National Council on Interpreting in Health Care
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SIGHT TRANSLATION AND WRITTEN TRANSLATION
Guidelines for Healthcare Interpreters

The National Council on Interpreting in Health Care
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I. Introduction

Language professionals are often assumed to be able to perform a number of language functions (or tasks or services) by the lay public. It is little understood that different language functions require different types of language skills, each of which, when used for professional purposes, is best honed through training and practice. Three of the functions that are the purview of language professionals are translating, interpreting, and sight translating. While these three functions require similar skills such as a good memory, the ability to analyze meaning, and knowledge of terminology, each also relies on different skills within the four domains of language – listening, speaking, reading, and writing.

While interpreting and translation tend to occur in different settings and contexts, there is a small but troublesome area of overlap. The overlap occurs when interpreters are asked to express orally what is in a written text (sight translation) or when interpreters are asked to convert into writing a text written or spoken in another language (translation). These scenarios present a number of questions. Under what circumstances is it appropriate to ask an interpreter to read a written text and simultaneously give an oral rendition in another language (sight translation)? Should an interpreter be expected to produce written translations in the course of his/her interpreting duties? If so, under what conditions? What additional training should an interpreter have to develop the necessary competencies in either of these functions?

This position paper focuses on the special demands of sight translation and written translation in the context of the work of spoken language interpreting. It offers general guidance on the appropriate provision of sight translation and written translation services by a spoken language interpreter. It is imperative that both consumers and providers of interpreter services understand the issues around on-the-spot translation by interpreters in order to ensure the highest quality of service.

In order to understand the distinctions among these three language functions, this paper first defines each type and describes the skills that are central to the competent exercise of each function.

1. *Interpreting:* Interpreting is the oral rendering of spoken or signed communication from one language into another. Central to spoken or signed language interpreting are the following skills: the ability to comprehend the intended message of oral communications in two languages (listening skills), and the ability to produce an accurate and complete conversion from one language into another (speaking or speech productions skills). Interpreting requires listening and speaking skills in the two languages being used. Depending on the context, interpreters are often called upon to provide bidirectional conversions – that is, from language 1 into language 2 and from language 2 into language 1 – in the moment.

2. *Written Translation:* Often referred to only by the term “translation,” written translation is the rendering of a written text in one language in a comparable written text in another language. Central to written translation are the following skills: the ability to comprehend written text in one language (reading skills), and the ability to produce a comparable rendition in written form in a second language (writing skills) into another. Most professional translators provide only unidirectional translations, as a rule working into their dominant language. Unlike spoken or signed language interpreters, translators often have the luxury of time and other resources to come up with the best way to capture the nuances of meaning in the original text.

3. *Sight translation:* Sight translation is the oral rendition of text written in one language into another language and is usually done in the moment. Central to sight translation are the following skills: the ability to comprehend written text in one language (reading skills) and the ability to produce an oral or signed rendition in another language (speaking or speech production skills). Sight translation is often requested of an interpreter during an interpreting assignment.

II. Background: Published Standards and Discussions in the Literature

Sight Translation

The literature on interpreting has paid little attention to sight translation. In the past, sight translation was used primarily as a pedagogical tool rather than as a separate function in itself.[1, 2]

The section of the American Society for Testing and Materials' (ASTM) Standard Guide for Language Interpretation Services [2089-01(2007)] on considerations specific to healthcare interpreting (11.2.3) observes that "[t]he interpreter may also be responsible for sight translation of patient instructions, consent forms, or health-care records" (11.2.3.6 (2)). At the same time, under responsibilities of those who engage interpreter services, the ASTM Standard Guide states that "The healthcare provider shall also: . . . (5) make available written translations of commonly used documents including educational materials, consent forms, and advance directives" (11.2.3.7 (4)). This suggests that there are limits to what an interpreter should be expected to translate orally during an interpreted encounter. But while the standard suggests that consent forms should be translated in advance, it also states that interpreters may, at times, be called upon to sight translate consent forms. Thus the limitations on what an interpreter may reasonably be expected to sight translate remain unclear in the ASTM Standard Guide.

The same section of the ASTM Standard Guide also addresses "on-the-spot" written translations by interpreters, under Limitations and Complicating Factors (11.2.3.8) "Written Translations—Interpreters should not be expected to do written translations other than very brief texts specific to a patient. Translations produced on-the-spot by interpreters cannot be held to the same standards as formally translated texts."

This section of the ASTM Standard Guide also addresses another task that interpreters may be asked to perform, under the heading of Patient/Guardian Literacy: "(2) Patient/Guardian Literacy—Not all languages have a written form in common use. Literacy may also be limited to a minority of speakers. If patients' ability to read their preferred spoken language is limited, and a durable record of instructions is needed, audio or video recordings of the oral text should be provided to the patient/guardian. Alternatively, a written translation may need to be read to the patient/guardian by the interpreter in the presence of the provider. It may also be appropriate to provide documents to a patient/guardian in a third language that the patient/guardian can read."

In the legal setting, it is generally expected that court interpreters must be competent to work in three modes: simultaneous interpreting, consecutive interpreting, and sight translation (often called "sight interpreting"). The Federal Court Interpreter Certification and the certifications offered now by more than half of the state courts in the U. S. through the Consortium for State

[1] Elif Ersozlu, Training of Interpreters: Some Suggestions on Sight Translation Teaching, Translation Journal, vol. 9, #4, October 2005, retrieved January 2009 http://accurapid.com/journal/34sighttrans.htm

[2] B.J. Epstein. Sight Translation. Brave New Words Blog, retrieved Jan. 2009, http://brave-new-words.blogspot.com/2007/05/sight-translation.html

Court Interpreter Certification require testing in all three modes. The healthcare and social service interpreter certification tests for the Washington State Department of Social and Health Services includes a component on both consecutive interpreting and sight translation.

Written Translation

On-the-spot translations by interpreters are unnecessary if materials have been translated in advance and are available for use in patient encounters. The Guidance Memorandum on LEP Access[3] issued by the Office for Civil Rights (OCR) of the Department of Health and Human Services (August 2000) addresses the subject of what types of written materials should be translated in anticipation of use in order to provide access to services by persons with limited English proficiency (LEP):

> (2) Translation of Written Materials -- An effective language assistance program ensures that written materials that are routinely provided in English to applicants, clients and the public are available in regularly encountered languages other than English. It is particularly important to ensure that vital documents, such as applications, consent forms, letters containing important information regarding participation in a program (such as a cover letter outlining conditions of participation in a managed care program), notices pertaining to the reduction, denial or termination of services or benefits, of the right to appeal such actions or that require a response from beneficiaries, notices advising LEP persons of the availability of free language assistance, and other outreach materials be translated into the non-English language of each regularly encountered LEP group eligible to be served or likely to be directly affected by the recipient/covered entity's program. (p. 9 of 12)

The operative words in the OCR quote above are “materials that are routinely provided in English” and “vital documents.” Such materials should not need to be sight translated by an interpreter; they should have already been translated in the “regularly encountered languages other than English.” This provision, however, leaves open the possibility that in the case of the less-commonly encountered languages sight-translation by the interpreter will be required, regardless of the length or complexity of the material, in order to accommodate speakers of any such language. The issue of length and complexity will be addressed below.

The imperative of the OCR document applies to recipients of federal funds subject to the provisions of the 1964 Civil Rights Act. However, it makes sense for any institution, in the interest of effective communication, to make frequently used written information available in languages that clients can read. Having English-language print materials hurriedly, and perhaps inaccurately, sight translated by an interpreter does not lead to clear communication and understanding.

The Federal Court Interpreter Certification process includes a written test on vocabulary and grammar and an oral interpreting performance test (including a component of sight translation). However, the written exam serves as a screening mechanism for general language proficiency, not as a test of translation skill. While the courts often use their certified interpreters for translation work, they recognize that this is a separate skill that requires different testing methods. Therefore, court interpreters who do translation work have to demonstrate their proficiency as translators by other means.

[3] Guidance Memorandum; Title VI Prohibition Against National Origin Discrimination – Persons with Limited English Proficiency, Office for Civil Rights, Department of Health and Human Services, August 2000.

The *CIT (Conference of Interpreter Trainers) Education Standards* for sign language interpreters never mentions sight translation or written translation by interpreters.

We see from this review of practices and standards in the field that there is very little consistent guidance for interpreters who are called upon to provide sight translation and/or written translations while performing their duties as interpreters. In addition, textbooks on interpreter training include very little about sight translation – and even less about "on-the-spot" written translations by interpreters. Both are areas that require further research in order to establish best practices and standards for training.

III. NCIHC Recommendations

> "In the healthcare setting, information is not always presented in spoken form. Signage, notices, medical documents, questionnaires, registration forms, brochures, patient education materials, invoices, appointment cards, prescription labels, discharge instructions, and other written communications are common. Therefore, the interpreter may be asked to translate written messages into spoken messages (sight translation), or to translate short passages of written text into written form in another language. An interpreter who is capable of doing both will be better positioned to meet the needs of those who use the interpreter's services."
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> *Guidelines for Initial Assessment of Interpreter Qualifications*, National Council on Interpreting in Health Care, 2001, p. 21, http://www.ncihc.org

The ability to sight translate and to do written translation is certainly an asset in an interpreter. However, sight translation requires different skills than oral interpreting, and sight translating long documents can consume quite a lot of time, fatigue the interpreter and increase the risk for error. Written translation requires yet a different skill set. Interpreters are not necessarily qualified as translators and, even if so qualified, few will have the time while interpreting to perfect a written translation. For these reasons, it is important for interpreters to limit themselves to performing the tasks for which they are trained and qualified.

Healthcare facilities and providers also need to understand that these different skills require different preparation so that they do not ask interpreters to do what they are not prepared or qualified to do. Ideally, organizations need to think about testing the skills of sight translation and written translation as separate modules, so that good oral interpreters can be recognized and work as oral interpreters apart from whether they can do sight or written translations. As noted earlier, a candidate without written language skills may still provide a valuable service as a healthcare interpreter. Other methods can be used by the medical provider to convert written information into a form (written or oral) that is accessible by the client or patient.

What guidelines can be offered, then, to assure that patients receive the information they need in a format they will understand?

In the following sections we address three issues: guidelines regarding an interpreter's responsibility with respect to sight translation and the production of written texts (Sections A and B), guidelines regarding interpreter assistance to patients in filling out forms (Section C), and questions concerning patient literacy (Section D).

A. Guidelines for Sight Translation by Healthcare Interpreters

Patients typically receive four types of documents in healthcare settings, which interpreters are at times asked to sight translate:

1. Documents that provide general background to how an institution functions (e.g. HIPAA, patient manuals, patient bill of rights)
2. Documents with key information about the patient's condition that he or she may want to access later (e.g. patient education materials)
3. Documents that contain specific instructions for patient care (e.g. prescriptions, preparation for procedures, discharge instructions)
4. Legal documents (e.g. financial agreements, consent forms, advance directives).

Not all of these are appropriate for sight translation. As a general rule, the NCIHC recommends strict limits on the length and complexity of documents that interpreters should be asked to sight translate.

1. Documents that contain general background information (patient bill of rights, HIPAA) and educational materials are often quite long and so **are not appropriate** for sight translation. Sight translating these documents is both time consuming and probably fruitless, as the patient is unlikely to remember what was read to him.
2. Documents with specific instructions **are appropriate** for sight translation, **with the provider present,** so that the patient's questions can be answered by the provider, not the interpreter.
3. Legal documents, such as consent forms, **should be translated professionally** and then, if necessary, read aloud by the interpreter for the benefit of the client. There are several reasons for this recommendation. First, legal documents are usually written in complex and formal language, with many legal terms. Medical interpreters are often unfamiliar with this high register legal terminology and are at risk for rendering it inaccurately if required to translate it on site. In addition, it is questionable how much patients will understand and retain of what they simply hear in a long and complex sight translation. Finally, in accordance with The Joint Commission's standards for obtaining informed consent, providers are expected to explain the procedure to the patient, including risks and alternate options, and to ensure that the patient has understood the explanation. This means that, even with a translated consent form, a provider needs to be present while the patient reads the form (or the interpreter reads it to the patient), so as to answer questions and guide the interpreter if there is text that can be omitted (e.g. consent for anesthesia when none is going to be administered).

B. Guidelines for "On-the Spot" Written Translations by Healthcare Interpreters

Because of the limitations of time and training, healthcare interpreters should be asked to do only very simple written translations on the spot. By "simple" we mean brief and non-technical, such as the dosage label on a medication package or notes added to standard discharge instructions. More complicated documents, such as the standard discharge instruction sheets themselves, should be translated in advance and kept on file in the location where needed. A recommended system involves storing documents electronically and then printing them on demand at the point of use.

If short written instructions *do* need to be sent home with the patient, we recommend that the provider first write the indicated text in English. The interpreter can then provide a written translation below on the same page. This way, if a patient returns to a doctor with the instructions in hand, staff can read the doctor's original text. In addition, were there ever a question as to whether an error was due to incorrect instructions or incorrect translation, both versions are available for comparison.

C. Guidelines for Assistance to Patients in Filling out Forms

Related to sight translation is the issue of whether interpreters should help patients fill out forms. In healthcare settings, patients are asked to fill out many forms, including registration forms, financial forms, health history forms, symptom indices, questionnaires and more. Beyond the issue of whether interpreters should sight translate the form to a patient lies the question of whether an interpreter should help the patient write down answers.

In some healthcare facilities, English-speaking staff members are expected to work through the interpreter to fill out the forms for LEP patients, with the interpreter providing only oral interpretation. This is similar to what the staff would do if the patient spoke English but were non-literate.

Time constraints, however, often do not permit busy clinic personnel to sit with LEP patients and an interpreter to fill out the many forms required by the facility. Because interpreters are considered part of the healthcare team, there is often an expectation that the interpreter will assist the patient with filling out forms. Where interpreters are well trained with strong bilingual language skills, including reading and writing in English, this is a reasonable expectation.

Therefore we recommend the following guidelines regarding interpreters helping patients to complete forms.

1. When possible, facilities should provide forms translated into the patient's language. The interpreter can then translate the patient's answers onto an English version of the form, which should then be stapled to the non-English version.
2. If the form is not translated, or if the patient cannot write easily, the interpreter may sight translate the form to the patient and record verbatim the patient's answer.
3. The interpreter should not explain terms, extrapolate answers or provide additional medical information.
4. The interpreter should leave no items blank, but instead write that patient declined to answer, that the question is not applicable, that the patient did not know the answer, that the patient did not understand the question, or that the answer was too lengthy to write down.

The following caveats apply:

1. Interpreters with limited reading and writing ability in English should not attempt to help patients fill out forms.
2. Any form that would be filled out by a provider for an English speaker should be filled out by the provider, working through the interpreter, for an LEP patient.

D. Guidelines for Durable Communications Prepared for Illiterate Patients

Speech is fleeting while writing endures. This is one reason that providing quality translation of vital documents is so important. Patients need to be asked, however, in what language they prefer a written document. Some patients may communicate orally better in their mother tongue, for example Quechua, but read better in the language of their schooling, for example, Spanish.

And of course no translated document is of use to a patient who does not read. For patients with limited literacy, or for patients whose language does not have a commonly used written form (such as Hmong or Navajo), audio or video recordings of vital documents can provide a viable alternative to written translation.

Literacy is an issue in the selection and training of interpreters as well and will be addressed below.

IV. Implications for the Training of Healthcare Interpreters

Because interpreters are so often expected to sight translate or produce written texts, this responsibility should be recognized by programs that prepare interpreters and in continuing education for working interpreters.

However, when the interpreter training is of limited duration, the emphasis must be placed on the interpreter's central task of interpreting spoken utterances. Additionally, for interpreters who have limited literacy in one or both of their languages, their training and their role after training must be limited to interpreting.

In a more extensive training program, the screening for admission can include asking the applicants to produce a sample of their writing (not translation) in each language, to assess levels of literacy. The screening will determine whether it is appropriate to include training in sight translation and brief written translation in their training.

Students in a short introductory course should learn what sight translation is and how to respond when asked to sight translate or write down information in the patient's language. It should be made clear that interpreters should comply with such requests only if they feel qualified. They need to be made aware of alternatives such as interpreting a provider's oral presentation of the content of a written text and asking a patient or guardian to write down information they want to retain, or making an audio recording.

In intermediate trainings, or in longer basic training programs, instruction in sight translation should be offered for interpreters who are sufficiently literate in English, keeping in mind the contexts in which these skills may be needed. Interpreter training should recognize that sight translation will be mainly into the patient's language and will be informational and semi-technical. Supervised practice in sight translation should make use of brief texts intended for the individual patients such as signage, discharge instructions, basic nutritional guidelines, etc. Students should discuss how to respond if asked to sight translate lengthy and/or legalistic documents such as consent forms and advance directives.

In advanced training, students can be given practice in preparing brief informal translations needed for patients who are literate in their non-English language. It should be kept in mind that any texts that interpreters might be expected to write in the patient's written language in order to provide a durable record should be brief and non-technical and intended only for that particular patient. These might include dosage information on medicine bottles, brief instruction for wound care, meal preparation protocols, etc. The training should include supervised practice in translating exactly these sorts of materials. Again, alternatives to translation by the interpreter should be discussed as well as how to provide these types of information to the illiterate patient.

V. Implications for Remote (Telephone or Video) Interpreting

We have taken the position that sight translation and brief written translations for individual clients may be expected of some but not all interpreters. Another reason for considering this task to be non-essential for interpreters is the increased use of telephonic or video interpreting. With the technology currently available in healthcare settings, it is unusual for a remote interpreter to receive written texts to be sight-translated or to produce a written text in a language that the client reads. The literature on telephone interpreting is generally silent on this subject. Nataly Kelly's landmark book *Telephone Interpreting* (2008), for example, does not address the handling of written texts. Of course, when improved technology makes it easier for

telephonic interpreters to send and receive written texts while interpreting, then the same considerations will apply as in face-to-face communications.

VI. Conclusion

A healthcare interpreter's primary duty is to convert oral communications from one language to another. Because some information needed by a patient or guardian may exist only in written form, an interpreter may be called upon to communicate the written information orally in the client's language, or the client may need to have a durable written record of information that only the interpreter can provide. Interpreters should, if possible, be prepared to assist in these situations, and interpreter training should recognize and prepare interpreters for these tasks. It must be recognized, however, that the length and complexity of texts to be sight translated or put into writing by an interpreter must be strictly limited. Wherever possible, in the interest of accuracy and efficiency, written texts in appropriate languages (or audio or video recordings of texts) must be prepared with the assistance of qualified translators in advance of their need in any particular provider-patient encounter.