The Other Side of the Curtain

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INTERPRETING FOR the deaf medical professional provides a unique opportunity for a designated interpreter to experience medicine from the eyes of a physician rather than a patient. With the increasing numbers of deaf doctors, there will be a rising demand for qualified interpreters who can work together with deaf doctors to achieve effective communication. The job of interpreting for a deaf professional is one that demands high expectations, relentless commitment, and the ability to perform deftly and skillfully with a wealth of information and knowledge. As an interpreter for a deaf medical professional, having the ability to quickly adapt to changing situations and being able to master a flurry of medical jargon is a must. This interpreting area requires that the designated interpreter be undaunted by the level of responsibility to communicate effectively. Ultimately, the designated interpreter in the medical profession plays a role in patient care from the provider standpoint.

Before entering the task of interpreting for the medical professional, the interpreter should consider his or her ability to tolerate the pace at which things occur, the exposure to sickness and surgery, and his or her willingness to be a team player. The interpreter should seriously personally assess the heavy demands that are expected of him or her before accepting such tasks and be fully aware of his or her personal limitations. If the demands are too high, then the interpreter should humbly not accept the challenge of interpreting for the deaf doctor. As a professional, the interpreter is bound by the code of ethics established by the RID.

As an interpreter for a deaf physician, the interpreter must be reliable, timely, and skillful at delivering information despite not having the medical background of trained physicians. Although it is ideal that a medical interpreter have a medical background, most interpreters do not. It is the deaf physician's responsibility to be familiar with the terminology and understand the information that is being shared.

This chapter will review the unique situations that an interpreter for a medical provider will experience. Discussion of the medical profession includes the medical team, attire, terminology, patient rounds, sign-outs, Grand Rounds and other lectures, and the operating room, having constant awareness of what is going on in the surrounding environment, and making medical decisions that influence patient outcome. Interspersed in that discussion is discussion of the designated interpreter's role. Interpreting for the medical professional will be a much needed area of investigation that will require exploring creative solutions. The authors hope this chapter stimulates new ideas and encourages the development of this highly skilled area of interpreting.

GENERAL MEDICAL INFORMATION

The Medical Team

It is important for the interpreter to be aware of all personnel involved in the care of patients and to have a basic understanding of their roles. By having this fund of knowledge, the interpreter can be better prepared to know and appreciate the flow of information from one person to another.

The medical team comprises many players, including attending physicians, resident-physicians, nursing staff members, technicians, and medical students. The attending physician is the most senior doctor on the team. The attending physician has a myriad of responsibilities that include but are not limited to ensuring good and acceptable care of patients, developing a plan of care for patients each day with the medical team, and teaching resident-physicians and medical students. The attending physician is responsible for the actions of the rest of the team members and is the person with the most authority on the team.

The resident-physicians are a team of physicians at different levels in their training in a medical specialty. The resident team comprises interns, upper-level residents, and the chief resident. The interns are in their first year of training and have the least amount of experience. Usually, the interns are the first to receive pages from the floor and remain very busy with running errands, ordering tests, following up on test results, and evaluating patients. The upper-level residents have had one or several more years of training; they also help carry out the duties of the intern and plan for the care of patients. In addition, the upper-level residents guide the interns and less-trained residents in making decisions and in providing care to the best of their abilities. The most senior resident is the chief resident who is in his or her last year of training in his or her area of specialty. The chief resident usually works closest to the attending physician and helps to supervise all of the activities of the medical team. It is the responsibility of the chief resident to be aware of all the pertinent things affecting the care of patients and events throughout the day. The chief resident also ensures that communication occurs among the nurses, lower-level residents, consulting teams, and attending physicians. The residents will often rotate every several weeks, and new teams are made from time to time.

Medical students in their third and fourth year of schooling will rotate through the various areas of medical specialties. Their primary responsibility is to learn through their exposure to various patients and to work with the residents, gradually learning how to become doctors. They often rotate four to eight weeks at a time and then leave for ã different rotation. The attending physician and residents will often teach the students throughout the day. The white coats worn by the medical students are usually waist length as opposed to the resident staff members and attending physicians who wear full-length lab coats.

The nursing staff members also have differing levels of experience and training. All units will have a "charge nurse," who is responsible for assigning nursing staff members to patients each shift. The charge nurse is also the one who helps control the number of beds available for new patient admissions and discharges.

The nurses are an integral part of the team in delivering health care. Because they work closest with the patients, they provide important information about the patient's status. Nurses are responsible for communicating with the resident and attending physicians if any concerns arise with respect to their patients. They are most commonly the people who page doctors. Nurses are the common link between patients and doctors and are to be respected. They also are the ones to do blood draws, carry out orders made by physicians, administer medication to patients, and assist in ensuring that tests are completed.

Technicians are those who take the patient's vital signs and document them on flow sheets. They must help communicate abnormal vital signs to the nursing staff. Technicians also assist in the care and transportation of patients throughout the hospital. They, too, have an important role in the care and safety of patients.

The interpreter must be aware of all the players on the medical team because he or she filters what information the deaf doctor receives from and communicates with everyone. The interpreter is considered to be a valuable member of this team and to have highest professional conduct and strong work ethic at all times because he or she is a representation of the deaf doctor.

Attire

The interpreter's attire should be similar to that of the deaf doctor. In the hospital, the doctor may or may not wear scrubs. Scrubs are usually worn on surgical units as well as in the obstetrics and gynecology wards. Professional attire is otherwise expected. Because the interpreter is part of the medical team, he or she is often mistaken to be a health-care provider. It is important for the interpreter to identify him- or herself with a name tag or badge.

It is questionable whether or not the interpreter should also wear a lab coat similar to those worn by medical students. Wearing the lab coat helps other medical staff members to associate the interpreter with the deaf doctor and to readily identify the interpreter as one of the members on the team rather than a stranger entering the work area and patient's rooms. The question of wearing a lab coat comes into play when patients assume the interpreter is a member of the team that can instruct them or when a team member outside of the deaf resident's immediate area mistakes the interpreter for a resident and provides him or her with medical information.

The Deaf Professional–Designated Interpreter Model of Interpreting during Patient Evaluations/ Medical Setting

In the Deaf Professional–Designated Interpreter Model, the interpreter needs to inform the deaf doctor of any abnormal breathing sounds or descriptive terms of coughing. For example, if a patient is wheezing, it is important for the interpreter to cue the deaf doctor because this information may help the deaf doctor to formulate a diagnosis or decide what is the next step of action. In the machine model of

interpreting, the interpreter would not inform the deaf doctor. As a result, important clinical information is missed and the deaf doctor could appear incompetent.

This approach also applies to interpreting telephone conversations that occur between the deaf doctor and patient. When the deaf doctor is on call, patients will be calling the doctor to ask questions and express concerns about their health. It is important again for the interpreter to convey whether or not the patient sounds distressed, as if in pain, or is having difficulty breathing, or is nonverbally sending any other unusual auditory cues. In medicine, many observational clues such as these will help the deaf doctor know the seriousness of the nature of the patient's complaints and whether or not the patient should come to the clinic or hospital for further evaluation.

Physical Arrangement

Interpreters in medical settings will find that many of the usual suggestions about physical placement of the interpreter do apply, with a few additional cautions. The interpreter must be mindful about interpreting for the deaf doctor, which is different from interpreting for a deaf patient. First, the interpreter needs to stay within visual contact of the deaf doctor during examinations and procedures, but be positioned so the hearing patient will not feel intruded on visually. Second, the interpreter needs to find a position that will not hinder the deaf physician's delivery of services, one that requires minimal adjustment of usual procedures.

Working in the clinic with an obstetrician and gynecologist (OB/GYN), where the interpreter stands is very important (more than in other specialties) to respect the patient's privacy. Thus, to respect the patient's privacy, the interpreter must move around as the doctor works with the patient. For the breast exam, usually the interpreter moves toward the patient's feet to allow the deaf physician to position toward the patient's head to perform the exam. Conversely, when the deaf physician performs the pelvic exam, the interpreter should be positioned near the patient's head. Often, the patients will use the interpreter as a source of comfort during the pelvic exam. For example, the patient may grab the interpreter's hand or arm or talk with the interpreter as a distraction during the exam. In these situations, it is appropriate for the interpreter to allow this interaction to occur and not clarify the interpreting role. One constraint to keep in mind is that many of the exam rooms in the office setting are small, and space to maneuver is limited.

During a vaginal delivery, the deaf doctor works at the end of the bed, and the ideal placement of an interpreter for a deaf OB/GYN provider would be by the patient's head on the opposite side of the deaf doctor. This position allows for greater patient comfort as well as a good sight line for the deaf doctor. Sometimes the interpreter may be asked to assist by holding the patient's arms or legs during pushing, especially if no friends or family of the patient are present. The interpreter should use his or her best judgment to determine whether or not he or she can participate without jeopardizing the role as an interpreter for the deaf doctor. In the situation where there is a lot of commotion and confusion, it would be best if the interpreter did not assist with the patient and focused only on interpreting. In

situations where there is little exchange of information, the interpreter can easily assist. Remember, the interpreter is viewed as a member of the medical team, which redefines the role of the interpreter. The machine model of interpreting cannot apply in this and many other situations while working for a deaf doctor. Placement of the interpreter during surgical procedures will be discussed elsewhere.

Environmental Cues

It is important to be aware that the doctor and the interpreter need to have enough of a well-informed relationship so the interpreter knows when the doctor might need things. The designated interpreter tends not to add as much information in a regular interpreting setting as he or she does in medicine. For example, while interpreting for a doctor-to-doctor conversation, it is also important to include background conversations that might be relevant to the deaf doctor's patients.

Whenever the deaf doctor is reading or writing in a chart, a lot of background conversations are going on. Hearing doctors can read or write and listen concurrently. However, in the case of a deaf doctor, it is necessary for the interpreter to be aware of the conversations that occur while the deaf doctor is reading or writing and either (a) remember the details and notify the deaf doctor when he or she is ready or (b) interrupt the deaf doctor if the interpreter determines that the deaf doctor might want to be a part of that conversation. Examples of conversations might be a nurse talking to another nurse, or an anesthesiologist talking with another doctor, or a specialist talking with the team providing care for the patient. If the deaf doctor fails to receive this information because the designated interpreter has not relayed it, then patient care may be jeopardized. In addition, the deaf doctor would lack pertinent information that the rest of the team already has, thus, making the deaf doctor appear less than prepared or inattentive to details involving the patient's care. Because of this crucial role of the interpreter in the medical profession, the deaf doctor really needs to be able to trust the interpreter's judgment because the interpreter filters a lot of information. If the designated interpreter's attitude or behavior reflects less than absolute commitment to communicating the ongoing conversations among medical personnel, then the trust relationship between the deaf doctor and the designated interpreter may be severely damaged.

For this reason, it is common sense for the designated interpreter not to be occupied with other things that may distract him or her from being able to be fully conscious of the ongoing conversations and activity while the deaf doctor is writing or reading a patient's chart or working on the computer. The interpreter should not be engaging in personal interests such as reading magazines or books, chatting on the phone, or sending messages on a text pager. Instead, the interpreter should be using every opportunity to listen and be aware to facilitate the deaf doctor's ability to provide the best possible care for patients. If the interpreter chooses to read, it should be relevant to the job. For example, the interpreter might (a) look over the deaf doctor's shoulder and peruse the patient's chart, thus grabbing an opportunity to learn more medical vocabulary, or (b) learn the material

relevant to the deaf doctor's specialty. By using these opportunities, the medical interpreter can strengthen his or her abilities and confidence in becoming a proficient interpreter in the medical setting.

Meals

Sometimes, the attending buys food or coffee for the whole team, including the interpreter. In addition, there may be meals provided by pharmaceutical company representatives. It is necessary to apply the principles related to social interpreting in this situation. The interpreter should use his or her best judgment to determine what is most appropriate for each situation. By accepting the offer for a free meal, the interpreter is projecting that he or she is part of the medical team. However, there may be other situations where accepting such an offer is a conflict of interest and makes the interpreter feel uncomfortable, for example, when there is a presentation during the meal in a small space and the interpreter needs to work throughout the presentation. Kindly refusing the offer in those situations is acceptable. Again, using discretion for each situation is best.

The interpreter should always have snacks and something to drink easily available. Snack bars such as protein bars or granola bars are very convenient to carry around. Often, the pace of the hospital is constantly busy, leaving very little time to eat a full meal. Physicians usually have become accustomed to eating quickly at irregular times. The interpreter may not have the opportunity to slip away and should be willing to adjust his or her schedule to accommodate the deaf doctor's demanding schedule.

Bathroom Breaks

There are times during the day when the pace of life in the hospital is slower than at other times. It is important for the interpreter to use these slower times to eat or go to the restroom. Medical interpreters need to be aware that the medical team often does not have time to eat or go to the restroom at the same moment the interpreter may need to. Therefore, the medical interpreter for the deaf doctor needs to learn to inform the deaf doctor when he or she needs a food or restroom break. However, it is important that the interpreter understands when is an ideal time and when would be poor timing. Although emergency situations cannot be avoided, the interpreter should develop a sense of which times during the deaf doctor's work there is no urgency or unfinished business.

It is helpful if the interpreter predicts what needs to be done before it has to be done. The experienced interpreter is keenly aware of an appropriate time and an inappropriate time to go on a bathroom or meal break. He or she develops a sense of whether there are things left unsettled. For example, if the deaf doctor is waiting for a phone call or waiting for someone to show up, it is not a good time to take a break. This principle applies to any interpreting setting. The difference in the medical setting is the liability of patient care. If the deaf doctor misses infor-

mation because the interpreter is "on break," then both the deaf doctor and interpreter are liable.

Role of Gender in Interpreting for a Deaf Doctor

It might be ideal to have a male interpreter for a male deaf physician. It can be confusing if a female interpreter is voicing for a male deaf doctor on the phone to other health-care providers who are expecting to hear a male voice (or vice versa). In addition, most female patients would be more comfortable having a female interpreter for a female deaf doctor during a routine gynecology exam.

Social Etiquette

The question of who should turn on the light in a patient's room is a question and responsibility that can be negotiated between the deaf physician and the interpreter. It is the authors' opinion that the deaf doctor should take responsibility for improving the environment for better communication, for example, by turning on lights. However, if the deaf doctor cannot do it, then the interpreter should be willing. If the interpreter refuses to help out, the team might view the refusal as a bad reflection on the deaf doctor–interpreter relationship. The concept of team should be favored, and everyone works together to achieve an efficiently run team.

When meeting patients for the first time, the authors also assert that it is the deaf doctor's responsibility to introduce the interpreter. Nevertheless, the interpreter should not be as impartial as in other interpreting settings in patient interactions. For example, if a patient says "Hi" to the interpreter before they have been formally introduced, it is helpful if the interpreter says "Hi" back. In this context, the exchange is a short conversation and there is not time to teach "how to work with an interpreter." Making no response might make the interpreter seem "cold," and then the patient might be "cold" to the deaf doctor because the interpreter's behavior reflects on the deaf doctor.

The interpreter, however, should try not to engage in casual conversations with patients or staff members because this level of communication blurs the line between the deaf physician and the interpreter. If the interpreter starts conversing too casually with the staff members, then the professional status of both the interpreter and doctor may be lost.

It is all too easy for the nurses to approach the interpreter and use the interpreter as a messenger of important information to the deaf doctor. It should not be the interpreter's responsibility to retain relevant information pertaining to a patient's health care or medical condition. The staff members should be kindly reminded to speak directly to the deaf doctor instead of using the interpreter as a middle person.

However, because the interpreter is identified as a team member, it is a natural tendency for various staff members to start casual conversations with the interpreter while the deaf doctor is working. The interpreter needs to use his or her

best judgment in terms of how long they should converse, limit the conversation to appropriate topics (excluding too personal information), and respectfully terminate a conversation if necessary. He or she must maintain appropriate boundaries, which requires a social skill that cannot easily be taught. Likewise, the interpreter must learn to find the balance between maintaining rapport with the health team while maintaining the role of the interpreter. Regardless, if the interpreter chooses to engage in casual conversation, then he or she must also be aware of other side conversations that are occurring that would be relevant to the deaf doctor's work.

Even while the deaf doctor is writing in charts or working on the computer, there are often various ongoing situations occurring that, normally, a hearing doctor would be aware of and would be able to filter. However, the deaf doctor does not have this luxury, and the interpreter must continue to be constantly aware of the surrounding activities and feed this information to the deaf doctor. The deaf doctor can then filter the environmental information and decide what to do with it, choosing to use it or disregard it, similar to how hearing people do.

Core Interpreters versus New Interpreters

New interpreters entering the medical environment will benefit from a mentoring-preceptorship situation for a full shift; making sure that they get to experience every aspect of the job with an experienced interpreter. If they are unable to experience everything, especially time observing surgery, then they will need another day to continue the preceptorship alongside the experienced medical interpreter on the job. Making sure that the new interpreter is paired up with an experienced interpreter who works regularly with the deaf medical profession is crucial for orientation and preparation of the new medical interpreter. Some interpreters who have not had exposure to working in the medical environment may have personal issues with working in this setting. If the experienced interpreter does not feel confident about the potential new interpreter, then he or she has a professional obligation to inform the new interpreter of the concern. If the new interpreter has difficulty adjusting to the expectations and demands of working in the medical setting, that person may never obtain a sufficient comfort level and could, thus, set up not only the new interpreter but also the deaf doctor for failure.

Medical Vocabulary

While working in various situations of the medical environment, interpreters will negotiate signs with the deaf doctor. It is critical to debrief with the interpreter who will work the next shift, giving that person the new signs. If work has been done to establish any signs in the medical specialty, the medical interpreters need to make sure that they always keep each other informed. Keeping a notebook of medical vocabulary with their respective sign is critical. Each interpreter on the team should contribute to developing the vocabulary list and knowing it, and no interpreter

should depend on one other interpreter as a crutch. Such a team effort generates a sense of unity and teamwork.

As new interpreters are added to the needed pool of interpreters who will work with the deaf professional, more experienced interpreters may overlook important vocabulary and signs as being important to explain because they may have used the signs so frequently that they would no longer think of a specific sign as being specialized but may have become accustomed to using it without giving a second thought. Therefore, the concept of developing a notebook of the vocabulary is beneficial for both the experienced and new medical interpreters.

When a new interpreter is added to the pool of ongoing interpreters, there may be a power struggle. It is human nature. Team members may feel that someone is coming into their territory and trying to take over. It is really important to have a meeting to introduce the new interpreters to all of the other interpreters and to make sure that everyone clarifies that the goal is to work together to provide the best communication possible at all times. The deaf professional has to take on this extra administrative task to make sure that the team is working to the best of its ability.

Outside interpreters or contract interpreters may be envious of or (perhaps) judgmental of those who are designated interpreters for the deaf doctor. Having a designated position is a great position to have. These opportunities to work with a highly successful deaf professional are rare and are often coveted by interpreters. Freelance interpreters who are not designated and are requested to team with or switch shifts with the designated interpreter may show some negative emotion, either because they are envious or because they may judge some of the interpreting practices that differ from the machine model of interpreting. Making sure that designated interpreters feel supported in their ability to share needs of their deaf professional with incoming interpreters will give them a sense of control over who works with them and what will and will not be accepted by the deaf professional. The designated interpreter who is able to share duties with additional interpreters who are on the approved list of the deaf professional will be supported by being able to work as a team with more interpreters whom they feel will provide a great interpreting job and do a professional job. What is often lost or misunderstood is that a considerable amount of time and effort has been invested in the designated interpreter team to make things as efficient as possible, but that same effort may also cause the core interpreters to perceive the outside interpreter as not doing what is expected.

The interpreter who is designated as the deaf professional's interpreter needs to create ways to maintain his or her value within the context of the medical team. One solution that some people may suggest is to have an interpreter with a "slash" (combined) position. A combined position would not be a good idea because a "slash" position devalues the role of the interpreter and creates a situation in which the interpreter could be pulled from working with the deaf doctor to fulfill other duties. One way the designated interpreter could easily maintain his or her value—or even increase it—is by teaching or doing his or her own research during down time.

Deaf Professional and Designated Interpreter Communication

The designated interpreter will often interpret didactic lectures or meetings that contain a wealth of information. Usually, the presenters speak rapidly as they go through their slides. The designated interpreter will benefit most if he or she collects as much material beforehand to prepare. The designated interpreter would contact the presenters or organizers to get materials for the presentations, unless making those contacts would end up negatively affecting the deaf professional. For example, it may be better to have the deaf professional, as a doctor, make contact with the presenting doctor instead of the interpreter who has a different status. Each job has a hidden hierarchy or set of politics. Knowing what boundaries the designated interpreter should stay within is very important to make sure that good relations are made and kept between the designated interpreter and other medical professionals and administrators because those contacts can affect the deaf professional in a negative or positive way.

Interpreting Medical Terminology

The most challenging aspect of sign-outs is the rapid pace and unfamiliar terms. Sign-outs are the occasions when the on-call team briefs the incoming new team on the current patients' status and management. These times are often complicated by mumbling doctors who rush their words together and often speak softly. This complication added to the medical jargon can make any interpreter very frustrated. Many abbreviations are used in medicine; therefore, interpreters should be willing to learn and use them to save time and make interpreting easier. Obstetricians will use the acronym SROM, which means spontaneous rupture of membranes when a patient's water breaks. Therefore, the interpreter should sign S-R-O-M. TVH is a well-known abbreviation used in gynecology that stands for total vaginal hysterectomy. Likewise, instead of developing signs for total vaginal hysterectomy, the interpreter should simply sign T-V-H. Laboratory tests will also have abbreviations. For example, when a hematocrit is ordered to evaluate for anemia, the medical abbreviation is "hct"; the interpreter can easily sign H-C-T rather than create a new sign for hematocrit, and the deaf physician would understand exactly what it means. In addition, the whole word *hematocrit* may not be used by medical doctors. Instead, they may use the jargon "crit," which means the same as the whole term, *hematocrit*. Other examples include *electrocardiogram*, which can be signed as E-K-G and *diabetes mellitus*, which can be simplified by signing D-M, an accepted abbreviation in the medical profession.

However, there are numerous medical terms that have no abbreviations or signs, and therefore, the interpreter and the deaf physician will often create their own. A consensus must be achieved between the interpreter and deaf physician for each term. For example, the term *tachycardia* means rapid heartbeat. The designated interpreter can simply sign the standard sign for *heartbeat* with a fast pace to indicate a rapid heartbeat. Once a sign has been established for a particular term, then the interpreter is responsible to remember and use that same sign in the future.

If the interpreter does not know the medical term, it is helpful to show what is being said phonetically.

Because medicine is replete with unfamiliar terminology, it is imperative that the interpreter develop a system for learning these terms from reading materials that may include standard textbooks, a medical dictionary, an atlas of anatomy, and journal articles. However, unlike needing to prepare for the deaf or hard of hearing person who is not familiar with medical terms, the interpreter need not prepare in the same way for a deaf doctor. The deaf doctor should already be familiar with most of the medical terminology and is responsible for knowing definitions and appropriate usage. It is also important that the interpreter give the deaf doctor the exact terminology used by the team members instead of a gloss over.

Procedures and Settings

Patient Rounds: Team Rounds and Individual Rounds

Rounding is when the resident sees patients either individually or with the health-care team. On a daily basis, the deaf doctor will round on his or her patients who are in the hospital. Team rounds involve dynamic conversations that occur among the players on the health-care team, usually led by the attending physician with the resident staff. Rounds are also a time of teaching by the attending physician. Medical students and nursing staff members are also participants in this process. Rounds usually occur earlier in the day. With the attending, the team reviews patients, their admitting diagnosis, and sequence of events since their hospitalization and then develop a plan. Plans may range from prescribing new medications, ordering new labs and other tests, or discharging patients from the hospital. Rounds are also a time when patients and their family ask the health-care team questions.

When the deaf resident makes individual rounds, the deaf doctor evaluates the patient alone. If the deaf doctor is a resident physician, then individual rounds are done early in the morning when patients are still sleeping and must be woken up. This setting can be difficult for the deaf doctor to see the interpreter well or speech-read the patients. One solution is to turn on the bathroom light to prevent rudely waking up the patient to bright room lights. Many rooms also have nightlights or lamps that also work well in providing enough light to visualize the interpreter. Either the deaf doctor or the interpreter can help find appropriate lighting because it should be a shared and joint effort for effective communication.

Outside of the Room

Usually before the deaf doctor or the medical team enters the patient's room, the patient's chart is reviewed. In group rounds, a short presentation describing the patient is given by one of the team members. After the short presentation, the team usually has a brief discussion about the patient with the attending before entering the room. The interpreter needs to figure out who will be talking during team rounds. The interpreter should try to stand next to or as close as possible to the

resident presenting the patient and to the attending. It is very important to be able to hear the attending physician because it is during this time when teaching and formulating plans for patient care occur. It is also important to be conscientious about whether the deaf doctor can see the interpreter as well as the others on the team. The interpreter needs to kindly and respectfully remind people to not stand between the deaf doctor and the interpreter because the team will move together during rounds from room to room. It is very important for the interpreter to be constantly aware of the surroundings and the deaf doctor's sight line as well as to be flexible and willing to change positions quickly.

While the deaf doctor and the team stand outside of the patient's room during rounds, there are many side conversations that occur among the members of the medical staff. Usually, the nurses caring for the patients are having ongoing conversations among themselves or on the phone that are pertinent to patient care. It is important that the deaf doctor is made aware of these conversations because they may affect patient care and plan of action. Therefore, the interpreter must also be listening to these side conversations in conjunction with the conversation that the deaf doctor is participating in during rounds.

After the patient is presented, then the entire team enters at once into the patient's room to evaluate the patient and discuss the plan with the patient. The last person to enter the patient's room should be responsible to close the door to respect the rule of confidentiality. If the interpreter is the last to enter the room, then it is his or her responsibility to close the door to respect the patient's privacy.

Once the team enters the room and talks with the patient, then the interpreter needs to reposition him- or herself to stand as close as possible to the patient at the head of the bed, if the patient is in bed. If the patient is out of bed and in a chair, then the interpreter should try to position him- or herself behind the patient. The reasoning behind trying to position oneself near and slightly behind the patient is to allow the deaf doctor to make eye contact with the patient. It may be difficult to maneuver oneself quickly enough to this position because usually four or five people enter the patient's room at the same time during team rounds. In that case, then the interpreter should stand around the patient's bed along with the other team members in a position where the deaf doctor can see the interpreter well. Also, be aware that the setup of the room can make it difficult for the interpreter to stand in an ideal location. In this setting, it is best to be flexible rather than ask family to move or move furniture because those efforts are more of a distraction and may upset the balance of the team. Remember that the interpreter is also a part of rounds, and it is important to maintain the balance of being a team member as well as being an effective interpreter.

Sign-outs

Sign-out is the process of transferring care of patients from the current team to the incoming team. The incoming team receives detailed information about current patients from the leaving team. This activity is one of the most important times

during the day in terms of patient care. It is the time when mistakes in patient care most likely occur, and therefore, accurate transference of information is crucial. The interpreter is relaying to the deaf doctor information that will affect patient care, and that interpretation is the primary way the deaf doctor will receive information on patients and what has been done.

Sign-outs tend to occur at the end of each shift. Nurses will sign out issues to nurses, residents will sign out to residents, and attending will sign out to attending. Sign-outs are a vital communication process in reference to patient care. All the patients on the service are presented, including their working diagnosis, the hospital course, lab results, pending tests, pertinent medications, treatments, active consulting teams, tentative plan of management, and other issues affecting patient care. Any pending tests are signed out for the new team to follow up on. The next step or plan of action is reviewed, if known. Ideas are also interchanged during this time. Often, the incoming team asks for further clarification.

The sign-out process is intense because it usually occurs at a fast pace. An overwhelming amount of information is given in short amount of time. Medical abbreviations and jargon are used continuously and repetitively. An outsider would perceive sign-outs as a foreign language because there are many inside jokes, abbreviations, and technical terms that are not familiar to the layperson. Each medical specialty has its own vocabulary. General surgery would have a different sign-out process and terminology than what is used for internal medicine. For example, to the emergency department and internal medicine, the acronym AMA means "against medical advice" in which the patient leaves the hospital against the recommendations of the doctor. However, in obstetrics, AMA is the abbreviation for advanced maternal age, implying pregnancy older than the age of thirty-five years, which is an important risk factor. Consideration of the context in which the abbreviation is being used is important during the interpreting process. The interpreter should use the deaf professional to help clarify the abbreviations and terms.

The interpreter should be an integral part of sign-outs and have the ability to understand the conversations taking place among the team players. Often, the presenters speak in low tones, at a rapid pace, and through a mumble. It is important for the team to realize that an interpreter is present for the deaf doctor at the beginning of the sign-out. Ideally, all team members should be willing to cooperate by slowing down and speaking as loudly and clearly as possible.

If something is unclear, the interpreter has the authority and responsibility to ask for repetition or to ask the speaker to speak more clearly or loudly. The interpreter should also keep in mind that it takes time to learn medical terminology and should be patient with him- or herself during this learning curve. The interpreter should not become frustrated with the lack of knowledge of specialized vocabulary. Over time, the interpreter will have sufficient exposure to the language. Remember that the deaf doctor and other physicians have been in training for many years and have an advantage over the interpreter in mastering and communicating medical jargon.

During sign-outs, each patient's hospital course is reviewed. In OB, there are postpartum, antepartum, or high risk, actively laboring patients; there are also GYN patients. Some places will have specialized services such as GYN-oncology. Other specialties will have their subdivision of patients on the ward. A summary of each patient is shared, including the presenting problem, diagnosis, pending tests, treatment plan, and other issues of concern.

At times, different conversations occur during sign-outs, which makes the interpreting process confusing and easily overwhelming. Therefore, the interpreter needs to get as much information as possible before sign-outs to make his or her job easier and more efficient. There are often lists with the patients' names and diagnoses. By becoming familiar with the names of each patient and their conditions, the interpreter's abilities and level of confidence improve significantly.

An important concept in the deaf doctor–interpreter relationship is the level of trust that needs to exist between the two during sign-outs. The interpreter needs to phonemically spell terms when the interpreter is unsure of what is being said. The deaf doctor often is able to figure out what is being said based on the context, familiarity with a particular patient, or both. However, sometimes both the interpreter and the deaf doctor are unsure and need to ask for clarification. Depending on the situation, sometimes the deaf doctor will ask a question that will require the speaker to clarify without directly asking the speaker to repeat what was just said. Often, this approach is more effective than frequently reminding a speaker to slow down. It also gives the deaf doctor some control over the conversation. Conversations are easier to interpret and understand when the deaf doctor controls the conversation.

Sign-out is the first part of the deaf doctor's shift. It is very important for the interpreter to be present before the sign-out period to ask the current doctors, residents, and nurses questions about patients as necessary; to listen to conversations at the nurse's station; and to prepare for the sign-out. This preparation gives the interpreter a sense of what is going on, and he or she will be a better interpreter if this effort is made. Nurses are often very helpful prepping the interpreter. The sign-outs are difficult without advanced preparation, but this prepping helps the sign-outs to be easier. Once sign-out begins, it is difficult for the interpreter to converse with anyone. However, before sign-outs, the current residents and nurses tend to be more available to give the interpreter information.

Another important concept is that of the interpreter conducting a sign-out with the incoming interpreter from one shift to another. The deaf physician may take a twenty-four-hour call, requiring multiple interpreters to cover the call in shifts to prevent fatigue. It is helpful to prep the incoming interpreter with respect to the names of the patients, what has been happening, and what will likely happen during the next interpreting shift. The interpreter-to-interpreter sign-out should be an abbreviated form of the doctor-to-doctor sign-out. Thus, the incoming interpreter should arrive early, and the outgoing interpreter ideally needs to be given time to prep the incoming interpreter. Generally, the interpreter for the medical doctor should arrive twenty to thirty minutes early to change into scrubs if necessary, get a sense of the ongoing situations, prepare, and obtain a sign-out from the current interpreter or medical staff member.

Occasionally, there is not time for the interpreters to complete sign-out with each other in the event of surgery or emergency. Often, the interpreter who is currently working might work overtime until the surgery is over rather than switch with the incoming interpreter in the middle of surgery. As a result, the incoming interpreter might need to wait for the surgery to be over. Both the current interpreter and the incoming interpreter need to make the switch as efficiently as possible, eliminating as much personal conversation as much as possible. Remember that the designated interpreter is there to interpret for the deaf professional. It is also very important for the departing interpreter to convey the seriousness of any situations to the incoming interpreter. For example, if the deaf professional is in the middle of an emergency situation, the current designated interpreter needs to inform the incoming interpreter about the urgency of the situation. If this information is not given, then the incoming designated interpreter may misunderstand the seriousness of the situation. The incoming interpreter needs to be mentally prepared for any type of situation he or she may walk into at the medical setting.

Grand Rounds and Lectures

Grand Rounds in medicine are formal didactic lectures for all levels of training in medicine. They are usually hour-long lectures dedicated to a specific topic of interest in an auditorium, large lecture hall, or board room. All medical staff members are invited to attend, and attendance is often required to obtain continuing education credit.

During Grand Rounds, there are often materials available to help the interpreter prepare for the presentation. The topics are usually known well in advance. Many times, the guest speaker will have a computerized slide presentation and handouts available for the audience. Ideally, the interpreter should obtain a copy of the presentation before the lecture to become familiar with the terms and be able to better anticipate the material given.

Because Grand Rounds and lectures tend to be more presentation style with continuous technical language, it is best to use the concept of team interpreting. Team interpreting would allow each interpreter to sign up to fifteen or twenty minutes to prevent fatigue and repetitive motion injury. The rules of educational interpreting are well applied in this scenario, having the interpreter stand in the front of the lecture hall, next to the screen. It is always courteous for the interpreter to introduce him- or herself to the speaker before interpreting so the speaker is not surprised. It is also advantageous for the deaf doctor to sit near the front to obtain the best vantage line. The slides should be used as a complement to the material that is interpreted; however, they should not substitute for the interpreter.

Phone Device

Depending on the personal preferences of the deaf professional, he or she may choose to use the interpreter to voice. In other situations, the deaf professional may speak for him- or herself on the phone. The designated interpreter needs to realize

that a significant amount of information and communication is exchanged with other medical personnel over the phone.

How to present the deaf doctor on the phone is a challenging task for many interpreters, especially during doctor-to-doctor conversations. Ideally, an interpreter of the same gender as the deaf doctor should provide the voicing. The designated interpreter should use the most professional conduct. Any cues to help the deaf professional with the exchange of information are important. For example, the deaf professional should be aware of the tone of the speaker, and therefore, the designated interpreter has the responsibility to be sure that the deaf professional knows whether someone is upset, anxious, pleasant, etc.

Pacing is important. On the phone, the interpreter needs to be able to keep up with the flow of the conversation without creating a lag. Keeping up with the flow is especially important over the phone because the other party cannot see the signing that is occurring on the other end of the line. Long pauses could lead the other party to assume that the deaf doctor is having difficulty understanding the content.

The deaf professional may receive pages from patients who are calling from their homes. The deaf professional has the responsibility of returning those pages and answering the questions and concerns of patients at home. Therefore, the interpreter needs to know who he or she is talking to on the phone and needs to let the deaf doctor know. The deaf professional also needs to know who answers the phone, particularly if it is a child or someone other than the patient.

While on the phone, the interpreter also needs to attend to conversations in the background to help the deaf professional know what is going on in the caller's environment. In the case of a deaf OB/GYN, for example, the designated interpreter needs to let the deaf professional know if a patient is moaning in pain with contractions. The designated interpreter who is interpreting within a family medicine context needs to let the deaf professional know if the patient has audible wheezing over the phone. The more information the interpreter provides to the deaf doctor, the better the deaf doctor will be able to work with the patient and determine the seriousness of the call and whether the patient needs to be evaluated in the clinic or sent to the hospital.

An option for the deaf doctor who chooses to speak for him- or herself is to use a double-splitter headset on the phone, which provides a separate headset to the interpreter and to the deaf professional. By adding a splitter to the phone, the designated interpreter and deaf professional both can have access to the phone conversation without needing to pass the headset back and forth. The deaf doctor can speak directly for him- or herself through the headset. The interpreter can plug in a separate headset that is hands-free, similar to those used in the video-relay call centers, to free up his or her hands for interpreting. This setup allows an efficient flow of conversation with minimal lag time. The type of splitter to use is dependent on the phones in the hospital. The interpreting team and deaf professional can choose from among various models of the hands-free headsets.

Surgery

If the deaf physician performs surgery, it will be necessary for the interpreter to working in the operating room and learn how to work in a sterile field. Most likely, the deaf surgeon will need the interpreter to be at the surgical table for ease of communication while focusing on the surgical procedure. The only way an interpreter can have this close proximity to the surgical table is by scrubbing in. "Scrubbing in" entails washing the fingernails, hands, and arms for three minutes and remaining sterile after washing. There is a sterile technique to dry the hands and arms as well as to don the surgical gown, gloves, and mask. Most hospitals have a training session to teach staff members how to scrub and perform using an appropriate sterile technique. The interpreter should take advantage of this teaching and inquire how he or she may obtain this training before scrubbing in with the deaf doctor for the first time.

The operating room also has a team of players, each with their respective roles. There is always a scrub technician, a circulating nurse, an anesthesiologist, a surgeon (or more than one), and surgical assistants in the room. The scrub technician is the person responsible for gowning and placing gloves for the surgeon. The scrub technician also gives the various tools, instruments, and sutures to the surgeon during the surgery. The scrub technician is responsible for making sure that all of the instruments, sponge counts, and needle counts are correct at the end of the procedure. That person usually stands further down on the table, but close enough to the surgeons to hand off instruments. Often, the scrub technician is the person who is least flexible about where the interpreter should stand because the technician needs to be close enough to the surgeon to pass instruments and needles. It is important for the interpreter to respect the scrub technician's territory without compromising the ability to effectively interpret for the deaf professional. It is best to communicate with the scrub technician before the procedure to establish where people will stand. The scrub technician is also the person who will help the interpreter don the gown, hood, and gloves.

The circulating nurse is the nurse in the operating room who helps bring in the requested instruments, ensures that there will be gloves for all the people who will be scrubbing in, and documents the course of the surgery. The circulating nurse also ensures patient safety and positioning. He or she has many tasks during the case and is frequently going in and out of the operating room. It is also important for the interpreter to introduce him- or herself to the circulating nurse before the procedure.

The interpreter has very little interaction with the anesthesiologist. However, it is important to interpret what the anesthesiologist may ask or share with the deaf doctor. If the patient's vital signs become unstable, the anesthesiologist will inform the surgeons. The anesthesiologist will also inquire about intra-operative antibiotics or other medications to give the patient if necessary—pertinent information the deaf doctor must know to ensure the best care of the patient. After the procedure, the surgeons will be asking the anesthesiologist about urine volume,

fluid volume, and blood loss. This information is also important for the interpreter to listen for and convey to the deaf professional.

Before accepting a job opportunity to interpret for a deaf surgeon, the interpreter should know his or her own ability to tolerate body fluids, blood, and seeing internal organs. It is highly recommended that the interpreter spend a couple of times shadowing someone to get exposure to the operating room as a test of abilities. Even some of the most proficient surgeons started out with fainting spells. After obtaining initial exposure, the interpreter can judge whether he or she can tolerate working in the operating room. This precaution is only fair to the deaf surgeon because it is critical to have an interpreter who is able to do the job instead of becoming a patient by fainting. It is also critical to patient safety that the interpreter does not faint because the patient always comes first.

If the interpreter begins to experience sensations of fainting, then it is important to inform the staff members in the operating room that he or she is not feeling well before actually passing out. Feeling faint includes sensations of feeling warm, dizzy, weak, short of breath, and even darkening of vision. If the interpreter realizes that he or she is having these feelings, the staff members in the operating room can assist by offering a wet washcloth, fluids, or a chair to sit down on. It is the responsibility of the interpreter, not the deaf professional, to monitor for these symptoms and do what is ultimately safe for everyone.

Equipment in the Operating Room to Accommodate the Deaf Surgeon

The deaf doctor may choose to have the interpreter use a special sterile surgical mask to assist with speechreading and seeing facial expressions clearly. The authors chose to use the Stryker orthopedic hood mask to facilitate communication in the operating room. These masks look similar to those helmets worn by astronauts. These sterile masks are routinely worn by orthopedic surgeons for extreme sterility to prevent infection. These masks have a plastic helmet part that goes on the interpreter's head. The helmet has a fan at the top to prevent fogging of the clear portion of the mask and to keep the person cool. This fan is operated by a battery pack that must be attached to the helmet. The battery pack is worn on the waist. Because the fan is noisy, it is cumbersome for the interpreter to be able to hear conversations during surgery. Therefore, the authors have found the solution of using an FM system in which the interpreter wears a receiver earpiece and the attending who directs the surgery wears a microphone. Anyone else who is next to the patient during the surgery can be heard by the interpreter. This system allows the interpreter to hear conversations more clearly and easily, although background noise is also amplified. The operating room staff and scrub technician need to be made aware of these accommodations well in advance before the surgery to allow enough time for preparation. The following Web-site address is a link to the Stryker hoods (Sterishield Face Shields) that the deaf doctor has used in the operating room: http://www.stryker.com/instruments/orproducts/protection.htm.

During surgery, the interpreter may be asked to become a participant as a second assistant. Sometimes the attending will ask the interpreter to hold a surgical

instrument. Because the interpreter is within the sterile surgical field and is often the second closest person to the patient, he or she is the next most convenient person to help. This situation is another case in which the interpreter cannot follow the machine model but must use his or her best judgment to determine whether or not it is feasible to hold an instrument while trying to interpret at the same time. At times, it is appropriate for the interpreter to quickly explain his or her role and kindly decline from assisting. In other situations, if there is not dialogue among the deaf physician and others, then it is appropriate for the interpreter to assist if he or she feels comfortable doing so. When it is clearly not appropriate, the deaf doctor will be the one to make the final call. Sometimes the attending forgets that the interpreter is there for communication.

Another important issue the interpreter needs to be aware of before interpreting in the operating room is the issue of liability. If the interpreter is not an official member of the hospital staff and covered under hospital insurance, then the interpreter is responsible for any possible injury or hazards on the job. Possible injuries or hazards include needle sticks or being splashed with body fluids and blood. Although each person in the operating room takes every effort to protect one another, there is always the chance that something can happen. Therefore, the interpreter needs to be prepared and have insurance in the event something goes wrong. If the interpreter is a contract interpreter, then he or she should have his or her own insurance to cover such incidences. The hospital will not take responsibility. However, if the interpreter is directly hired as a staff or salaried interpreter, then the interpreter should be under hospital insurance coverage.

Operating Room Sterile Procedures

The interpreter must remember that once he or she has scrubbed, he or she must not touch anything unless it is sterile. If the interpreter touches anything that is not sterile, then he or she is considered "contaminated," must leave the surgical field, and must re-gown, re-glove, or worse, re-scrub. The sterile field is a designated area. On a person, the area from the shoulders to the waist is considered sterile once a person has gowned. The surgical drapes covering the patient on the table are also sterile. Because the interpreter is wearing sterile gloves, he or she should have no limitations on signing—except that he or she cannot touch his or her face unless wearing a surgical mask or shield. Even when a surgical mask is worn, the interpreter can touch only the masked area and not other parts of the face. When the designated interpreter is not interpreting, he or she should stand with hands folded on the torso. Another option is to lay one's hands on the patient, being aware to stay out of the surgical area.

In the event of becoming "contaminated" the interpreter would be required to leave the surgical field, take off the gown and gloves, and proceed to scrub arms and hands again. Another gown and set of gloves must be used. In the event of a minor contamination, then only the gloves may need to be replaced. The circulating nurse and scrub technician will direct the interpreter on what to do if this situation should arise.

Sequence of Events during Surgery

A certain order of events occurs when a patient is taken to surgery. The deaf doctor will meet the patient and the family in the pre-anesthesia or pre-op area before the surgery. During this time, the deaf doctor answers any questions the patient may have and reassures everyone. Consent forms are reviewed and signed. The patient will have an IV placed during this time, and the anesthesiologist will also be talking with the patient. The doctor and interpreter should be wearing surgical caps as well as shoe covers, and should have a face mask ready before entering the operating room.

When the operating room is ready for the patient, then the anesthesiologist and surgeon, which may be the deaf doctor, will transport the patient into the operating room. On entry into the operating room, several members will already be in the room, including the scrub technician who will be preparing and counting the instruments. The circulating nurse will also be present. The deaf doctor may be having conversations with nurses, the patient, or the anesthesiologist at this point. It is important for the interpreter to be aware of such conversations and be available to interpret. Being there to interpret can pose as a challenge at times, but usually, all works out without difficulty. The patient will be transferred onto the operating table, and the anesthesiologist will prepare the patient for surgery during which the interpreter and the deaf surgeon will be getting ready to scrub in. The interpreter should start scrubbing as soon as the deaf doctor starts scrubbing.

Before scrubbing, the interpreter needs to ensure that an extra gown has in fact been pulled for him or her because many times the staff members forget that an interpreter will be present during the surgery. The interpreter also should be sure what his or her glove size is and should check that the gloves are ready. There are latex-free gloves for those with a latex allergy. If the interpreter is to wear a sterile clear mask, an FM system, or both, then he or she should also get these supplies ready and put them on before donning the gown and gloves. In addition, the deaf doctor or interpreter should also give the microphone to the appropriate personnel if an FM system is to be used. The preparations with the FM system must be done before scrubbing, otherwise the interpreter and person wearing the microphone will become contaminated. If the deaf surgeon routinely performs surgery, then the staff members will become familiar with the role of the interpreter and will likely learn to pull in advance all of the required materials that the interpreter will need, including the gloves, gown, and sterile mask.

The order of preparation is as follows, according to the preference of the authors. First the interpreter should have a cap, regular face mask, and shoes covers if desired. No person can enter the operating room area without having on a cap. Then the interpreter should put the earpiece in, before putting on the helmet. The interpreter should double-check to make sure the earpiece is working and the microphone is on. The Stryker hood helmet should be placed next and adjusted for comfort. Next, the battery pack should be placed on the waist and connected to the helmet. The fan should start when the battery pack is properly hooked up to the helmet. Then, the regular facial mask should go over the mouth

and be tied around the helmet. The sterile portion of the helmet system will be placed by the scrub tech after the interpreter has scrubbed. It is important to have the mouth covered by a regular mask before having the sterile face mask placed. After having all of the equipment, it is time for the designated interpreter to start scrubbing.

After scrubbing, the deaf doctor and interpreter enter the operating room and will obtain a sterile towel from the scrub technician. After drying, then the scrub technician will place the sterile helmet cover on the interpreter and will remove the face mask, then will place on the sterile gown and gloves. Then the deaf doctor, assistants, scrub tech, and interpreter position themselves at the operating table after the patient has been appropriately washed and draped. Before starting the procedure, the type of surgery and patient will be verified. This protocol is called a "stop check" to promote patient safety and decrease the number of errors made. If all is approved, then the surgery begins.

Although this sequence of events in the operating room may seem daunting and overwhelming, remember that it becomes very routine after one has experienced this process a few times. It becomes very natural with time. As mentioned above, it is helpful to watch a few surgeries before actually interpreting during one to learn the sequence of events. Ideally, experienced medical interpreters should take time to explain and mentor new interpreters on how to work in this environment. For those who love the human body, it is a privilege and wonderful learning experience to be on the other side of the curtain.

Conclusion

This chapter has covered a wide breadth of topics that an interpreter for a deaf medical professional will face. It is an exciting, unique, and incredible opportunity and should not be taken lightly. Interpreting for the deaf doctor requires one who has commitment and the ability to withstand many challenges, including long hours, demanding schedules, complex terminology, and high expectations. This job is not one for those who expect a leisurely pace. The interpreter for the deaf doctor must always remember that he or she is there for the deaf doctor first, and must consider the importance of patient safety. When interpreting for the deaf medical doctor, the interpreter should consider what attributes and character they would expect of a doctor for his or her own family members. The interpreter should then apply these same expectations to him- or herself as a medical interpreter for the deaf professional.

There are some unique characteristics for interpreting for the deaf medical doctor. It is a specialty within the interpreting profession that is undergoing development. One must consider having the responsibility of patient care and being a team player. There must be consistency in the team of interpreters because it takes much time to develop the vocabulary and understanding of the medical environment. This job is not one that can be filled by any interpreter but only by those who have a commitment to work diligently, maintain the highest professional conduct, and

have an appreciation for the human body. The interpreters who currently have this incredible privilege to interpret for a deaf doctor have a professional obligation to encourage and train new interpreters who possess the qualities of being able to work in the medical setting. It is our hope that designated interpreters and deaf medical professionals will work together in a joint effort to advance this new field of specialty interpreting and welcome new ideas along the way.