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Signed Language Interpreting in Healthcare Settings: Who is qualified?

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Abstract

The Americans with Disabilities Act (ADA) of 1990 requires medical facilities to provide auxiliary aids, including interpreters, to all patients who need them to ensure that they have the same level of access to effective communication as those without disabilities (National Association of the Deaf [NAD], n.d.). However, without a national certification for signed language interpreters who work in healthcare settings, that law is hardly enforced, which is problematic. Multiple communication breakdowns have resulted from: family members and friends taking on the role of an interpreter; an interpreter not being provided; medical facilities hiring unqualified interpreters; and controversial use of video remote interpreting (VRI). These negative experiences have also led to many Deaf people being less inclined to seek medical care and routine appointments. Ultimately, the lack of access to qualified interpreters has affected the general health of the Deaf community.

The goal of this thesis will be to examine the need for a national medical specialization certification for signed language interpreters. The research and findings are presented as a meta-synthesis of the existing literature on the topic. The thesis will also provide suggestions for how that certification could be implemented, and the training programs necessary to equip interpreters for the specialization certification.

Introduction

Signed language interpreting in the medical field can be a daunting task (Agan, 2009; Cha chi, Lagha, Henderson, & Gomez, 2010; Collaborative for the Advancement of Teaching Interpreting Excellence [CATIE] Center, n.d.a; de Vlaming, 1999; Garrett, 2012; Goldberg, 2003; Harmer, 1999; Harvey, 2001; Kashar, 2009; NAD, n.d.; National Technical Institute for the Deaf [NTID], 2015a ; NTID, 2015b; Oregon Health Authority [OHA], 2011; Oregon Health Care Interpreters Association [OHCIA], n.d.; Youdelman, 2013). Clear communication between doctors and patients has always been an important goal in any health care setting (Moreland, Nicodemus, & Swabey, 2014). Complex medical terminology can be overwhelming on its own, add a language barrier and this task almost seems impossible (Goldberg, 2003; Harmer, 1999; Moreland, Nicodemus, & Swabey, 2014; Youdelman, 2013). Due to the sensitive nature of conversations in health care settings, few interpreters who are aware of the demands brave this specialty, especially hospital situations (Agan, 2009; Cha chi et al., 2010; Harvey, 2001). Historically, interpreting has not been viewed as a practice profession, that is, a profession that deals primarily with people and has a long induction period in which the practitioner gains greater expertise in professional skills and abilities (Dean & Pollard, 2013), and lacked quality control, which may have led to some of the current issues we deal with today. For these

reasons, and more, it is important that there be a national standard for signed language interpreters who work in the medical field (Harmer, 1999; Youdelman, 2013). In spite of calls for a specialty certification for signed language interpreters in healthcare interpreting, the lack of a standard continues to exist. This leads to insufficient access to medical care for the Deaf community.

For the sake of this paper the definitions for qualified interpreter, certified interpreter, and unqualified interpreter are as follows. A qualified interpreter possesses both a National Interpreter Certification (NIC) (or older certification such as the RID CI/CT or NAD certification) and a specialization in medical interpreting. Due to the lack of a national certification for signed language interpreters specializing in interpreting in health care settings, the specialization in medical may be either Oregon Health Authority (OHA) or Rochester Institute of Technology (RIT) medical interpreting certification or some other relevant education. A certified interpreter possesses an NIC or other valid certification. Unqualified interpreters accept jobs that they, with professional discretion, should decline. This can range from interpreters who work in healthcare settings without being qualified, even if they are certified, and interpreters who work in entry level, lower risk settings but are not certified.

Due to the short period of time that interpreting has been recognized as a profession there is a limited amount of published research (Pöchhacker, 2016).

For this reason, the research synthesis will also include web sources and graduate theses to bridge the informational gap. There is only one PhD program in American Sign Language Interpretation in the United States, and as of 2015, that program had only been completed by two interpreters (Hunt & Metzger, 2015). Though changing, a Master's degree is still recognized as the terminal degree in the interpreting field.

Research Questions

The purpose of this exploratory meta-synthesis study is to examine the need for a specialist certification in healthcare settings and the issues that currently exist without said certification. Despite the small pool of published research, this meta-synthesis examines the following research questions.

RQ1: What unique factors do interpreters encounter in healthcare settings?

RQ2: What knowledge, skills, and abilities do interpreters need to be effective in healthcare settings?

RQ3: What are the obstacles that stand in the way of implementing a specialty certification for healthcare interpreting?

Literature Review

The Americans with Disabilities Act (ADA) of 1990 requires medical facilities to provide auxiliary aids to all patients who need them to ensure that

they have the same level of access to effective communication as those without disabilities (Harmer, 1999; NAD, n.d.; Youdelman, 2013). However, this law is not always enforced (Harmer, 1999; IMIA, 2014; Youdelman, 2013). There is also a disconnect between what is considered an appropriate interpreter (the most commonly required auxiliary aid) and what the hospital hires.

Unique Factors That Interpreters Encounter in Healthcare Settings.

Healthcare settings stand apart from other interpreting settings due to a unique set of environmental demands. The English used in the medical field is different from the everyday language of most English speakers (Harmer, 1999; Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999). The physical lay outs of the room can make establishing sightlines difficult (Harmer, 1999; Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999). And those who work in this environment are at higher risk of exposure to things like radiation and disease (Agan, 2009; Harvey, 2001; Registry of Interpreters for the Deaf [RID], 2007).

Medical terminology. Medical jargon is often foreign even to native English users. This is because medical terminology is made up of word parts, often derived from Latin, that all stand for very specific longer concepts not often used outside medical professions (Harmer, 1999; Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999). Therefore, medical terminology is

an added demand for interpreters working in the medical field. Understanding the source language is the interpreter's first challenge and without medical terminology training that task alone can be very taxing (Harmer, 1999). Interpreters also know that there is not a one-to-one translation for English words or ASL signs; often one English word is translated into an ASL phrase or sentence (Harmer, 1999). When it comes to medical terminology this elaboration is then taken a step further because one term actually stands for many English concepts all in one (Harmer, 1999; Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999).

Risks taken on by unprepared interpreters. Those who step in when a qualified interpreter is not provided, or in place of a qualified interpreter, whether that be a family member, friend, or unqualified interpreter, are often unknowingly putting themselves in a dangerous position (Agan, 2009; Harvey, 2001; RID, 2007). Signed language interpreting, in general, has its own occupational risks, including repetitive strain injuries and soft tissue conditions (RID, 2007). These are common enough that Registry of Interpreters for the Deaf (RID) has published *Self-care for interpreters: Prevention and care of repetitive strain injuries* as one of their standard practice documents (RID, 2007). These risks are then added upon in the medical setting. Medical personnel receive various immunizations and screenings as a standard safety precaution due to the

environment they work in, and medical interpreters are working in that same environment (Agan, 2009). Being aware of the illnesses and infections one is exposed to in health care settings is important for protecting one's self and those they interact with (Agan, 2009). Vicarious trauma is another thing that interpreters are subject to (Harvey, 2001). This can be caused by something indirect – like working with a minority group and witnessing their oppression, or by something direct – like when one has to take on the client's emotions while interpreting traumatic events (Harvey, 2001). Regardless, vicarious trauma can be damaging if not acknowledged and treated (Harvey, 2001).

Signed language interpreting in other high-risk settings. Other specialty fields stand apart due to the unique demands of those environments. The legal field has requirements for signed language interpreters that are hired to work in legal settings. There is a general interpreting certification that is required plus a specialization in legal called the Specialist Certificate: Legal (SC:L). These certifications are a national standard that are required for courtroom settings (Registry of Interpreters for the Deaf, n.d.b).

The educational system also has a similar system. To interpret in educational settings, in most states one must earn a specific score on the Educational Interpreter Performance Assessment (EIPA) (U.S Department of Education, n.d.). The score required varies a bit from state to state but a 3.5 or

higher is most common (U.S Department of Education, n.d.). The Registry of Interpreters for the Deaf (RID) had a specialization classification for education interpreters as well. The RID Ed K-12 specialization for interpreting in educational settings required the interpreter to have passed the NIC written and the EIPA written, earned an EIPA score of 4.0 (out of a 5.0 scale) or higher, and a bachelor's degree (Registry of Interpreters for the Deaf [RID], n.d.a). However, although one can still take the EIPA assessment and receive a rating, RID no longer offers the Ed K-12 certification (RID, n.d.a).

This leaves people questioning why the field of healthcare interpreting does not have a signed language interpreting specialization certification as well (Harmer, 1999; McKee et al., 2011; Youdelman, 2013). Legal issues where people can be convicted of crimes and punished or are in a place where they have to defend themselves and their rights is important. People's education, which impacts their quality of life is also important. But, one's health and life is just as important if not more. When in life or death situations is that not more high risk (Registry of Interpreters for the Deaf, n.d.b)?

Spoken language interpreting in American medical settings. Spoken language interpreters have similar requirements to those of signed language interpreters in high risk settings (National Council on Interpreting in Health Care [NCIHC], n.d.). They must have completed certain educational requirements,

passed certain skills assessments, logged a certain number of hours of experience, etc. (NCIHC, n.d.). One would think that signed language interpreting and spoken language interpreting would be held to the same standards considering the two are basically the same job (Harmer, 1999). They both are responsible for transferring meaning from one language to another. The main difference being that signed language interpreters are bimodal; which means that they work between a verbal language and a signed language instead of two verbal languages (Harmer, 1999).

The reason signed language interpreters don't legally have to meet these same (or similar) requirements is due to the wording of the law (NAD, n.d.). The law states that the interpreter must be qualified (NAD, n.d.). However, in the case of signed language interpreting there is not a standard definition of what qualified is (NAD, n.d.). This leaves a giant loophole from which much of the issue stems. The present study's introduction defined what qualified means for the sake of this paper but that is not a field-wide definition. As a profession, the field of signed language interpreting focuses on certification (NAD, n.d.; RID, n.d), so the word *qualified* does not hold any weight. The hiring party is then left with the ability to define it however they see fit. This is evident when, for example, an ASL student who is not even bilingual and has no interpreting education is hired as an interpreter for a medical appointment (P. Graham, personal

communication, January 4, 2016). Yet, in the field of spoken language interpreting the term *qualified* has a very specific definition (NCIHC, n.d.). Qualified means that the interpreter has met all the requirements mentioned above.

Knowledge, Skills, and Abilities Interpreters Need to be Effective in Healthcare Settings

An interpreter does not need to go to medical school to work in a healthcare setting, but it has been established that there is a need for some training (Goldberg, 2003; Harmer, 1999; McKee et al., 2011; Youdelman, 2013). One must understand what is being communicated before one can interpret it (Goldberg, 2003; Harmer, 1999; Youdelman, 2013). Therefore, knowledge of concepts, such as anatomy and physiology, and medical terminology, are needed as a foundation for effective interpretations in medical settings (Goldberg, 200; Harmer, 1999; McKee et al., 2011; Youdelman, 2013). However, there is ambiguity over how much medical training is needed (de Vlaming, 1999; Harmer, 1999; Youdelman, 2013); a three-day workshop or a yearlong internship. The varying perceptions regarding the amount of training needed has led to calls for the need for a medical interpreter specialization certification (Youdelman, 2013).

Deaf space. The term Deaf Space was coined recently but the concept has been around for a long time (Bauman, n.d.; Shannon, Quiroga, & Trimble, 2016;

Valentine & Skelton, 2008). Deaf Space is essentially the idea of recognizing that the world is designed for hearing people and changes can be made in areas populated with Deaf individuals to empower instead of oppress the Deaf (Bauman, n.d.; Shannon, Quiroga, & Trimble, 2016). When the term first began spreading it was in relation to architecture; a design style in which vision and touch can be used as for orientation. This idea then spread beyond making physical spaces Deaf friendly (Shannon, Quiroga, & Trimble, 2016; Valentine & Skelton, 2008). Those within the Deaf community already create Deaf space and make some of these changes because the changes support and are a part of the social norms of Deaf culture (Bauman, n.d.; Shannon, Quiroga, & Trimble, 2016; Valentine & Skelton, 2008), but being aware of Deaf space allows individuals to go one step further (Shannon, Quiroga, & Trimble, 2016). An example of this common courtesy within the signing community is that those who know how to sign will chose to sign instead of speak in environments where Deaf individuals are present so as not to exclude the Deaf persons (Shannon, Quiroga, & Trimble, 2016). If one spends time in the Deaf world one might also notice that there is rarely anything on tables that would block sight lines, like center pieces.

Incorporating an understanding of Deaf Space into an interpreter's work would be to be mindful of things such as sightlines when arriving for an assignment (Bauman, n.d.; Shannon, Quiroga, & Trimble, 2016; Valentine &

Skelton, 2008). Medical exam rooms are set up in very specific configurations, which should be respected, but it is still valuable to work with the medical professional to establish clear sightlines, appropriate lighting for visibility, and make other environmental changes to make the space more Deaf friendly (Shannon, Quiroga, & Trimble, 2016).

Consecutive interpreting compared with simultaneous interpreting.

Consecutive interpreting is an approach to interpreting that resembles classic turn taking; in which one person produces a chunk of dialog, then pauses for the interpreter to relay that chunk, then continues to finish a message or the second party can respond (Russell, 2005). Consecutive interpreting is the type of interpreting you often see with spoken language interpreters, it is assumed that this is because it avoids people talking over one another. Simultaneous interpreting, on the other hand, is a type of interpreting where the speaker and the interpreter are producing dialog at the same time, usually with a few second delay (Russell, 2005). Simultaneous interpreting is typically used by signed language interpreting because ASL / English interpreting is multimodal (Russell, 2005). Thus, signing while someone else is speaking or vice versa does not lead to the same issue with overlap that two spoken languages would. Thus, simultaneous interpreting offers a more smooth and efficient communication

process, or so it appears from the outside, and has become preferred in most environments (Russell, 2005).

For years there have been misconceptions around consecutive and simultaneous interpreting (Harmer, 1999; Russell, 2005; Youdelman, 2013). Some people believe that consecutive interpreting is easier than simultaneous interpreting, and thus a skilled interpreter should not need to use consecutive interpreting (Harmer, 1999; Russell, 2005; Youdelman, 2013). However, both types of interpreting are difficult and present different demands (Russell, 2005). Simultaneous interpreting does require the interpreter to do multiple things at once; produce one message in the target language, and mentally translate the next message, while taking in the message that will follow that (Russell, 2005). But, consecutive interpreting requires the interpreter to use a longer working memory, and to monitor / regulate the turn taking process; which can feel unnatural to participants and take some time to get used to (Russell, 2005).

The statistics also show that consecutive interpreting is more accurate than simultaneous interpreting, even amongst highly skilled interpreters (Russell, 2005). For this reason, leaders in the field of interpreting are suggesting that consecutive interpreting be used in healthcare settings and any other high-risk interpreting scenarios (Harmer, 1999; Russell, 2005; Shannon, Quiroga, & Trimble, 2016; Youdelman, 2013).

Use of a Certified Deaf Interpreter. Similarly, there are many misconceptions around working with a Certified Deaf Interpreter (CDI) (Harmer, 1999; Shannon, Quiroga, & Trimble, 2016; Youdelman, 2013). Some people feel that a skilled interpreter does not need the assistance of a CDI; however, this is simply not true (Harmer, 1999; Shannon, Quiroga, & Trimble, 2016; Youdelman, 2013). A hearing interpreter and a Deaf Interpreter are simply professionals with some differences in expertise and when working together produce a more accurate product (Russell, 2005; Shannon, Quiroga, & Trimble, 2016).

As native speakers of English, most ASL / English Interpreters can recognize, understand, and match many different dialects of English right away and with high accuracy, due to lifelong experience with the language and culture (Shannon, Quiroga, & Trimble, 2016). Similarly, Deaf interpreters can recognize, understand, and match different signing styles with the same high accuracy (Shannon, Quiroga, & Trimble, 2016). Thus, the use of a team interpreting system allows for the pairing of native skills in both languages (Russell, 2005; Shannon, Quiroga, & Trimble, 2016). Teaming with a CDI can also be extremely beneficial in healthcare settings where one party may be suffering from some medical condition that could impede language use, such as pain or impaired mental state (Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016). With the opportunity for clear communication in mind, leaders in the field of interpreting are

suggesting that team interpreting with a CDI be used in healthcare settings and any other high-risk interpreting scenarios (Harmer, 1999; Russell, 2005; Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999).

Medical terminology translated. Even when an interpreter understands the source message there are many ways in which medical terms are misrepresented in ASL. Part of this is due to the fact that there are not established signs for many medical concepts and fingerspelling is not always an applicable or desirable option (Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016). This leads to a lack of linguistic options for many interpreters without specific training in how to convey these medical concepts in ASL. Misrepresentations are often due to a lack of understanding of the human anatomy and comfort with elements of ASL discourse such as classifier use, which is the use of handshapes and body parts to depict different concepts, things, or actions (Shannon, Quiroga, & Trimble, 2016).

A common example of this is Pyrosis. A medical term for heartburn, which, after understood, is often signed as HEART FIRE or HEART B-U-R-N neither of which are conceptually accurate in ASL and may lead to misunderstanding about what is actually happening within the patient's body (Shannon, Quiroga, & Trimble, 2016). A more accurate interpretation would include a classifier

depiction of the esophagus, stomach, stomach valve and the acid reflux that causes heartburn (Shannon, Quiroga, & Trimble, 2016).

Another example is of a term that is often misrepresented is the term *cancer*. One sign that is commonly used in ASL has the connotation of cells being eaten which is not true of all types of cancer. For this reason, some interpreters have chosen to fingerspell cancer. Once again the English literacy rate of the Deaf population could result in fingerspelling not being viable, and knowledge of the type of cancer and what it looks like would be beneficial in using ASL classifiers to more accurately represent the concept (Shannon, Quiroga, & Trimble, 2016).

Some interpreters argue that this level of elaboration contradicts the RID CPC in regard to equal access because medical jargon often is misunderstood by native English users (Shannon, Quiroga, & Trimble, 2016). However, when the goal of the assignment is communication, this elaboration is necessary to take the information that is implicitly stated in English and make it explicit so that it is clear and understandable in ASL (Harmer, 1999; Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999). Trying to preserve the level of minor confusion that a hearing person undergoes in medical settings can quickly lead to communication breakdown (Harmer, 1999; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999).

Obstacles That Stand in the Way of Implementing a Specialty Certification for Healthcare Interpreting

The current system of certifying signed language interpreters who work in health care settings is complex and not standardized (NAD, n.d.; OHA, 2011; OHCIA, n.d.; RID, 2007). And there are currently only a few educational programs to equip sign language interpreters for work in healthcare settings (CATIE Center, n.d.a; NTID, 2015a; NTID, 2015b).

Multiple organizations contribute to the system of signed language interpreters in healthcare settings currently in place in the United States. The National Association of the Deaf (NAD) spreads awareness about the legal requirements about providing interpreters as stated in the ADA (NAD, n.d.). They also have a vast amount of information to answer questions one may have about interpreting services on their website.

Oregon Health Care Interpreters Association (OHCIA) is the organization that puts on the formal health care interpreter training offered at Oregon Area Health Education Centers. This training is required to attain the Oregon Health Care Interpreter Registry classifications of “qualified” and “certified” (OHCIA, n.d.). The Collaborative for the Advancement of Teaching Interpreting Excellence (CATIE) Center is a comprehensive resource for finding opportunities to gain experience in healthcare settings, or to earn continuing education credits. They

offer training modules, interpreting internships, immersion programs, and more (CATIE Center, n.d.a). Oregon Health Authority (OHA) provides the official certification for interpreters working in the healthcare setting in Oregon (OHA, 2011). In the fall of 2016, a new Healthcare Interpreting certificate program has also opened up at the Rochester Institute of Technology (RIT) (NTID, 2015b). In the summer of 2017 they are planning to open the first ever Master of Science in Health Care Interpretation program as well (NTID, 2015a).

Methodology

This research was conducted in the form of a meta-synthesis and the data was analyzed with an open coding approach. Knowing that there was not a national certification for signed language interpreters who specialize in healthcare interpreting, as there is for another specialization area such as legal, I set out to examine what other scholars have said about the need for a national signed language interpreting certification that specializes in healthcare settings. I first began researching the existing laws on the use of signed language interpreters in healthcare settings, which led me into reviewing related lawsuits that have been filed against medical facilities that did/do not adhere to these laws. From there, my research extended into the use of VRI in medical settings and how an interpreter is a part of the patient's healthcare team. The complexity of being a member of a healthcare team directed my research into the dangers of

interpreting in medical settings and how proper education can mitigate those risks. This finding then led me to investigate what education opportunities exist for signed language interpreters who want to work in the medical field. All of this research was rooted in the impact that less than proficient interpreters in healthcare settings have had on the Deaf community as a whole. After reading much of the literature available for all of these sub topics I chose to include those that viewed the issues from multiple angles: from the perspective of the Deaf community, the interpreting community, and from medical facilities.

After exploring signed language interpreting in the medical field and the issues related to qualifications and education, I expanded my research into similar fields. I researched spoken language interpreting in the medical field for these reasons: spoken language interpreting in the medical field and signed language interpreting in the medical field are similar, the large difference being the mode in which one language is produced. Also spoken language interpreting has been recognized as a profession for longer and thus their systems have had the opportunity to be perfected over time. I then looked into other high-risk settings in which signed language interpreters work, both legal and educational. The reason for looking into these fields was to see how the interpreting community and Deaf community have established certifications and laws that

require certifications for signed language interpreters who work in high risk settings.

The current study is based on: 17 journal articles, two books, one workshop, 12 organization web pages, and four web articles. In the process of selecting these 36 references I found and skimmed 96 other sources and determined that they were less relevant. The 96 less relevant sources were categorized as such due to the following reasons: the source was deemed not credible enough for an academic essay, the source was related to medical interpreting but did not relate to quality control in any way, and / or the source was not related to the issues or system here in the United States.

While all 36 selected sources were important to the research process and synthesis, three sources quickly stood out as essential. Dean & Pollard's (2013) concept of the Demand Control Schema (DC-S) played a large part in how the unique factors that interpreters face in healthcare settings were assessed and what knowledge, skills, and abilities interpreters need to be effective in healthcare settings. Harmer's (1999) article, Health Care Delivery and Deaf People: Practice, Problems, and Recommendations for Change, was written eighteen years ago with a similar purpose as this thesis. Reviewing this article provided a foundation and overview of the problem and it speaks to the longevity of the issue. Lastly, the Medical Interpreting 4-day Immersion Workshop

(Shannon, Quiroga, & Trimble, 2016), brought my research up to date with what is being taught in the field as the most recent strategies to improving the medical interpreting process.

Discussion

Impacts on the Deaf Community

The issues with communication and attitudes about interpreting mentioned above lead to a disparity of medical knowledge amongst the Deaf community (Harmer, 1999; McKee et al., 2011; Pollard, Dean, O'Hearn, & Haynes, 2009). Generally speaking, “The ‘average’ deaf person has a lower level of English literacy, a smaller fund of health care knowledge, and fewer health education opportunities than his or her average hearing counterparts” (Harmer, 1999, p. 75). As many as 80% of deaf people may not be fluent in English (McKee et al., 2011), and the average deaf high school senior is reported to have a fourth-grade reading level (Middleton, Turner, Graham, Bitner-Glindzicz, Lewis, Richards, Clarke, & Stephens, 2010; Pollard, Dean et al., 2009). Due to the grammatical differences between signed language and English, magnified by the lack of English fluency “it could be considered dangerous to assume that a deaf sign language user can ‘get by’ with a hospital consultation in speech” (Middleton et al., 2009, p.812) This once again highlights a deaf patient’s need for access to signed language in healthcare settings. “The results suggest that ASL-fluent

clinicians may be crucial to addressing healthcare communication barriers experienced by deaf ASL users" (McKee et al., 2011, p.77). McKee goes on to explain that it is not common to find doctors fluent in ASL, but the use of ASL interpreters has a similar effect (McKee et al., 2011).

This language barrier "can lead to lower patient satisfaction, adherence, use of health services, and education regarding healthy behaviors" (McKee et al., 2011, p.75) if not properly addressed. The statistics are shocking. The "Deaf community is approximately 8 years behind the hearing population in AIDS knowledge and awareness" (Harmer, 1999, p. 79). More recently, it has been published that "health disparities experienced by deaf ASL users include sexual health, cancer, preventative health, and cardiovascular disease" (McKee et al., 2011). Other results of this communication disconnect include inability to express symptoms and taking the incorrect dosage of medication (Middleton et al., 2009). Since it is so common for a hearing family member to speak for a deaf patient, especially in childhood and adolescence, some deaf adults have trouble reporting their own medical history (Harmer, 1999). These are just a few examples of the negative effects of not having a qualified interpreter in health care settings.

Lawsuits. A Deaf professor scheduled a doctor's appointment and requested that an ASL to English signed language interpreter be provided.

However, when he arrived at the appointment a qualified interpreter was not provided. Instead the doctor's office had hired an ASL 3 student (that is a student at the end of her first year of learning a foreign language) to work as his interpreter. This student was not even fluent in ASL, had no interpreting education or training, and was incapable of performing the task she was hired to do (P. Graham, personal communication, January 4, 2016). That is like hiring a first-year pre-med student to do a doctor's job. Luckily for this professor, this appointment was not life threatening and he was able to reschedule the appointment. Although, other deaf individuals who find themselves in scenarios similar to this one are not always as lucky.

Ronald Zapko and his partner Jon Towery filed a lawsuit against Rose Medical Center in Colorado after being denied an interpreter on two different occasions (Draper, 2014). Zapko called the hospital via a video relay service (VRS) to request an interpreter, but upon arrival no interpreter was present and the video remote interpreter (VRI) system was in use where the interpreter was not physically present, but would interpret via video conference (Draper, 2014). Harry and Elizabeth Sheffeild had a similar experience and filed a discrimination lawsuit against Erlanger Health System in Tennessee after multiple prolonged stays in which the hospital did not provide an interpreter (Belz, 2014). The

hospital claims that they did their best to provide VRI during each visit, but they experienced technical difficulties (Belz, 2014).

Interpreting Community Perspective

As stake holders in this issue the interpreting community has is also affected by the system currently in place. (Harmer, 1999; Youdleman, 2013). Often times friends and family are asked to interpret in healthcare settings and may not be aware of the dual role issues that presents, but those in the interpreting community do understand those risks (de Vlaming, 1999; Harmer, 1999; McKee et al., 2011; Youdelman, 20130). Also, VRS interpreters may not be qualified to work in medical settings, or with discretion in mind may decline other medical assignments (Youdelman, 2013).

Video Remote Interpreting. Video remote interpreting services are a prevalent option used when a medical interpreter is needed (Youdelman, 2013). Video remote interpreting services are often less expensive than hiring an on-site interpreter and they can be available more immediately, though they also have their limitations (Kashar, 2009). A patient who is having any mental issues or impairments (including having been administered medications) may have difficulty focusing on the video monitor, thus making an in-person interpreter more effective (Kashar, 2009). The position that a patient may be in, lying down for example, can make using a VRI system difficult, and once again having an on-

site interpreter would be more effective (Kashar, 2009). The limited number of VRI systems a hospital has can often be a problem in that they simply do not meet the demand (Draper, 2014). Of course, there are also times when technical difficulties render VRI services ineffective (Belz, 2014). There are also instances where the medical staff is not trained on how use the VRI system and are unable to work with the technology (Belz, 2014; Kashar, 2009). Video remote interpreting services are also not ideal in medical settings because the interpreter's view of the scenario is limited to what the camera can capture from its stationary position (Garrett, 2012; Harmer, 1999). This can limit the clarity and accuracy of the interpretation due to lack of information. For example, "The sign for "BANDAGE" is more meaningful when it can be sized up and if the area of the body it is to be applied can be spotted or is already known" (Garrett, 2012, p. 29). Additionally, VRS interpreters may not be qualified to work in medical settings, or may not have the intrapersonal ability to handle medical situations (Youdelman, 2013).

Issues regarding dual role scenarios. It is not uncommon for a family member to be so accustomed to speaking for a deaf person that they begin conversing with the doctor as if the patient is not capable of speaking for themselves; or for the patient to feel uncomfortable disclosing all information through a family member (de Vlaming, 1999; Harmer, 1999). Both of these are

problematic for communication. Family members are also discouraged from being used as an interpreter, by the interpreting community (de Vlaming, 1999; Harmer, 1999; McKee et al., 2011; Youdelman, 2013) similarly to how counselors or medical professionals are discouraged from treating family members.

Healthcare Team

Much of the confusion over the importance of having a qualified interpreter comes from lack of knowledge (Cha chi et al., 2010; Harmer, 1999; McKee et al., 2011 Middleton et al., 2009; Youdelman, 2013). This is because medical professionals are rarely trained on how to work with interpreters (Cha chi et al., 2010). A study was published in 2010 that tested the effects of implementing a workshop in training programs that focused on medical professional's interactions with interpreters (Cha chi et al., 2010). The researchers concluded "Implementing a workshop on working with interpreters provided much needed instruction for our students while closing a gap in our pre-clinical curriculum" (Cha chi et al., 2010 p. 6). Improving the health care interpreting system will require collaborating with the medical staff as well (Cha chi et al., 2010).

Interpreters are irreplaceable members of the health care team for many reasons (de Vlaming, 1999; Harmer, 1999; McKee, Barnett, Block, & Pearson, 2011; Youdelman, 2013). Often doctors want to communicate directly with

patients and will ask if the patient can read lips, or write notes back and forth (de Vlaming, 1999; Harmer, 1999; McKee et al., 2011). However, this is ineffective because it does not address the cultural differences that would be addressed by an interpreter (de Vlaming, 1999). It also is based in the assumption that all deaf people are bilingual and English literate which is simply not the case. The average English literacy rate of deaf individuals as they graduate high school is classified as a 4th grade reading level (de Vlaming, 1999; McKee et al., 2011; Youdelman, 2013). This can lead to patients nodding their heads out of embarrassment or fear because they are intimidated by the doctor and do not fully understand what is going on (de Vlaming, 1999; Harmer, 1999; McKee et al., 2011; Youdelman, 2013).

Conclusion and Recommendations

Friends, family, and other unqualified interpreters do not take on this work with malicious intent. They do so under the impression that *something is better than nothing*. They have some knowledge of signed language and they are available so they decided to do what they can to help (Harmer, 1999; Harvey, 2001; Youdleman, 2013). However, while the intentions are innocent *something* can actually be *worse than nothing*. By trying to help, they create an illusion of communication that masks the language barrier and thus hides the problem. It appears as though communication is happening and an interpreter is not

necessary. Unfortunately, full communication is not actually happening (Harmer, 1999; Harvey, 2001; Youdleman, 2013). This not only creates issues for that scenario, it perpetuates this issue for the entire community. In the moment, there is there is the chance for countless miscommunications and misdiagnosis with potentially deadly outcomes (Agan, 2009; Beltz, 2014; de Vlaming, 1999; Draper, 2014; Garrett, 2012; Goldberg, 2003 Harmer, 1999; Harvey, 2001;Kashar, 2009; Youdleman, 2013). Fixing the issues in medical interpreting also becomes less of a priority because the majority of people (the hearing community) do not see the problem as prevalent or pressing (Cha chi et al., 2010; Harmer, 1999; Youdelman, 2013).

It is clear that there is a need for qualified signed language interpreters in the medical field (Agan, 2009; Beltz, 2014; Cha chi et al., 2010; CATIE Center, n.d.a; de Vlaming, 1999; Draper, 2014; Garrett, 2012; Goldberg, 2003; Harmer, 1999; Harvey, 2001; Kashar, 2009; NAD, n.d.; NTID, 2015a ; NTID, 2015b; OHA, 2011; OHCIA, n.d.; Youdelman, 2013) Yet, we currently do not have a national test for certifying those who meet that standard (CATIE Center, n.d.a; OHA, 2011; OHCIA, n.d.; NTID, 2015b).

The Registry of Interpreters for the Deaf is rumored to be currently working on a certification like the one proposed in this paper. Unfortunately, that has been said for quite some time now and nothing has established so far.

The RID (in partnership with NAD) was once the organization that offered the NIC, as well as the specializations in educational settings and legal settings mentioned above (RID, n.d.). Recently, the partnership of RID and NAD dissolved. As of July 1st 2016 a new organization, Center for the Assessment of Sign Language Interpretation (CASLI) now administers the NIC testing (Center for the Assessment of Sign Language Interpretation, n.d.).

After a certification is created, a law will have to be made or a current law amended to require all health care facilities to hire only interpreters who have this certification. Without a law like this, medical facilities would continue to prioritize their bottom line and hire the interpreters who charge the least. Interpreters who are already working in these positions (qualified or not) could also see little incentive to go through the process of becoming certified. Why pay more to keep doing the job they are already doing?

If a certification like this is created, there would have to be a grace period for interpreters to get certified before the requirement of hiring certified interpreters is placed on medical facilities, similarly to how standards for educational interpreters have been phased in gradually in many states (V. Darden, personal communication, June 24, 2017). Otherwise, there would be no interpreters available for medical facilities to hire, and thus the problem would be worsened and not solved. To make this idea a reality, more educational

programs than currently exist will be necessary, like the RIT Master of Science in Health Care Interpretation program (NTID, 2015a), that prepare interpreters to pass that certification.

The exploratory meta-synthesis study to examine the need for a specialist certification in healthcare settings and the issues that currently exist without said certification, produced the following findings. The unique factors that interpreters encounter in healthcare settings include medical jargon (Harmer, 1999; Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999) and increased risk and occupational hazard due to the environment (Agan, 2009; Harvey, 2001; RID, 2007) The knowledge, skills, and abilities that interpreters need to be effective in healthcare settings include the concepts of Deaf space (Bauman, n.d.; Shannon, Quiroga, & Trimble, 2016; Valentine & Skelton, 2008), consecutive interpreting compared with simultaneous interpreting (Harmer, 1999; Mckee et al., 2011; Russell, 2005; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999), use of a Certified Deaf Interpreter, and translating medical terminology (Harmer, 1999; Mckee et al., 2011; Shannon, Quiroga, & Trimble, 2016; Youdelman, 1999). The obstacles that stand in the way of implementing a specialty certification for healthcare interpreting are the current system in place and the lack of educational programs meant to prepare interpreters for this field (CATIE Center, n.d.a; NAD, n.d.; NTID, 2015a; NTID, 2015b; OHA, 2011; OHCIA,

n.d.; RID, 2007). From this data it is clear that, in spite of calls for a specialty certification for signed language interpreters in healthcare interpreting, the lack of a standard continues to exist (Harmer, 1999; Harvey, 2001; NAD,n.d.; RID, n.d.b; Youdleman,2013). This leads to insufficient access to medical care for the Deaf community (Harmer, 1999; McKee et al., 2011; Youdelman, 2013). Thus, there is grounds to justify further exploration into the possibility of a national certification for signed language interpreters who work in healthcare settings.

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