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Designing Curriculum for Healthcare Interpreting Education:

A Principles Approach

In a classic in work in pedagogy, Brown states that "by perceiving and internalizing connections between practice (choices made in the classroom) and theory (principles derived from research) teaching is likely to be *enlightened*" (emphasis in the original) (2001, 54). This statement can certainly be applied to the teaching of healthcare interpreting. Healthcare interpreting (sometimes also referred to as medical interpreting or included in the term *community interpreting*) has been the focus of various studies that have shed light on the complexities and challenges of this specific setting (Angelelli 2001, 2003, and 2004a; Bolden 2000, Cambridge 1999; Davidson 1998, 2000, and 2001; Metzger 1999; Prince 1986; Wadensjö 1995 and 1998). Interestingly, the research produced in this field is not reflected either in current programs that aim to *train* healthcare interpreters nor in professional associations intimately connected with them (e.g., Mount San Antonio College and The California Healthcare Interpreting Association, or Bridging the Gap and the Massachusetts Medical Interpreters Association).[1] This lack of connection leads us to assume an unfortunate divorce between research and

1. In many interpreting programs and short courses, there is a tendency to use the term *training* in both degree and nondegree programs, instead of *education* or *professional development*, respectively.

practice that exists not only at the level of the individual, but also at the level of the organization.

The disconnect between research and practice to which Brown alerted us not only occurs in the teaching of healthcare interpreting, but also in programs that provide interpreter education in general. With a few exceptions, such as the University of North Texas Health Interpreting and Health Applied Linguistics master program, the curriculum of institutions granting master's degrees in interpreting in the United States mostly reflects the teaching of practice (Angelelli 2002).[2] Acquisition and learning of interpreting competence are narrowly defined. Coursework gives students endless opportunities to practice basic skills such as note-taking or split attention without necessarily diving into the specifics of each of the interpreting settings in which they may perform. Most of the programs are based on models of conference interpreting and, in many cases, education is equated to the training of basic skills, representing a cognitive approach to interpreting. This may be explained by how interpreting entered academia in the first place.

I have argued elsewhere (2004b) how the education of interpreters entered academia to satisfy a pragmatic need rather than to constitute a field of inquiry in its own right. In the early days (immediately after World War II), the education of interpreters was prompted by the need to ensure communication between speakers sharing similar socioeconomic status (i.e., heads of state, delegates of international organizations, or members of business communities). In the 1950s, the first university programs responded to the need for conference interpreting. Curricular decisions made at that time focused on the skills needed to perform a task rather than on the linkage between theory, research, and practice as applied to the communicative needs of speech communities who do not share the societal language. Because the training for conference interpreters represented the only academic training, many programs focusing on medical or community interpreting turned to these models for answers on how to design their curriculum.

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2. See, for example, the Graduate School of Translation and Interpretation at The Monterey Institute of International Studies (http://www.miis.edu/gsti-course-desc.html) or the University of Southern Carolina at Charleston.

Since interpreting entered academia to meet a pragmatic need, rather than to become an object of study, research questions about practice, specifically in community and then medical settings, and the practitioners, which are essential to understand the underlying complexities of the interpreted communicative event (Angelelli 2000; Metzger 1999; Roy 2000; Wadensjö 1998), were deferred to the market need of practitioners. Logistical questions directed to conducting training took priority over questions that were designed to understand what a well-rounded education of interpreters may look like and how it would account for the differences in settings where interpreters work. For example, based on educators' personal experience and opinions, rather than on research, many programs that teach healthcare interpreting are reduced to teaching terminology related to the field. While it would be pointless to argue that this is not relevant, it is not sufficient and should definitely not drive the curriculum. A strong focus on terminology is like giving a student a fish instead of teaching him or her how to fish. Terminology and glossaries derive from ways of speaking in a contextualized setting. They need to be studied in this way and should not constitute the centerpiece of any curriculum.

In the next section, I explore concepts on which a curriculum could be based. These concepts or components could be the general goals of a healthcare interpreting curriculum.

Basic Components of Healthcare Interpreting Education

Based on research performed on the importance of the context, the participants in the interaction, or the complexities embedded in the role of the interpreter, I would like to suggest that healthcare interpreting education (HIE) involves the development of skills in at least six different areas: cognitive processing, interpersonal, linguistics, professional, setting-specific, and sociocultural. Most of the commercially available short courses on healthcare interpreting (e.g., Bridging the Gap or Connecting Worlds) generally devote time to terminology or the ethics of the profession and do not even

discuss information processing skills. More elaborate programs focus on both information processing *and* linguistic skills, but may not dive into the specifics of the medical setting and the interpersonal role of the healthcare interpreter.

The cognitive processing area calls for the enhancement or development of specific skills related to the process of interpreting (e.g., active listening, memory expansion, split attention, and notetaking, to name a few). The interpersonal area allows for the unpacking of the concept of role to help students understand the continuum of visibility (Angelelli 2004a and b) and neutrality (Davidson 2000 and 2001; Metzger 1999), and gain awareness of the power they have, their agency, and the responsibilities and duties that arise from it. In the linguistic area, HIE requires ongoing work in the students' two languages (e.g., enhancing vocabulary, switching from formal to informal registers, etc.). The professional area is concerned with matters such as job ethics, certification processes, and professional associations' rules and regulations.

At the level of the specific setting, students need to learn the ways of speaking in a variety of discourse communities, as well as the content and terms that are at the core of it. This may mean, for example, studying anatomy and physiology to understand medical interviews, as well as mastering frequent expressions and terms that occur during a specific speech event (e.g., a concern expressed during an interview). Finally, at the sociocultural level, it requires healthcare interpreting students to (a) be aware of the impact that both the institution and society have on the interaction they broker and (b) realize its constraints and cultures. If these six areas are represented in a HIE curriculum, we can clearly see how we move from the narrow concept of teaching isolated terms to the broader concept of teaching interactional competence, which results in forming well-rounded professionals.

Existing Programs for Healthcare Interpreters

As I mentioned, existing programs vary significantly in what they offer students, from a quick overview of healthcare interpreting

ethics, to medical terminology, to exposure to a few interpreting exercises in the form of scenarios, to a full-fledged graduate program on healthcare interpreting at the master level. According to Jacobson (in Kennen 2005, 30), "[P]rograms available vary widely from 240-plus-hour classes complete with role playing and practicum to six-hour crash courses of dubious value." Admission requirements also vary accordingly, from none (not even the assessment of linguistic proficiency) in the most advertised forty-hour programs like Bridging the Gap or Connecting Worlds, to the normal academic requirements such as undergraduate degrees, a statement of goals specifically addressing the applicant's interest and potential in healthcare interpreting, demonstrated language proficiency, two years of related interpreting experience, and letters of recommendation (Kennen 2005, 31).

Some of the academic programs are standalone, while others are a concentration area within a program. At the University of North Texas, for example, the Health Interpreting Health Applied Linguistics concentration (known as HIHAL) is embedded in the Master of Public Health program. This means that students take eighteen units of core courses in Public Health (such as Introduction to Epidemiology), nine units in the HIHAL concentration (such as Healthcare Interpreting), nine units from the Department of Social and Behavioral Sciences (such as Disparities in Health, Medical Anthropology), a 200-hour supervised interpreting practicum at local healthcare sites, and six units of thesis on original research that focuses on investigating language in a healthcare setting (Jacobson in Kennen 2005).

As we can see from this quick overview, in most well-rounded programs, several of the six areas I discussed previously are generally present. Most programs include at least cognitive processing, professional, and linguistic; and in very specialized programs like HIHAL, content and setting-specific are also central. In the next section, I explore in more detail those areas that generally are not an integral part of existing programs of healthcare interpreting. Those areas are the interpersonal, setting-specific, and sociocultural ones.

PUSHING BOUNDARIES: EXPANDING OPTIONS IN HIE

In this section, I provide general guidelines for the specific areas which currently are not an integral part of HIE.

The Interpersonal Area: The Role of the Healthcare Interpreter

The role of the healthcare interpreter is complex, and education about the role should be a core component of HIE. Traditionally, the main focus of interpreter programs (and professional organizations) has been the prescription of how that role should be enacted, rather than an attempt to understand the complexity of such a role. These prescriptions are limited to the production of accurate renditions of a message, regardless of the constraints of the communicative event (i.e., with no consideration of who the interlocutors are, where they are interacting, the purposes of the interaction, etc.). This narrow approach limits the opportunities for students to understand, observe, and explore the multifaceted and complex role that interpreters play in the healthcare setting. The different contexts in which interpreters work, as well as the interlocutors for whom they interpret, impose different constraints and needs on the interpreted communicative events they facilitate. Thus, their performance and their role undergo constant changes so as to meet those needs and accommodate those constraints. This is a part of the practice of interpreting that should not be overlooked in HIE so that, as Brown reminded us at the beginning of the chapter, teaching continues to be enlightened. Various empirical studies conducted on interpreted medical discourse (Angelelli 2003 and 2004; Bolden 2000; Cambridge 1999; Davidson 1998, 2000, and 2001; Kaufert and Putsch 1997; Metzger 1999; and Wadensjö 1995 and 1998) illustrate the participatory role of interpreters. Healthcare interpreters, like interpreters in general, are co-participants who share responsibility in the talk (Wadensjö 1998). This responsibility needs to be made explicit to students.

Interestingly, neither power differentials nor the differences that result from the various situated practices (i.e., settings such as a healthcare center) have constituted an integral part of the education of medical interpreters. HIE needs to account for the role of the interpreter, so that students understand the agency that they have, how it falls within a continuum of participation or visibility (Angelelli 2004a and b), and what duties and responsibilities emerge from this agency that cannot be denied.

The Specifics of the Medical Setting

The effect that a setting can have on interpreters' behaviors and beliefs (Angelelli 2004b) has to be made explicit to students because, after all, interpreting is a situated practice. Students need to understand what it means for a practice to be situated. They have to learn about the research in the field that discusses the issues of this specific setting. This goes beyond medical terminology and content knowledge. It specifically means exposing students to medical discourse, to the ways of speaking between providers and patients in monolingual interactions, and then in bilingual interactions brokered by an interpreter. This will allow students to see the connection between setting, expectations, and actual performances. Students will benefit from learning about the research that illustrates crucial differences in the participatory role of interpreters and how these differences depend upon the nature of the interpreted communicative event (Hymes 1974; Angelelli 2000; Berk-Seligson 1990; Hale 2004; Metzger 1999; Roy 1989 and 2000; Wadensjö 1995 and 1998).

Additionally, both providers and patients have different expectations of medical interpreters (Bolden 2000; Davidson 1998, 2000, and 2001; Prince 1986). The physician sees the interpreter as a human instrument who helps keep the patient (and thus, the conversation) on track. However, the patient sees the interpreter as a co-conversationalist. These expectations on the performance of interpreters (that have been empirically proven) need to be discussed in HIE. Doing so will empower students and keep the teaching of healthcare interpreting aligned with the research in the field.

The Sociocultural Aspect of Healthcare Interpreting

Another important consideration is the historical and institutional context in which interpreters perform their job (Angelelli 2001 and 2004; Davidson 2000 and 2001). Therefore, either during planned explorations on role or setting (see above), or throughout the activities that they perform or observe, opportunities should exist to discuss the sociocultural aspect of the healthcare setting at length. While understanding ways of speaking and specific interaction rules that are typical of a setting help students become more efficient and proficient speakers in a community, reflecting on the influence of societal and institutional factors that get played out during a medical interview is also essential.

The interaction that interpreting students will help broker is constrained by social factors, such as gender, age, ethnicity, and the socioeconomic status of participants, to name a few, as well as the norms of the institution and the society where it takes place. Providers enact specific roles, as do patients. Students will benefit from an academic understanding of how people, as well as themselves, enact roles. Exploring questions such as

- What happens when providers and patients do not have the same gender or ethnicity?
- What happens when they belong to different socioeconomic classes?
- What is the culture of a patient?
- What is the culture of a healthcare provider?
- What are their beliefs?
- Are these beliefs aligned or do they clash?
- Why are patients so frequently interrupted and cornered?
- Why are providers under so much pressure?

allows interpreters to discover where they fit. Is the interpreter perceived by the provider as a team player, as a linguistic commodity, or as a patient's ally? And, in terms of culture, what is the culture of the healthcare organization? Whose culture can the interpreter broker? With whose culture is the interpreter familiar: that of the

healthcare organization or the patient? Healthcare interpreting students need to be exposed to these sociocultural aspects of their practice. Most importantly, HIE needs to account for them, and this means that HIE should provide time for reflection on these areas which are as essential to forming well-rounded professionals in the field as the analytical or information processing skills which generally constitute the core of the curriculum.

Healthcare Interpreting Education: Beyond Across-Language and Language-Specific Possibilities

HIE may also include instruction both across languages and in language-specific courses. Some of the instruction presented across languages might involve introductory courses to general aspects of interpreting, such as public speaking, active listening, memory enhancement, note-taking techniques, and overviews of interpretation as a profession (professional associations, ethics, certifications, working with interpretation organizers, etc.). In these introductory courses, students learn about interpreting and learn foundational skills necessary for its practice.

Instruction in language-specific courses deals with the development of skills and practice that require working intensively in the two languages of the students. For example, students learn strategies to help them paraphrase or enhance their current language abilities. They further develop presentation and public speaking skills in the target language and learn how to slide messages up and down a register scale to target their renditions to a variety of audiences.

Beyond across-language and language-specific courses, interpreting students need opportunities to discuss boundaries. Reflection opportunities need to be built into courses so that students understand this component as an integral part of being professionals, rather than as a search for one's own shortcoming. Sometimes the limits are due to the topic of the interaction. For example, if an interpreter is called upon to interpret an unfamiliar topic, it is her or his responsibility to ask to be excused rather than do a poor job.

Other times, the limits are imposed by the relationship of the interpreter to either the topic or the person for whom the service is needed. For example, an interpreter that has serious prejudices about chiropractic treatment may not be the ideal person to assist a minority language speaker during a visit to the chiropractor. Or in the event that the interpreter is an acquaintance of a parent who has been diagnosed with AIDS, and whose case is going to be discussed between the physician and the parents, he or she may need to be excused if his or her presence compromises the information that needs to be discussed during the conference. Knowing one's own limits constitutes part of an ethical professional behavior. Analysis of sample case studies brought into the classroom can illustrate these points without having negative impacts on students' self-esteem or motivation.

HIE: Suggested Tenets

Before looking specifically at the course components of HIE, in this section, I lay down some basic concepts that could be considered while designing curriculum. I would also like to suggest branching out to relevant fields such as general education, bilingualism, second-language acquisition, health education, and cross-cultural communication to lay out some principles for HIE.

Basic Principles

Ideally, HIE is based on principles of teaching that are tailored to the specifics of the educational task at hand (i.e., healthcare interpreting). These principles of language learning (adapted from Brown 2001, 54–90) navigate a continuum with arbitrary divisions. These divisions are cognitive (also called information processing), affective, and linguistic.[3] The linguistic division is not applicable to our discussion of interpreting learning, since interpreting students

3. For a more complete discussion on these principles, the reader is directed to Brown 2001, chapter 4.

Table 1: Teaching Principles for HIE

Cognitive	Affective
Automaticity	Self-confidence
Meaningful learning	Risk-taking
Intrinsic motivation	
Strategic investment	

are beyond the initial stages of language acquisition. Although this transfer of principles needs to be further evaluated and is very much a work in progress, it could be used as a starting point for a discussion on what the principles of HIE could look like. Table 1 summarizes the principles that are of interest to us.

- *Automaticity.* Through an inductive process of exposure to experimentation, students appear to acquire interpreting competence without analyzing it. In order to acquire the vast complexity and quantity of information, students must gradually move away from processing information bit by bit toward a form of processing where bits are only on the periphery of attention. Through the subconscious absorption of interpreting skills through meaningful use, students become aware of the process and become, in turn, more competent. Students need to be made aware that this is a process they need to go through to acquire competency.
- *Meaningful learning.* As opposed to rote learning (taking in bits and pieces of information without necessarily connecting them to existing cognitive structures), meaningful learning pours new information into existing structures and memory systems. This means, for example, moving away from long lists of isolated medical terms and discussing the discourse of healthcare interpreting in contextualized events.
- *Intrinsic motivation.* As opposed to external rewarding (like praise or grades), the most powerful rewards are those intrinsically motivated within the learner. This implies careful consideration of the motives of students in HIE and the design of tasks that feed

directly into those motives. This means, for example, meaningful opportunities of contextualized practices and observation in a specific setting (i.e., emergency room) followed by structured reflection in the classroom.

- *Strategic investment.* To a large extent, successful mastery of interpreting skills will be due to the student's own personal investment of time, effort, and attention. This means designing an individualized battery of strategies (e.g., coping, analytic, and interpersonal) for professional performance.
- *Self-confidence.* A partial factor in learners' success at a task is their belief that they are fully capable of accomplishing it. This means not only explicitly encouraging students, but also sequencing techniques from easier to more difficult, therefore avoiding the "sink or swim" technique many times observed in interpreting classes.
- *Risk-taking.* Successful learners will realistically appraise their potential to accomplish tasks and then decide to take the plunge, gamble in the game of learning, and attempt to produce in an area that is beyond absolute certainty. This means encouraging students to explore choices in their renditions. In other words, this principle encourages students to take risks rather than constraining them to guessing for one right answer.

NEEDS ASSESSMENT AND STUDENT LEARNING OUTCOMES

Curricular decisions vary significantly from course decisions. In a course, there is a definite group of learners that will be impacted by the decisions a teacher makes. Inside a classroom, a needs assessment generally focuses on the needs of the students attending a particular course (e.g., their strengths, the areas in which they would need more work, or their motivation [Nunan 1988 and 1991]). Learners bring beliefs and attitudes about the nature of the task at hand, and it is important to consider these when selecting content and materials for the course.

On the other hand, a needs assessment to design curriculum for an interpreting program can have various sources of input. The needs of prospective students are assessed together with the needs

of the market, as well as those of the community and the funding agents. At times, the focus of a curriculum can be determined exclusively by funding (e.g., Jacobson and HIHAL in Kennen 2005).[4]

The key towards a successful curriculum is the clear formulation of student learning outcomes (SLOs). Primarily they serve as indicators of program or course effectiveness and measure individual student performance (e.g., for grading). Additionally SLOs can diagnose both specific course problems and student problems. They can clarify students' expectations. They describe how learning will empower or enable students, reflect intentions that guide teaching and learning, indicate how students can demonstrate skills and knowledge, and suggest how other types of learning such as values and attitudes might be inferred from student choices or actions. Additionally, SLOs design curricular structures, articulate courses with their prerequisites and co-requisites, estimate student and instructor workload, recruit and motivate students, and communicate and negotiate course expectations. SLOs can also select or devise instructional strategies and tactics, guide student learning efforts, clarify grading and improve its validity and reliability, and market courses and programs. Moreover, clear statement of SLOs provides for consistency in all areas of the course.

Problem-Based Learning: A Relevant Pedagogy

The position I take in this chapter is that healthcare interpreting is an integral component of cross-linguistic communication in a healthcare setting. Healthcare communication is part of the medical school curriculum. Therefore, I would like to suggest that some components of the HIE could be developed in tandem with case studies in medical school. In order to do that, let's discuss the methodology that is currently more successful in medical schools and consider its application to the teaching and learning of healthcare interpreting.

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4. For more information, see the new master's in healthcare interpreting and healthcare applied linguistics (HIHAL) at the School of Public Health, University of North Texas funded by Hablamos Juntos/Robert Wood Johnson Foundation at www.hablamosjuntos.org

Problem-based learning (PBL) is a pedagogical strategy for posing significant, contextualized, real-world situations, and providing resources, guidance, and instruction to learners as they develop content knowledge and problem-solving skills (Mayo, Donnelly, Nash, & Schwartz 1993). In PBL, students collaborate to study the issues of a problem as they strive to create viable solutions. Because the amount of direct instruction is reduced in PBL, students assume greater responsibility for their own learning (Bridges & Hallinger 1991). The instructor's role becomes one of subject matter expert, resource guide, and task group consultant. This arrangement promotes the group processing of information rather than an imparting of information by faculty (Vernon & Blake 1993). The instructor's role is to encourage student participation, provide appropriate information to keep students on track, avoid negative feedback, and assume the role of fellow learner (Aspy et al. 1993).

PBL can be traced back to the times of John Dewey and apprenticeships, and it was pioneered at Case Western Reserve University in the early 1950s. The structure developed by Case Western now serves as the basis of the curriculum at many secondary, postsecondary, and graduate schools, including Harvard Medical School (Savery 1994). In fact, more than 80% of medical schools use the PBL methodology to teach students about clinical cases, either real or hypothetical (Vernon & Blake 1993; Bridges & Hallinger 1991).

Although we may argue that in many interpreting courses students are presented with a problem to solve, in general it is carefully structured. Often times there is only one (or a very limited number of) right answer(s), and the focus is on solving the problem, not on working through the process. However, real (professional) life problems seldom parallel those discussed in the safe environment of a classroom. They are generally more complex and accept a variety of approaches. Teaching students about problem-solving (with well structured examples in the classroom) differs significantly from teaching students how to problem-solve. Students must be guided to reach both the objectives involved in solving the problem and the objectives related to the process. In the field of interpret-

ing studies, many times, the discussions on pedagogy characterize some of the skills and strategies that students need to acquire as those related to problem-solving. Therefore, students in interpreting courses may benefit from having PBL as a teaching method. Interestingly, PBL seems not to be present in the healthcare interpreting pedagogy, although it is more prevalent in medical schools when student learn real or hypothetical medical cases. Since interpreting courses may also offer real-life situations to be interpreted, teachers of interpreting will find that PBL can prove useful when conceptualizing curriculum.

Like any other method, PBL presents its challenges. The main one is overcoming unwillingness to change. As Aspy, Aspy, and Quimby (1993) note, "[C]hanging a curriculum is like moving a graveyard." Faculty resists change not because it implies an effort, but because it takes time which, more often than not, is a rare commodity in higher education. It is documented that a ninety-eight-week lecture course requires 120 weeks using PBL, which equals 22% more time required (Albanese & Mitchell 1993). Additionally, faculty members receive no incentive for experimenting with new methods, and in most cases, no professional development workshops to discuss the role of a facilitator versus that of a lecturer. Faculty needs time to reflect on PBL and to develop new ways of teaching by implementing this method.

A Word about Assessment

The assessment of students' learning is significant for both university teaching and students' lives and careers. It begins with educational values, since assessment is not an end in itself, but rather a vehicle for educational improvement. Therefore, as teachers, we are responsible for taking adequate steps to ensure that assessment in HIE is meaningful and aligned with curricular goals, course objectives, and chosen methodology. This also means that in HIE, like any other educational field, teachers should be aware of the existing research on testing and measurement and be able to weigh the advantages and disadvantages of using traditional (e.g., performance

exam) or innovative (e.g., portfolios) assessment instruments, which can be as valid and as reliable as possible.

In the spirit of transparency, testing procedures and scoring standards of the HIE curriculum should be shared with students as they initiate their studies. The same needs to be done at the course level. In this way, students know exactly what the benchmarks are (what constitutes excellent, acceptable, or poor performance), and the scoring rubric turns into a helpful learning tool for students.[5]

Suggestions for Course Sequence

- Bearing in mind the principles described above, let's now consider what courses in HIE would look like and how they would be sequenced. As it has been suggested before, a curriculum in healthcare interpreting can exist in a variety of forms. It may be either an optional part of a curriculum designed to educate interpreters across settings (e.g., courses that amount to an area of specialization, or a track) or an area of concentration within a master's (e.g., HIHAL) or a stand-alone program composed of a series of courses culminating with, or involving a service-learning component. In either case, even in the least ambitious of possibilities, a course series could benefit by including the following:
- Introduction to medical interpreting
- Language enhancement for medical interpreting
- Strategies for medical interpreting
- The role of the medical interpreter
- Practicum in medical interpreting (with or without a service-learning component).

Introduction to Medical Interpreting

This introductory course is the key to a successful program. The course should be seen as an introduction for students to the basic

5. For a more thorough discussion and more examples on assessment tools, the reader is directed to the SDSU Center for Teaching and Learning at www.sdsu.ctl.

principles of healthcare interpreting. Its goal is to allow students to reflect on their bilingualism, to raise awareness on different talents students already may have in communication, and to help them explore resources that can become part of their lifelong task in enhancing their language and communication skills.

Skills developed in this course will help students to become more successful in other classes, as they apply new strategies in listening, note-taking, anticipating information, and speaking. Also, students' information processing abilities will grow as they learn to perform various tasks simultaneously, as any effective interpreter must.

Language Enhancement for Medical Interpreting

In this course, students will learn to approach the study of language in new ways, having seen the practical applications of their studies in class. The second course in the HIE curriculum aims at enhancing skills in both languages so that students are better prepared for tasks in interpreting. In Introduction to Medical Interpreting, students will have noticed that the level of language they use in everyday communication among friends and family may not be sufficient to accomplish a specific interpreting task. They will have also discovered how language production under pressure differs from language production used to accomplish more simple communicative goals. The goal of this course is, thus, to raise students' awareness of the difference between language for communication and language for work, and to provide them with tools to enhance their language skills in order to work with them (Angelelli and Degueldre 2002).

Students will benefit from this course in numerous ways. First, they will enhance their repertoire by reading about and listening to a variety of topics that range from everyday language used in healthcare settings to language used in medical interviews, technical discussions, legal documents that pertain to the healthcare setting, etc. Students will research medical discourse without limiting it to that used by the most powerful interlocutor (i.e., the healthcare provider). They will thus be exposed to formal and informal varieties of both languages, to ways in which patients complain about or

describe ailments. This will help them acquire a more extensive lexicon that will be an invaluable resource with which to perform under pressure. Second, they will develop coping strategies by learning, for example, paraphrasing or circumlocution, skills that are very helpful when they cannot find specific terms. This will undoubtedly increase their confidence in their linguistic skills. Beyond language enhancement, in this course, students will learn to approach the study of languages in a different way. They will learn to appreciate the scope and range that each language has, and they will become aware of cultural differences in communication inherent to both. Finally, the language course is specifically developed to allow the transfer of skills acquired in this course to research, writing, and presenting for other content courses both in English and the student's home language.

Strategies for Medical Interpreting

Students will benefit from the course in several ways. First, they will learn to apply the basic principles of interpreting to the healthcare setting. This will help students to choose more effective interpreting strategies. Students will gain practice both as speakers and interpreters as they change roles periodically. They will deliver speeches, role play (see Appendix A) in dialogues, and interpret to acquire practice in simultaneous and consecutive interpreting. They will interpret during both monologues and dialogues. They will try short and long pieces of discourse with a variety of registers, and work with slow and fast speakers as well as different text length. The length and speed of the task will increase according to their performance. The content of the texts will vary from week to week, building on the topics that students explored during Language Enhancement for Medical Interpreting. This recycling of materials will be extremely helpful for students at their initial stages of competency development.

The Role of the Medical Interpreter

In the multilingual and diverse society we live in, healthcare interpreters broker communication across major gulfs of class and cul-

ture. Interpreters are key players in linguistic minorities gaining access to services or in perpetuating instances of gate-keeping. If student interpreters have enough information processing skills and language but are not aware of their agency, of what a visible and active co-participant they could be during an interpreted communicative event, they are not fully equipped to succeed in their workplace. Students need to understand the power they have, the consequences and responsibilities that derive from such power (Angelelli 2004a and b). Students have to understand that their willingness to help others does not come without consequences.

In this course, students will explore the consequences of the various models they can adopt (the continuum of visibility). By looking at transcripts of authentic interactions, they can reflect on the role of the interpreter without taking risks. They can discuss the consequences of interpreters' behaviors. Then, during classroom activities such as role plays (Appendix A), students could reflect on their own performances as they pay close attention to their role. Students will benefit from this course in several ways. They will understand that their acts do not come without consequences, they will explore the options they have, and they will gain practice in ethical decision-making of exercising one's own judgment, especially if they seek to interpret for disadvantaged minority group members.

Practicum in Medical Interpreting (with or without a Service-Learning Component)

The purpose of this course is to bring together all the skills that the students will have acquired in the previous courses. In the basic course, students will have gained exposure to the principles of interpreting. In the second course, they will have enhanced their languages to what is expected at a professional level. In The Role of the Medical Interpreter, students will have had opportunities to explore the consequences of their agency. In this course, they will carry out real interpretations between English and their home language.

Students will benefit in a variety of ways from this practicum. First, it will help them enhance their interpretation skills within the

boundaries of the classroom. This can be extremely helpful for students as they gain practice in situated interpreted events that may differ from the ones they are used to doing (e.g., classroom exercises). In this way, students will be better prepared for future assignments when they must really interpret during these new situations. Second, students will be able to benefit from teacher's and mentor's feedback, which generally is not possible during real interpreted events. Third, they will transfer the skills learned in this practicum to the various interpreting situations at school and in real life, which call upon their skills to help themselves and others.

If a service-learning component is added, students will benefit greatly and enhance their skills in several ways. By having to act as supervised interpreters in community agencies, for example, students will continue to develop a sense of responsibility as communication brokers that will go beyond the limits of the classroom. Then, they will come back and use the classroom as a forum for reflection and discussion about their work done in the field.

Conclusion

In this chapter, we have briefly discussed the development of healthcare professional interpreters within the framework of education. We have explored the consequences of divorcing "training" from research and theory and the benefits of aligning HIE with both. We have also discussed some basic principles in which HIE can be based and suggested guidelines for curriculum design and course sequencing. Broadening our views on healthcare interpreter education will contribute to the development of well-rounded professionals who will be able to broker communication more responsibly and respectfully for all individuals in society.

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APPENDIX A

Interpreting During a Medical Emergency at the ER

Note: this role play is based on authentic materials and empirical observations (Angelelli 2001).

Divide students into groups of three. Assign them roles (patient's father, pediatrician, and interpreter) and hand them the prompt cards. There will be one card for the doctor, one for the father, and one for the interpreter. The cards will contain a description of the situation and the type of speaker to play.

For example:

- Pediatrician: You are a monolingual pediatrician working at the ER. You are very patient and kind with kids, but not necessarily with parents. Your time is limited. You sympathize with the father, but you also have many patients to attend to. You start to get tired of his complaints.
- Patient's father: You are a monolingual father. Your three-year-old has swallowed some detergent. You desperately drive him to the closest ER. They make you wait. The nurse is a little rude. You explain all of this to the doctor before you actually answer his questions about what happened. You talk a lot, you don't wait for your turn, and you manage to upset the doctor with your complaints.
- Interpreter: you are about to facilitate communication between a patient's father and a pediatrician in the ER. The patient swallowed a toxic product. There were no interpreters available in the ER. You are not a staff member, and you were called in form a nearby interpreting agency.

Present this activity to the students: "Mr. Loreto's son swallowed some toxic product. He is now in the ER explaining the situation to the pediatrician." Give the interpreter ten minutes to go over notes, the case, case questions, etc. During that time, speakers can plan how they will behave, the tone they will use, and what they want to say. Then, have the speakers engage in a conversation, each in their own language, and let the interpreter do her or his job.

While each group is working, you can ask the monolingual speakers to pay special attention to the interpreter's performance. Define it broadly, so that they not only focus on the information processing or linguistic skills, but also so they note the sociocultural and interpersonal skills. After the groups are done, facilitate a discussion where students can reflect on the successful and less successful roles in this activity. Ask for suggestions on how to improve what was less successful. Empower students by having them reflect on strategies. You will probably want to compile on a transparency a list of strategies that have been covered by this case.