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Training (Medical) Interpreters—the Key to Good Practice. MedInt: A Joint European Training Perspective

Anita Ertl and Sonja Pöllabauer, Department of Translation Studies, University of Graz

ABSTRACT

After a short description of some of the basic aspects of community interpreter training, different training options for community interpreter training in general and healthcare interpreter training in particular, the paper presents an EU-funded project (Grundtvig/Lifelong Learning Programme) which focused on developing a curriculum for medical interpreting (*MedInt—Development of a Curriculum for Medical Interpreters*). The MedInt project was a multinational cooperation project funded by the European Commission as part of the Lifelong Learning Programme under the Grundtvig subprogramme. Between 2007 and 2009 the project consortium jointly developed a sample curriculum for medical interpreting, designed teaching materials and concentrated on awareness raising and dissemination initiatives in the partner countries. In this paper, the authors summarise the project objectives and the outline of the curriculum developed under MedInt.

KEYWORDS

Community Interpreting (CI), Public Service Interpreting (PSI), Medical Interpreting, Interpreter Training, Curriculum Design.

1. Introduction

As historical sources show (e.g. Delisle/Woodsworth 1995), the services of interpreters have been employed for thousands of years in situations in which people who did not have the same linguistic background wished to communicate with each other. Nowadays not much has changed: interpreters still act as mediators for at least two parties in different situations and to varying degrees of neutrality (Ozolins 2000; Pöchhacker 2004: 13ff.). Interpreters are finding their services increasingly in demand in areas of administration where people who do not speak the country's official language wish to or have to contact authorities in the host country (Pöchhacker 1997). "Intra-social" interpreting, which encompasses interpreting that takes place in the community and in public-sector institutions and therefore differs from "international" conference interpreting (Pöchhacker 2000: 39), is commonly referred to as "Community Interpreting" (CI), Public Service Interpreting (PSI), and sometimes also Dialogue Interpreting. However, the professional and legal status of interpreters working in the public service and healthcare sectors is rather vague and endeavours to professionalise these sectors have only taken place on a very small scale (e.g. Hale 2007: 35, Pöchhacker 2007). A small number of 'pioneering' countries (for example Australia and Sweden) realised as early as in the 1960s and 1970s (cf. Niska 2007, Chesher 1997) that there was an increasing need for communication

within their countries and took the relevant steps towards professionalising and institutionalising interpreting services by introducing legislations, providing adequate training and certification measures for interpreters and ensuring that satisfactory interpreting services were made available to the community (Ozolins 2000). Many other countries however are currently lagging behind in their efforts to professionalise interpreting services (Pöchhacker 2004: 30).

Although employing the services of a qualified interpreter can guarantee communication and lay the foundations for professional service delivery, in practice, qualified interpreters often tend to be regarded as too expensive and there is usually no budget to cover the costs of their services (Puebla Fortier 1997: 168; Arocha 2009), let alone for establishing comprehensive interpreting services on an institutionalised basis, referred to as “generic language services” by Ozolins (2000: 23). This is also one of the reasons why the use of lay interpreters is widespread in CI (*ibid.*). This is especially true for the healthcare sector, where the demand for interpreting is solved on an ad-hoc basis in many countries (Angelelli 2004: 21f.). In what follows we first try to outline some basic aspects of community interpreter training before presenting a European cooperation project that focused on developing a curriculum for medical interpreting.

2. Community interpreter training: a few preliminary remarks on training as the key to professionalisation

What makes a profession (including that of Community Interpreter) a profession? A look at the results of research carried out in the sociology of the professions reveals that training is one of the major factors playing a role in forming a profession. (Johnson 1972/1993: 23). In the field of CI however, as opposed to other more prestigious fields of interpreting such as conference interpreting, training opportunities are still scarce and underdeveloped (Pöchhacker 2004: 30, Niska 2005). CI is also an area of interpreting where practitioners and researchers still hold highly divergent views on different aspects of the profession (e.g. the role of the interpreter, best practice, etc.) (Niska 2002: 138), depending on their institutional and/or geographic (national, social, legal) backgrounds, and still have to come to a consensus on even very basic aspects of what constitutes CI and how it should ideally be carried out (Leanza 2005). Although training is often regarded as the key to the provision of adequate interpreting services (Kalina 2002: 179) it remains one of the problem areas of CI, still lacking or not fully-developed in many countries (Ozolins 2000). Due to this fact it seems safe to conclude that, except in a few “pioneering” countries, CI has not yet advanced to the state of a fully-fledged profession (Ozolins 1995, 2000).

CI services were adopted as early as the 1960s and 1970s in pioneering “immigration” countries (for example Australia and Sweden) (Niska 2007; Chesher 1997); it was only in the 1990s however that it became a field addressed in Interpreting Studies (IS) (Pöchhacker 2004: 29f.) and since then it has gradually advanced from its Cinderella status, with only a few authors dealing with the field, to an accepted and varied field of research (Pöchhacker 2007: 122).

Today, the spectrum of CI training programmes ranges from non-existent in some countries to (and this is the exception) fully institutionalised full-scale training, with ad-hoc short-term solutions or semi-institutionalised initiatives however usually being the method of choice (Ozolins 1995: 156, Ozolins 2000). A review of the relevant literature shows that there exists a large array of often highly divergent training concepts (both at university level and outside academic institutions) (Phelan 2001: 22), differing with respect to duration (e.g. short-term training to full-scale academic programmes), content (e.g. language-specific, language-independent, theory-based, combination of theory-based and practical training, different views on interpreter roles and ‘cultural mediation’), qualification certificates or ‘degrees’ (e.g. proof of attendance, ‘certificates,’ internationally recognised academic degrees), selection/admission criteria (e.g. no selection progress to full-scale entrance examinations), testing procedures (e.g. no testing to full-scale final exams leading to accreditation), teaching methods (e.g. ‘traditional’ vs. ‘new’ teaching methods), language combinations (e.g. ‘Western’ languages vs. ‘rare’ languages) etc. (cf. e.g. Hale 2007: 168).

It will therefore not be possible to provide a complete overview of the existing range of programmes within the scope of this article. This would, however, also be difficult even with more space as the training landscape is constantly changing, in line with national requirements and global (immigration) trends. In addition to this, many of the available training options are either one-off programmes or courses offered by continuing education institutions (Roberts 2002) where little information can be found on their training concepts. In the remainder of this section we will therefore limit ourselves to a brief, exemplary overview of different training options. The major focus will be on university-based training programmes such as MedInt, the training curriculum described below, which was developed within a university context and would lend itself well to being implemented within an academic framework (advantages: e.g. use of university infrastructure, easier access to research findings). The MedInt training concept might, however, also be adapted to different contexts and implemented within non-academic settings.

Recently (community) interpreter training has also become a topic of discussion within EU institutions and forums (e.g. Lauridsen/Martinsen 2000). Recent developments show that there is now more awareness as

to the fact that there is more to interpreting than conference interpreting and that fair access for all (EU) citizens to national institutions as well as freedom of movement also necessitate a focus on CI. Though most of the larger EU projects have concentrated on legal interpreting so far (e.g. the GROTIUS, AGIS or Criminal Justice projects) (European Commission 2009a), the Commission's Communication *A new framework strategy for multilingualism* (COM 2005/596 final) reflects a new stance:

Interpreters also help the institutions of multilingual societies to function. They support immigrant communities in courts, hospitals, police and immigration services. Properly trained interpreters thus contribute to safeguarding human and democratic rights. (COM 2005/596: 11)

2.1. Training landscape

University or college training

CI training often takes place in non-academic settings. University or college training programmes (undergraduate or postgraduate) are largely underrepresented in the range of existing CI training options (e.g. Ozolins 1995: 156, Roat/Okahara 1998, Roberts 2002, Kalina 2002). In many countries CI has not yet achieved the status of a profession/discipline that merits full-scale academic training (Ozolins 2000). Academic interpreter training still often focuses on conference interpreter training with only a few exceptions (Kalina 2002, Niska 2005). If at all, CI, the less prestigious "sister" (Bahadir 2007: 219) of conference interpreting, is dealt with on an individual basis in single seminars or modules (Roberts 2002). This lack of interest in CI is also reflected in research: interpreting researchers concentrated their efforts for a long time on conference interpreting and later, to a lesser degree, on court interpreting whereas other community-based settings tended to be neglected (Pöchhacker 2004: 32ff.). Over the last few years however, this trend has gradually shifted: both research and (to a lesser extent) university curricula have started to take notice of CI (Pöchhacker 2007: 122).

Most CI training is offered at postgraduate level or as part of continuing education programmes (Roberts 2002). What is common to most of these university-based training programmes is that they often do not constitute full-scale undergraduate or post-graduate programmes leading to an official and internationally accepted degree (e.g. BA, MA). Instead, they are often limited in scope, highly diverse as regards their content and often lead to participants receiving only a certificate at best (Roberts 1994, Roberts 2002).

In what follows we focus on training initiatives in a selected number of countries. The selection of the countries and training programmes presented here are based on a study of literature on CI training: we focus on countries and training initiatives which are often discussed in

publications focusing on CI and CI training measures (e.g. Downing/Helms/Tillery 1992, Schweda-Nicholson 1994, Phelan 2001, Kalina 2002, Roberts 2002, Ozolins 2000, Valero 2003b). The information given in the next few paragraphs will help to give a rough picture of the CI training situation, but represents, of course, no exhaustive list of training initiatives¹.

Australia, which is often regarded as one of the pioneering countries in relation to CI (Ozolins 2007), was among one of the first countries to offer CI training both at undergraduate BA-level and graduate post-diploma level, for instance at Deakin University in Victoria (Burley 1990) (at the time of writing, no interpreting training programme was available at Deakin University, cf. Deakin 2010). A considerable number of other training institutions currently offer courses in translating and community interpreting that are approved by NAATI, the National Accreditation Authority for Translators and Interpreters in Australia (for a list of available courses see NAATI). Upon completion of a NAATI-approved training course participants are eligible for the accreditation exams held by NAATI (Bell 1997). Courses and accreditation exams are available for different levels (e.g. paraprofessional, interpreter/translator, advanced translator/conference interpreter level) (*ibid.*).

In the US and Canada, CI training is only seldom offered at university level (cf. e.g. Downing/Helms/Tillery 1992, Schweda-Nicholson 1994, Roberts 2002). A study by Roat and Okahara (1998) for instance showed that in the 1990s, out of 23 training courses for (medical) interpreting in the US, only four were offered by academic institutions. The situation has not changed much since then: even though now more training options are available, especially for medical interpreting, training is mostly offered as short informal training courses, as 'continuing education' or tackled in single specialised courses or integrated modules or offered by community colleges (see for instance Roat 2003 for a review of the situation in California; Angelelli 2004). In Canada, Vancouver Community College and Nunavut Arctic College offer well-established training courses in CI (cf. e.g. Sammons 1993; Roberts 2002: 170) (at the time of writing, courses were offered at both institutions, cf. Vancouver Community College 2010, Nunavut Arctic College 2010).

Apart from North America and Australia, CI training is also considered relevant in South Africa (e.g. Erasmus 2000), where the political situation has made short-term training the only option for a pressing language problem. The Language Facilitation Programme (LFP) of the University of the Free State (UFS) University began offering short-term interpreting courses training interpreters for the (then) newly installed Truth and Reconciliation Commission as of 1996. The UFS is still the only university in South Africa offering training in CI (Lotriet 2000: 266). The undergraduate CI training (called Liaison Interpreting) at the UFS has

been phased out as of 2005; interpreting training is available at the postgraduate level (cf. the course calendars for 2010, UFS 2010).

In Europe, Sweden appears to be most advanced as regards CI training and services (Roberts 2002), having offered publicly funded university-based training (at the Institute for Interpretation and Translation at the University in Stockholm) since the 1960s (Niska 2002: 136). Today, CI training is offered as vocational training at adult education centres. Funds for the courses are allocated by the Stockholm Institute for Interpretation and Interpretation, which also supervises the training (Niska 2005). As for the other Scandinavian countries, in Denmark, the Copenhagen Business School has been offering a two-year university-level CI training programme; there are similar plans for Aarhus Business School (Dubslaff/Martinsen 2003: 114, Niska 2005). Finland has established language services for the public sectors (Ozolins 2000) and offers interpreting training as a specialisation within translator training at five universities (Niska 2005). In Norway, there are hardly any training opportunities for interpreters (Sagli 2003). Due to its geographic location there is also little need for community interpreters. Minority groups such as the Lapps have the right to an interpreter in courts proceedings (Mortensen 1998).

In the UK, the Polytechnic of Central London (Schweda-Nicholson 1994: 135) (now called the University of Westminster) offered a “train-the-trainers” course for CI trainers as early as 1989, which can be regarded, retrospectively, as quite innovative: many researchers today still call for initiatives to train the trainers (e.g. Corsellis 2008: 65ff.). The CI training courses offered by the Institute of Linguists in cooperation with the Nuffield Foundation, which offer three specialisations (law, health, public service and local governments) and lead to different levels of certification (incl. the Diploma in PSI) and accreditation (Tribe/Sanders 2002: 55) are not strictly university-based training programmes, but can be counted among the more advanced and organised forms of CI training in Europe. These courses are available in adult and continuing education institutes and even as distance learning options. Training courses at national level are also offered by the Open College Federation and the London Open College Network (*ibid.*: 56) (cf. also Corsellis et al. 2007, Townsley 2007). In Ireland, Dublin City University offers a Graduate Certificate in Community Interpreting (DCU 2010).

In German-speaking countries, Magdeburg-Stendal University of Applied Sciences (Hochschule Magdeburg-Stendal) in Germany began offering a three-and-a-half-year BA course programme for court, community and health-service interpreting in 1999 (Nord 2003: 257). The Department for Translation and Interpreting at the Hochschule für Angewandte Sprachen in Munich, a private polytechnic college, also offers courses in CI (Gross-Dinter 2009). Apart from sign language interpreter training there are

currently no other training initiatives specifically for CI at university level (Witzel/Holzer 2007).

In Austria, the University of Vienna offers a specialisation in dialogue interpreting as part of its MA programme of studies, and the University of Graz is now offering a university-based training course for CI for the second time (Pöllabauer 2009: 105). Overall, CI training is highly underdeveloped in Austria (Pöchhacker 1997, 2007).

In Switzerland, the Zurich University of Applied Sciences in Winterthur offers training in court and public service interpreting (Hofer 2006).

In Spain, there are currently three university-level training programmes for CI in existence: one in Alcalá de Henares, run by Carmen Valero Garcés (Universidad de Alcalá 2008), one at the Universitat Jaume I in Valencia (Universitat Jaume I 2008), and one at the University of Salamanca (Universidad de Salamanca 2008). Regular course programmes offered by Translation and Interpreting Departments at other Spanish universities do not yet include CI in their curricula (Sales Salvador 2005; for list of programmes for translation and interpreting see Niska 2005). The training at Alcalá appears to be the most comprehensive (cf. Valero 2003a).

In Belgium, there are interpreting agencies providing interpreting services for the public sector, CI, however, still is a new discipline with little training available (Salaets/van Gucht 2008). The situation in the Netherlands is very similar: interpreting agencies (*tolkencentras*) have been established already in the 1970s, training courses for public service interpreting are scarce however (Vonk 2001, Niska 2005).

In countries like, for instance, France (ISM CORUM 2003), Italy (Putignano/Tomassini 2003), or Portugal (Feijoo 2003), no or hardly any CI training is offered.

Training offered by non-academic providers

In contrast to the scarcity of academic training courses in CI, the amount of highly divergent training initiatives offered in non-academic settings with (similarly to university-based training) no conformity as to content, length, certification etc. is very high. The literature available on this subject provides a glimpse into different training concepts offered by different institutions. Training is usually either offered by *interpreting services* for their pools of interpreters, or by *user institutions* (often hospital or local government agencies) or *government agencies* for in-house or volunteer (lay) interpreters (Roberts 2002). Training varies as regards language combinations, length, content, costs, certifications,

exams, standards, etc.—which can again be seen a symptom of the low status of CI as a profession (Ozolins 1995).

Distance education

A small number of institutions offer distance education courses (the pros and cons of which cannot be discussed in detail here) for CI training. Distance education is often an option for countries with sparsely populated regions, e.g. Canada, Australia. Vancouver Community College (Canada), for instance offers distance interpreter training in cooperation with the Open Learning Agency in Vancouver (Carr/Steyn 2000). A project with distance education elements was set up as early as 1993 by the Arctic College (Northwest Territories) (Sammons 1993: 49).

2.2. Selected facets of CI training

Section 2.1. provided a brief and by no means complete look at the multitude of training programmes related to CI. In what follows we attempt to provide an overview of some of the topics discussed in CI research as regards training. Based on a literature review (literature on CI training) we will point out some topics and problem areas which are discussed in research and may need to be considered when focusing on interpreter training and curriculum design.

Lack of expert status

Interpreting is often seen as an activity that can be undertaken by anyone who can speak the language. Language competence is often equalled with interpreting competence (Kalina 2002). Even though studies have proven that this assumption is often highly misleading (e.g. Pöchhacker/Kadric 1999), it is still one of the reasons why the use of non-qualified interpreters is widespread in CI (in the case of some language groups even in countries with a higher degree of professionalisation, cf. e.g. Chesher 1997: 289; Straker/Watts 2003: 175). Interpreters are not seen as experts and it is this lack of expert status which has negative consequences on the development of CI as a profession. If a profession lacks a certain aura of mysteriousness, which is usually conveyed by training, it may have a problem reasoning and legitimising the need for training (and the resulting costs) (Mikkelsen 1996).

Lack of trainers

The lack of training programmes relating to CI can be linked to another problem factor: the lack of skilled trainers. This is why a number of researchers are calling for 'train-the-trainer' courses, which should best be implemented before or at least parallel to CI training programmes (cf. e.g. Englund Dimitrova 2002; Corsellis 2008: 65ff.). As Kalina (2001: 58) rightly points out, it will not suffice to "use" conference interpreter trainers

for CI training courses. This may be a solution which, due to lack of staff, is practised in some institutions, but will entail specific problems, for example a visible lack of expertise in issues concerning CI specifically, something which could engender a lack of acceptance amongst students. Teachers with a research background and no practical experience in interpreting, however, might also meet with resistance with students, as they are sometimes considered too theoretical by students (Englund Dimitrova 2002: 74).

Lack of awareness

Lack of awareness of the importance of using skilled interpreters (e.g. Pöchhacker 2007: 136) or lack of efficient ways of using interpreters and organising interpreting services (Ozolins 2000) are also problem areas which need to be addressed when it comes to developing CI training measures. Several interesting examples for user training programmes demonstrating that user training is a prerequisite for gaining acceptance for the professionalisation of interpreting services can be found in literature relating to CI (e.g. Ozolins 2000; Tebble 2003; Corsellis 2008: 118ff.).

Language combinations

The languages used in CI are often not the prestigious “world” language taught in schools and at university (Gentile 1993; Ozolins 2000: 29). This further complicates CI training as training institutions have to decide whether it will be possible (availability of trainers, number of potentially available students, applicants’ language proficiency) to offer language-specific training or whether they will have to make do with language-independent, unilingual training (Kalina 2002). The issue is closely linked to the lack of CI trainers in general but especially of those with more unusual language combinations. For some countries, such as for instance South Africa, the language situation differs in as much as it’s not minority group (migrants, refugees) languages but national languages of different ethnic groups for which there is a lack of interpreters and interpreter trainers (cf. e.g. Erasmus 2000: 197).

Content

Much thought has to go into the ‘content’ of training programmes (for a discussion about possible content cf. e.g. Tebble 1996, Roberts 2000; Kalina 2002; Tribe/Sanders 2002 (for mental health interpreting training programmes), Hale 2007: 177ff.). As there still is no consensus as to the role(s) of interpreters and related issues (degree of involvement of interpreters, cultural mediation etc.) (e.g. Bolden 2000; Leanza 2005; Angelelli 2008), training providers have to decide which stance will be taken on their particular course; this of course needs to be communicated adequately to students, trainers and users. The relation between ‘theoretical’ and ‘practical’ units also needs to be discussed (Hale 2007: 168). Similarly, course designers and instructors have to decide whether

and if so, how to incorporate 'new' trends and content (e.g. video remote interpreting, new technologies, traumatisation and dealing with emotional stress, stress management, Niska 2002: 142). The integration and morphing of 'theory' (new research and findings) with practice also requires close attention. Angelelli (2008: 159), for instance, underlines the importance of "bringing theory and research to bear in the education of healthcare interpreters" to support a "dialogue" between researchers and practitioners (*ibid.*: 160) to be able to simulate interpreting scenarios in training which are close to real-life situations.

Length of training

The length of training programmes varies greatly, programmes range from courses with just a few hours to full-scale university training (Hale 2007: 168) (for a discussion on the effectiveness of short interpreter training cf. Lotriet 2002). The length of the training programmes will, on the one hand, depend on institutional and/or legal constraints (especially for university programmes such as BA or MA programmes) and, on the other hand, on available funding (Puebla Fortier 1997: 173), and the students' educational backgrounds (Niska 2002).

Degrees/certification

The degree or certification to be awarded to students may also depend on legal requirements. Closely linked to this issue are decisions regarding entrance exams (Lotriet 2002; Corsellis et al. 2007), exam structure and the final testing and assessment of skills (Fowler 2007).

Participants

One important aspect is the potential participants' qualification: it is important to attract students with sufficient language and cultural competence (Hale 2007: 169). For languages of limited diffusion in particular it may be difficult to find applicants who fulfil the requirements of training courses (Hale 2007: 169). Training providers have to decide how to include students with informally acquired skills who might be very suitable candidates (e.g. candidates with an immigrant background) but do not fulfil certain educational standards (different educational systems in their home countries, lack of training in certain areas, no acceptance of certificates/degrees in host country) or may need specific (e.g. language) training before they are fit to attend interpreter training (Niska 2002: 139).

Selection/admission process and entrance criteria

Depending on the course format and the students' backgrounds, attention needs to be paid to adequate selection/admission procedures (e.g. Lotriet 2002; Corsellis et al. 2007) and entrance criteria for CI training programmes. There are some tests available which might prove useful, e.g. the CILISAT (Cultural Interpreter Language and Interpretation Skills Assessment Tool) (Roberts 2000 and 2002), the recruitment test

developed by the Stockholm Institute for Interpretation and Translation Studies (Niska 2002: 141), or the Interpreter Interpersonal Role Inventory (IPRI) (Angelelli 2008).

Assessment/exams

Ways of assessing candidates' skills before, during and at the end of course programmes represent a further important aspect of CI training and must be taken into consideration (Hale 2007: 175ff.; Corsellis 2008: 60ff.).

Accreditation

In some, albeit very few countries there exists an official system of accreditation for interpreters for which training is a prerequisite (e.g. Australia) (Bell 1997; Lascar 1997). If an established system of accreditation is not yet available this may pose a problem for training programmes: if interpreting (and payment for interpreting jobs) are coupled with training and subsequent accreditation, this, in our view, may well prove to be a motivational factor for potential candidates to undergo training and take it more seriously.

Course format: With respect to the course format, training providers have to decide whether to offer in-class units only or also to incorporate other teaching methods (e.g. distance learning units) (Sammons 1993, Carr/Steyn 2000). The global spread of new media and ways of networking makes this an especially urgent issue. One particular decision to be made with regard to teaching methods (Tebble 1996; Hale 2007: 170f.) is whether to also include and enforce new teaching approaches such as body-centred methods and methods of theatre pedagogy (e.g. Kadric 2007, Bahadir 2009). With respect to teaching the scarcity of available teaching materials for CI (Hale 2007: 170) may also pose a problem. With respect to teaching, methods differ from methods used traditionally in interpreter training (Hale 2007).

So far, we have tackled basic aspects of CI and CI training. In what follows, we will focus more specifically on healthcare interpreting and training for healthcare settings. After a brief overview of the training situation we will present the MedInt project which focused on developing a curriculum for training healthcare interpreters.

3. Healthcare interpreting

The increased influx of people who do not speak the language of their host country, brought about by the right of freedom of movement within the EU (Lauridsen/Martinsen 2000) but also by immigration in general (Bolden 2000), has led to communication problems in different areas of life (Phelan 2001: 20, Niska 2002). In many countries, legal provisions for the appointment of interpreters for legal procedures (mostly for court

procedures and asylum hearings) are in force (Pöchhacker 2004: 29). When it comes to communication in medical encounters, the situation is less satisfactory (e.g. Angelelli 2004: 20f.; Arocha 2009). Access to medical treatment however is also a basic right (similarly to having the right to be understood in front of a court of law) which every person in the 21st century should be granted (cf. Article 25 of the Universal Declaration of Human Rights of 1948, cf. United Nations 2010). Although national and international Patients' Rights Laws and Charters (for a list cf. e.g. WHO 2010) state that patients should have equal rights and access to medical services, there are only a few specific regulations or documents that lay down the exact needs and specifics for interpreting in medical settings. The WHO Declaration on the Promotion of Patients' Rights in Europe, for instance, explicitly refers to interpreting under article 2.4:

Information must be communicated to the patient in a way appropriate to the latter's capacity for understanding, minimizing the use of unfamiliar technical terminology. If the patient does not speak the common language, some form of interpreting should be available.

And the European Charter of Patients' Rights states in Article 4:

Health care providers and professionals must give the patient all information relative to a treatment or an operation to be undergone, including the associated risks and discomforts, side-effects and alternatives. This information must be given with enough advance time (at least 24 hours notice) to enable the patient to actively participate in the therapeutic choices regarding his or her state of health. Health care providers and professionals must use a language known to the patient and communicate in a way that is comprehensible to persons without a technical background.

In spite of such endeavours to lay down patients' rights and establish anti-discriminatory legislation (e.g. the US Civil Rights Act 1964, cf. Puebla Fortier 1997), the right to adequate communication does not yet appear to be endorsed in all seriousness by many countries as can be seen by the lack of adequate interpreting services (Ozolins 2000; Pöchhacker 2007; Arocha 2009) and training programmes for healthcare interpreters in many countries (Angelelli 2004: 23). Even if trained healthcare interpreters are available, communication barriers are nonetheless often bridged by using untrained interpreters (e.g. family members, friends) (Arocha 2009). Studies indicate that the use of trained interpreters and the establishment of well-organised interpreting services help hospitals and care-givers to reduce costs (Hampers/McNulty 2002). Nonetheless, often due to low budgets and a lack of clear standards for the appointment of interpreters, the use of lay interpreters is still widespread (Arocha 2009).

A brief review of the general landscape of training programmes for CI clearly indicates a lack of comprehensive or standardised training for interpreters in the healthcare sector, even in countries where interpreting

has been institutionalised to a stronger degree (Angelelli 2004: 23). What is offered are highly divergent training formats (Hale 2007: 168), ranging from one-off courses lasting only a few hours to several semesters of training, after which students having completed the course are awarded some form of certificate or degree. In the following, we present a brief overview of the training landscape in the field of healthcare interpreting before describing the MedInt training concept.

3.1. Training landscape in healthcare interpreting

In Australia and the US, two pioneering countries with regard to CI (Pöchhacker 2004: 30), training programmes and curricula for healthcare interpreting are available (cf. e.g. Roat et al. 2000; Daneshmayeh 2008). They vary considerably with respect to content and comprehensiveness, involving anything from a few hours to several semesters of instruction (Roat et al. 2000, Hale 2007, Daneshmayeh 2008). It would thus be highly desirable to synthesise critical training elements and agree upon minimal training requirements (Roat et al. 2000). Currently, the development of national standards for training healthcare interpreters is discussed (NCIHC 2010).

Like for CI in general, there is also a lack of qualified trainers specifically for healthcare interpreting (*ibid.*). In order to address this problem, some train-the-trainer programmes have recently been developed in the U.S. (Roat et al. 2000).

With the exception of Sweden (Niska 2007), in Europe, the overall training situation is less advanced (Pöchhacker 2004: 40). In Austria, the Wiener Krankenanstaltenverbund (KAV) funded a pilot training course on medical interpreting in 2000, run and organised by F. Pöchhacker. 15 hospital employees (with a language and cultural background in German and Turkish, Bosnian, Croatian or Serbian) received special training in medical interpreting (total duration: 120 45-minute units) (Pöchhacker 2002). The 'Muttersprachliche BeraterInnen,' (mother-tongue advisors) who were employed by a number of Viennese hospitals in the 1990s, were also among the participants, besides medical staff who is regularly called upon to interpret. There was no follow-up training due to a lack of funding (*ibid.*). Neither in Germany, nor in Austria, are specific training measures for healthcare interpreting currently offered (Pöllabauer 2009).

In Switzerland, training initiatives for medical services are organised under the auspices of one single and independent association (INTERPRET Swiss Interest Group for Intercultural Translation and Mediation), which is also in charge of certifying interpreters. Its aim is to help immigrants to gain access to medical as well as other services. (INTERPRET 2010).

In Spain, the Universitat Jaume I in Valencia offers a post-graduate course for training in medical interpreting. The course encompasses 80 hours of training, half of which take place as part of an internship. The course comprises contextual knowledge about the settings and the migrant groups involved as well as techniques for interpreting and mediation in the medical field (Universitat Jaume I 2008). Although there are two further university-level training programmes relating to CI on offer in Spain, these do not offer a special module or course on medical interpreting.

In the UK, 'Health' can be chosen as one of three specialisations for the Diploma in Public Service Interpreting (DPSI). Training is provided at different training institutions (e.g. colleges of further education, community colleges, universities, interpreting agencies) (Townsend 2007). For none of the other European (or Eastern European) countries, information on specific training measures for healthcare interpreting was found.

This brief overview clearly shows that, apart from a few exceptions, medical interpreting still tends to maintain a low level of professionalisation. The MedInt project was instigated with the aim of remedying this situation

3.2. MedInt—Development of a curriculum for medical interpreters

MedInt was a multinational cooperation project funded by the European Commission as part of its Lifelong Learning programme in the GRUNDTVIG sub-programme (duration: December 2007-July 2009). The project consortium was made up of project partners from four different countries (Germany, Finland, Austria and Slovenia). This consortium consisted of universities with many years' experience in the field of developing curricula, interpreting training and CI (the University of Graz, the University of Tampere, the Faculty of Applied Linguistics and Cultural Studies of the University of Mainz in Gernersheim), of a hospital trust and an Austria-based NGO. This mix of project partners ensured a valuable exchange of experiences from different perspectives.

The main objective of MedInt was to develop a curriculum for training healthcare interpreters which would help to improve the quality of the training situation and, in the long-term, the quality of interpreting services in the project partner countries; the curriculum was also planned to allow for an easy adaptation by other parties wishing to introduce training in healthcare interpreting. (The MedInt concept could for instance, easily be adapted for training interpreters for mental health settings.)

Studies show that there often exists a lack of awareness of the importance of using qualified interpreters among users, (political) stakeholders and

decision-makers (Hale 2007: 166; Pöchhacker 2007; Arocha 2009). MedInt therefore also aimed to raise the general public's awareness for this topic and to sensitise potential users regarding the importance of employing trained interpreters (Bolden 2000). These awareness-raising activities were also considered vital for the long-term success of the training programme, since healthcare facilities will have to recruit professionally trained medical interpreters to be able to live up to standards and communicate efficiently (Leanza 2005).

Another goal was to develop new teaching materials. Details about the project outcomes, the curriculum and the teaching materials can be accessed via the project homepage (Pöllabauer 2009). The project results were evaluated by an external evaluator, an expert in the field of medical translation.

Due to time and financial constraints, the curriculum could not be implemented during the funding period. It is hoped that the MedInt curriculum will be implemented and tested as part of a follow-on project.

3.2.1. The MedInt curriculum in detail

On the basis of a lengthy process of discussion as well as reviews and analyses of different relevant fields, the project partners drafted a model curriculum which was later adapted to specific national needs in the partner countries (see below). Before drafting and elaborating the curriculum, the partners focused (in summary reports) on the status quo of the interpreting provision and training situation in the partner countries, aspects of healthcare for migrants and the use of ICT in medical interpreting). The different reports are available on the project homepage.

Target groups and beneficiaries

The joint curriculum for training medical interpreters in this project also focuses on interpreters needed for peripheral languages (cf. Linn 2006 for the distinction between central and peripheral languages). It is expected that in some environments these interpreters might also be recent immigrants, and will most probably not have higher education or, if they do, their degrees may not be recognised by the target society. To be able to provide training for these candidates as well, it is therefore assumed that training for medical interpreters should be an intensive course accepting (as a minimum requirement) secondary school graduates. The Common European Framework of Reference for Languages (Council of Europe 2001) was used to determine the levels to which a particular language can be mastered. Students are expected to have at least C1 proficiency in the patient's language and at least a B2 level in the language of the target society. If this level of language proficiency is not achieved, additional linguistic training should be provided.

The long-term project beneficiaries are lay interpreters who are often used as interpreters but have no official training in interpreting. Traditionally trained interpreters (with training in conference interpreting) form another possible target group and will benefit from specific training in medical interpreting. Patients with a foreign-language background are also long-term beneficiaries because they will have better access to medical services once the use of medical interpreters has been well established. Finally, medical and therapeutic institutions will also considerably benefit from increased interpreting quality in the long term.

Content

The overall objective of the project was not to strictly impose all contents and materials but rather to determine the training objectives and competencies to be acquired and offer a sample curriculum that could then be adapted to different national and institutional requirements.

With reference to a set of competencies, which was developed for the European Masters in Translation (European Commission 2009b) by a group of experts by the Directorate-General for Translation (DGT), the following competencies (and sub-competencies) were defined by the project consortium:

- Interpreting service provision competence (incl. operational skills, ethics and interpersonal skills);
- Language competence;
- Intercultural competence;
- Technological competence (mastery of tools);
- Information mining competence;
- Thematic competence.

This list of competencies (for detailed descriptions cf. the full curriculum, available on the project website) formed the basis for the training content included in the sample curriculum (see below). The sample curriculum was intended to be seen as a model that can be adapted to the legislation and context of the countries where it is implemented.

Course Unit name	Contact Hours	ECTS Points
Introduction to the healthcare system and legal background	15	6
Basic medical knowledge in the L1 and/or L2	15	12
Introduction to intercultural communication	15	6
Introduction to professional ethics <ul style="list-style-type: none"> · Professional ethics · Interpreting profession · legal background 	20	6
Computer and information-mining skills (15), terminological aids (15)	15	3
Interpreting training (practical training with case studies)	120	18
Interpreting practicum or mentoring	15	3
Exam: interpreting a medical examination	2	6
TOTAL	217	60

Abbreviations: L1 = Language 1; L2 = Language 2; ECTS = European Credit Transfer and Accumulation System Points (1 ECTS point = 25–30 hours of student workload).

Table: Sample curriculum (MedInt)

To enable medical interpreters to act confidently and flexibly in different settings, they need to be taught the basics of medicine, medical terminology and typical medical counselling processes with special emphasis on aspects of trans-cultural medicine. Moreover, the students should become aware of culturally determined concepts of sickness and health and their impact on doctor/therapist-patient communication. Another important module featured as part of the training programme is professional ethics and interpersonal communication skills. The students are to be familiarised with, among other things, standards of best practice, the legal background of medical interpreting and the responsibilities and rights of an interpreter. In order to organise their newly acquired knowledge and terminology the students will be taught computer and information-mining skills and how to make use of terminological aids.

The theoretical information acquired is to be put into practice and further discussed and problematised in interpreting training sessions, real-life interpreting situations as well as during an internship (see below).

Length of training/contact hours

Since the amount of contact hours in the curriculum is relatively low (217 contact hours, corresponding to 60 ECTS), students will have to take responsibility for their learning outcomes: they must learn to comply with instructions and timetables; to operate as a team; to manage stress and to work under pressure and with other experts (during their internship for

example.). The number of semesters for the course (2, 3 or 4) can be determined by the implementing institution and are dependent on the given context.

Course format and teaching methods

Students will be engaged in learning through a variety of teaching techniques such as discussions, group work, role plays, lectures and research techniques. Since physical presence, facial expressions, gestures and body language in general are highly important in (healthcare) interpreting it was decided that on-line classes would not provide an adequate course format.

Internship

As role plays and mock situations can only approximate real-life situations it is regarded advisable to confront students with their future working environment where they will have to interpret dialogues that actually take place in healthcare settings. They thus get the opportunity to apply the skills and techniques they have acquired in practice and carry out professional duties under appropriate supervision and guidance, helping them to bridge the gap between theory and practice. Students will receive in-depth feedback on their performance from their supervisors. Fieldwork and classroom debriefing meetings are required to complete the course. The internship represents an excellent opportunity to link interpreting theory with practical experience, enabling both interpreting students and healthcare professionals to learn more about each other and their respective professions (Valero Garcés 2009).

Assessment and exams

Students will be assessed according to their active participation, assignments (reading) and a written or oral exam. The final exam consists of an evaluation of interpreting a medical examination.

Unfortunately, due to the project design and its limited duration it was not possible to elaborate and include modules for training-the-trainers and training-the-users within the scope of the MedInt project. However these topics are central to a potential follow-up project which is currently under review.

3.2.2. Adaptation of the curriculum to the requirements of different countries

In a second step, the model curriculum was adapted to the national and institutional requirements of the project partner countries. The different national curricula (in translation in Finnish, German and Slovene) are available on the project website. The national curricula should only require minor changes and preparatory work before they can actually be implemented. If the partners manage to acquire funding (through follow-

up projects), the training courses will in some cases represent the first attempts to address the issue of medical interpreting (e.g. in Slovenia) or raise the standards of already existing practices (e.g. Austria, Germany).

3.2.3. Teaching materials

As already outlined above, another aim of the project was to develop teaching materials. A review of materials for the training of healthcare interpreters available on the internet (see project website) was conducted. Materials free of charge and readily available included mostly guidelines for CI situations in general, some of them focused on medical interpreting. Few sources featured video recordings. In brief, only few suitable materials were found. Consequently, the project partners focused on developing different multifunctional materials, which can then be adapted for different other languages and user groups. Materials created include video recordings of mock situations and their respective transcriptions, PowerPoint presentations dealing with different aspects of healthcare interpreting, a catalogue of questions regarding professional ethics, scripts for role plays as well as a proposal for contents of a theoretical course on medical interpreting. All materials (for different languages and language combinations, e.g. Croatian, English, German, Italian, Slovene) can be downloaded from the MedInt website.

3.2.4. Awareness raising and dissemination

As already outlined above, one of the main problems of CI is that interpreters are not seen as “experts”. This, unfortunately, also holds true for medical interpreters. One of the main project goals was therefore to address stakeholders in the healthcare sectors, users as well as the general public to raise awareness of the necessity of employing the services of professionally trained interpreters in healthcare settings. Three work packages focused on awareness raising and the sustainable dissemination of the project results. Promotion and awareness raising mostly meant to establish and maintain contact with relevant stakeholders in the medical sector. Decision-makers of medical institutions were invited to join discussions about different topics regarding the model curriculum. Another work package was dedicated to the dissemination of the project results. Activities consisted of inviting peers to comment on the project results and of discussing them in meetings, conferences etc. Especially noteworthy are a brochure on medical interpreting for stakeholders and users of interpreters as well as a collective volume on medical interpreting (Andres/Pöllabauer 2009). The brochure consists of guidelines for interpreter-mediated communication between patients and healthcare professionals, while the publication contains articles about different topics in healthcare interpreting, such as new approaches to interpreting didactics, communication as a determinant for the quality of treatment and the significance of non-verbal communication, etc. Both the brochure

and the entire collective volume can be downloaded from the project website.

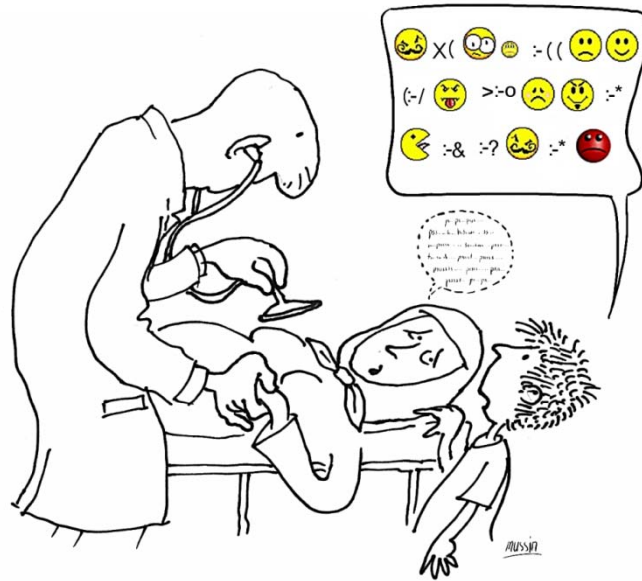


Illustration: Cartoon for the MedInt brochure by kind permission of Muhsin Omurca (<http://www.omurca.de>)

4. Conclusion

Communication in healthcare settings with foreign-language patients is still highly deficient (e.g. Bolden 2000, Angelelli 2004: 21ff., Pöchhacker 2007, Arocha 2009). It is therefore necessary to employ qualified interpreters and to ensure their specific training for their work in this field. There is, however, a prevalent lack of awareness of this amongst service providers as well as users (Hale 2007, Pöchhacker 2007). One of the reasons for this less than perfect communication situation is also lack of funding (Arocha 2009). It is therefore important to draw key actors' and policy-makers' attention to the necessity of improving the status quo. Recruiting professional medical interpreters should become common practice rather than remain the exception.

The MedInt curriculum represented a first step in this direction. The resulting benefits are manifold: with specialised training it will be possible to improve access for foreign-language patients to healthcare service providers. Better communication quality will help medical staff to do their work in a more professional way (helping to overcome communication barriers, which are frustrating and time-consuming) and will thus improve the quality of the treatment. This will enable healthcare service providers to respond to the requirements of an increasingly multiethnic and multilingual patient clientele. Furthermore, training can give lay interpreters the opportunity to professionalise their informally acquired skills and help them to enter the labour market in their host country.

It is hoped that even though the implementation of the training measures was not foreseen within the scope of this project, the ideas developed by MedInt will be taken up and implemented in the near future.

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Biographies

Anita *Ertl* is a Lecturer at the Department of Translation Studies at the University of Graz. Her Master's thesis dealt with slips of the tongue and self-corrections in the simultaneous interpretation of read speeches. She was involved in the MedInt project.



Contact: anita.ertl@uni-graz.at

Sonja *Pöllabauer* is a Lecturer at the Department of Translation Studies at the University of Graz. Her main field of research is Interpreting Studies, with a particular interest in CI. In 2003, she completed her doctoral thesis on interpreting in asylum hearings. She has been involved in research projects on CI and in developing and organising a training course for community interpreters.



Contact: sonja.poellabauer@uni-graz.at

¹ Not all of the references used in this overview of training measures are from the same year. We tried to use the most recent sources of information. For the older publications, where we could not find more recent sources, we verified the correctness of the information given through an Internet search.