*Evidenzbureau*, which provided – particularly during wars – for the training of military interpreters (Wolf 2015). Generally speaking, however, the level of institutionalization was relatively low when judged against the gigantic administrative apparatus of the pluricultural empire. On the other hand, the commercial translation sector, which developed in the late nineteenth century through the creation of an increasing number of translation and interpreting bureaus, experienced an explicit process of professionalization (Wolf 2013b), mostly driven by the struggle for recognition in this field.

The intricate communication system of the Habsburg Monarchy was constituted mostly by multilingual civil servants, whose work would have required not only linguistic skills but also quick wits in adapting to countless different permutations of language needs. Given the enormous need for linguistic and cultural mediation activities, large parts of the population in need of such services tacitly agreed to get by in everyday situations without the help of translators or interpreters, although the call for such professional help became louder over the years.

MICHAELA WOLF

## HEALTHCARE INTERPRETING

↑ COMMUNITY INTERPRETING
→ DIALOGUE INTERPRETING
↓ MENTAL HEALTH SETTINGS, ↓ PEDIATRIC SETTINGS, ↓ SPEECH PATHOLOGY

Healthcare interpreting, also known as medical interpreting, refers to interpreting activities that take place in healthcare contexts, with interpreters serving a larger communicative activity, namely, provider–patient communication in cross-cultural healthcare. Since the mid-1990s, healthcare interpreting has seen tremendous growth, both in its legal regulation and professional development as a field of practice and in its theoretical development as a field of research.

The literature has provided conclusive evidence of health disparities experienced by patients who do not share the same language, whether spoken or signed, as their providers (Jacobs et al. 2006). They often receive less preventive care, fewer referrals, follow-ups and public health services, but show more resource utilization (e.g. more diagnostic tests and longer hospital stays) when they do visit healthcare institutions. At an interpersonal level, they and their family members also tend to receive lower quality of care when judged by such measures as interpersonal support, patient-centered communication, and patient satisfaction, even in areas unrelated to language. Although researchers are uncertain about the exact processes and pathways by which language barriers create health disparities, interpreters have been viewed as the standard solution to improve language-discordant patients' access to and quality of care.

In various multi-ethnic societies, countries that receive many immigrants, and regions where international travelers are common (e.g. metropolitan areas for international commerce and destinations for medical tourism), efforts have been made by healthcare institutions, local governments, professional organizations, and academic institutions to develop appropriate guidelines and/or CERTIFICATION processes to ensure the quality of care.

### *Policy and regulation*

The literature on healthcare interpreting has been dominated by countries that have strong sociopolitical support for language access in healthcare settings. For example, the increase of research publications in the UK coincided with a new policy, introduced in the late 1990s, that allowed non-English speakers to use their own language when using public services. In

Canada, one of the objectives of the 1985 Canada Health Act was to facilitate reasonable access to health services without language barriers.

Several reviews have identified the US as the most productive country in research publications on healthcare interpreting, due to its extensive federal and state legislative efforts to ensure language access in healthcare settings (Youdelman 2008). At the federal level, Title VI of the 1964 Civil Rights Act prohibits discrimination on the basis of race, color, or national origin by any recipient of federal funding. In 2000, the White House issued an Executive Order on 'Improving Access to Services for Persons with Limited English', which gave rise to written guidelines by the Department of Health and Human Services. Although there are no federal requirements for the quality of interpreters in healthcare settings, many states have legislation to clarify or broaden federal guidelines, providing language access for specific clinical contexts. In 2009, California became the first state in the US to require health insurance organizations to pay for interpreting and translating services.

Healthcare facilities in many countries often struggle to locate sufficient resources to fund interpreting services. In some cases, such as Belgium, the Netherlands, and some Scandinavian countries, previously high levels of public policy support for interpreter services have suffered a decline, making it increasingly difficult to take positive action at the national or local levels (Phelan 2012).

### *Types of healthcare interpreters*

Healthcare interpreting includes a wide variety of interpreters and interpreting modalities, though researchers did not systematically examine the differences between various types of interpreters until the early 2000s (Hsieh 2006a). Topics examined in studies comparing professional and NON-PROFESSIONAL INTERPRETING in healthcare settings include differences in communicative patterns, participant dynamics, interpreting errors, patient/provider satisfaction, clinical impact, and ethical concerns.

Several reviews have found that *professional interpreters* can improve patients' quality of care. In healthcare settings, professional interpreting typically involves *on-site interpreters*, who are hospital-based or contracted through interpreting AGENCIES, and *technology-based services* such as TELEPHONE INTERPRETING and videoconference-based REMOTE INTERPRETING. This use of technology has gained popularity in the healthcare industry in recent years, thanks to its cost-effectiveness (e.g. by-minute rate) and high availability.

The core competencies of professional interpreters working in healthcare settings include (a) maintaining accuracy and completeness; (b) understanding medical terminology and the human body; (c) behaving ethically and making ethical decisions; (d) possessing nonverbal communication skills; and (e) possessing cross-cultural communication skills (Ono et al. 2013). Training for professional interpreters varies considerably, ranging from 40-hour courses to Master's degrees in interpreting. Interpreters' health-related expertise also varies significantly because some interpreters work exclusively in healthcare settings (e.g. hospital interpreters), while others (e.g. telephone interpreters) often work with a wider pool of clients.

Aside from recourse to *chance interpreters* (i.e. untrained persons used on a random basis, such as bilingual bystanders) and other ad hoc arrangements, it is not uncommon for healthcare facilities in many countries to rely on *family interpreters* (i.e. patients' family members and friends). For both these categories of interpreter, concerns have been raised about misinterpretation, patient privacy, disrupted social roles, and litigation risks. In particular when bilingual children serve as interpreters (also referred to as CHILD LANGUAGE BROKERING), they may not have adequate medical knowledge or emotional maturity to ensure

the patient's quality of care or their own personal well-being. Nevertheless, family interpreters constitute a unique category due to their knowledge of the patients and special relationship of TRUST, which providers can draw on in certain circumstances, such as history taking and patient advocacy. Some researchers have argued that family interpreters can be valuable resources when providers are properly trained to utilize them appropriately and effectively. Others argue that a universal rejection of the use of family interpreters may be unrealistic, not least in clinical emergencies. It can also be viewed as an imposition of Western values on minority/marginalized populations, especially when patients feel strongly about relying on family interpreters for reasons of social obligation and established cultural practices.

Many healthcare facilities also purposefully recruit *bilingual staff* (both medical and administrative) who can not only interact with patients directly but also serve as in-house interpreters. Because of the importance attached to language concordance, bilingual providers serving patients directly are often viewed as the gold standard in cross-cultural care and have been used as a reference group in many comparative studies of healthcare interpreting. When they serve their colleagues as interpreters, their medical expertise, availability, and institutional roles set them apart as a distinct category of interpreters. However, a bilingual healthcare provider interpreting for another may pose challenges to the primary provider's authority and control over the encounter. A bilingual nurse may feel obligated to align herself with the physician's therapeutic objectives, rather than to advocate for the patient's needs. In addition, such dual-role interpreters do not always have sufficient language fluency or cultural competency, and often struggle to balance their additional workload as interpreters with their primary duties. Their communicative patterns also tend to focus on their own clinical needs and fail to address patients' concerns. Studies have found that bilingual providers and their patients often differ in their perceptions about patient satisfaction and quality of care. Thus, appropriate training, organizational assessments, and institutional guidelines are critical to ensure providers' appropriate and effective use of their language skills for clinical purposes (Diamond et al. 2012).

### *Research approaches and themes in theoretical development*

Because healthcare interpreting is uniquely situated at the intersection of medicine, language, and culture, this interdisciplinary field has attracted researchers from various disciplines, including medicine, applied linguistics, and communication, as well as INTERPRETING STUDIES. While some of the earliest publications by healthcare practitioners date back to the 1960s, most studies until the late 1980s provided anecdotal observations and often focused on working with informal interpreters. The emergence of professional interpreters in the 1990s facilitated the development of systematic and evidence-based studies, with findings highlighting the authors' discipline-specific interests, such as clinical impacts for medical researchers, discourse pragmatics for applied linguists, and interpreter performance/visibility for researchers of interpreting studies. By the 2000s, a wide variety of interdisciplinary publications and reviews, including studies with sophisticated research designs and large samples, were beginning to address both the clinical/medical and the sociopolitical/sociocultural dimensions of healthcare interpreting (Bischoff 2012). Against this background, the themes and findings described below have shaped the recent theoretical development and practice of healthcare interpreting.

#### *Utilization patterns and barriers*

Patterns in use of interpreters by providers are central to assessing language access in healthcare settings. Studies on this topic typically rely on quantitative and/or qualitative

SURVEY RESEARCH as the primary data collection method. Various authors have found that providers consistently underutilize professional interpreters, who are involved in contacts with less than 20% of language-discordant patients, even where interpreter services are legally required and telephone interpreting is made accessible (Schenker et al. 2011). Although time pressure, lack of availability/accessibility, and cost concerns are often cited as providers' reasons for not using professional interpreters, research has pointed to a wide variety of issues involved in providers' choice of interpreters. Providers strategically utilize different types of interpreter depending on their communicative goals, including discussion of therapeutic objectives, interpersonal support, clinical urgency, clinical complexity, and legal considerations (Diamond et al. 2009; Hsieh & Hong 2010). For example, some providers would not consider using technology-based interpreting to disclose bad news, even when the interpreters are highly trained and easily accessible; telephone interpreters' anonymity may pose challenges for mental health providers, as their patients may be paranoid or distrustful; on-site interpreters may pose risks to patient privacy if the local immigrant community is small; bilingual nurses may choose to use a professional interpreter for discharge instructions, but use their own bilingual skills when administering medication. Thus, the different types of interpreter and the various interpreting modalities are not interchangeable, and may have unique clinical consequences in bilingual healthcare. Rather than focus on providers' utilization patterns, researchers have underlined the need to examine and regulate the providers' decision-making process in choosing the appropriate interpreting modalities.

### *Interpreter roles and functions*

Interpreters' roles and functions have been studied extensively, facilitating the paradigm shift from a blind preference for the conduit model in healthcare settings to recognizing the interpreter as an active participant. Traditionally, studies on this topic use data from INTERVIEWS and focus groups to explore interpreters' and their clients' attitudes to, and expectations of, interpreters' possible roles. Several researchers have also juxtaposed interviews with actual interpreter-mediated medical encounters, examining the discrepancies between participants' attitudes and practices.

The conduit model has been influential in shaping the early development of healthcare interpreting. Interpreters are trained to adopt a neutral, faithful, and passive presence in provider–patient interactions, casting themselves as invisible linguistic machines that transfer information from one language to another. Various codes of ETHICS have conceptualized healthcare interpreters' default role as that of a conduit, reflecting institutional efforts to minimize interpreters' control and influence over the medical encounter. However, due to the differences in provider–patient health literacy, communicative norms, and illness ideologies, a conduit role can reinforce the POWER hierarchy, social injustice, and miscommunication in cross-cultural healthcare. Many researchers and interpreters have thus argued that a conduit-only model is unrealistic and impractical in healthcare settings (Hsieh & Kramer 2012).

Numerous typologies of interpreter roles have been proposed for training purposes (e.g. Roat 1996) and/or through evidence-based research (e.g. Kaufert & Koolage 1984; Leanza 2005). Many of the typologies share similar roles. For example, a *cultural broker/specialist* provides the necessary cultural framework to facilitate understanding. An *advocate* works on behalf of patients, to ensure their quality of care in addition to the quality of communication. By noting a continuum of interpreter roles in practice, from the passive conduit role to active advocacy roles, researchers have found that interpreters strategically shift between various levels of visibility to ensure quality of care and to facilitate other speakers' identity

performances, communicative competence, and communicative goals (Angelelli 2004a; Brisset et al. 2013). While some roles (e.g. conduit and cultural broker) are primarily enacted during the medical encounters, others (e.g. patient advocate and system agent) may be adopted both inside and outside of medical appointments. In some role constructs (e.g. institutional gatekeeper), interpreters also appear to adopt organizational goals in monitoring resource utilization and institutional ethics (Davidson 2000; Hsieh 2008). By strategically constructing their relationships with others, interpreters define the communicative context, and thus shape what is appropriate behavior by others.

### *Communicative characteristics*

Many studies have examined actual medical encounters, using various DISCOURSE ANALYTICAL APPROACHES to study interpreters' and providers' communicative patterns and collaboration (e.g. Pöchhacker & Shlesinger 2007). Professional interpreters have been found to adopt a physician-centered *and* biomedical approach in managing provider–patient interactions, favoring providers' biomedical perspectives and often ignoring other speakers' non-medical talk (e.g. rapport-building talk) and the changing dynamics in medical encounters (Butow et al. 2011). Because professional interpreters are trained to assume a neutral role, they often experience conflict and frustration in situations in which emotional or advocacy work is necessary. In contrast, family interpreters are typically found to assume a third interlocutor role in provider–patient interactions, interjecting their agenda, providing background information, advocating for patients, and actively controlling the content and process of communication (Rosenberg et al. 2008).

Finally, the QUALITY of healthcare interpreting (and cross-cultural healthcare) is not solely dependent on interpreters' performance but a result of successful collaboration among all parties involved (Jacobs et al. 2010). For example, when providers are unwilling to incorporate interpreters' cultural expertise, are unfamiliar with interpreters' communicative styles, adopt complicated or ambiguous discursive structures, or have conflicting communicative goals and expectations, interpreters may face greater difficulties in managing the content and process of bilingual health communication. From this perspective, provider training for bilingual healthcare should include not only knowledge about access to interpreters and the associated benefits, but also the specific communicative skills necessary to work effectively with healthcare interpreters.

### *Clinical consequences and specialty needs*

The clinical impacts of healthcare interpreting have been investigated extensively by medical researchers. Recent reviews confirm that professional interpreters have a positive impact on patient satisfaction, clinical outcomes, and communicative processes. Though the assumption from earlier studies is that different types of interpreter may have distinct clinical impacts, the number of comparative studies and systematic investigations is too limited to provide conclusive findings.

Using content analysis to investigate actual medical encounters, researchers have confirmed that interpreter alterations (e.g. omission, substitution, and editorializing) are frequent. Whereas the earlier literature tends to see all interpreter alterations as errors or mistakes, several researchers have now argued that alterations introduced by the interpreter can actually be strategic acts to manage contextual demands in medical encounters. The findings about the clinical impacts of interpreter alterations have varied drastically, from nearly all interpreter alterations having a negative impact to most of them being inconsequential or