



The International Journal for  
Translation & Interpreting  
Research  
[trans-int.org](http://trans-int.org)

# Semi-authentic practices for student health interpreters

*Ineke Crezee*  
Auckland University of Technology  
[ineke.crezee@aut.ac.nz](mailto:ineke.crezee@aut.ac.nz)

DOI: 10.12807/ti.107203.2015.a04

**Abstract:** This paper will briefly describe some pedagogical tools used to provide semi-authentic practices for trainee healthcare interpreters. Such practices facilitate legitimate peripheral participation by a Community of Learners in the Community of Practice (Lave & Wenger, 1991; Wenger, 1998, 2000). Special emphasis will be placed on the importance of shared pre-professional practice, and an example of this will be described in some detail. The pedagogical tools outlined in this paper can be easily replicated by interpreter educators internationally.

**Key words:** semi-authentic interpreting practices; student health interpreters; shared pre-professional learning

## 1. Introduction

With the continued movement of migrants and refugees around the world, many countries have seen an increased need for interpreters in healthcare. The importance of good pre-professional training cannot be underestimated (Crezee, 2013). Hsieh (2006) observed disparities in the level of services health providers were able to offer patients of different cultural and linguistic backgrounds. She found that interpreting quality varied from low to moderate-high, depending on the level of training interpreters had received.

Hale (2012) emphasized the need for specialized pre-service training to prepare interpreters for work in settings such as healthcare. Countries vary in the level of training provided in terms of focus, duration and whether training is offered by practising community interpreters, hospitals, or tertiary institutions at either undergraduate or postgraduate level. This paper will discuss the focus of health interpreter training offered in New Zealand, briefly outlining its language-neutral approach. It will do so by, firstly, describing the pedagogical framework underpinning health interpreter education and the key pedagogical tools of teaching and learning practice in the interpreting classroom, and, secondly, by moving to specific examples of the use of semi-authentic practices for student health interpreters. Such practices facilitate legitimate peripheral participation by a Community of Learners in the Community of Practice (Lave & Wenger, 1991; Wenger, 1998, 2000). Special emphasis will be placed on the importance of shared pre-professional practice, and two examples of this will be described in some detail. The pedagogical tools outlined in this paper can be easily replicated by interpreter educators internationally.

## **2. Background**

New Zealand is a relatively small country (population 4.5 million in 2013) with a large number of community languages (Statistics New Zealand, 2013). In New Zealand, health interpreter training was first offered in 1990 following a series of medical misadventures which had involved neither Informed Consent nor the use of trained interpreters (Crezee, 2003). From inception, training was language-neutral as it aimed to fill the urgent demand for trained health interpreters working in a range of language pairs. It initially involved a 90-contact-hour course taught over two 15-week semesters. Student interpreters were introduced to the challenges of cross-cultural communication, interpreting theory, ethics and practice, as well as familiarization with the most common healthcare settings.

Over the years, other courses were developed, including community interpreting (1997), and advanced interpreting courses focusing on the legal (1998) and health settings (2000). The health and legal courses were designed to be taken after completion of the community interpreting course and involved consecutive and simultaneous interpreting of longer passages. Since 2009, the healthcare interpreting papers have been embedded in both the BA Interpreting and the Graduate Diploma in Arts (Interpreting) offered at Auckland University of Technology (AUT). Other courses offered as part of these qualifications include introduction to interpreting, societal contexts, oral discourse for interpreters, and legal and business interpreting. Courses include equal amounts of theory and practice. AUT is unusual in that interpreting courses are offered at undergraduate level. This is mainly due to historical developments, where the first courses were stand-alone training programmes offered to mature bilingual students who did not need language consolidation (at undergraduate level) before embarking on interpreter training.

## **3. Theoretical underpinnings**

Internationally, interpreter education focused initially on preparing conference interpreters and included a strong emphasis on note-taking and simultaneous interpreting practice (Gile, 1995). With the increased focus on interpreting in public service settings, scholarly attention gradually moved to liaison interpreting (Gentile, Ozolins, & Vasilakakos, 1996) and community interpreting (Pöchhacker, 1999; Salaets & Vermeerbergen, 2012). Legal interpreting (Berk-Seligson, 1990; Morris, 1999; Gonzalez, Vazquez, & Mikkelson, 2012; Hale, 2001, 2004) and health interpreting training have also started to attract the attention of scholars (Crezee, 2003, 2013; Angelelli, 2004; Pöchhacker & Shlesinger, 2007).

At the author's university, interpreter training is underpinned by the need to provide language-neutral programmes, and the desire to do so by including situated learning experiences incorporating (semi-)authentic learning components. I will discuss first the need to offer language-neutral courses, before moving on to an exploration of the literature on situated learning approaches and our implementation of elements thereof.

As stated above, offering language-neutral courses is the only way to meet the need for trained interpreters in an ever increasing number of community languages in New Zealand. Interpreters are most in demand in health settings, and in languages of limited diffusion. Slatyer (2014) describes a similar situation in Australia, where interpreter training also followed a non-traditional approach.

The *master-apprentice* model referred to by Pöchhacker (2010) is very useful in interpreter education. Sawyer (2004, 76) also stated that “[A]lthough leading interpreter education programs are situated in an academic environment, interpreter training has never truly left the realm of apprenticeship.” However, in language-neutral interpreter education, the *master-lecturer* is not able to provide immediate feedback to trainee interpreters in terms of their performance, necessitating the input of individualized feedback provided by (anonymous) *master* language specialists in relation to interpreting assessments. The language neutral approach at AUT also involves students receiving either immediate feedback on their performance in the classroom, or less immediate feedback on their recorded interpreted practice from same-language experts (often retired professionals such as lawyers and doctors) in their community who are capable of assessing whether something is worded in an appropriate or natural way in their native tongue. Students self-assess their interpreting practice with the aid of scripts to check for changes, omissions or additions. In addition, accredited interpreters anonymously assess student interpreting performance at set times by accessing de-identified student audio recordings which have been posted on the Blackboard Collaborate system.

At AUT, the aim is to foster professional competence in graduates, based on the reality of the contexts that interpreters can expect to be working in. Interpreting professionals need to be able to gather the information required for a task as it occurs. In order to do that, an underlying understanding of genres and socio-pragmatic norms is essential. A social constructivist approach to interpreter education has as its key the concept of learning through authentic action and this is one of the components Gonzalez Davies (2004) includes in her situated learning approach. Gonzalez Davies (1998) argues the benefits of mediated learning and the introduction of authentic learning materials into the translation classroom. In her (2004) monograph on situated learning in translator education, Gonzalez Davies proposes what Kiraly (2005, p. 1098) describes as an ‘eclectic pedagogical framework’ comprising four main components: the humanistic principle, the communicative approach, cooperative learning, and social constructivism. The humanistic principle (Gonzalez Davies, 2004, p. 12) views students as active participators who can “contribute actively to transforming the group’s as well as his or her own competence and performance”. In the interpreting classes at AUT, this is reflected in many pair and triadic activities, with students reflecting and providing feedback on their own and others’ performances. Such activities also prepare students for the path of lifelong learning as aware, resourceful and reflective professionals (Bernardini, 2004). The communicative approach used in AUT classrooms (Gonzalez Davies, 2004, 12) means that the focus is on “forefronting meaning and pragmatics in order to communicate adequately in given situations.” The component of cooperative learning, which also involves semi-authentic practices, results in students forming cohesive groups in which all contribute actively towards both the process and the end product. This concept described by Gonzalez Davies (2004) within the context of the translation classroom, is equally applicable to the interpreting classroom. Lastly, social constructivism (Gonzalez Davies, 2004, p. 13; Kiraly, 2000) involves the key concept of learner autonomy, in that it helps students to construct their own knowledge rather than merely regurgitating “passively received knowledge”. At AUT this occurs when students provide feedback on interpreting practice and reflect on observed interpreter-mediated interactions in their court observation journals.

Other authors, too, have described situated-learning approaches in relation to translator and interpreter education. Kiraly (1997, p. 144) described the underlying principle of a situated-learning approach, arguing that it is through personal experience that individuals can increase their personal

knowledge and their understanding of what is happening in the world around them. Daniels (2008) argues that both activity theory and situated-learning approaches can be seen as an extension of original Vygotskian ideas. Obviously, education delivery has changed radically following globalization, the advent of information technology and the worldwide web. Kiraly (2000) points out that there is a lack of educators researching their student cohorts to assess the ever changing knowledge and skills needed by those students. Kiraly's (2000) six principles echo the nine of situated learning (Lave & Wenger, 1991). Kiraly proposes that students should find several appropriate solutions arising from the authentic texts provided in class. He further believes that teachers should create a scaffold for learning and gradually allow students to construct their knowledge safely through practice.

Slatyer (2006) used an Action Research (AR) approach for innovation in interpreter education. Likewise, the author and her colleagues have used a slightly modified AR approach to implement and test student interpreters' performance and responses to innovative changes in preparing them for interpreting in real-life settings (Crezee, Burn, & Gailani, 2015; Crezee & Grant, 2015 – in progress).

This paper will describe the key pedagogical tools used in health interpreter education at the author's university. Headings will reflect pedagogical tools, rather than components of situated learning, for ease of elucidation and possible replication by other educators. I will link each tool to the components of situated learning described by Gonzalez Davies (2004) and other proponents of situated learning (Kiraly, 2000; Lave & Wenger, 1991; Ryu & Parsons, 2009; Wenger, 1998, 2000). A search of the literature did not reveal any other health interpreter education programmes using the same combination of pedagogical tools, although Montalt and Gonzalez Davies (2012) and Boéri et al. (2011) report having implemented situated-learning approaches in translation and conference interpreting programmes respectively.

#### **4. Health interpreter education: introduction to key pedagogical tools**

Situated learning involves moving students along the continuum from membership of the community of learners to membership of the community of practice (Lave & Wenger, 1991; Wenger, 1998, 2000). The situated-learning approach also involves lecturers attempting to introduce authentic or semi-authentic learning experiences wherever possible. In the traditional master-apprentice model, the student learns from the expert in the situation. We cannot take our students into the health setting to work as interpreters before they are qualified, as the health board interpreting services will only accept graduate interpreters. The author is a trained health professional as well as a linguist and did most of her health professional training in the setting, where she gained first-hand experience of the benefits of situated learning. This has shaped her approach to interpreter education, and a desire to familiarize students with components of the real-world setting. The author attempts to bring the healthcare setting into the classroom, using an approach that should perhaps be described as 'simulated situated learning'. This article will outline the most commonly used methods and materials. Pedagogical tools that can be readily replicated by educators in other educational institutions will be described in just enough detail to provide a rationale and allow replication. Another method, which involves shared pre-professional learning, will be described in more detail with an eye to lending itself to duplication by other educators. For each pedagogical tool the author will explain how it fits with a (simulated) situated-learning approach.

#### **4.1 Health literacy**

In the case of health interpreter education, the author equips interpreters with basic knowledge which they can build on as practising health interpreters (Crezee, 2013), combining health and linguistic knowledge, in trying to achieve health literacy. The approach entails teaching student healthcare interpreters anatomy, physiology and pathology of main organ systems, as well as familiarizing them with common investigations and procedures. Special health topics such as various common forms of mental illness, oncology, neonatology, speech language therapy, pregnancy and (in)fertility are addressed once students have co-constructed this basic health literacy. Students are also introduced to skills which will help them keep up-to-date with ongoing developments in medicine – which is what they will need as lifelong learners. To this end, Crezee (2013) provides a list of useful websites maintained by professional medical organizations.

#### **4.2 Authentic realia**

Realia are used wherever possible to give students a sense of what the words they are interpreting refer to. Thus, actual catheters used during balloon angioplasty procedures are passed around the classroom during the session on cardiology, and students watch a patient undergoing such a procedure. Similarly, asthma inhalers, nebuliser masks, peakflow meters and aerochambers are passed around during the session on the respiratory system. Students are encouraged to form study groups (preferably, but not necessarily, in their language groups) to allow them to study with the benefit of group feedback. Realia may be obtained by asking hospital staff to pass on material such as cardiac catheters which have not been used, but where the sterile packaging has been opened, rendering the equipment unsuitable for use with patients. The author has a collection of expired inhalers, unused balloon-catheters, stents and even a CPAP (continuous positive airway pressure) machine which was gifted to the programme as it was no longer in good working order. Realia can be used in combination with YouTube clips demonstrating their use.

In terms of the four principles of situated learning put forward by Gonzalez Davies (2004), the use of realia reflects both the communicative approach (forefronting meaning and pragmatics), and social constructivism where learners construct their own knowledge by handling authentic health-related equipment. This approach fits (simulated) situated learning, because students learn about paraphernalia used in real settings through seeing and touching it (tactile learning) (Perez, 2013).

#### **4.3 Use of audiovisual clips**

Audiovisual clips are used firstly to consolidate theoretical knowledge and secondly to assist interpreting practice. A good basic knowledge of body systems and common health conditions should be consolidated by the use of video clips showing patients in hospitals during related doctor-patient interviews and/or undergoing certain procedures. These clips involve patients who have given informed consent to footage being shared for educational purposes. Watching such clips will serve to give student interpreters the feeling of being ‘right there’ in the hospital room and will also help them remember important health-related information, thus providing a true semi-authentic experience. The author uses PowerPoint presentations to explain the main points, and reinforces the explanation by means of video clips. An example is the topic of insulin resistance which can be effectively illustrated by a YouTube animation clip showing how the insulin receptors become ‘blunted’ through overuse as a result of an individual’s ongoing high blood glucose levels which may, in turn, be due to a high Glycaemic Index (high GI) diet.

The second application of audiovisual clips involves manipulation by a technician, who inserts silent pauses into such clips, to allow students to interpret what they have just (seen and) heard. Documentary style programmes showing health professionals interacting with patients are converted into audiovisual interpreting practice clips simulating real-life interpreting practice. This has the advantage of re-introducing learners into the community of practice (Lave & Wenger, 1991; Wenger, 1998, 2000) by exposing student interpreters to real-life situations. Crezee and Grant (2015) describe the outcomes of such practice in exposing students to the real-life discourse of ambulance paramedics, including much colloquial language.

Both applications of audiovisual clips are closely aligned with (simulated) situated learning, where the authentic setting is brought into the classroom for students to construct their own knowledge. Seeing health professionals communicate with patients in authentic settings, both in video clips and through observing health interpreters in practice, also helps introduce learners to the community of practice.

#### **4.4 Exposure to expert performances**

The 'exposure to expert performance' component of situated learning is reflected in the use of a number of pedagogical tools. The use of videoclips for practice and to consolidate learning has already been discussed. The health interpreting observation assignment also involves exposure to expert performance. Interpreting students observe a qualified healthcare interpreter for their language in three different interactions, reflecting on that person's communicative strategies within the framework of the healthcare setting, the patient's sociolinguistic and sociocultural background and the interpreters' Code of Ethics (AUSIT, 2012; NZSTI, 2013)<sup>1</sup>.

In order to complete observation assignments, student interpreters need to obtain the consent of the patient, the health board, the health professional and the interpreter. Students need to observe three different interpreter-mediated health professional-patient interactions, de-identify all information and record their observations in a reflective journal. They need to describe their observations within the framework of the interpreters' Code of Ethics (NZSTI, 2013). They are also asked to assess the performance and actions of the interpreters they observe within the framework of the competencies, knowledge and skills required of health interpreters. Journals are of a confidential nature and made available to the lecturer only for the purpose of assessment. Students commonly comment on the conduct of practising interpreters both during, before and after interpreting assignments. Comments often relate to the interpreter role in practice (cf. Slatyer, 2014) and sometimes to perceived inadequacies in note-taking skills, omissions, changes or additions to the message as well as perceived breaches of the interpreters' ethical guidelines (NZSTI, 2013). Observation assignments combine all four principles of situated learning (Gonzalez Davies): the humanistic principle where students become active participants in their own learning; the communicative approach forefronting meaning and pragmatics; cooperative learning; and social constructivism.

---

<sup>1</sup> In New Zealand, almost all qualified interpreters are (affiliate) members of the professional body, the New Zealand Society of Translators and Interpreters (NZSTI) and as such have undertaken to abide by the NZSTI Code of Ethics (NZSTI, 2013). All qualified interpreters have gone through the same basic liaison interpreting training in order to be eligible for employment by the hospital interpreting service. A smaller number have also completed two additional 12-week health interpreting training sessions, as described in this paper.

#### 4.5 Oral assessments

Oral assessments, too, incorporate semi-authentic material based on real health professional-patient encounters, either based on the lecturer's own health professional and health interpreter experience of such encounters or based on real-life documentaries reflecting the same. From the very first iteration of the healthcare interpreting course, interpreting assessments have been written in English, translated into the students' languages and recorded as bilingual dialogues, similar to the NAATI paraprofessional interpreting tests (NAATI, 2014). Since the healthcare interpreting course aims to prepare students for a specialized level of practice, final interpreting tests are modelled on the NAATI professional tests in that they require students to interpret a 300-word health-related passage, either consecutively or simultaneously. These are placed online using the Blackboard Learning Management system (Blackboard) and only made available to students at the time of the oral assessments.

Online students take their oral interpreting tests in Blackboard Collaborate® sessions created for them individually and supervised by other lecturing staff to ensure that they have only 20 minutes to sit a 20-minute examination. Practice tests are used to allow students to check their microphone before sitting the real exams. The students' interpretations are recorded in Blackboard Collaborate®, de-identified and posted online on a website accessible only to the markers, using a special login and password. Scripts and grade sheets are posted there too. Grade sheets use performance-based criteria, including the accuracy of the message, any changes or omissions, use of medical terminology, paraphrasing when required, register, style and fluency. In short, both assessments and grade sheets emphasize skills needed in practice. The system enables distance students to participate with the same examination conditions as the Auckland-based students. With telephone interpreting becoming increasingly common, the fact that both practice and assessment are audio-based is considered a reflection of authentic real-life practice.

#### 4.6 Shared pre-professional practice

Shared pre-professional practice offers valuable semi-authentic learning experiences. Student interpreters are taken off-campus to practise interpreting with Post Graduate Speech Science students who have already qualified as Speech Language Therapists (SLTs), some of whom speak the same Language Other Than English (LOTE) as the students. Students and SLTs spend a few hours working through purpose-written real-life scenarios, alternatively playing the role of interfering parents, interpreters, preschool children with speech problems, or stroke victims. Students also share pre-professional practice sessions with student nurses and student midwives. This type of collaborative pre-professional learning is consistent with the models of Interprofessional Education (World Health Organization, 2010) as it promotes collaborative and interdisciplinary teaching and learning practices.

Kambanaros and van Steenbrugge (2004) stress the need for speech pathologists to share *more* of their professional knowledge with the interpreter, specifically knowledge about patients' typical responses and behaviours which form essential data or evidence in the diagnosis of a particular disorder, for example bilingual aphasia. Healthcare interpreting students learn about strokes and aphasia in their health studies course, but, until this point, are not aware of the role of the SLT in teasing out a differential diagnosis between aphasia and apraxia.<sup>2</sup>

---

<sup>2</sup> In aphasia, the patients' speech centre is affected somehow, meaning that language is not produced or processed correctly. By contrast, apraxia of speech involves difficulty

In September 2012, the healthcare interpreting lecturer and a lecturer in speech science of another university organized for their students a combined three-hour workshop which involved student interpreters working with SLTs in simulated real-life scenarios that had been prepared by the postgraduate SLT students. Scenarios will be described in detail below.

The session commenced with a brief presentation on the different demands placed on interpreters working with SLTs. This included the types of problems SLTs need to deal with (e.g. dyspraxia, aphasia, child speech and language difficulties, and the difference between speech and language), different scenarios (assessment, therapy), and the metalinguistic features of speech that language interpreters might be asked to comment on. SLTs were told about the role of the interpreter and the interpreters' Code of Ethics. This was important because, in fact, SLTs require interpreters to step outside their role occasionally to provide metalinguistic comment on a patient's utterances, including how something is said, whether the sentence or phrase makes sense, logically and grammatically, how sounds are pronounced, and whether any deviations in pronunciation occur (Kambanaros & van Steenbrugge, 2007; Kostich & Weiss, 2007; Merlini & Favaron, 2004).

After this brief introductory presentation, student interpreters and SLTs were divided into different groups, each comprising at least two student interpreters sharing the same language and at least two SLTs plus one student interpreter observing and taking notes. The group role-played a scenario with a client, partner or parent, an SLT and an interpreter. Incidentally, the group of SLTs also included several bilinguals, and most groups working with interpreters included one SLT who was also familiar with the language spoken by the interpreters.

Lively discussions ensued in each group, resulting in greatly increased awareness of potential problems on the part of both interpreters and SLTs. Scenarios written by the postgraduate speech science students were based on their experience as practising Speech Language Therapists and therefore (semi-)authentic in nature, with situations commonly occurring in their practice. Two of the scenarios revolved around the assessment of patients who had suffered a Cerebral Vascular Accident (CVA), also known as a stroke. The first scenario concerned a patient who had to remain 'nil by mouth' (NBM) until his/her ability to swallow had been assessed. The second scenario featured a patient who had suffered a stroke affecting the left hemisphere; the SLT needed to assess whether the patient had apraxia of speech or aphasia.

A further two scenarios focused on bilingual children who were showing signs of delay in their second language, English. The first preschool child scenario was about a four-year old boy whose speech appeared to be affected by a phonological disorder. In order to provide student interpreters with some background information, the scenario included information on the previous week's speech therapy session with this young boy:

Last week HF struggled to produce /s/ in isolation, sometimes using a lateral production and sometimes producing /ts/. HF was more stimutable for /s/. This is important considering the limited time left in this therapy block. /s/ is also typically acquired before /z/ in typical speech sound acquisition.

The scenario involved the SLT asking HF's mother if they could utilize one game or story each day, and give the boy and his mother the /p,b/ go-fish game, the 'Simon Snake' story and the snake bingo game.

The second preschool-child scenario was about KB, a young child, aged 3 years 10 months, whose parents had moved to New Zealand some twelve

---

making accurate movements when trying to produce syllables and words, resulting in problems with speech production.



months earlier. In this scenario, KB had been at kindergarten for seven months. According to the scenario, KB had been referred for speech language therapy by his kindergarten teacher who wrote: *KB rarely speaks at kindergarten and is quite hard to understand when he does speak*. The teacher was concerned that KB did not seem to have picked up any English words as yet. According to the scenario, KB spoke Cantonese at home, and his mother's English was very limited.

The plan for the SLT session included asking KB's mother why she had come to see the SLT today and what her concerns were, using reflective talking techniques. It also involved giving the child toys to play with and observing the child while talking to the caregiver. There were five groups of students. Each group included two to three student interpreters and two to three speech science students. Coincidentally, some of the speech science students shared a language with the trainee interpreters, and this allowed them to give immediate feedback on what was interpreted, especially in terms of objectives in phrasing particular questions in a specific manner. Student interpreters particularly enjoyed the scenarios which involved them interpreting for bilingual preschool children (as acted by either trainee interpreters or speech science students) and their parents (role-played by trainee interpreters).

Following this shared pre-professional semi-authentic practice, the speech science students and the trainee interpreters took part in a brief survey, the administration of which had been approved by the ethics committees at both universities. Students were asked what they had learned about working with each other. Some of the findings of the 2012 survey may be found in Table 1.

Overall, the speech science students and the student interpreters were very positive about the experience. Student health interpreters commented on their need to be aware of the objective of the SLT session. They also commented on the need for health interpreters to convey messages in the appropriate register and the ability to comment on how things were being said, i.e. at a metalinguistic level. Feedback from both groups showed a number of similarities regarding the need for briefing. However, some interesting divergences were also expressed. One of the speech science students commented:

This was a great experience as it allowed us to learn more about each other's roles, challenges and areas to work on, and ways to promote good working relationships & best practice strategies.

Overall, both groups of students felt that this type of shared pre-professional practice was very beneficial, allowing them to practise interpreting in a safe environment. One student summed up the effectiveness of the session as follows: "[T]his was very helpful as a way to identify potential difficulties so we are aware of the need to address them before a session." The setting was important because they were able to reflect on authentic real-life challenges and find solutions for these without being in a position where they might make mistakes that could have grave repercussions for real patients and health professionals.

The Speech Language Therapy lecturer and the interpreting lecturer circulated among the student groups, listening in, observing and occasionally interjecting with questions about problems and challenges students encountered and how to deal best with these. The SLT lecturer handed out tests commonly used by SLTs when working with preschool children. These tests allowed interpreters to conclude that they needed to position themselves in such a way as to have a clear view of the images on the cards or risk misinterpreting the questions asked of the child by the SLT.

Table 1: What sort of special skills and knowledge does the interpreter need to successfully work in SLT settings?

Student interpreters		Speech science students	
5	Understanding what SLT is trying to find out: purpose of the session/briefing	4	Awareness of why we need them to interpret exactly what we said
5	Patient's status/Background information	7	Basic knowledge of communication & swallowing disorders
0		7	Metalinguistic skills of being able to comment on the nature of the client's language (& their own)
0		6	Understand the difference between speech and language
4	Knowing how to use the right register for interacting with young children	3	Ability to use different registers
9	SLT procedures/assessment process	4	General knowledge of what an SLT does
1	Awareness that we should refrain from using 'helpful' gestures = impartiality	1	That it is a partnership and we need them
1	Debriefing	2	Knowledge of children and how to talk to them, and children's normal speech and language
4	Terminology used in SLT	1	Some SLT terms (e.g. the disorders)
		1	Proficiency in both languages
		1	Willingness to collaborate actively with SLTs
4	Knowledge of SLT test tools (e.g. picture naming cards, Boston naming test)	0	

*\*Several participants provided more than one answer, so numbers do not tally.*

Students also commented on the ambiguity of some questions, which made them difficult to interpret. One example involved a task where the SLT asked the child to “please draw a cross on these three leaves”. Chinese interpreting students remarked that this should be clarified as it was unclear whether the child was being asked to draw a cross on each of the three leaves in the picture, or being asked to draw a large cross across all three leaves. In this instance, the trainee interpreter in question discussed the need for the SLT to clarify the question to the interpreter in order to allow for correct interpretation from English to Chinese.

In order to make this type of semi-authentic practice work, the preparation of workable scenarios is of the utmost importance. In the examples presented here, giving students a voice in creating scenarios ensured that materials were based on their own real-life experiences. The examples presented here also showed that detailed scenarios with detailed assessment plans are best, and that realia such as picture-naming tasks and other tools add a further authentic flavour.

## 5. Conclusion and recommendations

The use of (semi-)authentic materials and practices is an excellent fit for a situated-learning approach to interpreter education. Many of the pedagogical tools described above may effectively be introduced in health interpreting classrooms in other countries, *mutatis mutandis*. Some of the semi-authentic tools outlined here could be used for flipped learning (Bergmann & Sams, 2012), in which the (online) student's homework is the traditional lecture, PowerPoint® viewed in their own time, outside of class, while (online) class time is used for further exploratory learning. Interpreter educators could explore the possibility of shared pre-professional learning by talking to lecturers in nursing, physiotherapy or occupational therapy studies and arranging such shared collaborative learning sessions. They could also explore the option of adapting existing reality television programmes showing health professionals in action for audiovisual interpreting practice (Crezee, Burn, & Gailani, 2015; Crezee & Grant, 2015). In short, there are many ways of using semi-authentic materials and practices in interpreter education and it is hoped that this paper may serve to inspire other educators to implement some of the pedagogical tools outlined above.

## References

- Angelelli, C. (2004). *Medical interpreting and cross-cultural communication*. Cambridge, England: Cambridge University Press.
- AUSIT (2012). *Code of Ethics*. Retrieved 9 November 2012 from: [http://ausit.org/national/?page\\_id=110](http://ausit.org/national/?page_id=110)
- Bergmann, G., & Sams, A. (2012). *Flip your classroom: Reach every student in every class every day*. Washington DC: International Society for Technology in Education.
- Berk-Seligson, S. (1990/2002). *The bilingual courtroom: Court interpreters in the judicial process*. Chicago, IL: University of Chicago Press.
- Bernardini, S. (2004). The theory behind the practice. In K. Malmkjaer (Ed.), *Translation in undergraduate degree programmes* (pp. 17-30). Amsterdam, the Netherlands: John Benjamins.
- Boéri, J., & de Manuel Jerez, J. (2011). From Training Skilled Conference Interpreters to Educating Reflective Citizens: A Case Study of the Marius Action Research Project. *The Interpreter and Translator Trainer*, 5(1), 41-64.
- Crezee, I. (2013). *Introduction to healthcare for interpreters and translators*. Amsterdam & Philadelphia: John Benjamins.
- Crezee, I. (2003). Health interpreting: The cultural divide. In L. Brunette, G. Bastin, I. Hemlin & H. Clarke (Eds.), *The Critical Link 3: Interpreting in the community*. Amsterdam & Philadelphia: John Benjamins.
- Crezee, I., Burn, J., & Gailani, N. (2015). Authentic audiovisual resources to actualise legal interpreting education. *Monographs in Translation and Interpreting* 7: 271-293. doi: <http://dx.doi.org/10.6035/MonTI.2015.7.10>
- Crezee, I., & Grant, L. (2013). Missing the plot? *International Journal of Interpreter Education*, 5(1), 17-34.
- Crezee, I., & Grant, L. (2015). Thrown in the deep end. How do student interpreters cope with authentic paramedic language? Manuscript submitted for publication.
- Gentile, A., Ozolins, U., & Vasilakakos, M. (1996). *Liaison interpreting. A handbook*. Melbourne, Australia: Melbourne University Press.
- Gile, D. (1995). *Basic concepts and models for interpreter and translator training*. Amsterdam, the Netherlands: John Benjamins.
- González, R. D., Vásquez, V. F., & Mikkelsen, H. (2012). *Fundamentals of court interpretation: Theory, policy, and practice*. Durham, NC: Carolina Academic Press.

- Gonzalez Davies, M. (2004) Undergraduate and postgraduate translation degrees Aims and expectations. In K. Malmkjaer (Ed.), *Translation in undergraduate degree programmes* (pp. 67-82). Amsterdam, the Netherlands & Philadelphia, MA: John Benjamins.
- Hale, S. (2012). *Are we there yet? Taking stock of where we are up to and where we are heading*. Jill Blewett Memorial Lecture. Keynote address delivered at the Jubilation 25 2012 Biennial AUSIT Conference. Sydney, Australia 1-3 December 2012.
- Hale, S. (2007). *Community interpreting: Research and Practice in Applied Linguistics*. Hampshire: Palgrave MacMillan.
- Hale, S. (2004). *The discourse of court interpreting*. Amsterdam, the Netherlands: John Benjamins.
- Hsieh, E. (2006). Understanding medical interpreters: Reconceptualizing bilingual health communication. *Health communication*, 20(2), 177-186.
- Kambanaros, M., & van Steenbrugge, W. (2004). Interpreters and language assessment: Confrontation naming and interpreting. *International Journal of Speech-Language Pathology*, 6(4), 247-252.
- Kiraly, D. (2000). *A Social Constructivist Approach to Translator Education: Empowerment from Theory to Practice*. Manchester, UK: St. Jerome Publishing.
- Kiraly, D. (1997). Collaborative Learning in the Translation Practice Classroom. In E. Fleischmann, W. Kutz & P.A. Schmitt (Eds.), *Translationsdidaktik* (pp. 152-158). Germany: Tübingen.
- Kostich, L. A., & Weiss, D. (2007). *Utilization of foreign language interpreters: A national survey of speech-language pathologists*. Paper presented at the American Speech-Language Hearing Association Convention, Boston MA.
- Lave, J., & Wenger, E. (1991). *Situated learning: Legitimate peripheral participation*. Cambridge, England: Cambridge University Press.
- Merlini, R., & Favaron, R. (2007). Examining the 'voice' of interpreting in speech pathology. In F. Pöchhacker & M. Shlesinger (Eds.), *Healthcare interpreting: discourse and interaction* (pp. 101-137). Amsterdam, the Netherlands: John Benjamins.
- Montalt, V., & González-Davies, M. (2014). *Medical translation step by step: Learning by drafting*. Routledge.
- Morris, R. (1999). The gum syndrome: predicaments in court interpreting. *Forensic Linguistics*, 6, 6-29.
- National Accreditation Authority for Translators and Interpreters. (2014). *Accreditation by testing*. Retrieved 15 March 2015 from: [http://www.naati.com.au/PDF/Booklets/Accreditation\\_by\\_Testing\\_booklet.pdf](http://www.naati.com.au/PDF/Booklets/Accreditation_by_Testing_booklet.pdf)
- NZSTI. (2013). *Code of Ethics and Code of Conduct*. Retrieved 20 June 2014 from: [http://www.nzsti.org/assets/uploads/files/nzsti\\_code\\_of\\_ethics\\_and\\_code\\_of\\_conduct\\_may\\_2013.pdf](http://www.nzsti.org/assets/uploads/files/nzsti_code_of_ethics_and_code_of_conduct_may_2013.pdf)
- Perez, K. (2013). *The new inclusion: Differentiated strategies to engage all students*. New York, NY: Teachers College Press.
- Pöchhacker, F., & Shlesinger, M. (Eds.). (2007). *Healthcare interpreting: discourse and interaction*. Amsterdam, the Netherlands: John Benjamins.
- Pöchhacker, F. (1999). Teaching practices in simultaneous interpreting. *The Interpreters' Newsletter* 9, 157-176.
- Pöchhacker, F. (2010). The role of research in interpreter education. *Translation & Interpreting* 2(1), 1-10.
- Ryu, H., & Parsons, D. (2009). *Designing learning activities with mobile technologies*. Hershey, PA: IGI Global.
- Sachtleben, A., & Crezee, I. (2015). Digital Innovation Serving Interpreting Education. In J. Napier & S. Ehrlich, (Eds.), *Digital Education in Interpreter Education* Gallaudet University Press (publication date: February 2015).
- Salaets, H., & Vermeerbergen, M. (2012). Assessing students upon completion of community interpreting training: how to reshape theoretical concepts for practice? In C. Kainz, E. Prunc & R. Schögler (Eds.), *Modelling the field of community interpreting. Questions of methodology in research and training* (pp. 152-176). Berlin & Münster, Germany: LIT Verlag.
- Sawyer, D. B. (2004). *Fundamental aspects of interpreter education: Curriculum and assessment*. Amsterdam, the Netherlands: John Benjamins.
- Slatyer, H. (2006). Researching curriculum innovation in interpreter education. The case of initial training for novice interpreters in languages of limited diffusion. In

- C. Roy (Ed.), *New approaches to interpreter education* (pp. 47-66). Washington DC: Gallaudet University Press.
- Statistics New Zealand (2013). *2013 Census Quick Stats about culture and identity*. Retrieved from: <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity.aspx>
- Wenger, E. (1998). *Communities of Practice: Learning, meaning, and identity*. Cambridge, England: Cambridge University Press.
- Wenger, E. (2000). Communities of practice and social learning systems. *Organization*, 7(2), 225-246.
- World Health Organization. (2010). *Framework for action on interprofessional education and collaborative practice*. Geneva, Switzerland: World Health Organization Press. Available at [http://www.who.int/hrh/resources/framework\\_action/en/index.html](http://www.who.int/hrh/resources/framework_action/en/index.html).