INTERNATIONAL MEDICAL INTERPRETERS ASSOCIATION
Leading the advancement of professional interpreters

MEDICAL INTERPRETING STANDARDS OF PRACTICE

Developed by:
International Medical Interpreters Association &
Education Development Center, Inc.

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For more information on the development of the standards, contact:

María-Paz Beltrán Avery
Education Development Center, Inc.
55 Chapel Street
Newton, MA 02458-1060

The Standards of Practice are available online at no cost at:
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International Medical Interpreters Association
750 Washington Street, NEMC Box 271
Boston, MA 02111-1845
E-mail: info@imiaweb.org

To Raquel Cashman,
friend and colleague, whose concern for excellence,
justice, and harmony guides this work.

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Acknowledgements

Subcommittee on Standards of Practice

Margarita Battle - Coordinator of Interpreter Services, Massachusetts General Hospital

Eduardo Berinstein - Director of Interpreter Services, Children's Hospital

Raquel Cashman - Former Director of Interpreter Services, Boston City Hospital

Jane Crandall - Coordinator of Interpreter Services, Beth Israel Hospital

Maria Durham - Director of Interpreter Services, University of Massachusetts Medical Center

María-Paz Beltrán Avery - Director, Medical Interpreter Training Project, EDC

Acknowledgement to the participants of the DACUM Process

Margarita Battle - Massachusetts General Hospital

Eduardo Berinstein - Children's Hospital

Alm Raa Chhan – Freelance medical interpreter

Jane Crandall - Beth Israel Hospital

Maria Durham - University of Massachusetts Medical Center

Gregory Figaro – Freelance medical interpreter

Carla Fogaren - Good Samaritan Medical Center

Alicia D. Hart - Brigham and Women's Hospital

Tot Nguyen – Freelance medical interpreter

Saly Pin-Riebe - Department of Mental Health, Refugee Assistance Program

Margarita Restrepo - Beth Israel Hospital

Raquel Santander-Nelson – Freelance medical interpreter

Joyce Malyn-Smith - Education Development Center, Inc., DACUM Facilitator

Preface

The International Medical Interpreters Association is very proud of its legacy as a pioneer in the medical interpreting field. The *Medical Interpreting Standards of Practice* document was the first set of standards to be developed in the field of spoken language interpreting in medical settings, and remains a vital evaluation and competency tool for professional interpreters all over the country, delineating core performance standards and competencies required of a 'competent' interpreter. These standards were developed using the DACUM process that was done by Education Development Center, which is a well known and validated method of occupational analysis for professional and technical jobs. It was developed with the intention of being the grounding work needed for medical interpreter certification. Adopted on a national level at the 4th National Working Group conference in Seattle, WA, May 17th -- 19th, 1998; see http://www.diversityrx.org/HTML/MOASSA.htm, it became widely used across the country and even abroad. Since the development of the Medical Interpreting Standards of Practice, other standards have been developed: notably the American Society for Testing and Materials (ASTM) Standards in 2001, the California Healthcare Interpreters Association (CHIA) Standards in 2002, and the National Council for Interpreting in Health Care (NCIHC) Standards in 2005, each with a different perspective and approach that has enriched the understanding of the practice of this profession.

While these organizations worked hard to develop their standards, we take this opportunity to focus on the continuous dissemination, implementation and enforcement of our standards for the profession. The IMIA noted recently that although our standards are most appropriate as an evaluation tool, many who have entered the field are not familiar with these Standards of Practice or have not been tested or evaluated by this tool. Several training organizations already utilize these standards as a teaching tool, and we encourage and promote its use as a final evaluation tool as well. Each IMIA member receives a copy when he/she joins the organization. In the absence of, and as interpreters wait for national medical interpreter certification, the profession will benefit from IMIA workshops to teach interpreters about this tool, and also to teach interpreter trainers on how to utilize this tool for performance evaluation. The IMIA wishes to collaborate with other organizations that work with, train, and hire medical interpreters who are ready to uphold the performance standards delineated in this document. We also welcome the feedback of those that use this tool on a regular basis and letters of endorsement to these standards.

The main obstacles to dissemination were the cost and availability of the standards. Therefore, the IMIA Board of Directors voted in 2006 to make this document available in pdf format and free of charge. Further dissemination will also promote adherence to the medical interpreting standards required to ensure patient safety. It is with this vision that the IMIA presents this document to all professional medical interpreters and other stakeholders in the field. I also take this opportunity to state that each of the four standards presented above are equally important to interpreters, who will benefit from becoming familiar with each one of them. These standards are now being translated into several languages to facilitate international dissemination.

Sincerely,
Izabel S. Arocha, M.Ed.
IMIA President
August 2007

Preface from October 1998 printing

The document, *Medical Interpreting Standards of Practice*, has received national and international recognition since it was first adopted in 1995. In May of 1998, the National Council on Interpretation in Health Care (NCIHC), a group of interpreters, managers of interpreter services, providers, educators, trainers, and other concerned entities committed to promote and support culturally competent medical interpretation to ensure equitable access to quality health care, made the following statement:

> The National Council on Interpretation in Health Care has reviewed the *Medical Interpreting Standards of Practice* and has voted to advocate use of this document as the best statement of standards for medical interpreters presently available. The Council congratulates the International Medical Interpreters Association and Education Development Center, Inc., co-authors of the document, on their valuable efforts in its development and encourages other organizations to join in offering feedback on this evolving work.

The most frequent and consistent feedback we have received is that the document provides a comprehensive and coherent picture of the tasks and skills required on the job and offers a unifying and consistent set of expectations for performance across institutions. In addition, the *Standards* have provided a framework for the development of self-assessment and evaluation tools. Many managers of interpreter services provide a copy of the *Standards* to all new hires, onstaff or free-lance, and use it as a basis for ongoing professional development activities. It has also proved useful in trainings designed to prepare health care providers on how to work with interpreters.

Much work still needs to be done in continuing to evolve a set of standards that is inclusive and culturally responsive to the specific contexts and needs of the many cultural/linguistic communities that depend on interpreter services to access quality health care. To this end, the International Medical Interpreters Association and Education Development Center, Inc. (EDC) are committed to revising the *Standards.* However, we chose not to do so for this second printing realizing that there was still much that we needed to learn and explore as we struggled to respect and affirm the deep and often out-of-awareness differences represented in our communities. Let me use a simple example to illustrate the work of revision that is still ahead of us. Under task A-7 "Encourage direct communication between patient and provider, one of the indicators of is: "Uses the first person ('I') form as the standard…." It was aptly pointed out by participants representing non-European languages and cultures at the May 1998 meeting of the NCIHC that this indicator set inappropriate guidance for cultural/linguistic communities for whom the form of address is

inextricably tied to such relational factors as the respective ages, gender, and/or status of the speakers. This criticism highlighted a broader issue. How do we set high standards of performance while accepting that there are different culturally appropriate ways of achieving them?

Another area that requires further deliberation is Duty C: Ethical Behavior. The intersection of ethical behavior and culture is a difficult one but one that cannot be ignored. Again, the discussions at the meeting of the National Council on Interpretation in Health Care highlighted two especially sensitive tasks under this duty: confidentiality and discrimination. Important philosophical and practical questions about the boundaries of the role were raised. The dialogue that ensued and that continues searched for consensus built on constructing a new vision of what can be in the triadic interaction between patient, provider, and interpreter.

Finally, I would like to publicly acknowledge the leadership of some key individuals in getting us to where we are. A long time ago, the idea of developing standards for this new emerging profession was a glimmer in the mind of an esteemed and beloved colleague, Raquel Cashman. Raquel, a pioneer in the field, was instrumental in setting up the Subcommittee on Standards. We were saddened that she died before they were completed. Under the presidency of Maria Durham, the *Medical Interpreting Standards of Practice* was approved by the IMIA as its professional standards of practice. Maria championed the dissemination of the standards, providing dynamic and focused leadership in getting the critical constituencies – hospitals, providers, departments of public health, hospital accrediting bodies – to pay serious attention to them. I had the pleasure of working closely with a deeply committed, caring group of individuals who formed the Subcommittee on Standards – Raquel Cashman, Maria Durham, Margarita Battle, Jane Crandall Kontrimas, and Eduardo Berinstein. There were times when we wondered if we would ever agree on anything but the results speak for themselves. Under the leadership of the IMIA president, John Nickrosz, the *Medical Interpreting Standards of Practice* was endorsed by the NCIHC.

I would also like to thank the many individuals across the country and the world who have taken the time and the interest to join us as “critical friends.” They are too many to name but I trust they know who they are. Their wisdom has strengthened these standards. We hope to continue our journey with them by our side and find other ‘critical friends” to join us along the way.

María-Paz Beltrán Avery, PhD
Education Development Center, Inc.
October 1998

Introduction

The primary function of the medical interpreter is to make possible communication between a health care provider and a patient who do not speak the same language. In performing this function, the medical interpreter's commitment is to the goals of the clinical interview. The presence of the interpreter makes it possible for the patient and provider to achieve the goals of their encounter as if they were communicating directly with each other.

The use of a third person to communicate between providers and patients who do not speak the same language has been going on for a long time. Unfortunately, however, this practice has been fraught with many misconceptions about the nature of the interpreter-mediated communication. One of the commonest misconceptions is that anyone with any level of bilingualism is capable of providing effective interpretation. Thus, we see the continued use of children, family members, and auxiliary staff (e.g., clerical, custodial, housekeeping) as interpreters. Even an equal level of fluency in two languages, however, is a prerequisite but not a sufficient skill for interpreting. In addition, the interpreter must be able to convert messages uttered in one language into the appropriate sociolinguistic framework of another language. And unlike conference interpreting, in which an interpreter converts into only one language, the medical interpreter must be able to make the conversion from and into two languages.

Another common misconception is that communication in health care settings is a relatively simple task in which much of the information can be gathered by 'scientific, objective' means and much of the meaning conveyed by gestures (de Jongh, 1992). The reality is that the clinical interview relies heavily on language for much of its information gathering.

These misconceptions are further exacerbated when the parties most affected by the interpretation lack the skills to judge its quality. Neither the patient nor the provider can monitor the accuracy and completeness of the interpretation, since each speaks only one of the languages. Neither has a way of knowing whether the interpreted message contained omissions, additions, interpreter opinions, guesses, or other distortions that could result in serious miscommunication.

It is for these reasons that standards of practice in medical interpreting are critical. Standards of practice provide a defining baseline of expectations for consumers and practitioners. They provide a measure against which individual interpreters can monitor the quality of their own performance. They establish criteria for certification and/or entry into the profession, ensuring quality and consistency of performance.

The Development Process

The standards of practice presented here were developed through the use of a modified DACUM (Developing a Curriculum) process. The DACUM process is a method of occupational analysis for professional and technical jobs. Through this process, expert workers are engaged in describing and defining the tasks that make up their job, including the specific knowledge, skills, tools, and attitudes needed to perform these tasks correctly.

Twelve experienced medical interpreters, members of the International Medical Interpreters Association, met in a two-day workshop with a DACUM facilitator to generate the universe of major duties, responsibilities, and tasks performed within their medical interpreter roles. The group was composed of coordinators of interpreter services, staff interpreters, and freelance interpreters, representing six linguistic groups. Each had at least three years' paid experience at major teaching hospitals, community health centers, and/or other health facilities. The data compiled covered a broad range of tasks, reflecting the different positions held by the members of the group. Thus, in addition to those tasks specific to the interpreting encounter itself, broader duties such as educating consumers on the use of interpreters, setting up delivery systems, and billing for services were also included. Using this data as a foundation, the Subcommittee on Standards of Practice then developed standards of practice focusing only on the competencies specific to the interpreting encounter.

In developing these standards of practice, the subcommittee faced a major challenge: setting standards that uphold excellence in the accuracy and completeness of interpretation while responding to the immediate, urgent need for interpreters within linguistic groups in which the number of individuals proficient in both English and another language is limited. This challenge was met by differentiating between two types of skills: linguistic proficiency and interpreting skills. Once this distinction was made, it was possible to conceptualize and define a broad range of interpreting skills that could be used as strategic interventions to ensure accuracy and completeness while accommodating differing levels of linguistic proficiency. Thus, at one end of the linguistic continuum are those individuals whose mastery of the two languages and breadth of understanding of the content ensure that they have little need to interrupt speakers, whether for retention or clarification, and whose depth of knowledge of linguistic variations virtually eliminates the need to pause to search for the appropriate form of expression. At the other end of the continuum are those individuals who are somewhat limited in their comprehension and depth of expression. However, with supportive skills such as the ability to ask for clarification, manage the flow of communication, and be aware of their personal limitations, such interpreters can maintain accuracy and completeness in their interpretations.

The Standards of Practice

The Medical Interpreting Standards of Practice are founded on the premise that an interpreter's primary task is interpretation, that is, the transformation of a message expressed in a source language into its equivalent in a target language, so that the interpreted message has the potential for eliciting the same response in the listener as the original message (Seleskovitch, 1978; Cokely, 1988; Downing and Swabey, 1992). To be able to do this, the interpreter must not only be fluent in both the source and target languages but must also have the skills and knowledge base to be able to comprehend the message quickly in the source language and just as quickly re-express it in the target language.

If all that the provider and patient need to achieve the goals of the clinical encounter is this linguistic conversion, then the interpreter's role is fulfilled simply by providing such a conversion. The standards, however, go beyond the skills of conversion and recognize the complexities of interpretation and the clinical interview. The medical encounter is a highly interactive process in which the provider uses language (the provider's and the patient's) as a powerful tool to understand, evaluate, and diagnose symptoms (Woloshin et al., 1995) and to mutually inform and instruct. The interpreter, therefore, cannot simply be a 'black box converter" but must know how to engage both provider and patient effectively and efficiently in accessing the nuances and hidden socio-cultural assumptions embedded in each other's language, which could lead to dangerous consequences if left unexplored.

These standards of practice also recognize the importance of the medical encounter in establishing a therapeutic connection between provider and patient. The formation of a therapeutic relationship is especially difficult when parties cannot communicate directly, and it becomes even more complex when different culturally based belief systems are involved. A competent interpreter can mediate these barriers by attending not only to the linguistic but also to the extra-linguistic aspects of communication.

The Medical Interpreting Standards of Practice are organized into three major task areas: (1) interpretation, (2) cultural interface, and (3) ethical behavior. Following is a brief explanation of each of these task areas.

A. Interpretation

As noted earlier, the primary task of the interpreter is to interpret, that is, to convert a message uttered in a source language into an equivalent message in the target language so that the intended recipient of the message responds to it as if he or she had heard it in the original (Seleskovitch, 1978; Cokely, 1988; Downing and Swabey, 1992). The primary test of a competent interpreter, therefore, is the accuracy and completeness of the interpretation.

Although the main task of the interpreter is to interpret, there are other complementary skills that an interpreter must possess, although they are not necessarily used in every encounter. The standards of practice in this section focus on both the skills of straight interpreting and these complementary skills. The skills in this section can be organized around five subtasks:

1) ***Setting the stage***. The role of the professional interpreter is still new and largely unknown in the medical setting. For this reason, it is important for interpreters to set clear expectations of their role at the very start of the triadic (provider-patient-interpreter) encounter, stressing in particular the elements of accuracy, completeness, and confidentiality. It is also important in the early moments of the triadic encounter for the interpreter to attend to other concerns, such as arranging the spatial configuration of the parties in the encounter, addressing any discomfort a patient or provider may have about the presence of an interpreter, or assessing the linguistic style of the patient, keeping in mind at all times the goal of establishing a direct relationship between the two main parties.

2) ***Interpreting***. The most basic task of the interpreter is to transmit information accurately and completely. Therefore, interpreters must operate under a dual commitment: (1) to understand fully the message in the source language, and 2) to retain the essential elements of the communication in their conversion into the target language. Interpreters whose linguistic proficiency (in terms of breadth and depth) in both languages is very high and who have a solid working knowledge of the subject matter are more likely to be able to make the conversions from one language to another without needing to ask for much clarification Those whose linguistic proficiency is limited can use appropriate strategies to ensure that they themselves understand the message before they make the conversion and that all the pertinent information has been transmitted.

3) ***Managing the flow of communication.*** In the interest of accuracy and completeness, interpreters must be able to manage the flow of communication so that important information is not lost or miscommunicated. Interpreters may also have to attend to the dynamics of the interpersonal interaction between provider and patient, for example when tension or conflict arises. The role of the

interpreter, however, is not to take responsibility for the actions of the two parties but rather to assist in establishing a communication process that allows the parties to work things out for themselves.

4) ***Managing the triadic relationship.*** The introduction of a third party into the medical encounter generates dynamics that are inherent in triadic interactions. A primary characteristic of a triadic, as opposed to a dyadic, relationship is the potential for the formation of an alliance between two of the three parties. Because the interpreter is the party to whom both provider and patient can relate most directly, both have a propensity to want to form an alliance with the interpreter. The provider and patient often exhibit this tendency by directing their remarks to the interpreter rather than to each other, which leads to the 'tell the patient/doctor' form of communication. Thus, the interpreter must work at encouraging the parties to address each other directly, both verbally and nonverbally.

   The natural tendency of both providers and patients is to perceive interpreters as an extension of either their own world or the other, rather than as partners in their own right, with their own role responsibilities and obligations. For patients, the desire to form an alliance with the interpreter is heightened because they are likely to perceive the interpreter as understanding not only their language but also their culture. This perceived cultural affinity often leads patients to act as if the interpreter were there as their friend and advocate. For providers, the danger lies in assuming that the interpreter is part of their world and therefore expecting that the interpreter can and should take on other functions, such as obtaining a medical history. On the other hand, when providers assume that interpreters are extensions of the patient's world, they tend to dismiss the importance of their role and ascribe inferior status to their work.

   As professionals in their own right, in the interpreter-mediated encounter interpreters owe their allegiance to the therapeutic relationship and its goals of quality health care. Their commitment is to support the other two parties in their respective domains of expertise – the provider as the technical expert with the knowledge and skills in medicine and health care, and the patient as the expert on his or her symptoms, beliefs, and needs. The provider offers informed opinions and options, while the patient remains the ultimate decision maker in terms of treatment. The role of the interpreter is not to take control of the substance of the messages but rather to manage the process of communication.

5) ***Assisting in closure activities.*** The responsibility of the interpreter in the closing moments of the clinical encounter is to encourage the provider, when necessary, to provide follow-up instructions that the patient understands and will therefore be likely to follow. In addition, the role of the interpreter is to make sure that the patient is connected to the services required (including additional interpreter services) and to promote patient self-sufficiency, taking into consideration the social context of the patient.

B. Cultural Interface

Language is not the only element at work in the interaction between providers and patients who speak different languages. The meaning inherent in the messages conveyed is rooted in culturally based beliefs, values, and assumptions. According to the linguists Whorf (1978) and Sapir (1956), language is an expression of culture and the way in which culture organizes reality. The interpreter, therefore, has the task not only of knowing the words that are being used but of understanding the underlying, culturally based propositions that give them meaning in the context in which they are spoken. Interpreting in the health care arena requires the interpreter to understand the ways in which culturally based beliefs affect the presentation, course, and outcomes of illness as well as perceptions of wellness and treatment.

If provider and patient share similar assumptions about medicine and its positivistic, scientific principles, it is more likely that the interaction will go as smoothly as if they were speaking the same language. In such a case, the interpreter simply has to make the conversion from one linguistic system into the other; the layers of meaning will automatically be understood.

As the dissimilarities between providers' and patients' assumptions increase, however, literal interpretations become inadequate, even dangerous. In such cases, to convey the intent of the message accurately and completely, the interpreter may have to articulate the hidden assumptions or unstated propositions contained within the discourse. Here the role of the interpreter is to assist in uncovering these hidden assumptions and, in doing so, to empower both patient and provider with a broader understanding of each other's culture.

Another major cultural linguistic problem occurs when a speaker uses 'untranslatable' words. 'Untranslatable' words represent concepts for which a comparable referent does not exist in the society of the target language (Seleskovitch, 1978). For example, the concept of bacteria, a living physical organism that is not visible to the naked eye, is a concept that has no equivalent in many rural, non-literate societies. To get the concept across, the interpreter may have to work with the provider to find ways to transmit the essential information underlying this concept.

Interpreters, therefore, have the task of identifying those occasions when unshared cultural assumptions create barriers to understanding or message equivalence. Their role in such situations is not to 'give the answer' but rather to help both provider and patient to investigate the intercultural interface that may be creating the communication problem. Interpreters must keep in mind that no matter how much 'factual' information they have about the beliefs, values, norms, and customs of a particular culture, they have no way of knowing where the individual facing them in that specific situation stands along a continuum from

close adherence to the norms of a culture to acculturation into a new culture. Cultural patterns, after all, are generalized abstractions that do not define the individual nor predict what an individual believes or does. They are simply hypotheses that may be more likely to occur in a member of that culture than in someone who is not a member (Avery, 1992).

C. Ethical Behavior

The role of interpreter, on the surface, appears to be straightforward and uncomplicated. The interpreter is present to convert a message uttered in one language into another. Professional interpreters, however, understand the profound complexities of what appears to be a simple task. In fact, even in the simplest of encounters, the interpreter may need to recognize and address a series of dilemmas.

In face-to-face, interpreter-assisted, medical encounters, the very presence of the interpreter changes the power dynamic of the original dyadic relationship between patient and provider. In a very significant way, the interpreter holds tremendous power, often being the only one present in the encounter who understands both languages involved. In addition, the interpreter enters the interaction as an independent entity with individual beliefs and feelings. Both the patient and the provider have to be able to trust that the interpreter will not abuse this power. They need to trust that the interpreter will transmit faithfully what it is they have to convey to each other and not the interpreter's own thoughts. They also need to trust that the interpreter will uphold the private and confidential nature of the clinician-patient relationship. "*It is the function of a code of ethics to guide the interpreter on how to wield that power*" (Edwards, 1988, p.22). A code of ethics provides guidelines and standards to follow, creating consistency and lessening arbitrariness in the choices interpreters make in solving the dilemmas they face (Gonzalez et. al. 1991).

Potential Uses

These standards of practice can be used for several purposes.

1. ***Guideposts in the development of educational and training programs.***
Too often educational and training programs are developed without clearly articulated connections to performance expectations in the field. These standards of practice were developed by practitioners with years of experience in the field who are also responsible for on-the-job training and supervision. As such, they reflect a comprehensive view of the basic skills and knowledge required on the job. Used as guideposts, these standards can serve as the foundation of course and/or training objectives.

2. ***Evaluation tool.***
Standards of practice can serve as pre-selected criteria against which the performance of students, trainees, or practitioners in the field can be evaluated. Both students and instructors can use the indicators as a formative evaluation tool in the academic or training setting to provide ongoing feedback on the skills students need to work on, the areas in which they have achieved mastery, and the tasks they still need to learn or improve. As an outcome measure, these standards can be used to determine whether or not a student has achieved mastery of the required skills. At the workplace, they can be used both to assess the level of competency at the point of entry and as a supervisory tool to provide ongoing feedback. Interpreters can also use these standards to continue to monitor and assess their own performance individually.

3. ***Preparation of health care providers to work with interpreters.***
These standards offer health care providers with a comprehensive overview of what to expect from interpreters.

4. ***Foundation for a certification examination.***
Since these standards represent a comprehensive articulation of the basic skills and knowledge a competent interpreter must master, they can also be used as a basis for a performance-based portion of a certification examination. For example, the certification candidate could be placed in a role play designed to include both a routine interpreting interaction and an unanticipated problem. The role play would require the interpreter to demonstrate in an integrated way the application of various skills to address the situation in an appropriate, professional manner.

Looking to the Future

Medical interpreting as a profession is in its infancy. The members of the Subcommittee on Standards of Practice recognize that this document represents a first step in what needs to be an ongoing, developmental process. It is expected that by simultaneously setting clear, high standards of performance and creating rigorous training and academic programs, a marked increase in the quality of interpreting in the health care arena will follow. This increase in quality will in turn lead to a full recognition of competent, professional interpreters, who will be accorded the status and compensation commensurate with the critical nature of their work; and it will also create the demand for higher-level training and academic programs.

Medical Interpreting Standards of Practice

Evaluation Method

The rating scale used to evaluate the Medical Interpreting services is the Likert scale, with values from 1-5 for which a person will select the number considered to reflect the perceived quality.

Likert Scale	
5	Fulfills the expectation completely and consistently, with ease and fluidity
4	Fulfills the expectation in a mechanical way
3	Performs the expectation but with hesitation or lack of confidence
2	Performs inconsistently, lapses into behaviors demonstrating lack of mastery
1	Is unable to perform the task; exhibits behavior consistent with lack of mastery

Duty A: Interpretation

A-1 Introduce self and explain role

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. When possible, holds a pre-conference to find out the provider's goals for the encounter and other relevant background information	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not attempt to hold a pre-conference, even when possible
B. Introduces self and explains role briefly and succinctly to provider and patient as follows: • Gives name • Indicates language of interpretation • Checks on whether either provider or patient has worked with interpreter before • Explains role, emphasizing: ✓ Goal of ensuring effective provider-patient communication ✓ Confidentiality ✓ Accuracy and completeness (i.e. everything said by either will be transmitted) ✓ Use of first person form, especially if provider and/or patient are unfamiliar with this • Asks if there are any questions about interpreter's role • Answers any questions	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Gives introduction missing one or more components

Indicators of Mastery		Rating	Indicators of Lack of Mastery	
C.	In the event that a pre-conference cannot be held and/or a full introduction made, at a minimum asks provider to state briefly the goal of the encounter and informs patient and provider that the interpreter is obliged to transmit everything that is said in the encounter to the other party and, therefore, that if either party wishes something to be kept in confidence from the other, it should not be said in the presence of the interpreter	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C.	Does not fulfill this minimum requirement
D.	Establishes and asserts the interpreter's role from the beginning	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D.	Shows uneasiness in establishing and asserting the interpreter's role
E.	Provides a clear and well-paced introduction	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	E.	Provides a confusing introduction with ineffective pacing
F.	Is able to adjust the introduction in response to the demands of the situation	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	F.	Is not flexible to the demands of the situation

Duty A: Interpretation

A-2 Manage the spatial configuration of patient-provider-interpreter to maximize ease and directness of communication.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Is able to hear and see both patient and provider.	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Strains to hear and/or maintain visual contact with either or both parties.
B. Can be seen and heard by both parties	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Cannot be seen and/or heard by both parties
C. Arranges spatial configuration to support direct communication between provider and patient	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Arranges spatial configuration to place the interpreter at the center of communication or otherwise disrupt direct communication
D. Respects the spatial and visual privacy of the patient when necessary (e.g. stands behind a screen during a physical exam), while maintaining, when possible and/or necessary, enough visual contact to “read the patient’s face”	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Chooses a physical location that makes the patient uncomfortable in situations where the patient needs spatial and visual privacy

Duty A: Interpretation

A-3 Maintain the linguistic register and style of the speaker.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. When possible, speaks to the patient prior to the triadic encounter to assess the patient's linguistic register and style (e.g. dialect, formality of speech etc.)	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not assess the patient's linguistic register or style
B. Preserves the register and style of language used in the source language when transmitting in the target language	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Changes the register or style of language used in the source language when transmitting in the target language

Duty A: Interpretation

A-4 Address the 'comfort needs' of the patient in relation to the interpreter with regard to factors such as age, gender, and other potential areas of discomfort.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. When the issue arises, assesses potential areas of discomfort for the patient (e.g., gender or age of the interpreter) and discusses them with the patient	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not assess potential areas of discomfort
B. Is cognizant of body language and/or specific verbalization suggesting discomfort and: • Checks to identify the source of distress • Reassures the patient by providing information about credentials, professionalism, and the ethics of confidentiality • Explains the reality of the situation (e.g., perhaps only one interpreter is available) and tries to put the patient at ease • Offers options to address the discomfort, when available	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Fails to observe signs of discomfort

Duty A: Interpretation

A-5 Select appropriate mode of interpretation (consecutive, simultaneous, sight translation; first or third person)

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Uses the mode that best enhances comprehension and least interrupts the speaker's train of thought, given the demands of the situation	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not use the mode that best enhances comprehension and least interrupts the speaker's train of thought, given the demands of the situation
B. Uses the mode that best preserves accuracy	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not use the mode that best preserves accuracy.
C. If the interpreter is competent in simultaneous mode, uses it when it is important that the speaker not be interrupted (e.g., psychiatric interview, periods of high emotion)	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Does not demonstrate use of alternative strategies to provide accurate and complete interpretation in such cases
D. Can switch from one mode to the other as needed	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Cannot switch from one mode to the other as needed
E. Can explain the reason for the switch, briefly and unobtrusively, if needed.	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	E. Cannot explain the switch briefly and unobtrusively.
F. Uses modes of interpreting in which competence has been attained	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	F. Uses a mode in which competence has not been attained

Duty A: Interpretation

A-6 Accurately transmits information between patient and provider.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Transmits message accurately, re-expressing the information conveyed in one language into its equivalent in the other language, so that the interpreted message has the potential for eliciting the same response as the original	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Transmits message inaccurately so that: 1) the transmitted message is not equivalent to but different from the original; 2) the elicited response does not answer the intended message
B. Transmits message completely (i.e., includes denotative, connotative, and metanotative meaning, taking into account the context, content, function, affect, and register of the original message	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Transmits message incompletely and with improper paraphrasing so that: 1) propositions are missing; 2) function and affect are not conveyed
C. Asks for clarification or repetition of information and/or concepts she or he did not understand or did not completely hear	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Omits, makes up, or inaccurately interprets information and/or concepts she or he did not understand or completely hear
D. Effectively uses mnemonic devices (e.g. note taking, visualization, etc.) to aid retention of information and accuracy of interpretation	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Does not effectively use mnemonic devices to aid retention and accuracy
E. Can explain the ramifications of inaccurate interpreting	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	E. Cannot explain the ramifications of inaccurate interpreting

Duty A: Interpretation

A-7 Encourage direct communication between patient and provider.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Suggests that the patient and provider address each other directly	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not suggest or explain that provider and patient should address each other directly
B. Uses the first person ("I") form as the standard, but can switch to the third person, when the first-person form or direct speech causes confusion *or is culturally inappropriate*	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not use the first-person form as the standard
C. Succeeds in having patient and provider address each other directly	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Fails to stop provider and/or patient from directing their communication to the interpreter
D. When necessary, cues provider and patient to return to direct communication	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Does not cue patient and/or provider to address each other directly when necessary

Duty A: Interpretation

A-8 Ensure that the listener understands the message.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Picks up on verbal and nonverbal cues that may indicate the listener is confused or does not understand	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not pay attention to verbal and nonverbal cues indicating possible confusion or lack of understanding
B. Checks whether clarification is needed by the listener	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not check to see whether clarification is needed
C. If needed, asks the speaker to explain further or to say the same thing using different terminology	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Does not request explanation or further clarification from speaker

Duty A: Interpretation

A-9 Ensure that the interpreter understands the message to be transmitted.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Asks for repetition if message is not understood or not heard, clarifying that it is due to the interpreter's need	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Ignores and omits messages she or he did not understand or hear completely
B. Asks for explanation or asks speaker to say the same thing using other terminology	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Guesses at what the speaker said or meant and transmits this
C. Verifies the meaning the interpreter understood, especially in situations of possible ambiguity	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Does not verify meaning

Duty A: Interpretation

A-10 Manage the flow of communication in order to preserve accuracy and completeness, and to build rapport between provider and patient

Indicators of Mastery		Rating	Indicators of Lack of Mastery	
A.	Manages conversational turn taking so that only one person talks at a time (interpreter can interpret only one voice at a time)	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A.	Does nothing to manage conversational turn taking when people talk at the same time, and so ceases to be able to interpret
B.	Asks the speaker to pause, when necessary, in order to maintain accuracy and completeness	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B.	Does not take the initiative to interpret in a timely manner in order to maintain accuracy and completeness
C.	When necessary, asks the speaker to pause in order to allow the other party to speak	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C.	Does not ensure that each party gets a chance to talk
D.	Asks the speaker to pause in a manner that is least disruptive and most culturally appropriate	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D.	Interrupts the speaker in a manner that is disruptive and culturally inappropriate
E.	Manages the timing of interpretations so that neither party feels or is left out of the communication loop	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	E.	Allows exchanges where one of the parties (either the provider or patient) does not know what is being said for an extended period of time
F.	Clearly indicates when speaking on her or his own behalf	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	F.	Gives no indication when speaking on her or his own behalf

Duty A: Interpretation

A-11 Manage the dynamics of the triad

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Manages the flow of communication to enhance the patient-provider relationship	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not manage the flow of communication
B. Appropriately addresses cultural issues	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Over explains possible cultural issues or ignores them
C. Can assert interpreter's role when necessary	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Cannot assert interpreter's role when necessary
D. Remains low profile when communication is going well and there is no reason to intervene	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Is too obtrusive
E. Keeps personal issues (feelings, biases, opinions) out of the triadic interview	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	E. Interjects own personal issues into the triadic interview
F. Encourages direct communication between patient and provider	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	F. Keeps focus of communication on self
G. Respects and enhances each person's primary sphere of 'power' or expertise (i.e., the patient as an expert on her or his own body with ultimate decision-making power over it; the provider's medical expertise and power based on knowledge that the patient does not have; the interpreter's expertise in understanding the two language systems and converting messages from one language to the other)	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	G. Takes over the role of the patient and/or provider (e.g., tells the patient what to do; makes up or adds symptoms, instructions; gives medical advice; etc.)

Duty A: Interpretation

A-12 Manage personal internal conflict

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Can identify and discuss own personal values and beliefs that may create internal conflict in certain medical situations	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Is not aware of and cannot articulate areas of potential internal conflict
B. Can clearly separate own personal values and beliefs from those of the other parties	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Projects own personal values and beliefs into the situation and as a result loses the meaning the speaker intended
C. Is able to withdraw from situations where strongly held personal values and beliefs may interfere with impartiality	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Continues interpreting even when it may not be appropriate to do so and attempts to impose own values and beliefs on provider and/or patient rather than allowing them to hold and express their own values
D. Can acknowledge potential areas of conflict within self and articulate them prior to start of the interview especially where no other alternatives are available (e.g., be able to say, “I need you to know this topic may be difficult for me but I will try”)	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Does not make explicit potential areas of internal conflict that may interfere with the ability to interpret accurately and completely

Duty A: Interpretation

A-13 Manage conflict between provider and patient

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Remains calm in stressful situations or when there is conflict	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Appears agitated and distressed when there is conflict
B. Acknowledges when there is conflict or tension between provider and patient	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Ignores or dismisses conflict or tension
C. Assists the provider and patient in making conflicts or tensions explicit so that they can work them out between themselves	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Takes it upon self to solve or handle the conflict; does not make the issue(s) explicit
D. Lets the parties speak for themselves and does not take sides in the conflict	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Takes sides and/or speaks for the parties

Duty A: Interpretation

A-14 Do a self-check on accuracy of interpretation and correct own mistakes.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Identifies own mistakes	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not recognize or acknowledge own mistakes
B. Stops and corrects own mistakes	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not correct own mistakes
C. When mistakes are pointed out, is able to accept this information and takes steps to learn from the feedback	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Denies or makes excuses for mistakes when they are pointed out and makes no attempt to benefit from feedback

Duty A: Interpretation

A-15 Assist the provider with interview closure activities.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Encourages the provider to give appropriate instructions, making sure the patient is clear about next steps and has asked any questions she or he may still have	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not encourage the provider to give appropriate instructions, and des not make sure the patient is clear about next steps, nor asks whether the patient has any further questions
B. Checks with the patient on the need for an interpreter at any of the follow-up appointments	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not check with the patient on the need for an interpreter at any of the follow-up steps
C. Observes “closure etiquette” by making closing remarks appropriate to each party	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Does not observe “closure etiquette” by making closing remarks appropriate to each party

Duty A: Interpretation

A-16 Ensure that concerns raised during or after an interview are addressed and referred to the appropriate resources.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Encourages the provider to make the appropriate referrals	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Takes it upon self to solve the problem
B. Understands or asks about the institution's system of service delivery	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not understand or does not ask about the institution's system of service delivery
C. Makes sure patient gets appointment with the appropriate resources and with an interpreter if needed	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Leaves patient with a lingering need or concern and walks away

Duty A: Interpretation

A-17 Complete appropriate documentation of the interpreter's work.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Finds out what the protocols are for each institution/health care setting in which work is performed	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not find out what protocols the institution requires
B. Knows and uses the protocols for each setting	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not know and/or does not use the protocols for each setting
C. Follows the documentation policies/ procedures/ guidelines of each institution's interpreter office, which may include: • Keeping phone log • Documenting all follow-up activities, such as follow-up appointments • Completing weekly invoice of hours worked • Submitting documentation to the appropriate person or filing documentation in the appropriate place and in a timely manner • Keeping interpreter's office informed of exact location (i.e., where assigned)	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Does not follow the documentation policies/ procedures/ guidelines of the institution, resulting in the following possible situations: • Errors in follow-up activities • Mishandled priorities • Not getting paid • Interpreter's office not being able to locate interpreter • Incomplete or inaccurate statistics at the end of the year

Duty A: Interpretation

A-18 Follow up (outside the triadic encounter) as necessary.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Notifies patients of follow-up, canceled, or rescheduled appointments when requested	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not notify patients of follow-up, canceled, or rescheduled appointments when requested
B. Reschedules appointments for patients when requested	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not reschedule appointments for patients when requested
C. When involved in follow-up telephone calls, conveys information back and forth, following established principles of accuracy and completeness	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Does not follow established principles of accuracy and completeness when involved in telephone communications

Duty B: Cultural Interface

B-1 Use culturally appropriate behavior.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Observes the rules of cultural etiquette and/or institutional norms (e.g., regarding behavior and language suited to age, gender, hierarchy, status, level of acculturation) appropriate to each party	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not observe the rules of cultural etiquette and/or institutional norms appropriate to each party
B. Adjusts behavior to observe the appropriate rules of cultural etiquette	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not adjust behavior to observe the appropriate rules of cultural etiquette

Duty B: Cultural Interface

B-2 Recognize and address instances that require intercultural inquiry to ensure accurate and complete understanding.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Pays attention to verbal and nonverbal cues that may indicate implicit cultural content or culturally based miscommunication (e.g., responses that do not fit the transmitted message; display of discomfort or distress when certain topics are brought up)	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Ignores verbal/nonverbal cues that indicate implicit cultural content or culturally based miscommunication
B. Assesses the urgency/centrality of the issue, at that point in time in that particular exchange, to the goals and outcomes of the encounter: • Assesses the best time and method by which to raise the issue • Interjects and makes explicit to both parties what the problem might be • Prompts the provider and patient to search for clarity	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not assess the urgency/centrality of the issue and becomes a barrier to communication by: • Interjecting disruptively (e.g., too frequently or unnecessarily) • Not making the problem explicit to both parties • Taking over and telling provider and/or patient what the problem is
C. Shares cultural information with both parties that may be relevant and may help clarify the problem (e.g., says, 'It's possible this is what is happening, because often people from … believe that …")	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Makes cultural assumptions and acts on them (e.g., tells the person what cultural stereotypes to live up to)
D. In cases where 'untranslatable'* terms are used, assists the speaker in developing an explanation that can be understood by the listener	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Does not assist the speaker in developing explanations for 'untranslatable' words, instead providing explanations for the words or omitting concepts

**Untranslatable words are words that represent concepts for which a referent does not exist in the society using the target language.*

Duty C: Ethical Behavior

C-1 Maintain confidentiality.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Can explain the boundaries and the meaning of confidentiality, and its implications and consequences	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Cannot explain the boundaries and the meaning of confidentiality, nor its implications and consequences
B. Knows and maintains the clinical parameters of information sharing, in keeping with the policies and procedures of the institution and/or team, for example: • Supervision • Patient conference/continuity of care meetings • Professional meetings, workshops, conferences, [taking responsibility for maintaining the anonymity of the parties by ensuring that any information shared at professional meetings does not contain identifying characteristics (e.g. hospital names, date of encounter, etc.) that can be attached to a specific individual]	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Intentionally or unintentionally reveals confidential information outside the clinical parameters
C. Knows how to respond to questions dealing with confidential matters that may be brought up in the community or health care setting	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Does not know how to deflect inappropriate requests for information and violates confidentiality
D. If privy to information regarding suicidal/homicidal intent, child abuse, or domestic violence, acts on the obligation to transmit such information in keeping with institutional policies, interpreting standards of practice, the code of ethics, and the law	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Fails to act on the obligation to transmit information to relevant parties

Duty C: Ethical Behavior

C-2 Interpret accurately and completely.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Can explain the concepts of accuracy and completeness, and their implications and consequences	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Cannot explain the concept of accuracy and completeness, nor their implications and consequences
B. Is committed to transmitting accurately and completely the content and spirit of the original message into the other language without omitting, modifying, condensing, or adding	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Is not committed to transmitting accurately and completely the content and spirit of the original message
C. Is committed to monitoring her or his own interpreting performance	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Does not monitor her or his own interpreting performance
D. Has the moral fortitude to admit and correct own mistakes	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Does not have the moral fortitude to admit and correct own mistakes, instead permitting mistakes to stand uncorrected

Duty C: Ethical Behavior

C-3 Maintain impartiality.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Is aware of and able to identify personal biases and beliefs that may interfere with the ability to be impartial, and has the moral fortitude to withdraw if unable to be impartial	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Is unaware of and unable to identify personal biases and beliefs that may interfere with the ability to be impartial, and does not have the moral fortitude to withdraw if unable to be impartial
B. Withdraws or refrains from accepting any assignment where close personal or professional ties or strong personal beliefs may affect impartiality (including conflicts of interest), unless an emergency renders the service necessary	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Accepts assignments where close personal or professional ties or strong personal beliefs may affect impartiality, even when other alternatives are available
C. Focuses on the communication between provider and patient and refrains from interjecting personal issues, beliefs, opinions, or biases into the interview	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Interjects personal issues, beliefs, opinions, or biases into the interview
D. Refrains from counseling or advising	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Counsels and advises

Duty C: Ethical Behavior

C-4 Respect patient's privacy.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Respects patient's physical privacy, and maintains spatial/visual privacy of patient, as necessary	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does not respect patient's physical privacy nor maintain spatial/visual privacy of patient
B. Respects patient's personal/emotional privacy: • Refrains from asking personal probing questions outside the scope of interpreting tasks • Does not use the role of interpreter to influence a social relationship with the patient outside the interpreting encounter • Refrains from becoming personally involved in the patient's life**	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Does not respect patient's personal/emotional privacy: • Asks personal, probing questions on own initiative • Uses the role of interpreter to influence a social relationship with the patient outside the interpreting encounter • Becomes personally involved

*** In small, close-knit communities, it is often not possible for an interpreter to remain personally and socially uninvolved with patients. However, interpreters should always strive to maintain the ethical and professional standards of confidentiality and impartiality while in their role.*

Duty C: Ethical Behavior

C-5 Maintain professional distance.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Can explain the meaning of professional distance, and its implications and consequences	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Cannot explain the meaning of professional distance, and its implications and consequences
B. Is able to balance empathy with the boundaries of the interpreter role	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Is not able to balance empathy with the boundaries of the interpreter role
C. Shows care and concern for patient needs by facilitating the use of appropriate resources	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Ignores patient needs or tries to resolve everything for the patient
D. Refrains from becoming personally involved	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Becomes personally involved to the extent of sabotaging or compromising the provider-patient therapeutic relationship, thereby misleading the patient as to who the provider is and effectively disempowering the provider
E. Does not create expectations in either party that the interpreter role cannot fulfill	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	E. Creates expectations in either party that the interpreter role cannot fulfill
F. Promotes patient self-sufficiency, taking into account the social context of the patient	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	F. Encourages and/or creates patient dependency on the interpreter.
G. Monitors own personal agenda and needs and is aware of transference and counter transference issues		G. Is unaware of transference and counter transference issues

Duty C: Ethical Behavior

C-6 Maintain professional integrity.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. Refrains from contact with the patient outside the scope of employment, avoiding personal benefit	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Initiates contact with the patient outside the scope of employment for personal benefit
B. Refrains from fulfilling any functions or services that are not part of the interpreter role	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Takes on functions or provides services that are not part of the interpreter role
C. Knows competency limits and refrains from interpreting beyond her or his training, level of experience, and skills, unless these limitations are fully understood by the patient and provider and no other source of interpreting is available	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	C. Is not aware of competency limits; becomes involved in situations that are beyond her or his level of training, skill, and/or experience; and on occasions where no other source of interpreting is available, does not inform patient or provider of these limitations
D. Refrains from interpreting in situations where there may be a conflict of interest	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	D. Persists in functioning as an interpreter in situations where there may be a conflict of interest
E. Engages in ongoing professional development	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	E. Does not engage in ongoing professional development

Duty C: Ethical Behavior

C-7 Deal with discrimination.

Indicators of Mastery	Rating	Indicators of Lack of Mastery
A. On occasions where the interpreter feels strongly that either party's behavior is affecting access to or quality of service, or compromising either party's dignity, uses effective strategies to address the situation	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	A. Does nothing or addresses the situation in an ineffective, disruptive manner
B. If the problem persists, knows and uses institutional policies and procedures relevant to discrimination	○ 5 ○ 4 ○ 3 ○ 2 ○ 1	B. Neither knows nor uses institutional policies and procedures relevant to discrimination

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