A PRESCRIPTION FOR CHANGE

REPORT ON EU HEALTHCARE PROVISION FOR DEAF SIGN LANGUAGE USERS.

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PART 1 – BACKGROUND & CONTEXT

Introduction

MEDISIGNS is a Leonardo da Vinci funded EU project with partners from Cyprus, Ireland, Poland, Scotland, and Sweden. The project focuses on providing language and communication skills to Deaf people, interpreters and those in the medical profession. In addition, knowledge about how to use an interpreter in medical encounters, knowledge about Deaf culture and information about how being deaf may affect assumptions that impact on communicative approach are considered. For example, general educational level and average literacy skills of the grassroots Deaf community are important issues to consider in this context.

A core goal of the project is to create a Continuous Professional Development (CPD) training course, which can be used by signed language interpreters and medical staff as well as by deaf people. An important part of the project entails surveying which types of information relevant for the project is available in each of the countries, as well as describing the current situation regarding interpreter provision in medical encounters. This will ensure that the correct type of content is built into both the training course and the other information materials that are part of the planned outcome of the project.

Background

Each member state in the EU strives for an effective and efficient healthcare system. However, whether this system is in fact accessible to all the citizens of a country is a different matter. For full access to medical services, Deaf sign language users need to have access to interpreting services as well as to general healthcare information translated into sign language.

In all of the partner countries there is the problem of not having enough professional signed language interpreters available. In addition, there are a highly limited number of signed language interpreters who have specialized training in healthcare or within a medical setting, if there are any at all. Figures on how many signed language interpreters have specialist medical and healthcare knowledge are not currently available from all of the project countries.

While absolute figures regarding the number of available signed language interpreters in each country may appear comparatively high or low when comparing one country to another, it must be remembered that what is of importance is the number of available interpreters per deaf signed language user in each country. This topic is further addressed in the section on interpreter provision below.

In terms of accessing appropriate healthcare, an additional issue to consider is the fact that the “average” deaf signed language user may have less knowledge regarding which services they need at any given point, as well as where to find information about this, due to a lower level of educational attainment. This is closely linked to the fact that in many countries, the general level of literacy is lower in the deaf
population, thus putting the group at a serious disadvantage. According to the Council of Europe (Leeson 2006) general trends internationally suggest that the average reading age for averagely intelligent deaf people across the European Union is 8.5 to 9 years.

From the perspective of a Deaf community and the project consortium, it is important to note that the provision of qualified signed language interpreters, and especially those trained in healthcare aspects, is not viewed as a luxury but as a fundamental human right to the access and provision of appropriate healthcare.

**EXPLORING THE CONTEXT**

**Rationale behind MEDISIGNS**

There is a growing field of research into the impact of having an interpreter present during a medical encounter. However, very little of this research has focused specifically on the situation of deaf signed language users. In addition, it is also known that in many instances signed language interpreters are not available, and if they are, they are not especially trained for medical encounters.

In some European countries a register of qualified interpreters is available which lists the level of expertise that an interpreter has, in areas such as educational, legal, or medical interpreting. If such registers indeed exist, they may or may not include signed language interpreters. The status of such registers will depend on whether it is maintained by a national interpreter association, a national organization of deaf people, a government agency, an NGO, or some other kind of body. In addition, the information in the register does not necessarily reflect the actual qualifications that an interpreter holds. In some countries, the status of “medical interpreter” can be a self-certification, often associated with experience in a healthcare setting but without due regard to any formal medical interpreting training or qualification.

There is anecdotal evidence, with individual stories reported on television programs, in newspapers and magazines, suggesting that deaf people are less healthy than hearing people and do not get proper access to health services. This lack of access to medical services is a significant issue for many European deaf people. Access depends on (1) appropriately trained interpreters, (2) access to information about medical services and processes in signed languages and (3) greater awareness on the part of professionals about Deaf communities and their languages.

According to Smeijers & Pfau (2009) the inclination for most members of the medical profession seems to be to consider deaf signed language users a group of people with severe hearing problems, but otherwise with the same linguistic preferences as hearing persons. Researchers in Great Britain (Ladd 2003) and the US (Padden & Humphries 1988, 2005) have convincingly argued for regarding deaf signed language users as members of a cultural and linguistic minority, and for the existence of a distinct Deaf culture. Such a difference in view will naturally be reflected in how the members of the medical professions communicate with deaf signed language users.
The Triadic Relationship

There are a number of issues that are important to consider when examining the triadic healthcare professional – deaf patient – signed language interpreter relationship. These include (but are not limited to) the healthcare professional’s knowledge of Deaf culture, the use of an interpreter, the level of literacy of the Deaf patient, the time the healthcare professional gives to the patient, and how much of the Deaf patient’s medical problem the healthcare professional understands.

Medical professionals, in general, are largely unaware about the deaf signed language users, their language and culture. In a study by Smeijers & Pfau (2009) this lack of knowledge was found to create a prominent gap in provision of healthcare. Their survey showed that while the majority of GPs (General Practitioners) were confident in correctly diagnosing a deaf patient, the research indicated that in over 50% of the deaf respondent’s comments, the GP did not understand the question asked by their deaf patient, presenting serious concerns for misdiagnosis and treatment.

Signed language interpreters, in turn, in most cases are not offered specialized training to enable them to deliver professional services in medical encounters and so this is a major aim of the course for them.

Interpreter Provision

In each of the partner countries there is a limited number of signed language interpreters who have received specialized training in healthcare or within a medical setting, in some instances there are no such interpreters at all. This problem is exacerbated by a general lack of available interpreters. European Union of the Deaf (EUD) figures suggest the number of qualified interpreters is 1000 in the UK, approximately 15 in Cyprus and 250 in Poland. In Sweden, it is estimated that some 500–600 interpreters have been trained to date, whereof 121 interpreters hold a generalized state authorization as ‘authorized sign language interpreters’.

In Ireland, 83 interpreters have been trained, but only approximately 60-65 ISL/English interpreters are practicing on a regular basis.

While such absolute figures may appear comparatively high or low when comparing one country with another, an actual figure of the availability of interpreters per deaf signed language user in each country changes the picture considerably. In an investigation of the need for Swedish Sign Language interpreters that was carried out in 1989, the Swedish National Board of Health and Welfare (Socialstyrelsen) estimated a conservative need for 1 interpreter per 30 deaf signed language users. The final goal was estimated to be 1 interpreter per 12 deaf signed language users (SOU 1991:97). Lack of reliable figures both regarding the number of deaf signed language users, and the number of interpreters that have been trained and are still practicing on a regular basis, in each country makes it very difficult to present reliable figures regarding the number of interpreters available per deaf signed language user.

Looking specifically at figures on how many interpreters have specialist medical training, the current situation is even more worrying: Ireland 1, Sweden 4, Poland 0, Cyprus 0, and in the UK the number is unknown.

1 www.kammarkollegiet.se accessed April 28 2012.
DELIVERING A EUROPEAN CPD PROGRAM

There is thus a pressing need to provide further training to signed language interpreters who may work in a medical context. However, there is currently very little in the form of training materials and CPD materials and courses regarding medical signed language interpreting available in Europe.

A few products addressing this need have been developed before. However, they have usually been produced to serve a single geographic market and a single user group. Using the experience of the proposed consortium, MEDISIGNS is planned to be used in five countries, and it targets three different user groups in Ireland, Cyprus, Poland, Sweden and the UK.

From the planned information materials, members of the medical professions will be able to gain insight into the Deaf community and also learn how to work with a signed language interpreter. Deaf signed language users will have the opportunity to acquire increased knowledge both regarding how to access medical information and regarding how to get the most out of interpreted medical encounters. Signed language interpreters will be offered a CPD course that provides them with the knowledge and skills to improve the services rendered by them in medical encounters.

The planned output of the project includes:

- an on-line course on medical interpreting with content in 5 countries, 4 spoken languages and 5 signed languages;
- a European report on Deaf healthcare provision;
- an information pack for the medical profession with guidelines on treating sign language users;
- master classes series;
- project information leaflets and posters;
- workshops for medical professionals providing them with a better understanding of what they need to know when working with Deaf patients and interpreters;
- workshops for Deaf people to inform them on issues that arise in medical encounters and tips on how to get the best from interpreted medical encounters;
- a guide to better communication in healthcare encounters;
- an iPhone App for healthcare professionals;
- practical tips resources;
- video footage of good practice, experiences and policy.
PART 2 – FRAMING SIGN LANGUAGE INTERPRETING

Since the groundbreaking work of William C. Stokoe (1960), it has become widely recognised that natural sign systems are amenable to linguistic description in parallel with spoken languages, and are therefore identifiable as complete, independent languages (eg Sutton-Spence and Woll 1999). Sign language (SL) interpreting therefore aligns analytically, professionally and pedagogically with other forms of interpreting, fitting the prototype formulated by Franz Pöchhacker (2004:11): “Interpreting is a form of Translation in which a first and final rendition in another language is produced on the basis of a one-time presentation of an utterance in a source language.” In the case of SL interpreting, one of the languages is typically spoken and one signed. SL interpreting is exceptional in requiring the transfer of meaning between language modalities (visual-gestural and oral-aural) as well as languages.

SL interpreting differs in several key ways, however, from those forms dominant within the early years of Interpreting Studies (where analysis often centred upon international gatherings, war crimes trials and the like). Firstly, its norms correspond much more closely to those of community interpreting (CI) than to those of conference interpreting (Mikkelson 1999). In particular, since SLs have occupied the position of ‘minority languages’ (in socio-economic and geo-political terms), issues of relative power and status – of the interpreters and of their clients, expressed through their languages – have been prominent in the theoretical development of the field. Furthermore, like CI, the work of SL interpreters is most commonly bi-lateral: but the biological inaccessibility of spoken utterances to Deaf people results in a profession staffed almost exclusively by people whose dominant language is spoken, resulting in a highly imbalanced workforce where issues of cultural allegiance therefore become intense (Mindess 1999).

Secondly, the nature of the language pairs present in SL interpretations makes simultaneous, rather than consecutive, interpreting by far the more typical form, largely because the linguistic interference effects are minimised when the languages are produced and received using entirely different channels. The tacit expectation is therefore likely to be that SL interpreters will work in the simultaneous mode, despite the fact that they will be transferring meaning between modalities as well as languages – twice the task, to be done in a fraction of the time.

Historically, SL interpreting of some description has doubtless existed wherever communication has been mediated between signing and non-signing people. The hearing children of deaf, signing parents, becoming fluent bilinguals through natural language transmission, were most likely to act as interpreters (Preston 1994). This task began to receive formal recognition in the 1960s, (Frishberg 1990). The need to carve out a distinct role for interpreters reflected anxiety about the conflation of interpreting with other relational positions – such as that of assistants or advocates – and with separable professions whose members had often undertaken to mediate communication – e.g. welfare officers, teachers, priests. The drive to formalize and tightly define the interpreter’s role has been addressed in widespread debates over Codes of Ethics which recognize the interpreter’s unique position of responsibility (Tate & Turner 1997). In recent decades, SL interpreting has thus developed as an
independent profession in many countries (see, for instance, http://www.efsli.org.uk/links.html), regulated in order to institutionalize altruism, with increasingly structured and extensive education leading to professional status, and practitioner associations providing collective representation and strategic development (Stewart, Schein & Cartwright 1998).

As SL interpreting emerged, the dominant paradigm inherited from the wider field inscribed a role representing the interpreter as a mere conduit through which messages could be transferred. Interpreters were understood and expected to have no more influence on meaning or on discourse dynamics than the hand-held apparatus has on a cellphone conversation. In keeping with the paradigm, attempts to describe and explain the process of interpreting centred upon the desire to unpack the cognitive activity required, sometimes acknowledging the relevance of social context (Cokely 1992).

In the late 1980s, however, an alternative perspective rose to prominence, inspired in particular by recognition that the ‘conduit’ model described a passive role for SL interpreters which was simply unrealistic. The natural lexical disparities between languages and the non-linear, multi-layered structure of naturally-occurring dialogue required practitioners actively to reach decisions about how to convey meanings and maximise communicative equivalence (Roy 2000). In the United Kingdom, the switch to an ‘interactional’ model was signified by a small but momentous change in the SL interpreters’ Code of Ethics: to the statement ‘Interpreters shall interpret truly and faithfully and to the best of their ability between the parties without anything being added or omitted’ were added the three significant little words ‘from the meaning’. This paradigm shift also drew upon the steady growth in awareness of CI in general: the normative image of the SL interpreter as an ‘invisible’ non-presence within the prototypical interpreting triad has been superseded by accounts which explore the co-participant status of the interpreter (Harrington and Turner 2001).

A key element in the development of understandings of the SL interpreter’s role has been the attention paid to matters of power and control in discourse. Popular social misperceptions of Deaf people as intellectually incapable (see Lane 1992 for discussion) have historically led to a paternalistic approach towards them. Since the profession began to grow independently, interpreters have been at pains to identify their impartiality. Whilst more radical ideas do circulate, the strong but misguided normative expectation – that interpreters are communicatively neutral, do not change the course of dialogue and make no self-generated contribution to interaction – remains largely in place, making the education of consumers a continuing priority (Marschark, Peterson and Winston 2005).

**References to Part Two**


PART 3 – COUNTRY SNAPSHOTs

The current situation in the partner countries

In order to ensure that the content of the planned project output is tailored to the specific needs of the three different user groups, a survey of the current situation has been conducted. The information gathered in this way will also be of use for targeting the right audiences in the project countries, as previous knowledge as well as current needs are likely to differ for each group in each of the different countries.
For some of the project countries very little is available in the form of interpreting services for deaf signed language users at all, and even less so in the form of specialized medical interpreting services. Additionally, whether healthcare services in general are accessible to deaf signed language users is in many instances an issue that has not been considered at all, and therefore no official information regarding this can be found. In some of the project countries, information regarding the provision of healthcare services to deaf people and of specialized sign language interpreters may in fact be available. However, this information in several cases consists of statements to the effect that current levels of provisions are highly inadequate.

In many EU member states, signed language interpreter training is generic in nature, and there is very little opportunity for specialist training despite a significant requirement to work precisely in the medical area. Given this, there have been several reports calling for specialist medical training (e.g. Comhairle, 2006 (Ireland)), a recent empirical study looking at hearing doctor-deaf patient interactions (the first of which we are aware) (Smeijers and Pfau (2009)), studies on Deaf women’s access to accessible maternity services (Steinberg, 2006), Irish Deaf Women’s Association (2007) and media coverage of issues relating to accessing medical services (Hands On, RTE, 2008a, b, 2009). In short, the lack of appropriate access is institutionalized by the lack of a cohesive framework for ensuring equal access for deaf patients.

In this report on healthcare provision for deaf signed language users in the project countries, the collected information has been divided into sections after deliberations with the project members as regards what the key areas of interest are for the project. Initially, information regarding the organization of provision of services and accessibility of services for deaf signed language users is presented. This is followed by information as to whether there is currently (or has earlier been) any relevant training available for each of the three intended user groups for the project outputs. In addition, information is presented regarding any studies conducted on the nature of quality in interpreting in medical settings, in conjunction with examples of good practice and Codes of Conduct/Ethics that could potentially be spread to other project countries. Studies looking at participants’ views on interpreted medical encounters are also of key interest, including perspectives on professional’s attitudes, which is an area that anecdotally has been reported to be troublesome. Finally, information regarding studies conducted on after-care and the healthcare outcomes for signing patients has also been sought after. A special section with an inventory of the types of tools supporting communication (such as signed language dictionaries and medical phrase books, etc.) that are available in the different project countries has also been included.

As the situation varies between the different project countries, the type of information available also varies greatly. Where one country may provide services and have legislation in place, no information at all might be available in another country. In Ireland and Cyprus, the researchers involved in MEDISIGNS have attempted to collect data through surveys and focus groups in order to obtain precisely the kind of information that is needed. The information about Sweden has mainly been gathered from official reports, but also from meetings with deaf sign language users and sign language interpreters.

Finally, it is important to realize that even when this report does not specifically mention that a certain type of training or services does not exist in a specific country, that does not mean that it does in fact exist in that country. If the need is not
understood or recognized, no information of the lack of training or services is likely to be found either.

The main part of the information that formed the knowledge base for the country snapshot below was supplied by the members of the MEDISIGNS consortium. The information regarding Poland has been provided by Dr Iwona Grzesiak.

ORGANISATION OF PROVISION OF SERVICES AND ACCESSIBILITY OF SERVICES

Cyprus

In Cyprus, there are no healthcare provisions or laws that regulate health issues specifically for deaf people. Deaf persons are not entitled to have an interpreter present during their visit to the hospital. The only situation where a deaf person is entitled to an interpreter, just as any individual that does not speak the official language, is for a legal court proceeding.

A signed language interpreter needs to have a diploma certifying knowledge of the national signed language from the Ministry of Education and Culture. However, there are some national complications regarding who is regarded as an interpreter that are further discussed in the section on training of interpreters for medical interpreting, below.

Ireland

In accordance with the Equal Status Acts 2000 and 2008, and the Disability act 2005 all Irish Government Departments and Public bodies are legally obliged to provide ‘reasonable accommodation’ to services, and failure or refusal to do so is seen as discriminatory. The Health Service Executive (HSE) therefore has a legal obligation to serve all service users on a non-discriminatory basis. The guidelines for HSE staff regarding the provision of interpreting services (Health Service Executive, 2009) contain a definition of what Irish Sign Language (ISL) is, and some specific advice regarding how to work with an ISL interpreter. The bulk of the document is, however, written with interpretation between two spoken languages in mind.

Recently, the Kerry Local Health Office (LHO) developed a policy and procedures for deaf signed language users to access interpreting services when visiting a General Practitioner (GP). According to this policy, Kerry LHO will pay for an interpreter for “non routine appointments”, which is defined as appointments “where a new medical issue or concern has emerged and the client feels that the GP would not understand the problem without an interpreter”.

The number of ISL interpreters is still a major concern, both as regards the general lack of interpreters available and as regards the lack of ISL interpreters with specific training to interpret in medical encounters. At a focus group meeting with Irish deaf signed language users several persons voiced concerns both regarding the lack of knowledge frequently displayed by doctors and other medical staff and their unwillingness to provide a signed language interpreter. In addition, the lack of interpreters means that even if a decision to provide an interpreter has been taken, no
interpreter may be found. In a study of Deaf Irish mothers experiences of maternity care (Steinberg, 2006), communication issues and the lack of interpreters are two of the major problems described.

At a focus group meeting for Irish signed language interpreters, concerns were also raised regarding who should pay for interpreting services in private and alternative health care settings. Fragmented service provision leads to a point where it is impossible to know how many requests for interpreting in medical settings are actually filled and how many are turned down because of funding issues and/or lack of interpreter availability.

**Poland**

The right to healthcare and the entitlement to healthcare services financed from public resources are among the basic rights guaranteed by the Constitution of the Republic of Poland. Public authorities are responsible for ensuring equal access of citizens to healthcare services financed from public resources. A patient has the right to receive accessible information, and s/he has the right to ask for explanations until the transmitted information is completely understood.

The document that stipulates the specific rights of the disabled is the Charter of Rights of Disabled Persons, adopted by the Polish Parliament on 1 August 1997. In accordance with the Constitution, this act is not a universally binding law, however, but an expression of the state’s obligation to observe its principles and to deliver its objectives. Among the ten rights listed is the right of access to information and the possibility to establish interpersonal communication.

Both the provision of a signed language interpreter to a Deaf person in healthcare settings and making documents available in a form that they can comprehend are provided for in the ‘Act on Sign Language and other ways of communication’ of 19 August 2011, which came into effect in April 2012. According to this Act, an entitled person can freely use a chosen method of communication and an administrative body is obliged to make available the service that enables such a communication. At present Deaf people are usually assisted by their families or interpreters from non-governmental organizations to communicate with healthcare professionals. There are not yet any executive regulations in place that set the obligations for medical institutions to provide interpreting services for Deaf patients, so it is not yet possible to see what the actual effect of the Act will be. This is the first Act of law to specifically mention Polish Sign Language (polski język migowy (PJM)), stating that it is a natural, visual-spatial language.

**United Kingdom**

The Disability Discrimination Act (1995), the subsequent Equality Act (2010) and the Mental Health Act (1983 and 2007) make discriminatory actions against individuals with disabilities unlawful in the United Kingdom. Additionally, these laws state that auxiliary aids for persons with disabilities must be provided when the person is put at a substantial disadvantage. Since sign language interpreters as auxiliary aids provide access to communication and information, they would be required for appointments with general practitioners (GPs), in hospitals and in urgent care centres.

Healthcare providers can book interpreters through a variety of interpreter referral agencies in the UK including through many spoken language interpreting agencies.
De Wit, Salami and Hema (2012) have recently reported on the current condition of sign language interpreting services for deaf patients in healthcare in three European countries including the United Kingdom (UK). They report that while many interpreters feel comfortable working in general medical settings, fewer feel the same about work in mental health settings; mental health interpreting is considered a specialty and therefore requiring additional training. Several UK charities have been established to provide direct mental health services to deaf people including, the National Deaf Services, National Centre for Mental Health and Deafness, and Alpha Hospitals. These services employ both full time staff interpreters and those who work on a freelance basis. Most interpreters find work through private contract or booking agencies.

De Wit, Salami and Hema (2012) report that the number of working interpreters in the UK is unknown but the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD) reports that there are 1000 registered interpreters. Since there is no legal requirement to register as an interpreter in order to work in the UK, it is assumed that this number is much higher (pp. 236). Currently, in order to be registered as a member of the register of sign language interpreters (RSLI) in the UK, one must achieve NVQ Level 6 in both BSL and interpreting or have completed a course recognized by the NRCPD to be at an equivalent standard. However, there are no licensures laws regarding interpreters and therefore, anyone can claim to be an interpreter and practice in healthcare settings. As a result, the shortage of interpreters is not the only concern, problems of standards and quality of healthcare interpreting services can vary greatly (Tribe & Thompson 2008).

**Sweden**

In Sweden, interpreting services are comparatively well developed, and free of charge for both the individual deaf signed language user and for the service provider. In 2010 there were approximately 6,200 registered deaf and hard of hearing users of these signed language interpreting services. A total of 75,000 interpreting assignments were performed by interpreters in these services, which are organized and paid for by regional authorities (landsting), totaling approximately 201,100 hrs. Approximately 30% of these interpreting assignments concern health care issues.

The earlier problem of a lack of professional signed language interpreters has recently been more or less overcome. In 2010, the figure for unfilled requests for signed language interpreting stood at only 4.6%. Problems are now more related to the quality and organization of services. One specific concern is that many service providers are not aware of the fact that, as opposed to interpreters for immigrants, the services of signed language interpreters are free of charge also for the service providers (hospitals etc.). Members of the medical professions have therefore been known to call for family members (even young children) to interpret, believing that they are thus saving money for their employer.

There are a few health care teams and centers specializing in care for signed language users, employing both deaf and hearing staff that are fluent signers. Despite the fact that it is comparatively simple for deaf signed language users in Sweden to access health care via a sign language interpreter, several persons have reported that they prefer to communicate directly in sign language with health care staff and would like to see more of this.
In addition, a practical problem regarding access to medical care in general has recently been taken notice of, which at present is a more urgent matter than the accessibility of interpreting services. Most local ‘care centers’ (which are the first place to turn to for any medical issue that is not urgent enough to warrant a visit to an emergency clinic, Swe: vårdcentral) are using an automatic callback system, which is creating problems for deaf and hard of hearing persons. To make an appointment, you have to call up using a telephone where you can punch the right number to get to the correct part of the queue system, and you also have to punch in your telephone number and your ‘personal id-number’. A nurse will call you back at a time that is convenient to the staff in the center. If you cannot hear the automatic voice telling you what numbers to punch in and when, you cannot make an appointment. As it may be an hour or more before they call back, it is generally not possible for a deaf signed language user to have an interpreter with them the whole time, to first punch in the right numbers and then wait for the return call to come. Similar problems have been reported for Holland (Smeijers & Pfau, 2009).

The National Board of Health and Welfare (Socialstyrelsen) presented a report on how accessible health care services and social welfare services are to different groups in society in general, not only for deaf signed language users (Socialstyrelsen, 2010). According to a questionnaire sent out to local ‘care centers’ approximately 75% can be reached on the phone without being able to hear well enough to make choices by pressing the right button on your phone. However, 38% can be contacted via web chats, but only 5% can be reached via text messages. The possibility for booking an appointment via internet is offered by 36% of local ‘care centers’ and 87% of them state that they have routines for how to contact signed language interpreters should the need arise.

In December 2011 a government commission presented their report, including suggestions for new legislation regarding both how to organize and how to finance signed language interpreting services in Sweden in the future (SOU 2011:83). A new guiding principle is suggested, according to which each sector in society pays for the interpreting services it needs. If this is carried through, several public authorities and others that have previously used the services of signed language interpreters employed by the regional health authorities free of charge will be expected to pay for these services in the future. It is, however, made explicitly clear in the report that interpreting in the healthcare sector should not be affected by the suggested legislation. Signed language interpreting in all kinds of healthcare settings will continue to be defrayed by public funds, and not by service providers (nor by deaf sign language users themselves).

**TRAINING; FOR HEALTHCARE STAFF, INTERPRETERS, AND DEAF SIGN LANGUAGE USERS**

**Cyprus**

*Training of interpreters for medical interpreting*

Cypriot Sign Language was officially recognized in 2006, and is thus considered an official language, with a dictionary, which is available from the Ministry of Education and Culture in printed, and DVD formats. The Cyprus Deaf Federation (CyDF)
appoints people to become official interpreters. There are no official training courses for interpreters in Cypriot Sign Language, and the present course being offered by the Ministry of Education and Culture is not officially accepted by the CyDF. According to the Cypriot information on the European Union of the Deaf (EUD) website, there are approximately 18 qualified signed language interpreters who learned sign language in Greece and have completed training in Cyprus. In Cyprus there are also some interpreters that are not “accredited” by the CyDF.

There is no specialized training regarding interpreting in healthcare settings available to sign language interpreters in Cyprus.

**Training for deaf signed language users**

There has been no formal training offered for deaf signed language users to ensure that they know what they are entitled to, and that they have sufficient knowledge to defend their rights.

**Ireland**

**Training of interpreters for medical interpreting**

Formal training of Irish Sign Language (ISL) interpreters began with two EU funded courses in 1992–94 and 1998–2000, leading to a Diploma in Deaf Studies/Sign Language Interpreting. In 2001, the Centre for Deaf Studies in Trinity College, Dublin University, was established. They offered a two-year Diploma in Deaf Studies/Sign Language Interpreting, which in 2009 was extended to a four-year degree course. To date, 83 Irish Sign Language interpreters have been trained to Diploma level and the first cohort of Bachelor level trained interpreters will graduate in 2013.

Of the 25 Irish Sign Language interpreters who responded to an on-line survey 80% had interpreted in medical settings, and 30% stated that they frequently (more than 10 times a year) interpret in medical settings. However, 70% of them state that they have not received specific training for this. Of the interpreters who stated they had received some specific training 47% reported that this training consisted of a general first aid course. A total of 78% of the interpreters state that they have experienced difficulties in interpreting in medical settings, and 77% report having had difficulty in conveying information about specific medical terms to a Deaf patient and 38% reported having difficulty with the accents of medical frontline staff. All of the respondents stated that they would like to avail of training focused on interpreting in healthcare settings.

**Training for healthcare staff**

There have been some local initiatives in training HSE staff, but not on a national scale. The recent financial problems in Ireland and ensuing funding restrictions have created problems for this kind of training. During focus group meetings of both signed language interpreters and deaf signed language users frequent mention was made of the problem with health care staff’s lack of knowledge. Steinberg’s study of Deaf Irish mothers’ experiences of maternity care (Steinberg, 2006) also makes frequent mention of problems due to health care staff’s lack of knowledge.
Since 2009, the Centre for Deaf Studies at Trinity College Dublin has been offering a module called, Perspectives on Deafness (POD) to nursing students at the university. This is a blended learning course that was developed as part of the Leonardo da Vinci SIGNALL 2 project. To date, some 150 student nurses have taken this course.

Training for deaf sign language users
There has been no formal training offered for deaf signed language users to ensure that they know what they are entitled to, and that they have sufficient knowledge to defend their rights. However, in 2011, the HSE established a committee to explore issues of access to healthcare services in Ireland and this is one of the issues that have been raised (Carmel Grehan, personal communication, 2012).

Poland

Training of interpreters for medical interpreting
In Poland there is a huge gap in training for signed language interpreters, with both materials and training syllabuses practically non-existent. The Act on Sign Language and other means of communication of 19 August 2011, which came into effect in April 2012, may provide grounds for future development of training for signed language interpreters as the Polish Board of Sign Language will be established to support the development of sign language.

Training for healthcare staff
Communication barriers in contacts with a deaf patient in healthcare institutions are not sufficiently overcome by physicians and other medical professionals, largely due to their inability to use signed language. Only very few healthcare practitioners are able to use signed language. Some positive changes can be noticed, as selected Schools of Medicine, schools for nurses and paramedics have introduced signed language courses.

Training for deaf sign language users
In Poland, there is only occasionally training available in signed language for deaf signed language users. There are neither materials nor training syllabuses or structures available to train deaf signed language users specifically in the area of communicating with healthcare professionals.

There has been no formal training offered for deaf sign language users to ensure that they know what they are entitled to, and that they have sufficient knowledge to defend their rights.

United Kingdom

Training of interpreters for medical interpreting
Interpreters can gain practice skills and attain RSLI registration for general practice in the UK through the university avenue. There are currently two training programs in
England and a new four-year degree in Scotland at Heriot-Watt University. Interpreters who have never attended university but are working interpreters and wish to be registered can take advantage of the National Vocational Qualifications framework, which encompasses BSL, or a number of short courses offered by the Association of Sign Language Interpreters (ASLI) and other organisations that provide training. These workshops are usually one-off and focus on information necessary for working in particular settings. Within the last few years, there have been healthcare and mental healthcare workshops offered to the interpreting community (De Wit, Salami and Hema 2012, pp. 246 – 247).

As reported in De Wit, Salami and Hema (2012) a survey sample of interpreters (n=80) working in the UK are highlighting the need for training in both healthcare and mental healthcare settings. Through this survey, the following curricular topics were identified for both health arenas: content knowledge, working with deaf professionals and deaf trainers, working with healthcare professionals, working with experienced interpreters, interactional dynamics in healthcare, relevant legislation, mental health service areas, disorders and diagnoses, differences in services for deaf people (De Wit, Salami and Hema 2012, pp. 246 – 247).

A sample curriculum for healthcare interpreting was developed over a three-year period as a result of a project funded by the European Commission’s Lifelong Learning Program. The curriculum includes teaching materials, and materials that are designed to raise awareness and to aid partnering countries in dissemination (De Wit, Salami and Hema 2012, pp. 243). In addition, Tribe and Raval (2003) have created a sample curriculum for interpreter mental health training in their book, Undertaking Mental Health Work Using Interpreters. Both of these training material examples are designed for both spoken and signed language interpreters.

**Training for healthcare staff**

According to Tribe & Thompson (2008), local NHS Trusts can provide resources for deaf awareness training. In Scotland, the NHS has partnered with Signature, an organization focused on improving communication for persons who are deaf and deafblind to provide deaf awareness training to NHS staff (http://www.signature.org.uk/page.php?content=87). Additionally, the Board of Medical Education of the BMA has outlined in, Communication Skills Education for Doctors (BMA 2004) the expectation that medical education will teach and assess medical students on how to effectively work with interpreters.

**Training for deaf sign language users**

Provision of information for Deaf people regarding healthcare is generally through the dissemination of signed video material, either on DVD or via websites. A variety of material is available on-line either through NHS related sites or through other organizations such as SignHealth. Some material concerns specific conditions and treatments while other information is more generic and relates to general accessibility to services and how best to use them.

While much of this material is designed to improve awareness and understanding about the different healthcare professionals and their roles, there is currently no information on how Deaf people will experience these services when mediated through a sign language interpreter.
So while existing information usefully details different health conditions, there is a lack of information for Deaf people on how best to access services through an interpreter and what to expect from an interpreter in these environments.

Dissemination of the existing information is also problematic. Many of the DVDs are free of charge, but are not distributed to those who need them automatically and need to be requested. If Deaf people are not aware that this material exists they will therefore not have access to it. Other information, freely available on the internet, presumes that individuals have access to the internet and the confidence to locate this information. Many Deaf people, particularly older members of the community may find this problematic.

Sweden

Training of interpreters for medical interpreting

Sweden has a long tradition of training signed language interpreters, delivering the first (6 week) training in 1969. The current training is a 4-year full-time training program, located in ‘folk high schools’ (i.e. non-academic training). It is estimated that some 500–600 signed language interpreters have been trained to date in these programs. In 2012, Stockholm University will begin to plan a new program (3 years full time studies) that will lead to a Bachelor degree in Swedish Sign Language and interpreting. According to current plans, the first cohort of students from this program will graduate in 2016.

There is a state authorization system, run by the Legal, Financial and Administrative Services Agency (Kammarkollegiet), authorizing community interpreters in 38 different languages, whereof Swedish Sign Language is one. Currently (April 2012) 121 Swedish Sign Language Interpreters hold the general authorization level, whereas only 4 hold the specialized authorization in medical interpreting.

Signed language interpreters who are holders of the general level authorization, and want to take an additional test to be awarded the ‘specialist competence as a medical services interpreter’ cannot find any specialized training for that.

Training for healthcare staff

One of the major concerns of both the deaf signed language users and the signed language interpreters interviewed for this report is the lack of knowledge they meet in their dealings with healthcare staff. The lack of knowledge is described as pertaining to two different areas. Firstly, healthcare staff in general does not know anything about deaf people and do not even know that Swedish Sign Language is a language. There are also reports of deaf signed language users being referred to as ‘Deaf and Dumb’ (even in case notes), which of course is highly offensive. Secondly, in an emergency situation when the deaf signed language user has not brought a signed language interpreter with him/her, healthcare staff frequently do no know where and how to find an interpreter. There have been several attempts made by organizations of deaf people to remedy this lack of knowledge, but so far to no avail. Deaf signed language users are only one of many groups who feel that information regarding them should be included in the already quite extensive training programs for various
medical professions, and it has not been possible to convince authorities of the need to make this kind of specific information about deaf signed language users compulsory.

Training for deaf sign language users

Though the level of schooling and literacy for deaf signed language users in Sweden is generally considered to be comparatively high, there are neither materials nor training syllabuses or structures available to train deaf signed language users in how to best communicate via an interpreter. There are no materials specifically in the area of communicating with healthcare professionals either. During the compilation of this report it became clear that there is a need for training for deaf signed language users regarding their rights, and how to defend these rights when faced with medical staff that are unaware and unwilling to make the necessary provisions.

Another factor to take into consideration is that Sweden has a large group of deaf immigrants and refugees, who are sometimes illiterate when they arrive in Sweden, or do not know any signed or spoken language when arriving. For many of these refugees, the hardships suffered during their journey to Sweden means they are in immediate need of medical care, but they may then be unable to communicate with caregivers even if an SSL interpreter is provided.

QUALITY IN MEDICAL INTERPRETING, GOOD PRACTICE & CODES OF CONDUCT

Ireland

Quality issues

While the majority of interpreters working have had formal training, there are some interpreters working who have not undertaken a formal pathway to training. The majority of these are adult children of deaf adults (or ‘CODAs’). To allow for this, one former agency Sign Language Interpreting Service (SLIS), (now a referral service) requires any interpreter wishing to work via their service to undertake a registration test. There are three different levels of registration: TI – trainee interpreters, who ideally should only work with an accredited interpreter; R2 – which allows interpreters to do generic work, but not legal or high level medical interpreting; R1 – which is the highest level and allows interpreters to do both generic interpreting and legal or high level medical interpreting. However, non-accredited interpreters, members of a deaf signed language user’s family, and even under age children are often used instead of professional, trained and/or registered interpreters.

In a study of the experiences of Deaf Irish mothers in their meetings with maternity care services in Ireland (Steinberg, 2006) several structural problems relating to both the quality and the accessibility of services were noted. The study is discussed more with regards to participants’ views below.
Codes of Conduct

Until 2009, ISL interpreters worked with the Irish Association of Sign Language Interpreters (IASLI) Code of Ethics. This association was disbanded in 2009 and in 2011; the Council of Irish Sign Language Interpreters (CISLI) was established and has published a Code. Some interpreters are also members of the Irish Translators and Interpreters Association (ITIA), which also has a published Code of Ethics.

Poland

Quality issues

In Poland, matters relating to the quality of interpretation in signed language are dealt with only by NGOs, with the Association of Interpreters of Polish Sign Language playing the leading role in identifying the needs of interpreters and standards for their work. It is the objective of the Association of Polish Sign Language Interpreters, active since 2009, to ensure multilayer support to interpreters and to their Deaf and hearing clients. The objectives of the Association are delivered by organizing training on the quality of interpretation, organization and participation in conferences on signed language and drafting standards binding for interpreters.

Codes of Conduct

The Association of Polish Sign Language Interpreters undertook a pioneering effort to draft a Code of Ethics for signed language interpreters, to support them in ethical conduct when performing their duties connected with interpretation and striving for professionalism. This code is recommended to all members of the Association and to those who use such interpretation. The code includes the principles of:

- Confidentiality
- Professionalism
- Professional development
- Impartiality
- Respect for the Parties
- Respect for other interpreters.

The Code is based on the conviction that people from the Deaf community have the undisputable right to communicate fully and that they also have the right to make informed choices based on information received via the highest quality interpretation.

United Kingdom

Quality issues

In a 2004 report by the Royal National Institute for Deaf People (now re-named Action on Hearing Loss), it was estimated that £20 million a year is wasted by the National Health Service due to the lack of awareness in regards to people who are deaf or late-deafened (as cited in Timehin et al 2006). Almost all of the reasons for such waste implicated poor communication and insufficient interpreting services. In an audit of one local hospital, only 10% of staff (n = 242) had exposure to some deaf awareness training at the time of the survey. Also, when asked if the department had policies regarding communication with deaf patients, a full 84% reported that either no known policy existed or they didn’t know of any such policy (Timehim et al 2006).
The three authors of the aforementioned healthcare interpreting report on three European countries state in conclusion: “As practitioners ourselves, we strongly recommend more structured research projects involving interpreters, the users of sign language interpreting services, and the healthcare profession, and we urge the implementation of specialty courses in mental health and healthcare settings” (De Wit, Salami and Hema 2012, pp. 257). This plea comes amidst claims of not only poor quality services provided to deaf people but a shortage of interpreters that result in the cancellation and the delay of appointments for sign language users in these contexts (De Wit, Salami and Hema 2012).

A recent development in the UK and elsewhere has had a worsening impact on the quality of services for deaf sign language users. More and more interpreting referral agencies who specialize in spoken language interpreting services have expanded their businesses to include sign language interpreting services as well. These business owners have no connection to the Deaf community nor to the sign language interpreting community and as a result are unaware of the issues involved in matching client to service provider. Due to their low fees, providers might be drawn to contract with these agencies but since these agencies cannot afford to pay the rates of qualified interpreters, seek out and hire individuals who are not competent to practice but cannot secure work through agencies who have community connections (De Wit, Salami and Hema 2012).

Existing conceptually between “quality issues” and “codes of conduct” are initiatives. The fact that an initiative has been put into place is evidence that concerns of quality exist and in response, an initiative is enacted. De Wit, Salami and Hema (2012) report on an EU-wide initiative launched in late 2010 focusing on creating a barrier free Europe for those with disabilities. This initiative is designed to provide ways in which the EU and national governments can empower people with disabilities to exercise their rights (pp. 251).

Additionally, in the UK and in Scotland in particular, several initiatives were identified in response to quality concerns of healthcare services (http://www.healthscotland.com). Those include:

1. Deaf Mental Health Charter commissioned by Sign and Mental Health Foundation
2. Deaf Mental Health Working Group sponsored by Islington LINk (local involvement network)
3. Equality and Human Rights Scheme 2010 – 2013 through NHS Lothian (Scotland)
   Includes information and help for clinicians on working with various patients with disabilities including information and guidelines for interpreting and translation services:
   • NHS Scotland Competency Framework for Interpreting
   • NHS Scotland translation, interpreting and communication support strategy June 2010
   • NHS Scotland translation, interpreting and communication support programme delivery for 2010/11.

Translation, Interpreting and Communication Support (TICS Programme)
• Seeks to develop a procurement framework to improve quality and service delivery for BSL (British Sign Language). This covers face to face, telephone and online interpreting.

Scottish Accessible Information Forum (SAIF, http://www.saifscotland.com)
• Includes information on making information accessible to deaf sign language users.

The most notable initiative that hopefully will lead to good practices for communication with deaf sign language users is the NHS’s GP Patient Survey, which has been translated into BSL for deaf patients (http://www gp-patient.co.uk/blslusers). The survey asks patients about a range of issues related to healthcare appointments from logistics (e.g., booking appointments) to their satisfaction with communication and care from clinical staff.

Codes of Conduct
Codes of Conduct in the United Kingdom pertain to either interpreters or health professionals, and these are treated separately below, beginning with interpreters.

General:
All registered interpreters with the NRCPD are expected to adhere to their Code of Conduct with the key tenets being: confidentiality, competence, integrity, impartiality, and professional development. The Code of Conduct is arranged by a list of the tenets, their definitions and a longer guidelines section which further elucidate for the practitioner the meaning and application of these tenets. Unique to other codes of ethics of sign language interpreters, the NRCPD Code of Conduct is designed to apply to all professionals who work with deaf people including note takers and speech to text reporters.

Mental Health:
In addition to this general practice Code, a code of practice for sign language interpreters working in mental health was developed by ASLI in 2006 (http://www.asli.org.uk). This document outlines a variety of issues faced by interpreters working in this service setting. First, the document defines terms to be used centering around the setting-specific interaction and participants. Second, the document provides examples of the types of professional conduct expected while working in these settings (pre and post sessions with clinicians and other salient staff, issues of safety within these settings, concerns with advocating for deaf clients, issues of dress and external clearance for work with vulnerable populations. Third, specific attention is paid to the issue of language and communication within the mental health setting. It is widely known that diagnostic information is revealed through language and that treatment is provided through communication and communication techniques (Pollard, 1998). As a result, ASLI’s Code of Practice has a section devoted to the unique issues (e.g., idiosyncratic language) and strategies (e.g., employing deaf interpreters) expected in this type of work. The last two sections discuss confidentiality and professional competence with special attention to how these might be uniquely defined and understood in mental health contexts.

Healthcare:
No UK-specific codes of conduct were found for general healthcare interpreting. However, relevant to this review, it is worth noting Codes for healthcare interpreters outside of the UK and EU. The International Association of Medical Interpreters (IMIA, http://www.imiaweb.org/code/default.asp) developed the first ever code of ethics for spoken language interpreters in medical settings in 1987 (and revised in 2006). However, this Code is not particularly unique to medical settings and can be easily mapped onto ethical codes of general practice. As a result, the single-paged document is rule-based and straightforward. In contrast, in the United States, the National Council on Interpreting in Healthcare (NCIHC, http://www.ncihc.org/nmc/page.do?sitePageId=57768) has developed the National Code of Ethics for Interpreters in Healthcare and the National Standards of Practice for Interpreters in Healthcare. Both of these documents, totally over 40 pages of information and guidance, acknowledges the unique issues that might arise in healthcare. Toward that end, the NCIHC anchors their ethical code on core values, many of which are akin to healthcare values, and by avoiding limiting dos and don’ts, this Code allows the interpreter decision-making flexibility. As a result, these standards have been endorsed by two other US-based medical interpreting associations: The California Healthcare Interpreting Association, the Massachusetts Medical Interpreters Association.

We now turn to Codes of Conduct for health professionals in the United Kingdom.

Healthcare:
The British Medical Association’s (BMA, Code of Ethics is multi-layered and complex including broad topics such as confidentiality to specific issues such as relationships and associations with pharmaceutical companies. Surveying relevant topics, it is likely that the “Right to Health” ethical tenet in a broad sense implicates the use of interpreters. This tenet emphasizes the importance of effective communication with patients, including those with communication impairments and elsewhere, non-native speakers. In the latter example, trained interpreters are recommended. Similarly, the UK’s Nursing and Midwifery Council’s (http://www.nmc-uk.org/Nurses-and-midwives/The-code/The-code-in-full) ethical code is broad and the likely relevant tenet is outlined first: Treat people as individuals. This tenet prohibits discrimination and sets the expectation that nurses will find the necessary support for patients when accessing relevant health and social care information.

Rather than ethical codes of healthcare associations and organisations, it is likely more relevant to consider how the NHS outlines expectations for effective communication with interpreters. The East London Foundation NHS Trust has created, The Best Practice Guide: When Using Interpreters (Soondar 2008, as a way of ensuring the delivery of the Trust’s values. Topics of this document include introductory information on healthcare interpreting, when an interpreter is required (including for deaf sign language users), the concerns of using family members or friends as interpreters, how to find and work effectively with interpreters, the responsibilities of the interpreter, the importance of pre and post sessions with interpreters and other issues of etiquette.

Mental Health:
Similar to the above document on working with interpreters, British Psychological Society has created an exemplary document on effective practice when working with interpreters (Tribe & Thompson 2008). While the document is designed to address both spoken and signed languages, there are special notes about deaf sign language
users. For example, the authors recommend that when working with deaf clients that clinicians should be educated on issues of deaf identity and deaf culture and suggest a local deaf awareness program through the NHS trust or external organisations. The document contains the following sections: executive summary, key recommendations for practice, introduction, and finally a listing of the guidelines which include:

1. Relevant policies and legislation includes additional acts and initiatives which call for the use of interpreters in mental health settings: National Service Framework for Mental Health and Mental Health Act Code of Practice;
2. Booking / finding an interpreter includes issues of training for interpreters who work in mental health;
3. Preparation before the consultation / meeting includes a section on how interpreters change the therapeutic dynamic;
4. Practical considerations includes advice on time, pace and communication flow issues, technical jargon, avoiding proverbs and sayings;
5. Preparation with the interpreter includes descriptions of the types of roles an interpreter might take in a session (conduit, advocate, etc.)
6. During the meeting / consultation includes traditional information on etiquette when working with clients through an interpreter
7. After the consultation / meeting includes topics to review with the interpreter about the session and communication;
8. Written translations;
9. Psychometric tests;
10. Telephone interpreting;
11. Other issues to consider includes a section on including interpreters as part of the mental health team and issues associated with deaf sign language users access to written English;
12. Recommendations for improvements for the future includes support for interpreters through agencies or supervision.

Our attention now turns to interpreters, clinicians and clients for online interpreting services.

As mentioned above, SignHealth provides online interpreting services (sometimes called Video Remote Interpreting, VRI) in urgent care situations through a program called SignTranslate. It is not unusual for agencies and organisations who book and hire interpreters to create their own ethical codes, guidelines, or standards of practice. This review of the literature does not include those individual codes (often available on websites) but brief attention to SignTranslate’s code is warranted. This code is unique in that it includes information for all parties in the communication event: interpreters, clinicians and deaf clients. Topics include: issues of appropriate use of online versus a face-to-face interpreting services, right of the deaf client or the interpreter to conclude online services are insufficient, the required triadic nature of communication given the impact of technology, and the how assurances of quality services are ensured and assessed. Most of the focus of this Code is on the responsibility of the interpreter and how the interpreter might actively and deliberately work to ensure quality communication. However, foregrounding the active nature of the online interpreter’s work informs and prepares clinicians and deaf clients.


### Sweden

#### Quality issues

The Legal, Financial and Administrative Services Agency (Kammarkollegiet), which is the national agency in charge of authorizing interpreters, also supervises authorized interpreters and translators. Complaints made against an interpreter or a translator authorized by them may be reported to the Agency. If there is found to be just reason, the Agency can take disciplinary actions, either by giving the interpreter or translator a warning or by revoking their authorization. However, the majority of Swedish Sign Language interpreters are not yet authorized.

The Swedish Government commissioned the National Board of Health and Welfare (Socialstyrelsen) to conduct an investigation and prepare a report on inequalities in the Swedish healthcare system (Socialstyrelsen, 2011). This 182-page report mentions deaf people once, stating that there are plans to develop a national resource center to gather knowledge about deaf people with psychiatric problems. In addition, there is a figure that presents a condensed version of the results reported in another study (Socialstyrelsen, 2010, mentioned above) regarding how accessible local ‘care centers’ are to different groups of people.

In January 2012 the Swedish National Board of Health and Welfare (Socialstyrelsen) published a handbook for healthcare staff regarding their obligation to make sure that patients are fully informed and can take an active part in a medical encounter (Socialstyrelsen, 2012). The handbook contains one reference to a passage in current legislation stating that deaf people have the right to the services of a sign language interpreter in healthcare settings. However, the discussions regarding the need for linguistic and cultural adjustments describe the need with regard to immigrants and members of the “national minorities”, which according to Swedish law does not include deaf signed language users.

There is no research known that pertains to the quality of signed language interpreting in medical encounters. During an information meeting regarding the MEDISIGNS project, several of the deaf signed language users present expressed their concerns with the level of knowledge of Swedish Sign Language of some interpreters.

#### Codes of Conduct

The Swedish National Association of Sign Language Interpreters (STTF) has a Code of Professional Conduct for Sign Language Interpreters. The code has to be abided by all full members of the association, and the following is an official translation into English of the Code2:

1. The interpreter shall treat all people with respect regardless of the method of communication, language, functional disability, gender, social status, cultural background, religious beliefs, political views, sexual orientation or age.
2. The interpreter shall maintain confidentiality at all times.

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3. The interpreter is responsible for insuring that the target language accurately reflects the source language. If more than one interpreter is present, the responsibility is shared between them.

4. The interpreter shall convey the consumer’s characteristics and spirit.

5. The interpreter must be impartial and objective in relation to the consumer.

6. The interpreter shall, based on his/her professionalism and social competence, act in an assured and confident manner towards the consumer.

7. The interpreter should refrain or withdraw from the assignment if:
   a. the assignment is felt to violate the integrity or safety of the interpreter.
   b. the assignment is beyond the linguistic competence of the interpreter.
   c. the assignment may result in a conflict of interest.

8. The interpreter shall cooperate with all parties concerned during the assignment.

9. The interpreter shall adapt his/her image and dress code to suit the nature of the assignment.

10. The interpreter shall keep up to date with the latest developments in his/her field of activity.
PARTICIPANTS’ VIEWS, INCLUDING PROFESSIONALS’ ATTITUDES

Ireland

In a study where eleven Irish Deaf mothers were interviewed (Steinberg, 2006) it was concluded that it was “in the areas of information access, communication, and respect for personal agency that Deaf mothers experienced the most severe problems” (2006:283). The study gives a detailed account of many of the problems these women faced before, during, and after giving birth.

The general lack of signed language interpreters, in combination with the fact that the group of deaf signed language users and interpreters is small, makes privacy an issue and this was frequently mentioned also in the focus group with deaf signed language users. When regulations and policies are constructed, it is essential to take these concerns into account.

Signed language interpreters themselves, both in a focus group meeting and in an online survey also express grave concerns when it comes to the lack of knowledge and understanding they face in medical encounters.

Poland

In Poland there is no research concerning communication between a deaf patient and a medical professional from a healthcare institution. Opinions of physicians, interpreters and patients are rather convergent, i.e. all of them are convinced of the need to create an effective support system for communication with deaf patients in healthcare institutions. Among the proposed solutions are: direct co-operation with a professional signed language interpreter using Internet cameras (a video relay system) and training some of the medical staff of healthcare institutions to be able to communicate in signed language.

Patients and interpreters also highlight the problem of instances where the patient is disregarded in the medical encounter, and focus seems to be on the conversation between the interpreter and a medical professional instead.

United Kingdom

In a survey conducted in 1990, Jones and Pullen surveyed deaf individuals in eleven European countries on a number of topics associated with quality of life issues. In addition to employment and education, deaf people responded to questions in healthcare and interpreting service provision. The issues identified were deaf people’s access to healthcare delivery, effective communication between patient and provider, and access to health information and preventative care. While this report is twenty years old, a recent interview with Avril Hepner of the British Deaf Association (BDA) reveals a similar picture and in response to these continued problems, recommends the following: healthcare specialist training, apprenticeships with experienced interpreters to improve readiness to work, and funding for healthcare training (De Wit, Salami and Hema 2012). Lacey-Davidson (2012) reports a very recent analysis of Deaf people's access to interpreters at healthcare appointments in the UK, and concludes that lack of
awareness – on the part of all participants, including interpreters – is the root cause of most of the problems that arise in these settings. Over 60% of Deaf people, says Lacey-Davidson, "have put off going to a health appointment because they were worried about communication problems" (2012, p 19).

With respect to sign language interpreters in particular, the European Union of the Deaf (EUD) sets a unique expectation for sign language interpreters. They stipulate that interpreters have at least ten years of experience before working in medical settings. The EUD considers these five areas of attention in any curriculum: sign language, medical information, people or “soft” skills, vicarious trauma and professional performance (De Wit, Salami and Hema 2012, p 243).

**Sweden**

There are no official studies of participants’ views of interpreted medical encounters. However, at an information meeting about the MEDISIGNS project several deaf signed language users expressed their concerns. The stories they told support the commonly reported irritating issue in Smeijers & Pfau’s study (2009) that members of the medical profession continue to use outdated and insulting terms like ‘deaf and dumb’ (even in case notes), and will talk about the deaf patient rather than to him/her.

Concerns have also been voiced during the project regarding the lack of knowledge evident even among staff employed by those authorities where a deaf signed language user can file a complaint, if, for example, no interpreter is provided in a situation where that was called for. It is therefore sometimes felt that filing a complaint will be of no use.

**AFTER-CARE AND HEALTHCARE OUTCOMES**

**Ireland**

A major issue with regard to after-care and healthcare outcomes is the lack of Irish Sign Language interpreters, and the problems with financing the provision of interpreting services, particularly in certain medical settings (e.g. primary care (General Practitioners, dental services, etc.). In addition, the abovementioned lack of knowledge about deaf signed language users and Irish Sign Language create problems as well.

A major barrier is the lack of data surrounding deaf people in medical settings. Linked to this, the lack of centralized figures around interpreter provision, requests for provision, refusals to provide services or lack of availability of interpreters confounds the problem as there is no way of benchmarking the scale of the issue.

What we can say is that follow up care is fragmented due to a combination of factors. These include the lack of consideration of the specific needs of deaf patients and the challenges that can be faced in booking interpreters on the part of hospitals, financial rules that require interpreters from a tendered organization only to be used or which forbid payment of travel expenses for interpreters coming from outside a geographical
region, the lack of access officers within hospitals, the fact that there is no central system for monitoring interpreting requests, provision or problems with services at hospital, regional or national level. Very often, the community of interpreters strives to informally shore up gaps. For example, in a recent data collection process, interpreters reported on the fact that when a hospice in Munster (south of Ireland) required interpretation for a home visit with a patient but could/would not pay for the only interpreter who could be identified as available to travel from Ulster (northern Ireland), some 4-5 interpreters swapped their interpreting schedule to accommodate the hospital’s schedule.

**Poland**

As both convalescence and patients’ treatment are long-term processes, deaf patients have significantly limited possibilities to communicate with medical staff. That is because even if a deaf person is provided with interpretation during the initial stages of treatment, at later stages the patient usually is left to him/herself due to the small number of interpreters, on the one hand, and to the unsolved problem of the State’s paying the interpreters, on the other. For a patient and for medical staff the best solution would be to provide the medical staff in healthcare institutions where patients receive long-time treatment with the basic ability to communicate with a deaf patient. However, we emphasize that this basic communication should never be seen as a replacement for the need for professional interpretation for consultations and securing informed consent from patients.

A serious problem highlighted in the research report “Identification of the current situation and needs to participate in professional and social life of persons with hearing problems in Mazovia” drafted by the Polish Forum of the Disabled (2011) is the absence of specialist care for elderly, sick deaf people due to difficulties in communication. Inability of medical staff in healthcare institutions to use signed language results in the complete isolation of a deaf patient.

**United Kingdom**

Some recent developments in the UK’s national “GP Patient Survey” for the first time have provided quantitative data on Deaf people’s health and their satisfaction of healthcare access. First, a question was added to the survey so deaf respondents could be identified and secondly, a BSL version of the survey was made available to deaf respondents. The overall database of this survey, hearing and deaf people, contains responses from almost two million people.

In data that was preliminarily analysed by SignHealth, several disparities were identified. Compared to their hearing counterparts,

1. Deaf people have more trouble accessing their surgeries by telephone during opening and out-of-hour times (SignHealth, 2008).
2. Deaf people have higher rates of referrals to specialists (SignHealth, 2008).
3. Deaf people have more appointments (SignHealth, 2008).
4. Deaf people are less likely to see the doctor they prefer (SignHealth, 2009).
5. Deaf people are more likely to have a chronic condition (e.g., blindness, learning disability, mental illness) (SignHealth, 2009).
6. Deaf people have higher unemployment (SignHealth, 2009).
7. Deaf people rate their own health as poorer than their hearing counterparts (SignHealth, 2009).
Even the indirect findings noted above can be interpreted as indicators of poor health outcomes (e.g., more appointments, referrals, unemployment). Not only is there data to suggest that deaf people have poor access to healthcare as in the study mentioned above, now there is additional data here to suggest in part that deaf people have poorer health as a result. This is not unique to the UK; SignHealth (2009) reports concerning health disparity data for deaf people in Austria. Similarly, studies conducted in the US corroborate these findings (Steinberg et al, 2006).

In a qualitative study conducted for the NHS Executive North West Research and Development Directorate, Reeves et al (2004) interviewed approximately 100 deaf people, 30 GP practice managers, and 22 managers at Accident and Emergency (A&E) services to assess to what degree these health services in the North West were meeting the requirements of the Disability Discrimination Act (Reeves et al, 2004, pp. 2). Some of the data collected was able to be compared to the overall population in the North West based on an earlier study. In addition to semi-structured interviews, policies were reviewed and site visits were conducted.

For the purposes of this report, a brief summary of the data is provided: Access to healthcare across the healthcare continuum was identified as a significant problem for deaf people, including: difficulty in making appointments, in waiting rooms and know when they had been called, understanding office staff and health professionals, making themselves understood, accessing all the information they needed, understanding follow up and discharge plans, incomplete understanding of how to take prescribed medications (Reeves et al, 2004, pp. 2). Additionally, for those who required interpreting services, only 17% of GP appointments and 7% of A&E appointments were conducted with the help of an interpreter further exacerbating the problems noted above. When asked if they complained or would have liked to complain about the services they received at an appointment within the last twelve months, 40% of those interviewed said they did/ would have. In the larger hearing sample, only 11% answered in the affirmative (Reeves et al, 2004, pp. 2).

**Sweden**

It has not been possible to find any information regarding studies of the after-care and healthcare outcomes for deaf signed language users in Sweden. In a PhD-thesis published in 2006 the quality of life as perceived and described by signing old age pensioners was compared to that of a group of hearing old age pensioners in the same region (Werngren-Elgström, 2006). In her literature review, the author refers mainly to information and research from other countries, as she suggests that there is “practically nothing” to be found from Sweden.

The Swedish National Board of Health and Welfare (Socialstyrelsen) are producing an information leaflet titled *Min guide till säker vård.* (“My guide to safe health care.”), aimed at patients in general, and especially those who have extensive health care needs. According to telephone conversations with the project coordinator for this, there are plans to translate it into Swedish Sign Language. Hopefully, such information in an accessible format will make deaf signers more aware of their rights, and more prone to inform authorities of problems with after-care and healthcare outcomes.
TOOLS TO SUPPORT COMMUNICATION IN MEDICAL ENCOUNTERS

Cyprus

The Ministry of Education and Culture with the collaboration of the School for the Deaf and the Cyprus Deaf Federation started to compile material in the Cypriot Sign Language in April 2007. On the 14th October 2011 they launched a dictionary, a grammar and a communication grammar in Cypriot Sign Language in written and CD formats. It contains a few signs slightly related to health issues such as the signs for: pain, taste, vision, hearing, tired, breathing, fever, nausea, inflammation, cough, headache, contagious disease, recovery, birth, genetic inheritance, etc.

Ireland

There have been a number of health information DVDs prepared by the Irish Deaf Society in recent years, but these are geared towards deaf signed language users. Additionally, there are short glossaries and posters containing key terms for medical settings that have been distributed to both medical staff and clients.

Further, a Leonardo da Vinci funded project, D-Signs, has developed an on-line course for basic Irish Sign Language, Greek-Cypriot Sign Language and British Sign Language, which could be made available to front line medical staff. However, it is essential that we emphasize that providing medical staff with basic signed language skills will never replace the requirement for signed language interpreting provision.

Poland

The number of publications on communicating in signed language in healthcare institutions is very limited in Poland. There are some dictionaries with general signed language vocabulary including a small number of words from the medical realm. In most cases, however, just as is the case with other publications, the communication described is in fact not the signed language used by deaf people in Poland, but a constructed system of signs used to support the lip reading of spoken Polish.

At present, the only publication related to medicine based on the signed language actually used by deaf people in Poland, Polish Sign Language (Polish abbr. PJM), is Minirozmówki migowo (PJM)-polskie; polsko-migowe (PJM) ze słownikiem. Znaki migowe i przykładowe dialogi przydatne w placówkach opieki zdrowotnej (Mini conversations Polish Sign Language (PJM) – Polish; Polish – Polish Sign Language (PJM) with a dictionary. Signs and examples of dialogues useful in healthcare institutions), (Grzesiak (ed.) 2010). This material is intended for both hearing staff of healthcare institutions, Deaf patients and signed language interpreters. The publication contains dialogues in Polish and in Polish Sign Language (sign notation and DVD movies) and PJM signs (photographs and clips on a CD) thematically linked to various fields of medicine.
United Kingdom

While a face-to-face interpreter is preferable in medical settings, a UK charity called SignHealth (http://www.signhealth.org.uk) provides video remote health interpreting for urgent situations through their service, SignTranslate. In Scotland, NHS24 launches a pilot video remote service in 2012 (http://www.nhs24.com/Press/Latest-News/040512-NHS-24-Introduces-British-Sign-Language). Given the sign language interpreter shortage, such technologies can be helpful in such situations and to ensure quality standards has a Code of Practice outlining policies and engagement protocols for providers, interpreters and deaf clients (see explanation below).

Reeves et al (2004) mention the use of some technologies in the North West of England; though they were infrequent. For making appointments, patients appear to use the following approaches: text telephone at the surgery, Typetalk (relay service offered by British Telecommunications), email or SMS text access. In the waiting room, we see the following: use of a number system, or a visual display with the patient’s name. For the medical encounter itself: BSL interpreters or lip-speakers are used, and some health providers have learned to schedule longer appointments for Deaf patients. As mentioned above, SignTranslate is a service through SignHealth which can provide interpreting services through the use of video remote technology. In Reeves et al (2004) and in Timehim et al (2006), Deaf Awareness Training was highlighted as an essential key for improving access to healthcare services.

Sweden

In Sweden, there are several Swedish Sign Language dictionaries publicly available on the Internet, of which two are specialized for the areas of medical interpreting and for sexuality and living together. However, most medical staff is likely not to be aware of their existence, and the same is probably true for most deaf people too. Signed language interpreters are more likely to know that these dictionaries exist. However, information leaflets will be produced about the MEDISIGNS project that include information about these dictionaries, and spread to all three target groups of the project.

There is also an iPhone application, distributed for free via AppStore, containing these dictionaries. This “app” will make the dictionaries more readily available for many people, and it is hoped that with the help of MEDISIGNS it will soon be followed by a version for other smart phones (Android). The application can show either a continuous list of Swedish words (presented in alphabetical order) or a list of categories that in turn lead to lists of Swedish words within that category. These categories currently (April 2012) include: body parts (101 signs), sexuality and living together (386 signs), and healthcare (204 signs). When you click on a Swedish word, a film with a person producing a sign for that concept is shown, and in addition there is a written description of how to produce the sign.

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PART 4 – INTERNATIONAL COMPARISONS

QUALITY ASSURANCE OF HEALTHCARE INTERPRETERS: INTERNATIONAL TRAINING AND STANDARDS

In Part Two of this report, we have outlined how healthcare professionals and interpreters in the Medisigns partner countries conceive of their ethical and practice duties. In this section, we examine the state of healthcare interpreting more generally, including spoken language interpreting, and we examine it through an international lens. In reviewing the wider literature within North America and Australia, the primary focus for healthcare interpreters is on ensuring quality care. This is evident through educational programs for medical interpreters and other quality assurance measures such as the introduction of standard practice documents and ethical codes for healthcare interpreters.

The International Medical Interpreting Association (IMIA) is a US-based international organization with chapters in fifteen other countries. Their mission is to advance the professionalism of healthcare interpreters and to promote culturally and linguistically accessible healthcare for populations with diverse linguistic needs (IMIA, 2012). The IMIA offers its members a certification in healthcare interpreting though, at present, this does not extend to signed languages. European chapters of the IMIA include Spain, Italy, Switzerland and the UK (IMIA, 2012).

The IMIA website maintains a registry of training opportunities for interpreters. These range from university degree programs to continuing education, and include online programs. At present, the only face-to-face programs in the registry are based in North America. However, links to international chapters indicate that educational opportunities are also available in these home countries. Trainings are also available to healthcare staff on cultural diversity and working effectively with interpreters. There are over 150 training programs listed on the IMIA website. While the minimum length of these programs is set at forty hours, there are no guidelines for trainers or trainees on what topics should be covered in a medical training program (IMIA, 2012). The most prominent training programs, Bridging the Gap, covers topics such as: basic interpreting skills, ethics, communication techniques, medical vocabulary, key health care information, communication skills for advocacy, practical working solutions and professional development (CCHCP, 2012).

For sign language interpreters in North America there has been some advancement in training expectations and standards (Angelelli, 2006; Bowen-Bailey, 2012; Crump, 2012; Moreland & Agun, 2012; Swabey & Faber, 2012). A set of domains and competencies for healthcare interpreters was established by two American Sign Language (ASL)/English interpreter organizations, College of St. Catherine CATIE Centre and the National Consortium of Interpreter Education Centres in the US (CATIE Centre, 2008.). This document, Medical Interpreter Domains and Competencies, is the result of a national, collaborative project funded by the US Department of Education. The domains and competencies expand the topics covered in the Bridging the Gap curriculum and provide standards and guidance for
establishing healthcare interpreting curriculum. The thirteen domains include: healthcare systems, multiculturalism and diversity, self-care, boundaries, preparation, ethical and professional decision-making, language and interpreting, technology, research, legislation, leadership, communication advocacy, professional development (CATIE Centre, 2008). In addition to the domains, there are a total of eighty competencies listed. These competencies set interpreter expectations which range from knowledge of healthcare content and healthcare systems to the skills required in working effectively in healthcare settings (including collaborative decision-making with healthcare professionals). The domains and competencies were developed as a result of a literature review and vetted through a process of intermittent reviews from stakeholders and national focus groups (Swabey & Faber, 2012).

Healthcare educational programs for sign language interpreters within the US are on the rise. This is due in part to the increase in need for qualified healthcare interpreters (Swabey & Faber, 2012). Of note is a new yearlong certificate program that includes 160 hours of instruction. The Certificate in Healthcare Interpreting is offered by the National Technical Institute for the Deaf (NTID, 2012). This program while initially offered as a face-to-face program is slated in fall 2013 to become a hybrid program requiring an online and week-long, face-to-face component. The CATIE Centre at St. Catherine University also offers several online healthcare interpreting modules that are designed as continuing education materials for interpreters (Bowen-Bailey, 2012). Other organizations across the US and Canada also offer online educational resources for sign language interpreters in healthcare (e.g., https://www.signlanguagespecialists.com).

In Australia, linguists, interpreters, and members of the Deaf community collaborated on the creation of an online sign bank of medical terms in Australian Sign Language or Auslan. The overarching goal of this project is to improve deaf patient and healthcare provider communication in hopes of improving the overall health and mental health of deaf people in Australia. “It is being used to create an effective, accepted, and shared sign language vocabulary for the discussion of medical and mental health issues by deaf clients and health professionals in interactions mediated by Auslan interpreters” (Johnston & Napier, 2010, pp. 258-259).

In a new book published by Gallaudet University Press, authors from the US, Europe and Australia illustrate techniques and methods for educating healthcare interpreters. Major, Napier & Stubbe (2012) discuss the benefits of using authentic healthcare dialogue between two hearing participants as a way of teaching practical discourse analysis tools for interpreters. Dean & Pollard (2012) also talk about the use of recorded materials of hearing participants. They emphasize how to structure analyses for optimal student learning and offer several structured experiential learning examples in healthcare. Doug Bowen-Bailey (2012) describes the development of several online modules for healthcare interpreting created via the NCIEC. Another important development in healthcare interpreter is the use of Deaf interpreters (Morgan & Adam, 2012).

A second organization in the US that has made significant advancements in the professionalism of healthcare interpreters (primarily spoken language interpreters) is the National Council on Interpreting in Healthcare (NCIHC). The NCIHC’s goal is to improve language access in healthcare settings and towards that end developed a national examination that certifies spoken language interpreters to work in healthcare settings (Downing & Ruschke, 2012). This examination does not currently include sign language interpreters. The contribution of the NCIHC has primarily been in the
advancement of a Code of Ethics for healthcare interpreters (NCIHC, 2004) which distinguishes itself from most ethical codes. It is not customary for interpreters’ ethical codes to include tenets that compel interpreters to consider and prioritize setting-specific values – values that come into conflict with traditional interpreter values.

The NCIHC’s Code (2004) is a twelve-page document which includes an introduction, a preamble to the nine ethical tenets, a description of each ethical tenet and common value conflicts, and a conclusion. The introduction and the preamble explain the appropriate use of the Code (e.g., it is to be understood as a guide and not a “how to” document intended to answer every situation) and highlight the importance of decision-making. Two noteworthy tenets which deviate from more traditional ethical tenets are:

*The interpreter treats as confidential, within the treating team, all information learned in the performance of their professional duties, while observing relevant requirements regarding disclosure (NCIHC, 2004, pp. 3).*

*When the patient’s health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem (NCIHC, 2004, pp. 3).*

Both of these tenets recognize unique aspects of the healthcare setting – how confidentiality is perceived (as belonging within the confines of the team versus residing with an individual) and supporting the ultimate goal of good healthcare outcomes. The message to healthcare interpreters and consumers of interpreting services is also unique in that it includes core values which underpin the tenets. Those are: beneficence, fidelity, and respect for the importance of culture and cultural differences. These core values are intended to guide interpreters’ decision-making when other ethical tenets appear less applicable.

Much of the IMIA’s Code of Ethics does not include setting-specific values or appear to deviate much from a generic interpreter code. While advocating on the part of the patient is a controversial aspect to the work of the healthcare interpreter (Downing & Ruschke, 2012), the IMIA’s Code also includes a tenet about patient advocacy:

*Interpreters will engage in patient advocacy and in the intercultural mediation role of explaining differences/practices to healthcare providers and patients only when appropriate and necessary for communication purposes, using professional judgment (IMIA, 1987/2006).*

In addition to the extensive NCIHC Code of Ethics for Healthcare Interpreters is the NCIHC’s National Standards of Practice for Interpreters in Healthcare (NCIHC, 2005). The Standards of Practice are defined in the document as, “a set of guidelines that define what an interpreter does in the performance of his or her role, that is, the tasks and skills the interpreter should be able to perform in the course of fulfilling the duties of the profession” (NCIHC, 2005). The distinction between the function of a code of ethics and the function of the standards of practice is noted in the introduction: “…code of ethics provides guideline for making judgments about what is acceptable and desirable behaviour in a given context or in a particular relationship while the standards focus on the practical concerns of what the interpreter does in the
performance of his or her role, offering ‘best practice’ strategies for observing the principles of the code of ethics in day-to-day practice” (NCIHC, 2005, pp. 1). The NCIHC’s Standards of Practice are: accuracy, confidentiality, impartiality, respect, cultural awareness, role boundaries, professionalism, professional development, and advocacy (NCIHC, 2005, pp. 5-10). Each standard is coupled with the related ethical tenet of the NCIHC code. Several examples of illustrative behaviours accompany each of the above standards.

There seems to be much collaboration between the IMIA and the NCIHC (e.g., the IMIA posts the NCIHC’s Standards of Practice document on its website) as well as other medical interpreting organizations such as the California Healthcare Interpreters Association (http://www.chiaonline.org) and the Massachusetts Medical Interpreter Association (http://www.massmedicalinterpreting.org) all of which have endorsed the Code and the standards of practice documents created by the NCIHC. The ASL/English interpreters document, Medical Interpreter Domains and Competencies also encourages consideration and application of the NCIHC Code of Ethics.

HEALTHCARE INTERPRETING RESEARCH AND EFFECTIVE PRACTICE

Along with practice standard documents such as those reviewed above, it is important to review how the profession conceives of and articulates the role of the interpreter in healthcare settings. Whilst ensuring that interpreters have the linguistic resources to deal with medical situations remains a significant issue (see Napier et al for a contemporary response to this matter), any development of personal skills which overlooks the vital significance of interactional resources will face limited success. The many role constructs available to the healthcare interpreter are a controversial matter – what an interpreter needs to do to function effectively in the settings and the inherent consequences of those actions has been the topic of several research articles (Davidson, 2000 & 2001; Hsieh, 2006, 2008; Leanza, 2005). The tension always seems to centre on a conflict between upholding the values of patient/provider autonomy or self-determinancy and “supporting the health and well-being of the patient…” (CHIA, 2002, pp. 10).

Indeed, there has been an evolution in how interpreters have imagined ethical behaviour in healthcare settings. Such was the focus of another manuscript published by the NCIHC, The Role of the Health Care Interpreter: An evolving dialogue. In this document, Avery (2001) discusses the possible healthcare interpreter roles which fall on a continuum, from interpreter as conduit to interpreter as active participant – all of which are evidenced in research and remain in practice today. Interpreter as conduit has been the longest-standing conceptualisation of how interpreters function within settings and interactions (Angelelli, 2004; Clifford (2004). Adopting a conduit role usually means also striving to be as neutral and impartial as possible during participant interactions. The ground-breaking research by Metzger (1999) showed that neutrality and impartiality within interpreter-mediated interactions was not possible. Clifford (2004) also suggests that they might also be undesirable.

Angelelli’s research (2004) also suggested that interpreters make behavioural choices that run along a continuum. Many scholars in interpreting have offered that these behavioural differences are directly influenced by salient and changing contextual factors (Davidson, 2000 & 2001; Dean & Pollard, 2005; Hsieh, 2006 & 2008; Turner,
Angelelli’s continuum draws on how “invisible” the interpreter is able to behave in a given interaction. Some interactions require that the interpreter be active in the process and therefore, visible while at other times being unobtrusive is not only possible, it is optimal (Angelelli, 2004).

Nicodemus, Swabey, and Witter-Merithew (2011) suggest that interpreters not only be visible but establish a presence amongst participants. Establishing a presence will enhance their ability to behave in more active ways and allow them to work in concert with other healthcare professionals toward good healthcare outcomes. The more active role of the interpreter or the interpreter as interactional participant, one who co-constructs meaning is, as noted above, a common theme of current interpreting research (Angelelli, 2004; Dean and Pollard, 2005; Turner, 2005; Wadensjo, 1995, 1998).

There are many ways to assess the values inherent in professional practice. In this review, we have reviewed the documents which intentionally describe how healthcare providers and interpreters view and convey their ethical expectations and duties. However, how the healthcare and interpreting professions establish educational expectations and quality assurance standards is another important measure of professional values. Medisigns has sought to examine those values of effective practice in Europe and internationally.

DEAF ACCESS TO HEALTHCARE IN THE USA

Deaf adults have reported poorer health, and are less likely to have been seen by a physician than the general U.S. population (Barnett and Franks 2002). It appears that deaf adults find emergency departments more accessible than primary care services (Steinberg et al 2006), possibly due to availability of interpreter services. Few data are available on use of preventive services by deaf people, in general (Barnet and Franks 2002; MacKinney et al 1995; Tamaskar et al 2000).

The fund of information on health is ill-defined in the Deaf Community. U.S. deaf adults’ knowledge of English language medical terminologies is similar to that of non-English speaking immigrants in the U.S. (McEwen and Anton-Culver 1988). As a consequence, deaf people have a limited fund of knowledge about many health related topics (Barnett 1999). U.S. deaf adults’ knowledge of English Language medical terminology is similar to that of non-English speaking immigrants to the U.S. (McEwen and Anton-Culver 1988). Moreover, adults who use ASL report being dissatisfied with doctor-patient communication (Lass et al 1978; Witte and Kuzel 2000) and prefer qualified interpreters or sign-fluent and/or deaf clinicians (Schein and Delk 1980; Steinberg et al 1998).

Few health education resources are otherwise available for primary ASL users, to substitute for the extremely limited numbers of ASL-fluent clinicians. The results lead to findings such as the following: In a survey of deaf adult patients in a sign language accessible healthcare system, fewer than half the women could correctly define the term “Pap smear” but, after the term was explained, 90% reported ever having had one. (Orsi et al 2007). In an ASL interview survey of deaf adult patients enrolled in sign language accessible healthcare systems, 52.2% correctly identified high cholesterol as a risk for cardiovascular disease (Margellos-Anast et al 2006). And in an ASL interview survey of deaf adult patients enrolled in sign language accessible
healthcare systems, 71% of those in an urban patient population who recognized the term “HIV/AIDS” reported prior HIV testing compared with 34% of a suburban patient population who recognized the term (Margellos et al 2004).
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