Proposed National Standards for Healthcare Interpreter Training Programs

Statement of Purpose
This document presents standards for programs providing initial training/education for spoken-language interpreters who plan to serve in healthcare settings. They are intended to provide guidance to interpreter candidates, trainers, and program administrators regarding the following four areas:

1. The knowledge, skills and abilities in which a candidate should demonstrate competency before assuming the full responsibility for conveying provider-client communications between speakers of different languages.

2. Current best practices in training interpreters.

3. Recommended entry screening into interpreter training programs.

4. Recommended qualifications for interpreter training program instructors.

These Standards for Training may be used for multiple purposes. For interpreter instructors, the Standards may serve as a guide for the evaluation of existing programs of instruction, or as a guide to the design, redesign or expansion of new training programs. They may provide validity and credibility to a program or inform interpreter candidates about the knowledge, skills and abilities they must master in order to pass certification exams. The Standards can serve as a reference point for individuals entering the profession who may want to assess the quality of a training program that they are considering or the adequacy of a program that they have completed. The Standards can also establish a point of reference for employers, so they know what to expect from interpreters who have completed different levels of training, eliminating expensive retraining costs when an interpreter moves from one organization to another.

Scope of Application of Standards

These standards are written to apply to programs training any individual providing interpreter services, whether a dedicated staff interpreter, a dual-role interpreter with other job responsibilities, or a freelance interpreter, since the aim of any interpreter is always understanding in communication between the parties to the encounter. Likewise, they apply equally to interpreters preparing to work face-to-face and those preparing to work remotely.

They are also applicable to trainings offered by employers, community-based organizations and referral agencies, as well as credit or noncredit educational programs in colleges and universities.
that may include additional elements required for the awarding of degrees but that are not specific to the work of the interpreter.

These standards are not designed to include all the knowledge, skills and abilities that an interpreter will ever need in any circumstance presented in healthcare settings. While at the time of this publishing (late 2010), there is not in the United States a clear differentiation in the workplace between entry level, intermediate level and master level interpreters, there is a general sense that some skills (such as solid consecutive conversion skills) should be required of even novice interpreters, while other skills (such as fluid simultaneous interpreting skills) can be developed after an interpreter starts working. These standards focus on skills identified as necessary for all interpreters, even those just beginning to provide services.

In the same vein, this document does not make specific recommendations about the required length of training. The number of class hours necessary to learn the content identified here will depend largely on the prior interpreting experience, specialized knowledge of healthcare, and general level of education that a candidate brings to interpreter training. Our focus has been on the elements of training needed to assure that interpreters are prepared to interpret competently in their initial professional encounters. If for practical reasons the length of instruction is fairly short, it cannot be assumed that preparatory training ends with this initial program: additional training may be needed before trainees are ready to interpret on their own. At the end of such training, candidates should be given a ‘road map’ pointing out the additional competencies they need and how they can get them.

The end point of training is determined not by the clock but by the readiness of the trainee for independent professional service. Therefore preparatory training could be said to have been completed when a trainee has received all the training considered essential for competent independent performance in the role of healthcare interpreter.

Having said that, it is important to keep in mind that, for speakers of some languages of lesser diffusion, especially those spoken by recent arrivals in the U.S., some of the pre-requisites for training or some content included here may not be appropriate. When literacy is not widespread in the culture, when dictionaries and other tools do not exist, when considerable dialect variation exist but terminologies and concepts for healthcare do not, programs must be flexible in order to meet the specific needs of particular linguistic groups. In some cases, instruments for testing language proficiency may not exist, and potential interpreters may have limited formal education in the Western sense. Instructors will have to make adjustments as needed in order to best prepare interpreter candidates for employment under these circumstances.

**Background/ History of NCIHC**
The National Standards for Healthcare Interpreter Training Programs were developed by the Standards, Training and Certification Committee of the National Council on Interpreting in Health Care (NCIHC), with continuous input from interpreters and interpreter trainers from around the country, and with guidance from an Advisory Committee of experienced interpreter trainers. They represent the fourth of five steps that the NCIHC, in the year 2000, agreed were necessary to standardize the expectations that the health care industry and patients should have of
interpreters and to raise the quality of health care interpreting. This five-step strategy for the advancement of the profession of healthcare interpreting included:

1. Agreement on the role of the healthcare interpreter (completed in 2001)
4. National Standards for Training Programs
5. National Certification

When the NCIHC first met in 1994, formal training for interpreters in health care was uncommon. When this five-step development plan was undertaken in 2000, training was becoming available in some places in the U.S., largely in shorter courses sponsored by community-based organizations or healthcare facilities seeking to train their staff. Over the past decade, the availability of training for health care interpreters has increased significantly, spreading to community colleges and universities in many more parts of the country. Initial language assessment tests are also emerging and continuing education opportunities are being developed.

However, the differences among programs are vast. Trainings may last two hours or 200. Some cover only the Code of Ethics, whereas others focus principally on medical terminology. Still other programs incorporate interpreting theory and skill-building modules. Programs are taught in English only, taught in English with language-specific practice, or taught bilingually to interpreters of one specific language pair. Classes meet in person, over the telephone, or over the internet. Clearly no single course or any one approach will meet the training needs for interpreters in all parts of this country. However, whatever content, approach or methodology is used in a training program, it must ensure that, upon completion of the program, the trainee has acquired the essential knowledge and skills to function competently as a healthcare interpreter. For this reason, the NCIHC embarked in 2010 on the development of the National Standards for Healthcare Interpreter Training Programs.

Development Process
The NCIHC Standards, Training & Certification Committee developed these standards using the following process.

1. Review existing knowledge
   The STC began by asking what was already known about: setting standards for training in other fields, effective methods of training interpreters, and healthcare interpreter competencies. A team of consultants was hired to produce a background paper which included a review of the literature and of ten diverse healthcare interpreter training curricula. The Committee also conducted a series of focus groups around the country.

2. Form an Advisory Committee
   A Project Advisory Group was formed, including experts with extensive experience in different fields relevant to the training of interpreters. They were selected for their expertise in the development of curricula in interpreter training and/or the education/training of interpreters. This group met twice, first in April 2010 to review the
results of the previous step, and later in November 2010 to review feedback to the draft standards and make recommendations for the final standards.

3. Draft Standards
   The STC drafted an initial version of the standards, based on the information gathered.

4. Seek feedback from interpreters, trainers and administrators
   Two national on-line surveys – one for interpreters and one for trainers – were used to obtain feedback on the draft standards.

5. Revise and finalize the Standards
   The draft Standards were finalized in December 2010, taking into account input from the Advisory Committee and the on-line survey results.

6. Disseminate the Standards
   The Standards have been sent to interpreters, trainers, educational institutions, and employers via website, email and hard copy.
Healthcare interpreting

Healthcare interpreting is understood as any interpreting that is performed in settings where the communication concerns the physical or psychological well-being of an individual (and his or her family) who is being examined, treated, tested, counseled, educated, and in any other way comes into contact with a person or persons trained in the broad field of health care, including medicine, nursing, pharmacy, dentistry, physical and occupational therapy, etc., as well as communications regarding admissions, payments, ordering meals, pastoral care, etc. that take place in healthcare settings. It does not necessarily include worker’s compensation interviews, police interviews, etc. that may take place in such an environment but are not directed at the well-being of the client or patient, communications initiated by the client or patient asking questions, providing a history, deciding on a course of treatment, etc.

These standards address content areas and methods of instruction; standards and processes for screening and admission to training; qualifications of instructors, the nature and quality of resources (such as reference and self-instruction materials), and opportunities for on-the-job or internship experiences and continuous professional development.

Standards for Content of Instruction (Knowledge and Skills)

I. Programmatic Standards
   A. Operational Policies
      Standard: Programs will operate in an open and transparent manner.
      1. Program description, publications, announcements, and advertising will accurately reflect the program offered.
      2. Program will provide opportunities (e.g. orientation session, pre-course communication) for prospective students to ask questions before enrolling.
      3. Information on admission requirements, completion/graduation requirements, tuition, and fees will be available to prospective students.
      4. Policies and processes for student withdrawal and for refunds of tuition and fees will be available to students.
      5. Records will be maintained regarding student admission, enrollment and achievement.

   B. Program Design and Curriculum
      Standard: Programs will have an explicit and reviewable curriculum.
      1. The program design will:
         a. identify program goals and learning objectives consistent with the knowledge and skills outlined in Section II Program Content Standards below and the National Code of Ethics and Standards of Practice for Interpreters in Health Care;
         b. follow a plan that provides evidence of appropriate learning experiences and curriculum sequencing to develop the competencies necessary for graduation, including appropriate instructional materials, classroom presentations, discussions, demonstrations, community exposure, and supervised practice;
         c. integrate background knowledge, theory, skill development and assessment;
d. provide a student-to-teacher ratio that will facilitate the achievement of the stated program goals and learning objectives;
e. provide students with ready access to course materials.

2. The curriculum will be in written form and include:
   a. learning objectives
   b. content
   c. instructional methods
   d. expectations of students
   e. training materials
   f. student assignments
   g. assessment criteria

3. Practice and reference materials will be made available in the working languages of the students as much as possible.

4. Supervised practicum will be an integral part of the educational program. The experience will provide the student with the opportunity for carrying out professional responsibilities under appropriate supervision and professional role modeling. The practicum will be:
   a. supervised by qualified personnel;
   b. completed within a reasonable time frame in order to ensure continuity of application of academic concepts;
   c. conducted in settings equipped to provide application of principles learned in the curriculum and appropriate to the learning needs of the student;
   d. formally evaluated and documented by the practicum supervisor, and shared with the student.

C. Entry Requirements / Screening

Standard: Programs will screen candidates prior to entry into the program to maximize the likelihood that they will be able to successfully complete the program. Exceptions to these standards may be made due to the particular circumstances of a given language community or the goals of the specific training program.

1. Students will be at least 18 years of age.
2. Students will have at a minimum a high school diploma, GED, or country-of-origin high school equivalent.
3. Students will be able to demonstrate a level of oral fluency in their working languages that enables them to converse in a culturally appropriate fashion to ensure the meaning of the message is conveyed accurately and completely (equivalent to ILR Level 3 or ACTFL scale Advanced High).
4. Students will be literate in their working languages, with the exception of those languages in which the written form is not in common use.
5. Students will have had life experiences either in the countries and/or in cultural communities in which their working languages are spoken.
6. Students will have basic health literacy.
D. Instructor Qualifications

Standard: Teaching teams will collectively have the academic and experiential qualifications and professional background appropriate to meet program objectives.

1. Teaching teams will have the knowledge, skills and attitudes needed to work effectively in cross-cultural settings.
2. Teaching teams will have the knowledge, skills and attitudes needed to facilitate a positive and respectful learning environment.
3. At least one member of the teaching team, preferably the lead instructor, will have significant experience as a healthcare interpreter.
4. At least one member of teaching teams, preferably the lead instructor, will be competent in adult education techniques, either through study or proven track record, and be able to apply them to instruction, assessment, classroom management, strategies to encourage participation and approaches to active learning.
5. Instructors will be able to incorporate into their instructional methods the diverse learning and communication styles of their students.

E. Lead Instructor Responsibilities

Standard: Lead instructors will have the following responsibilities:

1. Instructors will remain up-to-date on developments in adult pedagogy and healthcare interpreting, (e.g. Code of Ethics revisions, Standards of Practice revisions, legislative changes, certification efforts).
2. If subject matter experts are used, the knowledge imparted will be at a level that is appropriate to achieve the learning objective.
3. Subject matter experts will be supervised by the lead instructor to assure
   a. appropriate register of presentation;
   b. application of content to interpreting;
   c. appropriate teaching methods.
4. Lead instructors will be able to work with subject matter experts to ensure the effectiveness of the presentations.

F. Program Evaluation

Standard: The program will have an ongoing system for evaluating its effectiveness (e.g. student feedback, teaching team debriefing and subsequent employers).

G. Assessment of Students

Standard: The program will provide formative and final assessments.

1. The content and methods of assessment will be consistent with the objectives and competencies described for the educational program.
2. Ongoing formative assessments will be employed to provide students with timely indications of their progress.
3. At the conclusion of the program there will be a formal assessment of knowledge and performance to determine whether the student has met the identified exit criteria.
II. Program Content Standards
   A. Standard: The program will provide essential understanding of interpreting and the interpreter's responsibilities and techniques.

   Background Knowledge
   1. Overview of the profession of interpreting: (differences and skills required for each)
      a. Bilingualism vs. interpreting
      b. Interpreting vs. reported speech
      c. Translating vs. interpreting
      d. Summarizing vs. interpreting
   2. Fields of interpreting (e.g. diplomatic interpreting, liaison interpreting, business interpreting, community interpreting [including judicial, healthcare, social service, forensic, and educational interpreting]; employment status [dedicated vs. dual role, staff, contract or freelance interpreter])
   3. Overview of the history of healthcare interpreting in the U.S.
   4. Laws, standards and regulations relevant to healthcare interpreting (e.g. Title VI of the 1964 Civil Rights Act, Department of Health and Human Services [DHHS] Standards for Culturally and Linguistically Appropriate Services [CLAS], The Health Insurance Portability and Accountability Act of 1996 [HIPAA], The Joint Commission [TJC])
   5. Media of interpreting (e.g. face-to-face, remote [telephonic, video])
   6. The purpose and functions/responsibilities of the healthcare interpreter
   7. Modes of interpreting in health care
   8. Liability

   Essential understanding of language and communication issues
   9. Language and communication elements (e.g. regional and social dialects, style, register, discourse; literal and figurative language; idiomatic and frozen language; meaning and sense; literalness vs. accuracy; paraphrasing; power dynamics; negotiation of meaning; conversation vs. interviewing)
   10. Cultural elements of language (e.g. forms of address; politeness markers; turn-taking and interruptions; body language)

   Essential understanding of ethical principles and standards of practice
   11. The general concept of ethics and its application to interpreting in healthcare
   12. Ethical principles consistent with the National Code of Ethics and Standards of Practice for Interpreters in Health Care

   Essential understanding of health systems; terms, concepts and beliefs
   13. Overview of the U.S. healthcare system (e.g. venues, insurance, primary and specialty care; types of hospital services; categories of healthcare workers)
   14. Concepts and terminology in biomedicine
      a. General understanding of biomedicine, the biomedical view of origin of illness, anatomy and physiology, symptoms, common diseases, diagnostic procedures, common medications, treatments, apparatus, legal concepts and terms
b. Overview of common healthcare interview routines and medical decision-making (understanding of the process of differential diagnosis)

Essential understanding of culture and its impact on health and communication
15. Overview of culture
16. Cultural competence
17. Concepts and terminology from the patient’s perspective related to the human body and its functioning, description of symptoms, common diseases and treatments, expectations around insurance, origin of illness, complementary and alternative medicine

B. Interpreting Skills
Standard: The program will provide demonstration of and practice in the necessary skills for interpreting in healthcare.

1. Interpreting protocols: (including the rationale)
   a. Use of the first person
   b. Accuracy
   c. Positioning
   d. Conducting introduction / pre and post-session
   e. Intervention techniques (e.g. use of third person, maintaining transparency)
   f. Managing the flow of communication
   g. Interpreting for groups (e.g. team and family conferences, teaching sessions)
2. Modes of interpreting
   a. Consecutive (as the primary mode)
   b. Simultaneous (basic exposure)
   c. Sight translation
3. Message conversion
   a. Active listening, message analysis, target language rendition
   b. Managing regional dialects
   c. Maintaining/changing register
   d. Memory skills (e.g. chunking, prediction, visualization, note-taking)
4. Culture brokering (e.g. role of culture in communication, cultural competence, recognition and management of cultural misunderstandings)
5. Ethical decision making
6. Advocacy
7. On-the-spot translation or transcription of simple oral or written instructions.
8. Interpersonal skills (e.g. how to work with healthcare professionals/patients, dealing with disrespectful providers or difficult patients, de-escalating conflict)
9. Self-monitoring and self-assessment
10. Self-care: physical safety and emotional well-being

III. Instructional Methods Standards
Introduction
When training adult learners, it is important to select the most appropriate instructional methods. This section provides best practices informed by the field of adult education and based
on the insights of highly successful trainers. There is no single model for training new interpreters; shorter community based programs and longer academic programs vary widely in terms of curriculum, contact hours, scope, face-to-face vs. distance learning, cost and what is awarded after successful completion (anything from a certificate to a graduate level degree). Regardless of the training format, it is important to utilize effective instructional methods which include: 1) interactive and guided-practice strategies, 2) clearly stated learning objectives, assessment expectations and feedback, 3) instructional methods and activities reflective of different learning styles and backgrounds, and 4) instructional methods that utilize varied modalities.

1. **Interactive and Guided-Practice Strategies**

Preparing bilinguals to be practicing interpreters requires more than the presentation of theory and protocols. It calls for the careful integration of instructional methods such as lectures, readings, guest speakers with discussions and other interactive techniques that draw upon students’ own experience and challenge them to internalize the content and develop skills.

2. **Clearly stated learning objectives, assessment expectations and feedback**

Adult learners need to know what to expect. Since shorter courses will probably require homework assignments, any such content to be covered in assessments must be clearly indicated. The comparative weight of written assessments (essays, journals, quizzes, tests) and practice assessments (language conversion exercises, role plays, participation in class discussions, shadowing) needs to be clearly stated. Feedback from all instructors needs to be specific and on-going.

3. **Instructional methods and activities reflective of different learning styles and backgrounds**

It is desirable to use a variety of both practical and conceptual teaching techniques to accommodate different learning needs based on the participants’ cultural background, prior educational experience, prior experience with health care and interpreting, level of language proficiency and learning styles (auditory, visual, tactile, reading/writing). It is especially critical for shorter courses to dedicate a significant proportion of their time to interactive, practice-oriented strategies, especially with students who may not have had much formal education. Although academic programs will have more time to devote to theoretical and conceptual content, they must also devote a significant percentage of time to practice (labs, role plays, shadowing and practicum).

4. **Instructional methods that represent varied modalities**

Even in a graduate level program, there is never enough contact time to expose students to everything useful. In shorter programs it is even more important to carefully integrate knowledge and skills. Teaching techniques that increase the learners’ sense of purpose and participation, such as presentation methods, skill-building exercises, guided consecutive interpreting practice, critical thinking analysis, structured feedback, self-directed study

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1 Some institutions may offer courses on translation and/or interpreting theory regardless of the students’ bilingual proficiency levels since there is no reason not to learn about the theory and expectations of a field before being able to competently practice it.
and observation followed by discussion are crucial. It is desirable to have permeable boundaries between content and practice. For example, the central concepts of communication management (e.g. knowing how people take turns speaking) can be covered through discovery by watching both successful and unsuccessful exchanges, role play and sharing experiences.

A. Standard: Instruction will be interactive.
B. Standard: Instruction will include a significant amount of guided practice.
C. Standard: Directed feedback from the teaching team will be provided on an ongoing basis.
D. Standard: Instruction will be differentiated according to students’ cultural background, prior educational experience, prior experience with health care and interpreting, and level of language proficiency.
E. Standard: A variety of teaching methods will be utilized, including 1-7 (and 8 when a practicum is included):

1. Presentation methods  
   Examples of best practices  
   a. Interactive lectures  
   b. References and links to resources  
   c. Readings  
   d. Guest presenters – practitioners, working interpreters  
   e. Student presentations

2. Skill building exercises (for conversion accuracy)  
   Examples of best practices  
   a. Message conversion exercises (uni-directional)  
   b. Message analysis exercises such as conversational analysis, text analysis, error analysis, back translation  
   c. Memory exercises  
   d. Note taking exercises  
   e. Terminology building exercises

3. Guided practice of consecutive dialogue interpreting  
   Examples of best practices  
   a. Behavior rehearsal through role plays – scripted and unscripted, progressive  
   b. Simulations with invited practitioners, standardized patients  
   c. Supervised practicum or internship  
   d. Video/audio recording

4. Critical thinking analysis for decision-making  
   Examples of best practices  
   a. Case studies  
   b. Ethical dilemmas/scenarios  
   c. Application of code of ethics  
   d. Guided discussions
e. Experiential scenarios brought by students (experience sharing)

5. Structured feedback
   Examples of best practices
   a. Instructor to trainee: in class, internship/practicum
   b. Peer to peer
   c. Self-evaluation
   d. Coaching (online, in-person, video) – language coach, interpreting coach
   e. Back interpreting for languages where there is no language coach

6. Self-directed study
   Examples of best practices
   a. Development of personal glossaries
   b. Language conversion practice
   c. Homework assignments
      i. report on self critique of performance
      ii. observational reports

7. Observation followed by discussion
   Examples of best practices
   a. Videos
   b. Audio recordings
   c. Shadowing
   d. Field trips such as a visit to a hospital

8. Practicum
   a. Supervised practicum will be an integral part of the educational program. The experience will provide the student with the opportunity for carrying out professional responsibilities under appropriate supervision and professional role modeling.
   b. To ensure continuity of application of academic concepts, the practicum will be completed within a reasonable time frame.
   c. Practicum will be conducted in settings equipped to provide application of principles learned in the curriculum and appropriate to the learning needs of the student.