interpreter
  - b. Use of the first person
  - c. Positioning,<sup>10</sup> including the dynamics of different positions
  - d. Conducting a pre-session or session introduction and post-session
  - e. Intervention techniques (e.g., speaking as the interpreter in the third person and maintaining transparency)
  - f. Managing the flow of communication
  - g. Monitoring comprehension among listeners
  - h. Interpreting for groups (e.g., team and family conferences and teaching sessions)
  - i. Interpersonal skills (e.g., how to work with healthcare professionals, dealing with disrespectful providers or difficult patients, and de-escalating conflict)
  
4. **Cultural brokering:** A basic program of study demonstrates and gives the student opportunities to develop skills for mediating cultural differences.
  - a. Recognition and management of cultural conflicts and misunderstandings
  - b. Ability to recognize the interpreter's own cultural biases and maintain objectivity in the interpreting encounter
  
5. **Decision-making:** A basic program of study gives the student opportunities to explore ethical and other professional dilemmas and situations.
  - a. Ethical decision-making—The ability to think through an ethical dilemma and make an informed choice based on the National Code of Ethics for Interpreters in Health Care.<sup>11</sup>

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<sup>10</sup> Information on positioning is found at National Council on Interpreting in Health Care. (2003). *Guide to Interpreter Positioning in Health Care Settings*. November.

<http://data.memberclicks.com/site/ncihc/NCIHC%20Working%20Paper%20-%20Guide%20to%20Interpreter%20Positioning%20in%20Health%20Care%20Settings.pdf>.

<sup>11</sup> National Council on Interpreting in Health Care. (2004). *A National Code of Ethics for Interpreters in Health Care*. Working Papers Series, July.

<http://data.memberclicks.com/site/ncihc/NCIHC%20National%20Code%20of%20Ethics.pdf>

- b. Critical thinking—The ability to think through a situation and make an informed choice about the best course of action to take and to justify this action
6. **Translation in the interpreting context:** A basic program of study teaches the student basic skills in on-the-spot translation and transcription of simple oral and written instructions.
- a. Ability to decide when on-the-spot translation or transcription is appropriate
  - b. Ability to respond to requests for translations/transcriptions ethically and professionally

## II. Instructional Methods Standards

### Introduction

Effective training of interpreters requires an understanding of the key principles of adult learning and appropriate methods for helping candidates develop the knowledge and skills required by this field.

When training adult learners, it is important to select appropriate instructional methods. Adults are not “blank slates.” They come to training with knowledge and life experiences that affect how they understand health and health care, culture, and the work of interpreting. Eliciting existing knowledge gives the student a framework for incorporating new concepts, ideas, and skills. In addition, misconceptions may need to be corrected and assumptions based on limited experience may need to be challenged.

Adults will have developed learning styles that vary from individual to individual. Some learn better by hearing, others by watching, and others by reading. Generally speaking, teaching methods that engage the learner in an active exchange with the material will be more successful. Skill-building is a particularly important part of interpreter training. Interpreting is not something one learns simply by reading or watching. Learners need to practice the skills, receive feedback, learn from their mistakes, and continue the cycle in order to develop and improve.

As part of this cycle, interpreter trainers have come to appreciate the importance of a practicum—that is, an opportunity for student interpreters to observe professional interpreters in the workplace and provide real-life interpreting services while being observed themselves. Practicum programs are challenging to set up and supervise, and feedback from the field has underscored the difficulties that many programs of study encounter in trying to create practicum opportunities for their students. However, no classroom experience can, by itself, adequately prepare interpreters for the real-life challenges of interpreting in the wide variety of settings that constitute the healthcare system. The one-on-one supervision provided through a well-run practicum is invaluable in helping students adapt their classroom learning to the real world. For this reason, the standards strongly recommend that training programs include a practicum.

Adults typically lead busy lives with many responsibilities outside the classroom; they bring to training a lifetime of experience and specific learning goals, all of which must be considered and addressed if the educational experience is to be successful. Choosing appropriate teaching methods that make learning achievable, interesting, and immediately applicable to real life will maximize the success of that experience.

This section, then, deals with standards related to teaching methods and includes best practices informed by the field of adult education and based on the insights of successful trainers.

## Instructional Methods Standards

- A. Interactive methods:** *Instruction is based on interactive techniques that engage students in ways that challenge them to internalize the content and develop the skills required of an interpreter.*
- B. Guided practice:** *Instruction dedicates a significant amount of time to guided practice, gives students directed feedback, and monitors their skill development (especially in message conversion).*
- C. Student learning needs:** *Instructional methods accommodate different learning styles and the knowledge and skills students bring with them.*
- D. Varied teaching methods:** *A variety of appropriate teaching methods are used, including the following.*

### 1. Presentation methods

#### Examples:

- a. Lectures using visual aids and opportunities for interaction
- b. Readings, references, and links to resources
- c. Guest presenters, such as practitioners or working interpreters
- d. Student presentations
- e. Instructor modeling of effective practice
- f. Video, film, and vignettes to demonstrate real practice
- g. Storytelling providing real world situations

**2. Skill-building exercises (for conversion accuracy)**Examples:

- a. Parroting in the same language (for close listening)
- b. Paraphrasing (in the same language)
- c. Message analysis exercises (based on the source utterance)
- d. Message conversion exercises (unidirectional and bidirectional consecutive interpreting)
- e. Error analysis
- f. Prediction skills
- g. Memory exercises
- h. Note-taking exercises
- i. Terminology-building exercises

**3. Guided practice of consecutive dialogue interpreting**Examples:

- a. Behavior rehearsal through role plays—scripted and unscripted, progressive
- b. Simulations with invited practitioners or standardized patients
- c. Supervised practicum (also referred to as internship)
- d. Video/audio self-recording (pairs or individuals) and review

**4. Critical thinking analysis for decision-making**Examples:

- a. Case studies
- b. Application of code of ethics to ethical dilemmas/scenarios
- c. Guided discussions
- d. Sharing of experiences brought by students

**5. Structured feedback**Examples:

- a. Instructor to trainee: in class or practicum
- b. Peer to peer

- c. Self-evaluation (self-reflective evaluation process, journaling, or audio recording with transcription and error analysis)
- d. Coaching (in person or remotely) by both the instructor and an interpreting coach who speaks the students' language pairs.
- e. Back interpreting or use of a language coach for languages for which there is no interpreting coach
- f. Formative and final assessment.

## **6. Self-directed study**

### Examples:

- a. Development of personal glossaries
- b. Language conversion practice
- c. Homework assignments
  - i. Report on self-critique of performance or error analysis
  - ii. Observational reports
- d. Readings (on patient culture, interpreter experiences, etc.)

## **7. Observation followed by discussion**

### Examples:

- a. Videos
- b. Audio recordings
- c. Shadowing
- d. Field trips, such as a visit to a hospital

## **8. Practicum**

- a. A supervised practicum is highly recommended to be an integral part of the program of study. The experience will provide the student with the opportunity to observe working interpreters, be observed, and receive feedback from a supervisor/mentor while carrying out professional responsibilities under appropriate supervision.
- b. To ensure that academic concepts continue to be applied, the practicum will be completed shortly after completing the training program. The time frame



for completing a practicum may be longer for speakers of languages of lesser diffusion.

- c. The practicum will be conducted in settings where principles learned in the program of study and appropriate to the learning needs of the student can be applied.

### III. Programmatic Standards

#### Introduction

The programmatic standards are intended to identify common desirable features in setting up and administering training programs. They include standards related to operational policy, program design, student entry requirements, instructor qualifications, and student assessment. They emphasize the importance of having a well-designed curriculum that is planned in advance in consultation with appropriate specialists and utilized by instructors. By curriculum, we mean a general description of the program of instruction: learning objectives, content, sequencing, methods of instruction, teaching materials, activities, assignments, resources, and evaluation methods. The syllabus made available to students at the beginning of the course will provide an outline of the curriculum so that the students will know what to expect. A curriculum usually encompasses a series of courses, while a syllabus is specific to a single course or component of the curriculum.

While these programmatic standards can be applied to any course or course of study, we recognize that training is offered under circumstances that vary greatly from program to program. Clearly, staffing will be handled differently in a community college than in a hospital-based program, and a hospital might have different entry standards for candidates than a university. Because training contexts will vary, these programmatic standards should be implemented with a degree of flexibility to accommodate the circumstances of the training organization, the available resources, and the needs of the prospective learners.

#### Programmatic Standards

##### **A. Operational Policies:** *Programs operate in an open and transparent manner.*

1. A program's description, publications, announcements, and advertising accurately reflect the program of study offered, including information on the following:
  - a. Application process
  - b. Admission requirements and methods of assessment
  - c. Training or course syllabi
  - d. Criteria for successful completion and methods of assessment

- e. Type of certificate or other credential provided
  - f. Tuition and fees
  - g. Withdrawal and refund policies
  - h. Other policies covering such areas as retakes of the final assessment and test-out options for specific content areas
  - i. Instructor/teaching team qualifications
  - j. Organizational affiliation
2. A program provides opportunities for prospective students to find out about the program through direct communication (e.g., orientation sessions and pre-program communications).
  3. A program maintains records that are accessible to students for a minimum period of 3 years, including the following:
    - a. Attendance and enrollment status
    - b. Grades and assessments
    - c. Type of certificate or credential received
  4. A program has an ongoing system for evaluating the effectiveness of its program of study and making improvements based on the evaluation results (e.g., assessment results, student feedback, teaching team debriefs, and feedback from employers of the program's "graduates").

**B. Program Design:** *Programs have an explicit and documented program of study.*

1. The program design
  - a. identifies the goals and learning objectives that the program of study covers, consistent with the knowledge and skills outlined in "Section II: Program Content Standards," and the National Code of Ethics and Standards of Practice for Interpreters in Health Care;
  - b. provides a scope and sequence of instruction that will meet the program's goals and learning objectives;
  - c. integrates background knowledge, theory, skill development, and assessment;
  - d. provides a student-to-teacher ratio that will facilitate the achievement of the stated program goals and learning objectives;
  - e. provides students with ready access to course materials; and

- f. is based on sound pedagogy and research on the acquisition of the required knowledge and skills.
- 2. Each course or training in the program of study has a written description that includes
  - a. learning objectives;
  - b. content covered;
  - c. instructional methods used;
  - d. training materials;
  - e. expectations of students (e.g., attendance and assignments outside training or course time);
  - f. assessment criteria (language proficiency, knowledge, and skills); and
  - g. resources for further study for both knowledge and skill areas.
- 3. Practice and reference materials are available in the working languages of the students where feasible.
- 4. Whenever possible, a program of study includes a practicum/internship. When a practicum is provided, it
  - a. is supervised by qualified personnel,
  - b. is scheduled and completed within a time frame that ensures the transfer of classroom learning to application in the field/real world,
  - c. is conducted in settings conducive to applying the principles learned through the program of study,
  - d. is appropriate to each student's learning needs and levels of proficiency, and
  - e. provides a formal evaluation documented by the practicum supervisor and shared with the student.

**C. Entry Requirements / Screening:** *Programs screen applicants prior to admission to maximize the likelihood that they will be able to successfully complete the program.*

*Entry requirements include the following:*

- 1. Students are at least 18 years of age.
- 2. Students have, at a minimum, a high school diploma, GED, or country-of-origin high school equivalent.

3. Students demonstrate a level of oral proficiency in their working languages that enable them to develop linguistic conversion skills that maintain the meaning of the message accurately and completely (equivalent to ILR<sup>12</sup> Level 3 or ACTFL<sup>13</sup> scale Advanced High).
4. Students are literate in their working languages, with the exception of those languages in which the written form is not in common use.
5. Students have had life experiences in countries or cultural communities in which they communicated regularly in their working languages.

**D. Instructor Qualifications:** *Individual instructors or teaching teams collectively have the academic and experiential qualifications and professional background needed to meet program goals and objectives.*

1. At least one member of the teaching team, preferably the lead instructor, is an experienced interpreter who is able to bring relevant, real-life examples into the training.
2. At least one member of the teaching team is competent in adult education techniques, either through study or a proven track record, and is able to apply this knowledge to instruction, assessment, and classroom management.
3. Ideally there is one interpreting coach for each language pair represented among the students.
4. All members of the teaching team have the knowledge, skills, and attitudes needed to work effectively in cross-cultural settings and teach to diverse learning and communication styles.
5. At least one member of the teaching team has a degree or equivalent.
6. The lead instructor will remain up to date on developments in adult pedagogy, classroom management, techniques in interpreting pedagogy, and the field of healthcare interpreting, (e.g., Code of Ethics revisions, Standards of Practice revisions, legislative changes, and national certification).
7. The lead instructor will work with guest subject matter experts (speakers brought in to speak on specific topics, such as anatomy or culture) to ensure the effectiveness

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<sup>12</sup> Interagency Language Roundtable. <http://www.govtilr.org>.

<sup>13</sup> American Council on the Teaching of Foreign Languages Proficiency Guidelines, Speaking. <http://www.actfl.org/files/public/GuidelinesSpeak.pdf>.

of their presentations (e.g., the knowledge imparted is at a level appropriate to the learning objective, the appropriate register is used, the content presented is relevant to the role of the healthcare interpreter, and effective instructional methods are used).

**E. Student Assessment:** *The program provides an ongoing assessment system consistent with the stated goals of the program of study.*

1. The program provides students with periodic and timely feedback on their progress.
2. At the conclusion of the program of study, students' acquisition of the knowledge and performance competencies is formally assessed to determine whether the student has met the identified exit criteria.

## GLOSSARY

<b>ACTFL scale</b>	A system for rating proficiency in speaking, hearing, writing, and reading in a foreign language that was developed by the American Council for the Teaching of Foreign Languages, a national organization dedicated to promoting the learning and teaching of other languages. For a detailed description of the levels, see the ACTFL website: <a href="http://www.actfl.org/files/public/Guidelinespeak.pdf">http://www.actfl.org/files/public/Guidelinespeak.pdf</a> . Compare <b>ILR scale</b> .
<b>active listening</b>	A skill or method of listening that focuses on what is being said for content and purpose in order to achieve full understanding.
<b>adult pedagogy</b>	The theory and process of using instructional practices best suited for adult learners. These practices build on the characteristics of adult learners (e.g., they are self-directed and autonomous, bring a wealth of prior life experiences and knowledge, and are goal- and relevance- oriented). See <b>interpreting pedagogy</b> .
<b>back interpretation</b>	A technique for checking the accuracy of an interpretation by rendering it back into the source language and then comparing the second interpretation to the original message.
<b>behavior rehearsal</b>	The use of role plays as a teaching strategy to give students the opportunity to practice the behaviors and skills exhibited by an interpreter as if they were in a real setting. The opportunity to practice goes hand in hand with providing feedback that identifies both what the student is doing well and the areas in which the student needs to improve. See <b>guided practice, directed (guided) feedback</b> .
<b>certificate</b>	“A document, such as a certificate of attendance or completion, that attests to participation in a course of study and attainment of some learning objective. A person who holds a certificate related

to basic interpreter training is not thereby certified as in credentialed.”<sup>14</sup> See **certification**.

**certification**

“A process by which a certifying body (usually a governmental or professional organization) attests to or certifies that an individual is qualified to provide a particular service. Certification calls for formal assessment, using an instrument that has been tested for validity and reliability, so that the certifying body can be confident that the individuals it certifies have the qualifications needed to do the job.”<sup>15</sup>

**chunking**

An analytical technique used for spoken or written discourse that organizes information into communicative units (such as whole phrases and clauses) to more effectively understand a message, retain and recall the meaning when interpreting, and render the information in the most natural way in the target language whether interpreting, sight translating, or translating.

**classroom management**

Maximizing the use of time and resources to promote the best possible learning experience. It includes ordering and pacing to present new information, physical arrangement of the learning space, dealing with diversity, establishing good rhythms for different types of activities (including breaks), incorporating various learning styles, and providing adult learners with leadership as well as traditional learning roles.

**colloquialism**

A grammatical structure or an expression used in informal speech, often associated with regional dialects. See **idiom**.

**communication dynamics**

Characteristics of a communicative exchange reflecting relationships such as power, status, intimacy, or formality.

**community interpreting**

A branch of the interpreting profession that facilitates linguistic access for limited-English-proficient individuals to public services

<sup>14</sup> [The Terminology of Health Care Interpreting: A Glossary of Terms](#), NCIHC, revised August 2008, pp. 3-4.

<sup>15</sup> [The Terminology of Health Care Interpreting: A Glossary of Terms](#), NCIHC, revised August 2008, p. 4.



such as health care, education, social services, law enforcement, and legal services.

<b>cultural awareness</b>	Understanding how a person's culture may shape his or her experience of and response to the world around them, especially with respect to behavior.
<b>cultural brokering</b>	As used in this document, "any action taken by the interpreter that provides cultural information in addition to linguistic interpretation of the message given." <sup>16</sup>
<b>cultural sensitivity</b>	As used in this document, a willingness to accept and value cultural differences. <sup>17</sup>
<b>culture</b>	As used in this document, a shared system of beliefs, values, and assumptions that defines how we interpret and interact with the world around us.
<b>dedicated interpreter</b>	A staff interpreter whose only job assignment is interpreting. Compare <b>dual-role interpreter</b> .
<b>dialogue interpreting</b>	Interpreting between two or more individuals speaking different languages (also known as bidirectional interpreting). Compare <b>unidirectional interpreting</b> .
<b>directed (guided) feedback</b>	The process of providing students with information about their performance and use of the skills and knowledge being taught and the consequences of this performance or application in light of the goals of healthcare interpreting. For feedback to be useful, it must be set in the context of what the skills and knowledge are intended to accomplish and be specific enough for the student to follow through on the information provided. See <b>guided practice</b> .
<b>discourse</b>	As used for these standards and generally in linguistics, an entire or complete conversation or written text.

<sup>16</sup> [\*The Terminology of Health Care Interpreting: A Glossary of Terms\*](#), NCIHC, revised August 2008, p. 4

<sup>17</sup> Bancroft, Marjory A. and Rubio-Fitzpatrick, Lourdes (2011). *The Community Interpreter: A Comprehensive Training Manual*. (5<sup>th</sup> ed.) Columbia, MD: Culture and Language Press.

<b>dual-role interpreter</b>	A bilingual employee whose language skills have been screened, who has been trained as an interpreter, and who is called upon to interpret occasionally in addition to other unrelated professional duties. Dual-role interpreters should not be confused with bilingual employees who are asked to interpret without language screening or training as an interpreter; the latter are best considered ad-hoc interpreters. Compare <b>dedicated interpreter</b> .
<b>entry-level interpreter</b>	Someone prepared to begin work as a professional (competent) interpreter.
<b>error analysis</b>	A technique (originating in second language acquisition research) to determine the type and source of errors in a written text or a transcription of speech. In interpreting, it is a detailed comparison of a source text and an interpretation of it with the aim of identifying and classifying errors (additions, omissions, and deviations, such as change of register, reference, or lexical errors).
<b>figurative language</b>	A way of encoding meaning through comparisons, associations, or relationships of one form to another. It often exploits cultural perceptions. Figurative language may involve an analogy to similar concepts or other contexts and may involve exaggeration. Compare <b>literal language</b> .
<b>final assessment</b>	An assessment conducted at the end of the training program that is intended to measure the knowledge, skills, and aptitudes a student has acquired during the course. Compare <b>formative assessment</b> .
<b>formative assessment</b>	The assessment at regular intervals of a student's progress with accompanying feedback to adjust the focus of instruction in a timely manner as needed to improve the student's performance. Compare <b>final assessment</b> .

<b>forms of address</b>	Ways of addressing others used in a particular language or culture based on gender, marital status, age, or social status and indicating politeness, formality, intimacy, respect, etc.
<b>frozen language</b>	A fixed, conventional, and sometimes archaic way of saying something. Examples include the following: “How do you do?,” “Cross my heart and hope to die,” “All rise!” (in a courtroom), “Thy will be done” (in a religious service), and “At ease!” (in a military setting).
<b>GED</b>	General Educational Development, a credential considered the equivalent of a high school diploma in the United States or Canada.
<b>guided practice</b>	Teaching strategies that give students opportunities to demonstrate specific skills or groups of skills they have learned through direct instruction or demonstration and to receive feedback on their performance of those skills. See <b>directed (guided) feedback</b> .
<b>healthcare interpreter</b>	An interpreter who works in a variety of healthcare settings, including hospitals, clinics, and physicians’ offices. Healthcare interpreters facilitate communication between patients with limited English proficiency and their physicians, nurses, lab technicians, and other healthcare providers.
<b>idiom</b>	A fixed phrase, usually of two or more words, <sup>18</sup> that yields a meaning very different from the literal meaning of the individual words it contains. Examples include “a penny for your thoughts,” “shake a leg,” and “dead as a doornail.” See <b>colloquialism</b> .
<b>ILR scale</b>	A second language proficiency evaluation system developed by a group of agencies and institutions called the Interagency Language Roundtable. The scales evaluate core skills in speaking, listening, reading, and writing and in applied skills for

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<sup>18</sup> Beekman, John and John Callow. 1974. *Translating the Word of God*. Grand Rapids, MI: Zondervan Publishing House. p. 121.

translation and interpreting. For more information, see the ILR website: <http://www.govtilr.org>. Compare **ACTFL scale**.

**internship**

See **practicum**.

**interpreting coach**

A person who is highly proficient in at least two languages and who is preferably a practicing healthcare interpreter. An interpreting coach provides constructive feedback to students on their interpreting performance or skills during guided practice, role plays, or other message-converting activities. Coaching may take place in a one-on-one or group setting, in person, over the telephone, or via video conference. Compare **language coach**.

**interpreting pedagogy**

Theories and methods used in teaching the knowledge and skills needed in the practice of interpreting. See **adult pedagogy**.

**interpreting protocols**

The established norms for conducting interpreted sessions based on experience in the field of the strategies that allow for the most direct communication between primary participants (e.g., patient and doctor).<sup>19</sup>

**judicial interpreting**

Interpreting related to legal processes, proceedings, or lawyer-client representation or advocacy.

**language coach**

A person who is highly proficient in at least two languages. A language coach provides constructive feedback to students on their use of language during interpreting exercises. Coaching may take place in a one-on-one or group setting, in person, over the telephone, or via video conference. Compare **interpreting coach**.

**literal language**

The use of language adhering to the most obvious, basic meaning of the word or words, without metaphor or irony. For example, a patient, in describing his chest pain, may say to a doctor, “I thought I was having a heart attack.” He means exactly that and is using the language literally. In contrast, a teen-age girl who uses the same sentence to describe how she felt on a roller-coaster is trying to say that she was really excited and that her heart was

<sup>19</sup> [\*National Standards of Practice for Interpreters in Health Care\*](#), NCIHC, September 2005.

	beating very fast. She is not using the language literally, but figuratively. See <b>figurative language</b> .
<b>message analysis</b>	Detailed analysis of the form and meaning of a source text (oral or written) as a basis for interpretation into another language.
<b>modes of interpreting</b>	The various forms of turn-taking in speech that interpreters adopt when interpreting. The modes include consecutive interpreting, simultaneous interpreting, and sight translation. See <b>sight translation</b> .
<b>observational report</b>	Remarks, comments, or statements based on what an interpreter trainee has observed during his own interpreting performance (real life or recorded interpreting) or someone else's (e.g., role play or another interpreting exercise.) Observational reports can be effective in evaluating interpreter performance during and after the course of study. For example, they can be used to rate the trainee's knowledge of medical terminology, decision-making, intervening/cultural brokering skills, or accuracy.
<b>paraphrasing</b>	Re-expressing in the same language what a speaker says, but using different words or phrasing. This kind of exercise can help students focus on listening for meaning rather than the words used and finding alternative ways to express the meaning as a preliminary to interpreting. It is especially useful in classes where students share one language (e.g., English) but not their other language. Example: There's a book on the table. Paraphrase: The table has a book on it. / A book lies on the table.
<b>parroting</b>	Also called oral repetition, repeating verbatim (word for word) what a speaker says, in the same language. This kind of exercise gives practice in active listening but may lead trainees to focus on the words used rather than the meaning. See <b>active listening</b> .
<b>politeness markers</b>	Linguistic or culture-specific strategies used to indicate levels of formality, respect, or politeness appropriate to the context, participant, and intention of the speaker.

<b>post-session</b>	A debriefing between a service provider and an interpreter held after an interpreted encounter.
<b>power dynamics</b>	How individuals' differences in status or power are played out in their conversational interactions.
<b>practicum</b>	A supervised opportunity for trainees to practice interpreting, sometimes without pay, in an actual service setting to gain work experience.
<b>pre-session</b>	"A short discussion, held prior to the interpreted session, between the interpreter and the service provider or between the interpreter and the limited-English-proficient patient." <sup>20</sup>
<b>prediction</b>	In interpreting, using well-known routines or scripts to anticipate what will be said next as a technique to improve understanding and accuracy.
<b>progressive role plays</b>	Role plays that become more difficult with each session.
<b>regional dialect</b>	A variety of language that is characteristic of a particular geographic area.
<b>register</b>	"A style of speaking or writing (intimate, casual, vulgar, formal, etc.) or a way of communicating associated with a particular occupation or social group (slang, criminal argot, medical jargon, business jargon, legal language, etc.). Interpreters are generally expected to maintain the register of the person whose utterances they are interpreting." <sup>21</sup> See <b>social dialects, style</b> .
<b>self-assessment</b>	Reviewing one's own performance (often using an audio or video recording) to identify areas for improvement. See <b>self-monitoring</b> .
<b>self-monitoring</b>	Conscious awareness of the appropriateness of one's own behavior and the accuracy of one's interpreting while performing as an interpreter. See <b>self-assessment</b> .

<sup>20</sup> [The Terminology of Health Care Interpreting: A Glossary of Terms](#), NCIHC, revised August 2008, p. 7.

<sup>21</sup> [The Terminology of Health Care Interpreting: A Glossary of Terms](#), NCIHC, revised August 2008, p. 7.

<b>sight translation</b>	A process in which “an interpreter reads a document written in one language and interprets it into a second language.” <sup>22</sup>
<b>social dialects</b>	Distinctive varieties of a language related to social status. Dialectical differences are connected with <u>social classes</u> , educational levels, or other factors. See <b>register</b> , <b>style</b> .
<b>source language</b>	“The language of a speaker/signer who is being interpreted” (ASTM). <sup>23</sup> Compare <b>target language</b> ; see <b>working language</b> .
<b>standardized patients</b>	Also called <i>simulated patients</i> or <i>patient instructors</i> . Individuals trained to portray various scripted clinical scenarios in which they provide predetermined accounts of a condition and answer any questions posed. They allow learners to participate in realistic treatment and diagnostic simulations to gain experience interacting with patients from diverse cultural backgrounds and to practice addressing specific communication challenges.
<b>style</b>	Situationally or personally distinctive use of language. Every individual has a personal style of speaking or writing. Examples of situational style include the language of advertising, politics, religion, and individual authors or the language of a period in time; all are used distinctively and belong in a particular situation. Often used in reference to formal or informal styles of speaking or writing. See <b>register</b> , <b>social dialects</b> .
<b>target language</b>	The language of the person receiving interpretation (ASTM). <sup>24</sup> The language into which an interpreter is interpreting at any given moment. <sup>25</sup> Compare <b>source language</b> ; see <b>working language</b> .

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<sup>22</sup> [The Terminology of Health Care Interpreting: A Glossary of Terms](#), NCIHC, revised August 2008, p. 8.

<sup>23</sup> *Standard Guide for Language Interpretation Services* (F 2089-01 (reapproved 2007)). For information on obtaining this document, contact ASTM Customer Service at [service@astm.org](mailto:service@astm.org) or go to the ASTM web site, <http://www.astm.org>.

<sup>24</sup> *Standard Guide for Language Interpretation Services* (F 2089-01 (reapproved 2007)). For information on obtaining this document, contact ASTM Customer Service at [service@astm.org](mailto:service@astm.org) or go to the ASTM web site, <http://www.astm.org>.

<sup>25</sup> [The Terminology of Health Care Interpreting: A Glossary of Terms](#), NCIHC, revised August 2008, p. 8.

<b>teaching team</b>	Two or more individuals collaborating in the delivery of a course. A teaching team may consist of lead instructor, subject matter specialist, guest speakers, and language or interpreter coach(es). A method of classroom instruction in which several teachers combine their individual subjects into one course they teach as a team to a single group of students.
<b>transcription</b>	Writing out what was said in one or more source utterances or interpretations, usually based on oral or video recordings. Students are sometimes asked to review transcriptions of oral communications or prepare transcriptions of their own or others' performance as a preliminary to error analysis. Transcriptions may include symbols to denote such features as pauses, interruptions, concurrent speech by more than one person, or uhms and ahs. Compare <b>translation</b> .
<b>translation</b>	"The conversion of a written text into a corresponding written text in a different language. Within the language professions, <b>translation</b> is distinguished from <b>interpreting</b> according to whether the message is produced orally (or manually) or in writing." <sup>26</sup> Compare <b>transcription</b> .
<b>transparency</b>	"The principle that everything that is said by any party in an interpreted conversation should be rendered in the other language, so that everything said can be heard and understood by everyone present." <sup>27</sup>
<b>turn-taking</b>	The structure of conversation reflecting the social rules that regulate who can speak and when and how another participant can have a "turn" to speak. The rules are based in social and cultural concepts of politeness and cooperative communication, but the rules may vary greatly among different ethnicities or social groups.

<sup>26</sup> [The Terminology of Health Care Interpreting: A Glossary of Terms](#), NCIHC, revised August 2008, p. 8.

<sup>27</sup> [The Terminology of Health Care Interpreting: A Glossary of Terms](#), NCIHC, revised August 2008, p. 9.



<b>unidirectional interpreting</b>	“Interpreting from only one source language,” <sup>28</sup> e.g., English to Spanish. It can be used as a practice exercise before starting dialogue interpreting (bidirectional). Compare <b>dialogue interpreting</b> .
<b>working language</b>	A language in which an interpreter has sufficient proficiency to use it professionally. The source and target languages an interpreter uses in an interpreted encounter. See <b>source language, target language</b> .

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<sup>28</sup> [\*The Terminology of Health Care Interpreting: A Glossary of Terms\*](#), NCIHC, revised August 2008, p. 9.

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The National Standards for Healthcare Interpreter Training Programs, produced by the National Council on Interpreting in Health Care (NCIHC), is the result of a systematic, deliberate and reflective process. The NCIHC is confident that this document represents the standards that working interpreters and interpreter educators in the United States believe are important in the preparation of healthcare interpreters for entry into practice. The document is designed as a guide for both interpreters and the healthcare systems in which they work, and is not meant to supplant or expand policy or regulations pertinent to the provision of competent interpreter services or the training of interpreters. The NCIHC regrets any inadvertent result which may arise from the application of these standards for training programs.

