Assessing Healthcare Interpreting Performance Skills in an English-to-English Format

Summary of the National Healthcare Interpreting Experts' Focus Group Discussions held by CCHI in the fall of 2017.

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Introduction

The Certification Commission for Healthcare Interpreters (CCHI) has administered the national certification programs for healthcare interpreters since 2010. The two currently available certifications – Core Certification Healthcare Interpreter™ (CoreCHI™) and Certified Healthcare Interpreter™ (CHI™ - Spanish, Arabic, Mandarin) – are aimed at the entry-level healthcare interpreter.

The entry-level certified healthcare interpreter is defined as:

> *A person who is able to perform the functions of a healthcare interpreter competently, independently, and unsupervised in any setting and in any modality where health care is provided, with the knowledge, skill, and ability required to relay messages accurately from a source language to a target language in a culturally competent manner and in accordance with established ethical standards.*

As part of a continuous evaluation process of its certification programs, CCHI reviewed the current knowledge regarding valid and efficient assessment of interpreting skills of interpreters of *any* language. CCHI engaged several experts in the field of healthcare interpreting (see acknowledgments) during this analysis. Developing dual-language performance exams at the CHI™ level for every language is not feasible economically or psychometrically. Thus, the final goal of this effort is to create a valid and reliable performance examination for interpreters of languages that do not currently have a dual-language performance exam.

Forty experts representing interpreter educators, managers, practicing interpreters and quality assurance specialists in the healthcare interpreting field from the U.S. participated in ten expert group conference calls and six interviews between September-November 2017.

The purpose of these discussions was to collect a representative number of professional opinions to assess the value and feasibility of developing an interpreter performance examination in a monolingual modality. This review also considers current trends in the industry and profession, and how these affect the demand for certification. The present document reflects the discussions and opinions of the participants and the CCHI Commissioners.

CCHI will be using this information for the CoreCHI™ certification program enhancement. The actual examination development will adhere to the processes CCHI employs in all its current certification examinations, which are in compliance with the NCCA's Standards for the Accreditation of Certification Programs.

Definitions of terms and concepts used in this document are available in *Appendix A*. References and additional resources are provided in *Appendix C*.

Value and Challenges of Performance Assessment of Interpreters of Less Common Languages

The healthcare interpreter profession requires a specific body of knowledge, sets of skills, and professional code of ethics that differentiate a practitioner from a layperson. These parameters establish professional standards of performance that can be verified through an objective assessment process.

The primary variable among healthcare interpreters is their particular non-English language of service (language of interpreting). In the context of assessment, the interpreter's language of service is somewhat similar to a specialty or subspecialty, such as cardiovascular, neonatal, or palliative care specialization in the nursing profession.

Languages of service are not equal in terms of:

- educational opportunities available in the U.S. for studying and *mastering* a specific language to the level appropriate for interpreting;
- existence of terminology and concepts/constructs pertaining to Western biomedical and scientific tradition;
- number of speakers of a specific language residing in the U.S.;
- pool size of potential healthcare interpreters in the U.S.;
- opportunities to earn one's livelihood by interpreting in a specific language in a specific geographic region;
- existence of written resources about health, medicine, and provision of health care;
- online presence of a specific linguistic community.

All of the above directly affects the ability and feasibility of creating a valid assessment instrument to measure the interpreter's performance in a specific language of service.

Likewise, the equal opportunity tenets require establishing equitable certification standards that allow interpreters of *any* language to demonstrate their qualifications and skill level. CCHI is strongly committed to operating equitable and inclusive certification programs. For this reason, CCHI has developed and administers the CoreCHI™ certification which is accredited by NCCA as a stand-alone, language-neutral, knowledge-based certification.

Languages of service in healthcare interpreting could be broadly grouped into three categories:

1. ***Languages of common demand*** – languages with significant population of patients with limited English proficiency (LEP) residing across the U.S. and which also have widely accessible educational opportunities to study these languages in the U.S. (e.g., Spanish, Arabic, Chinese, Korean, Russian).
2. ***Languages of limited diffusion*** (LLD) – languages with relatively small population of patients with LEP residing across the U.S. and which have no educational opportunities to study these languages in the U.S. (e.g., Burmese, Hmong, Kirundi, Mayan languages, Nepali, Somali). For example, there are over 30,000 Somalis residing in Minneapolis, MN, and Columbus, OH, each, yet very few outside of these cities. There are no college-level programs teaching the Somali language in the U.S.
3. ***Languages of lesser demand*** – languages of relatively small population of patients with LEP residing in a specific area in the U.S., yet which have reasonably accessible educational opportunities to study these languages in the U.S. (e.g., French, German, Japanese). For example, the demand for interpreters of Japanese may be non-existent in Akron, Ohio, yet significant in Los Angeles, CA, and there are many college-level programs teaching Japanese in the U.S.

To establish a language-specific certification program, both languages of limited diffusion and of lesser demand present similar challenges. For the sake of narrative efficiency, we refer to both groups herein as "**less common languages,**" understanding that the term requires further exploration.

Challenges of creating assessment instruments for less common languages

Regardless of the nature of the assessment instrument, be it a language proficiency test, an interpreter performance exam, or an interpreter certification program, creating an assessment instrument for less common languages faces the following challenges:

- Convening a representative group (15-25 people) of healthcare interpreters of a specific language who meet the minimum educational (in our case, High School diploma and 40 hours of medical interpreter training) and work requirements (practicing interpreters in *healthcare* settings) to *volunteer* as subject matter experts (SMEs) to create the initial examination content, and update it regularly afterwards;
- Accessing a statistically relevant pool of pilot testers to validate the initial exam content (minimally 50, best practice – about 200);
- Recruiting, training, and *retaining* human test raters (optimally 5-10) who have the qualifications and are available to perform efficient rating. Currently, this requires the use of online scoring tools and completing rating within a specific timeframe. Retention is a significant challenge. Due to the low volume of tests, raters' earnings will not be a significant source of income, yet the time investment is demanding for continuous training and secure rating procedures;
- Sustaining an adequate testing volume (50 annually) to maintain best rating practices and reduce subjectivity of human raters. Firstly, rater skills are correlated with a regular volume of tests to rate (the more tests, the higher the skill); secondly, the possibility of rater bias is reduced when more raters are available per test; thirdly, larger sample sizes provide better psychometric data for the performance of raters (as well as test items).
- Maintaining an adequate number of tests annually (200 at a minimum) to allow the testing organization to recover the initial investment of developing an exam and the ongoing maintenance costs.

Ultimately, the challenge in the healthcare interpreting context is estimating how many certified interpreters in a specific, less-common language are able to earn their livelihood as a healthcare interpreter. For example, does the U.S. healthcare system need 10,000 or 1,000 or 500 full-time interpreters of Chamorro or Estonian? If the answer is 1,000 or 500, then without continuous financial subsidies, creating and maintaining a *valid* certification exam in those languages is not feasible. At present, there is no consistent country-wide tracking of healthcare interpreter jobs per language. Thus, it is a nearly insurmountable task to estimate the number of potential certified interpreters the industry requires for any language.

Although several *language proficiency* testing opportunities exist for many—albeit not all—less common languages, these assessments face the challenges we list above. Moreover, all these language proficiency tests are commercial and have not been validated through an independent third-party review or accreditation. An objective comparison of their value across languages and testing agencies is impossible when there is no transparency about the development of these tests, the statistical sampling used to validate them, the psychometric parameters of their annual performance data, etc.

It is important to note that language proficiency testing may be helpful in establishing a person's fluency and communication abilities (i.e., listening comprehension and response/speech production), yet in no way does it assess their *interpreting* abilities and skills (i.e., preserving accuracy of meaning while converting a message from one language into another). And although recommendations exist as to at what level of language proficiency a person could work as an interpreter, there is no supporting data for these recommended levels. There have been no studies comparing the language proficiency levels of candidates who pass an interpreter certification exam with those who fail.

The participating experts agreed unanimously that there is a definite need for exploring the possibility of creating a monolingual interpreter performance assessment tool in English. The healthcare interpreting profession and industry would benefit if a valid and reliable English-to-English (EtoE) performance examination

could be created to assess the interpreter's core cognitive skills/subskills necessary for successful conversion of meaning from one language into another. This is seen as an important step to advance the profession.

The following **benefits** of the EtoE performance exam were identified:

- Recognizing that it is impossible to create a *valid* interpreter performance examination for *all* languages, the EtoE exam would provide some *predictive* validity and a *uniform* way of assessing some interpreting skills/subskills in a reliable manner.
- Candidates of *any* language would be able to demonstrate their ability to *perform* some interpreting, not just their knowledge *about* interpreting.
- Candidate's English language skills would be assessed in a manner pertinent for interpreting, i.e. beyond simple comprehension and speech production/communication.
- The EtoE exam would be especially valuable for interpreters of "less common" languages for which developing a dual-language performance exam at the CHI™ level is not feasible.
- Such an assessment would contribute to better hiring and retaining decisions by managers and language services companies (LSCs) in health care and potentially in other settings, such as emergency response, education, law enforcement.
- Including the EtoE exam as part of the CoreCHI™ certification would improve its overall value leading more candidates to seek and obtain the CoreCHI™ certification, which, in turn, support the development of additional dual-language CHI™ examinations.

The participants distinguished between two types of skills and abilities that define a minimally competent healthcare interpreter of any language:

a) Cognitive skills and abilities that relate to successful conversion of meaning from one language into another, e.g., memory skills, maintaining accuracy and speaker's register, avoiding loss of meaning, etc.
b) Behavioral skills and abilities ("soft skills") that relate to performing their role and managing communication effectively, e.g. asking for clarification in the least intrusive manner, explaining the interpreter's responsibilities or limitations, recognizing when their intervention is needed and effectively performing such an intervention, etc.

Because behavioral skills and abilities are not currently assessed in the dual-language CHI™ examinations, they are *outside the scope* of the EtoE performance exam as well. In other words, **the focus of the EtoE performance exam is the interpreter's cognitive skills.**

Participants agree that there is value in developing an assessment of the healthcare interpreter's behavioral skills, yet such an assessment would be an *additional* step for interpreters of all languages. CCHI considers this type of assessment as one of possible future enhancements of its certification programs.

Healthcare Interpreter Competencies

Review of the few existing publications on the interpreter's competencies supports the premise that cognitive-linguistic interpreting skills exist separately from language proficiency skills and could potentially be assessed independently of the specific languages.

Frantz Pöchcacker (2004) expresses the general consensus among interpreter educators and researchers that the "competence profile of professional interpreters" includes "knowledge (of languages and of the world), cognitive skills (relating to analysis, attention and memory) and personality traits (including stress tolerance and intellectual curiosity)."[1] Recognition by conference interpreting professionals that "the basic tenet is that language acquisition must precede training in interpreting (e.g. Arjona 1984)"[2] is the foundation for exploring assessment of interpreting skills separately from proficiency in the working languages.

The hypothesis for this project is additionally supported by the existence of the following interpreting "memes" described by Pöchcacker: the "process(ing) supermeme," i.e. interpreting viewed as a "set of information processing operations" and the "meme of making sense, which conceptualizes the interpreter's task as grasping the intended meaning ("sense") of an original speaker and expressing it for listeners in another language."[3] Their descriptions provide a potential "menu" of test items for the EtoE assessment.

Pöchcacker also outlines the key general interpreting skills described by various authors as "analytical skills in text comprehension (e.g. Seleskovitch and Lederer 1989, Kalina 1992, Setton 1994, Winston and Monikowski 2000), expressive skills for 'public speaking' (e.g. Weber 1990), situation analysis (e.g. Thiery 1990), and assignment preparation, with special regard to terminology research and documentation (e.g. Schweda Nicholson 1989)."[4]

Moreover, Daniel Gile (2005) reminds us, "it is important to remember that interpreting relies on strategic and cognitive skills which can to a large extent be acquired in the course of monolingual consecutive interpreting exercises."[5] He describes further a commonly accepted practice in conference interpreting, "Students can be asked to reword the source-language speech into a target speech in the same language. The advantage of this procedure is that the mechanisms of memory and the importance of the comprehension of the "logic" of the speech can be demonstrated: in such exercises, students cannot incriminate language switching in the problems they experience (in particular misunderstandings and logical contradictions)."[6]

Every valid certification examination is based on the corresponding job task analysis (JTA) study. CCHI conducted its second national JTA study in 2016. The interpreter's job tasks and competencies were defined for the domain "Interpret in Healthcare Settings" (for the complete list, see pp. 36-37 of the *Report on CCHI's 2016 Job Task Analysis Study* presented in *Appendix B*).

The JTA Study results confirm the usefulness of conceptualizing interpreting as a set of rather complex cognitive-linguistic component subskills. These subskills cannot be reduced to a direct "transcoding," i.e., substitution of a source language word with an equivalent target language word. Knowledge of the "words" in two languages does not result in interpreting. Or, as Gile puts it, "Since the actual words and sentence structures of the source speech disappear from memory after a few seconds, interpreters who rely on words

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[1] Pöchhacker, Franz. 2004 (2016-2nd Edition). Introducing Interpreting Studies. Routledge. P. 180.
[2] *Ibid*.
[3] *Ibid*., p. 53
[4] *Ibid*., p. 183.
[5] Gile, Daniel. 2005. Teaching Conference Interpreting. In M. Tennent, Training for the New Millennium: Pedagogies for Translation and Interpreting. Amsterdam and Philadelphia: John Benjamins. P. 144.
[6] *Ibid*., p. 132.

they have taken down while listening without gradually building a mental model of the content of the speech inevitably fail to reconstruct the speech properly.”[7]

Currently, the CHI™ performance exams in Arabic, Mandarin, and Spanish assess such cognitive-linguistic skills and abilities in a dual-language format.

The participating experts agree that a significant number of these cognitive-linguistic skills may be assessed to a relevant degree in a monolingual, EtoE format. Namely:

- Active listening/reading
- Anticipatory listening/reading
- Message analysis
- Comprehension of oral speech/written text
- Retaining and recalling information (short-term memory)
- Accurate reformulation of the source speech/text in the same language (fidelity to the message)
- Understanding of the concept of ‘register’
- Attention-sharing skills
- Fluency (lexical and grammatical) in English (speech production)
- Speech quality in English (pronunciation, prosody, pace/speed)

The overall recommendation is to identify a menu of test items that can potentially assess these skills in an efficient manner in a monolingual, EtoE format and conduct a study comparing candidates’ performance on the EtoE exam as well as a corresponding dual-language exam. Because the current dual-language CHI™ performance exams – Arabic, Mandarin, and Spanish – represent significantly different languages by many parameters, the findings of the study involving interpreters of these languages will be plausibly transferrable to other spoken languages.

[7] *Ibid*., 146

Assessment Elements

Item types

The following components of an examination have been proposed for consideration:

1. Accurate reformulation
2. Comprehension of English speech and text (for sight translation)
3. Production of speech in English
4. Multi-task simultaneity and memory

The participants noted the following types of activities that could potentially measure the interpreter's cognitive-linguistic skills in a monolingual, EtoE format.

- Bilingual/interlingual reformulation as a two-step activity with the English input and output

E.g., Consecutively interpret a conversation between a provider and patient, presented only in English, into Language 2 (L2). Listen to own recording in L2 and interpret consecutively into English.[8] While the activity performed by a candidate is what is often called "back translation/interpreting," the skill assessed by comparing accuracy of the English output (interpreting from L2) to the English input (source, exam prompt) is the skill of meaning-oriented reformulation, not of actual interpreting.

- Monolingual/intralingual reformulation

E.g. Paraphrase,[9] accurately and completely, a provider's recorded speech in English, either consecutively or simultaneously.

The value of interlingual reformulation as an assessment element is supported by researchers and educators of conference interpreting. Pöchcacker summarizes (emphasis his), "Much less controversial than shadowing have been preliminary exercises with a focus on content processing, such as simultaneous **paraphrasing**, shadowing tasks combined with cloze exercises (see Kalina 1992, 1998) or simultaneous interpreting of well-known fairy tales (see Seleskovitch and Lederer 1989). Russo (1995), who had proposed paraphrasing as a test for aptitude in simultaneous interpreting (see Russo 1993), used a questionnaire to elicit students' perception of difficulties and found that the paraphrasing task was experienced as particularly taxing. Moser-Mercer (2000) asked beginning students to keep a journal recording their difficulties with introductory exercises (including shadowing and interpreting a fairy tale) and found "concentration" to be the crucial problem area."[10]

- Memory and concentration

E.g. Shadowing - listen to an English speech and repeat it in English simultaneously with décalage.

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[8] See description of a similar item on the State of Washington DSHS Screening Exam for Medical Interpreters in *State of Washington DSHS. Professional Language Certification Examination Manual. Pp. 14-15, 21,* accessed in November 2017 at https://www.dshs.wa.gov/sites/default/files/FSA/ltc/documents/ExamManualWebVersion.pdf.

[9] "Since paraphrasing is a meaningful verbal indicator … of the cognitive ability to understand and reproduce a message (unlike exercises such as shadowing during which repetition does not always entail comprehension, since each process involves a different functional area of the brain, see Luria quoted in Kurz, 1992), it seems likely that those who spontaneously and effortlessly show this ability to process a text stand a better chance when embarking upon a training course in SI whose main focus is the processing of meaning and not of words only." - Mariachiara Russo, "Self-Evaluation: The Awareness of One's Own Difficulties as a Training Tool for Simultaneous Interpretation", in: The Interpreters' Newsletter, 6 (1995), p. 81.

[10] Pöchhacker, Franz. 2004 (2016-2nd Edition). Introducing Interpreting Studies. Routledge. P. 184.

Although some educators[11] question the value of shadowing as a preparatory exercise for simultaneous interpreting, in this context it is used as an assessment of the candidate's general concentration and English speech production, especially quality of speech aspects such as prosody and tempo. At the same time, data collected during the administration of this element may shed further light on its relevance to interpreting skills overall.

E.g. Repeat English sentences consecutively, with incremental difficulty, i.e. longer and more complex sentences.

E.g. Allow the candidate to pause a pre-recorded speech, interpret up to that point, and then continue. A special scale could be developed to account for how often and at what points in the recording the pauses are made, keeping in mind that fewer pauses do not necessarily mean better skill.

- Production of speech in English

E.g. Read an English text or listen to a speech in English and answer a question in English that not only checks for comprehension but requires spontaneous speech production. The question could be related to the interpreter's ethics, standards of practice, or other important topics relevant to the profession.

- "Cloze" items in an aural or written format, to demonstrate anticipatory and analytical abilities as a higher level of English proficiency.

E.g. Candidate listens to a relatively long speech with gaps to fill in, possibly with incremental difficulty – from one or two words to larger and/or more complex "chunks" or units of meaning.

- Semantic equivalence determination (could be done through a multiple-choice item)

E.g. Ask candidates to either select or produce (in English) synonyms or antonyms to healthcare terms or terms of art. Knowledge of the concept of register can be assessed. Possibly develop a weighted scoring rubric to reward for better choices.

E.g. Paraphrase medical terminology or statements by expanding them to meaning-oriented explicitation.

- Listening and reading comprehension in English

According to Gile, "the practice of consecutive interpreting demonstrates beyond doubt the importance of analytical listening as opposed to plain word identification. Since the actual words and sentence structures of the source speech disappear from memory after a few seconds, interpreters who rely on words they have

[11] Ibid., p. 185: "Kurz (1992), citing neuropsychological findings, characterizes mono-lingual repetitive speech production as a poor approximation to simultaneous interpreting, pointing out that "a crucial element is missing in those exercises: the active analysis of the speech input" (1992: 248). In a longitudinal study, Kurz (1992, 1996) tested five first-year students on a shadowing task and two simultaneous question and answer tasks at the beginning and at the end of one semester of regular training in simultaneous interpreting. While test results were significantly better on all three tasks, Kurz found the most pronounced improvements for the more demanding task (i.e. answering a why question while listening to the next question). This is in line with the results of the pioneering study by Moser (1978), who found that a program of introductory exercises (including abstraction of ideas, message prediction, dual-tasking and shadowing) resulted in the least significant difference between the test performance of course participants and a control group for the shadowing task, whereas the most pronounced difference was found for the 'décalage' or extended lag test, which required subjects to repeat or translate input sentences while staying one or two sentences behind. Moser's (1978) conclusion that shadowing requires less processing for meaning was confirmed in a recent expert-novice study: Moser-Mercer et al. (2000) found that their five student subjects were more efficient shadowers than the five professional interpreters, who presumably brought their acquired content-processing strategies to bear on the task. Similarly, Elisabetta Sabatini (2000/01) found that the near-professional student subjects in her experiment adopted a meaning-oriented approach to the shadowing task, thus obscuring the performance difference expected between shadowing and SI."

taken down while listening without gradually building a mental model of the content of the speech inevitably fail to reconstruct the speech properly."[12]

E.g. Use multiple-choice and open-ended questions that require spontaneous speech production in English.

E.g. Summarization and key concepts identification activities to assess analytical skills.

Item content (scripts and texts)

It is important to maintain the same level of difficulty and diversity of the speeches and texts in the EtoE exam as are present in the CHI™ performance exams, i.e. appropriate for the entry-level interpreter.

However, to test some cognitive skills, it may be beneficial to use speeches/texts with confusing or complicated logic, speaker's backtracking, tangential comments, etc., in order to test certain cognitive skills. Candidates on the EtoE exam are not actually required to interpret such speeches/texts. Therefore, it is important to develop a scoring scale to assess how well candidates preserve the core logic and concepts of the speeches and texts.

It is important to include items consisting of English texts typical for healthcare settings as reading comprehension of those types of texts may be a good indicator of the overall English proficiency.

It may be beneficial to include texts/recordings intended to test understanding of scientific (e.g., biomedical) concepts.

Scoring the EtoE Examination

Ideally, scoring of the EtoE examination should be similar to the scoring scales and procedures of the dual-language CHI™ performance exam.

Therefore, the following elements should be the same as in scoring of the current CHI™ performance exams:
- All raters are interpreters with a minimum of 5-years' experience in healthcare interpreting.
- All raters undergo a similar training.
- Every audio response is scored by two raters independently.
- Raters do not see each other's scores nor the total score of a candidate.

However, the actual rating scales may need to be adapted since the EtoE test items are different than those of the dual-language CHI™ performance exam. For example, the scales of "speech cohesion/fluidity" and "confidence of rendition" may be considered for reformulation or speech production items. Review of the existing language proficiency scales (e.g., ILR, ACTFL, CEFR, IELTS, TOEFL)[13] might provide guidance for defining the EtoE examination scales.

The participants agree that it is important to develop clear scoring parameters, especially for assessing EtoE reformulation accuracy, with special attention to circumlocution and explicitation related to how different languages treat ambiguity. For the bilingual reformulation item, it is important to include a step when raters listen to the candidate's non-English recording and assess insertion of any English words, with a corresponding penalty. (It is important to exclude from the item content words/concepts that many languages may borrow from English.)

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[12] Gile, Daniel. 2005. Teaching Conference Interpreting. In M. Tennent, Training for the New Millennium: Pedagogies for Translation and Interpreting. Amsterdam and Philadelphia: John Benjamins. P. 146.
[13] See corresponding references in the definition of "language proficiency scale" in *Appendix A*.

Special consideration should be given to candidates of languages without a written or Western biomedicine tradition where during actual interpreting very little word-level transcoding is possible. A special scale may be needed to address these candidates' ability to produce accurate and efficient meaning-oriented explicitation when appropriate (i.e. lexical specification, generalization, and disambiguation as well as culturally relevant additions).

If possible, the overall certification program should address the issue of language proficiency of the non-English language, perhaps by way of more specifically defined eligibility criteria.

Feasibility & limitations

Language proficiency in the non-English language

One of the key limitations of the EtoE interpreter performance examination is the absence of assessing the actual dual-language interpreting and, co-dependently, of assessing the non-English language proficiency/fluency of the candidate. The first performance competency may be partially assessed via reformulation items, especially the "back interpreting/translation."

The absence of the non-English language proficiency/fluency component may be addressed either by modifying eligibility requirements for language proficiency at the time of application, or by awarding a certification credential only to candidates who, in addition to passing the EtoE exam, present evidence of their non-English language proficiency at a certain level. Both of these approaches would require further national discussion regarding the validity of specific language proficiency exams, and the required score/level on these exams for a certified interpreter. Current recommendations to this effect are not supported by significant statistical data nor have been reviewed by a diverse and comprehensive group of stakeholders at the national level. Therefore, it is important to conduct national focus groups and/or a national survey on this topic.

Some participants pointed out a mitigating factor: most interpreters of less common languages are native speakers of those languages. Thus, verification of a high-school-level education in the respective language may be sufficient, i.e. no changes to the current eligibility criteria are required. At the same time, it would remain a challenge for non-native speakers and heritage speakers of less common languages to demonstrate proficiency.

One possibility to adjust for this limitation of the EtoE exam may be establishing special requirements for certification renewal, e.g., supervisor observation reports after one year of practice post-exam; passing an OPI in the non-English language at a particular level.

Bilingual/intralingual reformulation with a "back interpreting/translation" component

The "back interpreting/translation" method has been used as an assessment tool in the profession for a long time, e.g. in the State of Washington DSHS Medical Interpreter Screening Exam, in some state court interpreter programs screening tools (CT, NY), in private employment screening tools. The profession does not have statistically valid evidence of its performance. Without such evidence it is impossible to assuage doubts currently associated with its use.

Many participants point out that such a test item may help identify candidates who are significantly below the passing level. However, it would not vet candidates who are more competent, but not competent enough to be certified. A psychometric performance analysis of this item may shed light on this assumption.

Carefully determining the parameters for validating the content (audio scripts or texts) of this item is important in order to ensure it avoids the following pitfalls:

- Some languages may have borrowed certain medical terms from English while others created their own term, i.e. candidates of some languages will appropriately use the English term without translating it and this will not be an error, while for candidates of other languages the use of the English term presents an error because a native term exists.
- The human brain tends to remember unusual, new information (e.g. EpiPen®, Alzheimer's), so a candidate may interpret this unit of information into their non-English language completely incorrectly, but when "back-interpreting" from their recorded response into English, they may use the correct English word(s).

The most challenging aspect of constructing these test items is creating rating scales and rubrics. It is important to define the behavioral anchors that can be consistently applied by raters. The fact that languages may use different lexical/semantic ways to convey the same meaning, and the words of the English input may be different from the candidates' output presents a challenge. Defining a unit of meaning in its conceptual rather than lexical form is crucial, as well as defining parameters of what constitutes an "omission" and "addition" of meaning.

Heritage speakers of less common languages and native English speakers

Heritage speakers with English as their dominant language, as well as native speakers of English, may have an advantage in the EtoE testing format. However, their cognitive skills of reformulation may be a good indicator of their interpreting ability. Without statistically valid psychometric data, it is hard to prove or disprove this assumption. In view of this potential bias and because the majority of ASL interpreters are native speakers of English, it is recommended the EtoE examination be limited to candidates of spoken languages until data confirms the absence or acceptably low impact of this bias.

To control for this potential bias (if its existences is ascertained), candidates of spoken languages who are heritage speakers and native English speakers may have an additional eligibility requirement of passing a language proficiency test at a higher level than acceptable for their counterparts.

It should be noted that heritage speakers may bet at an advantage because some of them may have a broader educational background (received in the U.S.) than the native speakers of their non-English language. At the same time, heritage speakers with low access to their linguistic community (especially outside their family) may have a significantly lower language proficiency in the non-English language than heritage speakers who either spend significant time in the country of their language or interact regularly with monolingual speakers of their language. Thus, it may be advisable to require more documentation regarding heritage speakers' experience with their non-English language in lieu of a language proficiency test, especially if no such test exists for that language.

For some less common languages of new immigrant populations in the U.S., it may be helpful to establish an "age at immigration" criterion to designate them as "heritage" rather than "native" speakers of their home country languages. The consensus seems to consider children younger than 16 when they immigrated to the U.S. to be "heritage" speakers, because their high-school-level sciences education (i.e. relevant for health and healthcare knowledge) is conducted in English in the U.S. It may be worthwhile to conduct a national survey of interpreter educators and sociolinguists on this issue.

Objective disparity in exam preparedness

There exists an objective disparity in overall preparedness for certification testing among interpreters of less common languages due to:

- Absence or limited availability/accessibility of language-specific training and reference materials in those languages about healthcare terminology and concepts, or for practicing interpreting and/or translation;
- Absence or lower availability of language-specific interpreter or translator training programs with instructor feedback;
- Limited financial resources because they are either newcomers to the U.S. or there are fewer full-time or part-time interpreting jobs for their languages.

To ensure a fair and standardized testing experience for all, the EtoE examination and scoring parameters must be clearly explained, and affordable sample or practice tests should be created along with descriptions of existing resources and training opportunities.

It is hard to estimate if such interpreters would seek certification out of their own volition, especially, if language service providers continue working with bilinguals whose interpreting skills have not been assessed in a valid way. Thus, it will be imperative to educate all stakeholders in the industry about the benefits and value of the EtoE examination.

Transparency about the EtoE exam limitations and future steps

Any examination, written or oral performance, possesses inherent limitations compared to the real-life performance of a candidate. Any certification program should be considered a continuum, not a static product. Introduction of the EtoE exam to assess some cognitive-linguistic interpreting skills *and* English fluency of candidates is a step in the right direction in advancing the profession.

It is critical to clearly define the purpose of such an exam and its limitations, as well as educate all stakeholders about its value. The EtoE exam is not the same as a dual-language CHI™ performance exam, but it is a step closer to the latter than a written knowledge exam alone.

Considerations should be given to potentially establishing different designations based on the EtoE examination results and the candidate's portfolio of their non-English language proficiency documentation. E.g., if a candidate scores between X and Y but below the passing score and they have XYZ evidence of the non-English language proficiency, they may get a designation at the "level of bilingualism" with XYZ types of interpreting assignments to assist with. In other words, define a progression of limitations of practice for candidates who are close to passing.

Some of the future improvements to consider for the EtoE examination (including certification renewal requirements) are the following:

- Adding items with the non-English language content (texts or audio) that are interpreted into English. Although, of course, this is not possible for all languages, it may be less costly to develop and maintain than a full dual-language CHI™ exam, considering raters will only be needed for the English output.
- Once a library of audio recordings by candidates in a specific language is accumulated, introduce them as audio prompts for candidates to comment on the quality of the non-English speech and interpret as much as possible as a way of assessing their non-English oral comprehension and understanding of interpreting accuracy. However, this approach would require additional validation of such recordings and protection of the original speakers' identities.

Conclusion

CCHI Commissioners are grateful for all the ideas and suggestions the participants shared during the in-depth discussions. There is a definite need and value in exploring the possibility of creating a monolingual interpreter performance examination in English. The healthcare interpreting profession and industry would benefit if a valid and reliable English-to-English (EtoE) performance examination could be created to assess the interpreter's core cognitive skills/subskills responsible for the successful conversion of meaning from one language into another. At the same time, assumptions about validity of such an examination need to be tested.

The next step in this project is to design and conduct a concurrent validity study to determine if the EtoE examination (or any of its specific types of test items), in fact, measures interpreting skills and abilities. The study will involve candidates of the Arabic, Mandarin and Spanish languages who will take both the EtoE exam and the corresponding CHI™ dual-language performance exam.

If the study results conclusively prove that scores on the English output portion of the EtoE examination are not significantly different from the scores on the dual-language CHI™ exam, then the EtoE examination will be developed in accordance with the NCCA accreditation standards, and to enhance the CoreCHI™ certification.

If the study results are inconclusive or negative, the profession and educators will have evidence-based proof that only dual-language interpreter performance examination can reliably assess interpreting skills.

Regardless of the results, the study will benefit interpreter educators and employment recruiters providing them evidence-based information for training and job preparedness of interpreters of less common languages.

CCHI will convene a diverse National Task Force and seek research partners to design and implement the study and follow the NCCA accreditation standards during the development of test items.

Appendix A. Definitions

Ability	Developed knowledge and understanding of a subject matter or task, learned or acquired, i.e. not innate.
(Interpreting) Accuracy	The interpreter's ability to convey the intended meaning of a message in its totality within the constraints of a specific language.
Aptitude	A component of a competence to do a certain kind of work at a certain level. Aptitude is innate potential to do certain kinds of work whether developed or undeveloped.
Assessment	A wide variety of methods or tools used to evaluate, measure, and document the academic or professional readiness, learning progress, skill acquisition, or educational/professional development needs of students or practitioners of a profession. (For more info about assessment types, see https://www.edglossary.org/assessment/.)
Assessment instrument (tool)	A test or examination or any other special process of evaluating a candidate's knowledge, skills and abilities in a certain area of study or practice.
Back interpreting	An oral version of "back translation," the procedure according to which an interpreter interprets a speech that was previously interpreted into another language back to the original language. E.g., the original English speech or text was interpreted into Language X, interpreting the speech in Language X into English is "back interpreting."
Certification exam	A part of a certification program that constitutes the assessment instrument utilized to establish a candidate's knowledge, skills and abilities in a certain area of practice. E.g., CCHI's CHI™-Spanish exam.
Certification program	An entirety of various certification aspects, including candidate's eligibility requirements, testing policies, examination(s), certification maintenance requirements, etc. E.g., CCHI's CHI™-Spanish certification program includes specific eligibility requirements, passing of 2 examinations, adherence to CCHI policies, and certification renewal requirements.
Competence	A combination of practical and theoretical knowledge, cognitive skills, behavior and values used to improve performance; or as the state or quality of being adequately or well qualified, having the ability to perform a specific role.
(Speech) Complexity	The degree to which a speaker utilizes in their speech vocabulary that is beyond-basic, complex grammatical/syntactical structures, and discourse strategies.

Comprehension	The ability to process text or speech, understand its meaning, and to integrate it with what the recipient already knows. For the interpreting profession, both listening and reading comprehension skills are important.
Criterion-referenced test (CRT)	A test which compares a candidate's performance to a pre-defined set of criteria or a standard. The goal with these tests is to determine whether or not the candidate has the demonstrated mastery of a certain skill or set of skills. Either the candidate has the skills to practice the profession, in which case they are certified, or does not. CCHI exams are criterion-referenced.
EtoE interpreter performance exam	This is a proposed working term for a monolingual, English-to-English, oral performance examination of healthcare interpreters that assesses the interpreter's core cognitive skills responsible for a successful conversion of meaning from one language into another and whose scoring is based on evaluating the exam's English input to the candidate's English output.
Explicitation[14]	Making something that is implicit in the source speech/text explicit in the target speech/text during interpreting. Explicitation may be dictated by the target language due to lexical or grammatical differences from the source language. Explicitation when it is not dictated by the target language is considered an error of addition; a common example of such an error is explanation of a term when an exact equivalent exists in the target language.
(Language) Fluency	The ability to produce language on demand (speaker's automaticity) and be understood, to convey the message unhaltingly. In other words, fluency is achieved when one can access language knowledge and produce language unconsciously, or automatically. Language fluency is sometimes contrasted with accuracy (or correctness of language use) and complexity (or a more encompassing knowledge of vocabulary and discourse strategies). Fluency, accuracy, and complexity are distinct but interrelated components of language acquisition and proficiency.
Heritage speaker	A language speaker who is raised in a home where a non-English language is spoken, who speaks or at least understands the language, and who is to some degree bilingual in that language and in English (based on the definition of a "heritage language learner", see *Valdés, Guadalupe. (2001). Heritage Language Students: Profiles and Possibilities.* In J. Peyton, J. Ranard & S. McGinnis (Eds.), Heritage Languages in America: Preserving a national resource (pp. 37-80). McHenry, IL: The Center for Applied Linguistics and Delta Systems).
Languages of lesser demand	Languages of relatively small population of patients with LEP residing in a specific geographic area in the U.S., but which have reasonably accessible educational opportunities for studying these languages available in the U.S. (e.g., French, German, Japanese). For example,

[14] For detail exploration, see *Tang, Fang. 2018. Explicitation in Consecutive Interpreting, John Benjamins*.

	the demand for interpreters of Japanese may be non-existent in Akron, Ohio, yet significant in Los Angeles, CA, and at the same time there are quite a few college-level programs teaching Japanese in the U.S.
Languages of limited diffusion (LLD)	Languages of relatively small population of patients with LEP residing across the U.S. and which have no educational opportunities for studying these languages available in the U.S. (e.g., Burmese, Hmong, Kirundi, Mayan languages, Nepali, Somali). For example, there are over 30,000 Somalis residing in Minneapolis, MN, and Columbus, OH, each, yet very few outside these two cities, and there are no college-level programs teaching the Somali language in the U.S.
Language of service (language of interpreting)	The language of the non-English-speaking recipient of what is being interpreted. In healthcare interpreting, it is the language of the patient or the patient's family.
Language (linguistic) Proficiency	The ability of an individual to communicate or perform in a specific language. Proficient speakers demonstrate both accuracy and fluency, and use a variety of discourse strategies.
Language proficiency scales	ILR scale: Interagency Language Roundtable descriptions of proficiency levels 0, 1, 2, 3, 4, and 5 characterize spoken-language use (http://www.govtilr.org/Skills/ILRscale1.htm). ACTFL scale: Developed from the Federal Government's ILR scale by the American Council on the Teaching of Foreign Languages, the ACTFL proficiency scale has four main levels (Novice, Intermediate, Advanced, Superior). The first three levels are each subdivided into three sublevels (Low, Mid, and High) (https://www.languagetesting.com/actfl-proficiency-scale). CEFR scale: The Common European Framework of Reference for Languages: Learning, Teaching, Assessment is a guideline used to describe achievements of learners of foreign languages across Europe and, increasingly, in other countries. The CEFR distinguishes between four kinds of language activities: reception (listening and reading), production (spoken and written), interaction (spoken and written), and mediation (translating and interpreting). Four broad domains are distinguished: educational, occupational, public, and personal. A language user can develop various degrees of competence in each of these domains and to help describe them the CEFR has provided a set of six Common Reference Levels (A1, A2, B1, B2, C1, C2). (http://ebcl.eu.com/wp-content/uploads/2011/11/CEFR-all-scales-and-all-skills.pdf) IELTS scale: The International English Language Testing System is an international standardized test of English language proficiency for non-native English language speakers. It is jointly managed by the British Council, IDP: IELTS Australia and Cambridge English Language Assessment. No minimum score is required to pass the test. An IELTS result or Test Report Form is issued to all test takers with a score from "band 1" ("non-user") to "band 9" ("expert user") and each institution

sets a different threshold. (https://www.ielts.org/en-us/about-the-test/how-ielts-is-scored)
TOEFL scale: Test of English as a Foreign Language is a standardized test to measure the English language ability of non-native speakers wishing to enroll in English-speaking universities. TOEFL is scored on a scale of 0 to 120 points by adding scores from each of the four sections (Reading, Listening, Speaking, and Writing) which each receives a scaled score from 0 to 30. The test is accepted by many English-speaking academic and professional institutions; each institution establishes the minimally accepted score which varies from 61 to 111. (https://www.ets.org/toefl/institutions/scores/interpret/)

Less Common Languages

The term used in this document to refer to both languages of lesser diffusion (LLD) and languages of lesser demand. Recognizing that this is not an ideal term, it is used for the sake of efficiency.

NCCA Accreditation

The process by which a credentialing or educational program is evaluated against defined standards by a third party, in this case the National Commission for Certifying Agencies (NCCA, http://www.credentialingexcellence.org/p/cm/ld/fid=86), and is awarded recognition when found in compliance with these standards. NCCA was established in 1987 by the Institute for Credentialing Excellence. The NCCA standards are consistent with *The Standards for Educational and Psychological Testing* (AERA, APA, & NCME, 1999) and are applicable to all professions and industries. Certification organizations that submit their programs for accreditation are evaluated based on the process and products and not the content; therefore, the Standards are applicable to all professions and industries. Program content validity is demonstrated with a comprehensive job analysis conducted and analyzed by experts, with data gathered from stakeholders in the occupation or industry.

Oral Proficiency Interview (OPI)

A standardized, global assessment of functional speaking ability. Taking the form of a conversation between the tester and test-taker, the test measures how well a person speaks a language by assessing their performance of a range of language tasks against specified criteria.

Paraphrase

Re-stating the meaning of the source speech or text in the same language accurately and completely yet using different lexical and syntactical units. *Syn*. Reformulation

Reformulation

Intralinguistic translation, re-stating the meaning of the source speech or text in the same language accurately and completely yet using different lexical and syntactical units. *Syn.* Paraphrase

Shadowing

"The immediate repetition of auditory input in the same language with either minimal delay ('phoneme shadowing') or at greater latencies ('phrase shadowing')." (Definition by Pöchcacker (2004), p. 184)

Skill	The ability to carry out a task with determined results often within a given amount of time, energy, or both.
Transcoding	Substituting words in the source language with their equivalents in the target language; interpreting at a word-for-word level instead of the meaning-level. Transcoding is acceptable only when specific terms are used, otherwise it produces literal interpretation that maybe incorrect in addition to being hard to understand by the target language listener.

Appendix B. Excerpt from the *Report on CCHI's 2010 Job Task Analysis Study and Results*

The following is the excerpt of *Appendix A. Content Outline for the Certification Examinations For Healthcare Interpreters* of the *Report* (pp. 36-37). The full text is available at http://cchicertification.org/about-us/publications/.

Domain VI. Interpret in Healthcare Settings

1. Interpret consecutively between source and target language to facilitate communication.

Knowledge of:

a. Terminology, idioms, usage, and cultural significance
b. Structure and grammar of working languages

Skill in:

a. Retaining and recalling information in short-term memory
b. Notetaking
c. Listening actively
d. Communicating fluently in working languages
e. Hearing and discerning dialects
f. Maintaining accuracy and transparency
g. Maintaining the register
h. Reducing interpreter accent to avoid impact on understanding
i. Self-monitoring for comprehension and output
j. Anticipatory listening

2. Interpret simultaneously from the source language into the target language to facilitate communication.

Knowledge of:

a. Terminology, idioms, usage, and cultural significance
b. Structure and grammar of working languages

Skill in:

a. Listening, processing, and interpreting simultaneously
b. Retaining and recalling information in short-term memory
c. Notetaking
d. Listening actively
e. Communicating fluently in working languages
f. Hearing and discerning dialects
g. Maintaining accuracy and transparency
h. Maintaining the register
i. Reducing interpreter accent to minimize impact on understanding
j. Self-monitoring for comprehension and output
k. Anticipatory listening

3. Sight translate a written message by rendering it into a spoken or a signed language to facilitate communication.

Knowledge of:

a. Healthcare documents that are appropriate for sight translation
b. Sight translation protocols
c. Terminology, idioms, usage, and cultural significance
d. Structure and grammar of working languages

Skill in:

a. Reading and comprehending written text in English
b. Converting written text into the spoken or signed target language
c. Anticipatory reading
d. Maintaining accuracy and transparency
e. Maintaining the register
f. Reducing interpreter accent to minimize impact on understanding
g. Self-monitoring output

4. Translate a written message by rendering it into a written or signed language to facilitate communication.

Knowledge of:

a. Healthcare documents that are appropriate for written translation
b. Written translation protocols
c. Terminology, idioms, usage, and cultural significance
d. Structure and grammar of working languages

Skill in:

a. Reading and comprehending written text in source and target languages
b. Converting written text into the written target language
c. Maintaining accuracy
d. Maintaining the register
e. Self-monitoring output
f. Writing in target language

5. Maintain fidelity to the message by taking into consideration register, cultural context, and nonverbal content to convey the original intent. (Assessed in all aspects of CHI examination)

Knowledge of:

a. Self-capacity for retaining and recalling information
b. Terminology, idioms, usage, and cultural significance
c. Culture of the linguistic community

Skill in:

a. Self-monitoring for accuracy
b. Researching unfamiliar and emerging terminology
c. Evaluating the validity of resources
d. Interpreting without additions, omissions, or substitutions

Appendix C. References and Additional Resources

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