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Delys Magill
delys.magill@gmail.com

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Interview with Kim de Jong, Interpreting and Translation Service Manager

Delys Magill¹

New Zealand Sign Language Interpreter

Kim de Jong

Counties Manukau Health Interpreting and Translation Service

Abstract

Kim de Jong is the manager of interpreting booking services for the Counties Manukau District Health Board in Auckland, New Zealand. In this interview she describes the challenges of meeting the needs of a culturally diverse population within the constraints of a large organization. She also shares her observations on the skills and knowledge an interpreter must have before undertaking work in healthcare.

¹ Correspondence to: delys.magill@gmail.com

Interview with Kim de Jong, Interpreting and Translation Service Manager

Delys Magill is a New Zealand Sign Language (NZSL) interpreter with 14 years' experience, currently working in Auckland, New Zealand. She has previously worked at Auckland University of Technology as a lecturer on the NZSL-English interpreting programme. Delys is in the final stages of her MA in Applied Language Studies thesis research, with a focus on healthcare interpreting.

Kim de Jong has been the manager of the Counties Manukau Health Interpreting and Translation Service in New Zealand, where she enjoys the challenge of managing a culturally diverse workforce, since 2012. Currently, Kim is involved with a project that is reviewing interpreting service needs and delivery modes, with the goal of optimizing and designing a modern, efficient and cost efficient service that meets the needs of its community. Prior to joining Counties Manukau Health, Kim spent 20 years in management roles within the private healthcare sector.

Background Information

New Zealand is divided into different District Health Boards (DHBs) which deliver primary and secondary health services to their patient populations.

In 2015 the Counties Manukau Health District population was estimated to be 520,140 people, or 11% of the total New Zealand population. The population is ethnically diverse with 16% Māori (16% of total NZ population are indigenous Māori), 21% Pacific (6% of the total NZ population are Pacific) and 24% Asian (13% of NZ population are Asian). 'New Zealand European and Other' make up 39% of the Counties Manukau Health District population compared with 65% of the total population of New Zealand (Counties Manukau Health, 2016). This cultural diversity brings a range of challenges when providing healthcare services. For example, 'Pacific people' is a representative term used to describe people descended from the Polynesian nations, including the Cook Islands, Tonga, Niue, Samoa, Tuvalu, and Tokelau. Each of these cultural groups has its own language and customs which need to be considered when providing healthcare services (Lemanu, 2010).

Interview

Delys: Thank you, Kim, for allowing me to come in interview you today. It's lovely to meet you.

Kim: Thanks, Delys.

Delys: How many years has Counties Manukau Health Board had its own interpreting service?

Kim: The service was established in 1991. It was formerly known as the Middlemore Interpreting Service and it came about because there was the Cartwright enquiry² about cervical cancer research project [see Cartwright, 1988]. That was in the late 1980s. And that was all around the informed consent for women who didn't have English as their first language. The Cartwright [Committee] recommendation led to the pilot interpreting service which was set up in 1991. It became the CMDHB [Counties Manukau District Health Board] Interpreting Service and that is what it is known as today.

Delys: So these services are not centered around Middlemore [Hospital]³, are they? They are centered around here at the Super Clinic⁴ and ...?

Kim: So we provide an interpreting service, a free interpreting service, to all Counties District Health Board patients. That means our biggest number of requests for interpreters come from the Manukau Super Clinic which is outpatient based. We are appointments-based and we have a high turnover. And then we do inpatients at Middlemore [Hospital]. So we are doing all the acute care, ward rounds, any services over at Middlemore, and of course we service all Counties DHB localities. This includes services such as community midwives, breast screening, home healthcare visits, community rehab treatment, and contracts the DHB runs like the ophthalmology clinics in the community. Of course also we are funded by the Primary Health Care interpreting [schedule]⁵. This covers all GPs and primary health organizations; we offer free interpreter services to them as well. So that includes GP clinics, nongovernment organizations, like Plunket⁶, family planning, and retinal screening. There's a whole host.

Those are all the free interpreting services that we offer to the community in the region and we also offer interpreting to external organizations. These are mostly government organizations who pay for our service. So that could be the Police, High Court, [other] courts, Ministry of Social Development, Ministry of Housing,

² The Cartwright Inquiry was held in response to magazine article written in 1987 by Sandra Coney and Phillida Bunkle which made serious allegations about the treatment of women with cervical cancer at National Womens' Hospital in Auckland. The final report by Dame Sylvia Cartwright was released in August 1988 and contained recommendations which were key to setting up a national cervical screening programme for New Zealand women.

³ Middlemore Hospital is a large hospital run by Counties Manukau District Health Board.

⁴ The Manukau Super Clinic provides outpatient services and day-stay procedures to patients resident in the catchment area of Counties Manukau District Health Board; medical staff at the Super Clinic usually also work at Middlemore Hospital.

⁵ This provides for interpreting at primary care level, at no cost to the patient or the General Practitioners (GPs/PCPs).

⁶ Child health visit services offered to all children aged between 0 and 5, at no cost to the parents.

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Immigration, ACC⁷, anybody who wants an interpreter that's outside healthcare or that doesn't come under the CMDHB free interpreting umbrella.

Delys: And how much of your workload would come from the paying [clients]?

Kim: 5%. We'd like to increase it because we get revenue from external customers; however, our main focus is healthcare. And because the demands of healthcare interpreting are so high, if we want to satisfy an external agency, something's got to give. We won't be able to satisfy our internal jobs.

Delys: Is CMDHB the biggest District Health Board in New Zealand?

Kim: I don't know. We have probably the most diverse population in New Zealand but I don't know if it's the biggest geographical area. I know for interpreting numbers we are, probably, [although] Auckland [District Health Board] are actually up there too. We are doing about 40,000 to 47,000 interpreting requests a year, about 200 to 240 jobs a day. And I think Auckland do about 160 to 180 jobs a day, so we're almost on a par.

Delys: I had a look at the health website and 11% of the population lives within the catchment area. Quite a significant number of those would have English as a second language.

Kim: And they're all identified in the system. I think as soon as they get into a hospital, they are registered with the DHB through their GP, and they are identified then as needing an interpreter. That's how we know. So they don't need to ring up and say, "I need an interpreter". The system automatically generates a job that they need an interpreter, and we allocate an interpreter to that job.

Delys: Do you have many jobs that you aren't able to cover?

Kim: Not really. We have some languages, of course, that we cannot cover, but we share our interpreting pool with other DHBs. So that's in Auckland, the Waitemata and Auckland [DHB]. So if we don't have that language, for example if we don't have a Rohingya interpreter, we'll contract to another DHB to get one.

We do everything we can do to satisfy the needs of the service, and if the DHB doesn't have what we need we'll go to external agencies, like Language Line⁸, or we have even gone to Australia [to find interpreters]. It's very difficult for an urgent 'ad hoc' job, but for a pre-booked job we do everything we can to find an interpreter. Otherwise that patient would have to bring in a family member. We had a recent case where we had a person that spoke [Dialect A⁹], that's a South Sudanese dialect. I could not find a [Dialect A] interpreter anywhere in the country, let alone a qualified one. But there just happened to be a healthcare worker who was South Sudanese and spoke this dialect. She's unqualified but we employed her with an approval letter, saying that we would use her as a nonqualified interpreter whenever that family came in to be seen.

⁷ Accident Compensation Commission, which provides compensation for New Zealand residents or citizens following accidents, in or outside of the workplace.

⁸ LanguageLine is a government funded telephone interpreting service.

⁹ Potentially identifying dialects and languages (due to very small populations of speakers) have been anonymized.

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So, yeah, if we didn't have her, that would have been a case where we couldn't help them. But that's the only one we have ever had that was a bit of a challenge.

Delys: How many languages do you cover?

Kim: We cover... 83 languages and dialects.

Delys: Has the language base changed over the time?

Kim: Yeah, the language numbers have grown, but the general high-demand languages are the same. So, we have our core languages and we are a little bit different from other DHBs: I have 21 permanent employees who are reviewed on an annual basis to make sure we are employing them on the basis of our language utilization. Our main languages in order are: Mandarin and Cantonese, then Hindi, Punjabi and then Samoan, Tongan, Arabic, Vietnamese, Cambodian, and Cook Island language. So quite different from other DHBs. When I first started, we had quite a high number of Korean patients; they have moved out of the area. But [the demand for] Pacific Island languages is still as high as it was and definitely showing an increase, every year we had an increase. In the last four years, requests for Asian languages have increased by 20%; that's Chinese and Indian languages.

Delys: That's quite a significant increase.

Kim: Yes, and I don't have the capacity. . . . I probably need three more full-time Chinese interpreters and three more interpreters of Indian languages, but I don't have the funding to do that, so I have to increase the casual (hourly-paid) pool. That's not cost efficient, but that's the only way I can work to satisfy the needs of the number of jobs.

Delys: What kind of impact does that have?

Kim: It has a big impact, especially when I haven't got funding to employ. I would have to make people redundant [lay people off], but because we have already carefully employed to meet the needs, I maximize. I have 23 permanent staff, but I could do with 30. So I use casuals, but a lot of our casuals for the high-demand languages, which would be Chinese and Indian, are utilized almost full time.

Delys: So, your casual and permanent budget are separated?

Kim: Mixed. Unfortunately not, there's just one pool of money, but it's easy to identify the permanents in the budget. I always run a risk of HR telling me that I'm using casuals like permanents.

It's a difficult thing, so they are employed as permanent employees but are paid quite a different rate. Sometimes I wonder why my salary pool don't up and leave and become casuals. But [then] they obviously wouldn't get the annual leave and they would not be entitled to sick leave.

The ones that have been here for so long are here because they're passionate and enthusiastic and lovely. We're extremely lucky to have such loyal, caring people working as permanent interpreters.

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Delys: And I guess because interpreting is such a supply-and-demand job as well, there's always the fact that job security is quite nice.

Kim: Yeah it is. And that's exactly why some of our casuals say "Any opening, can you let me know, because I'll be in". Because of course the casuals are employed on an as-needed basis, so there's no guarantee of jobs.

I obviously follow closely immigration trends so that I'm constantly on the lookout out who's coming in, and I know there's a lot of Syrians coming, so we need to be aware of satisfying the needs of them coming, and are they going to stay in our region? No, often not. But initially they are here at the Refugee Center¹⁰ so we do have to be able to look after them while they are here and before they transition out of the area.

Delys: It's a lot of a juggling.

Kim: Yeah, it's a lot of juggling and a guessing game, too. Often we sort of make do with the numbers we've got and then all of a sudden at the last minute I am running around trying to find somebody for that [language].

Delys: What types of services do you provide?

Kim: Ninety-eight percent of our jobs will be face to face; 2% would be telephone, and we will soon be rolling out video-remote interpreting, which will be a new mode of interpreting. It's new to the services.

Delys: For spoken language interpreters or for both spoken and sign language interpreters?

Kim: It would be for both, spoken and sign.

Delys: So interpreters based here within a call center environment?

Kim: Of course, it would have to be in a call center environment. So we are currently setting up a pilot phase and have identified a small number of clinical end points to trial video remote interpreting. At this initial stage, there will be a purpose-built office which will hold 6 interpreters (in interpreting pods). Currently the booking process is being developed, however what is envisaged is that from the service end, the clinician will click into a shared calendar to locate the interpreting-job reference number. This reference number will identify the patient and the date, time, nature of the appointment. The clinician will then be taken through into the Lync meeting where they will join with their video remote interpreter. This mode of interpreting will be used for both spoken and sign interpreting requests.

¹⁰ Refugees stay at the Refugee Resettlement Center at Mangere, in the catchment area of the CMDHB for 6 weeks after arriving in New Zealand.

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Delys: Which is interesting because I know it's really difficult for sign language users who live outside of main centers to access emergency interpreters.

Kim: So that's where that'll come into play. At the moment, services will need to have Lync capability. Initially video remote interpreting will roll out to a few identified services, and then eventually organization-wide and then in the future this mode of interpreting will enable hospital services to offer home-based support.

Delys: Which is great, really.

Kim: It's long overdue and it will keep our costs down because our costs for travel, for doing face-to-face, are immensely high for us.

Travel costs are high, and even though our schedulers do an amazing job, we only allocate jobs within 1–2 days of that job. This is to ensure we keep our team in the same area. So we are thinking “Delys is going to be doing all of Middlemore today or all the Super Clinic or out in the community.” So she's out in Mangere where she can do Mangere Health, Diabetes Clinic at Mangere, and a breast clinic out there. We are trying to keep the travel time low. But of course, the environment of healthcare being as it is, all of a sudden you get factors affecting the job list, such as clinics being rescheduled, clinicians that are sick, or a patient that doesn't turn up and that whole day's roster for that interpreter goes out the window. That's where there are a lot of inefficiencies and costs because we are juggling that whole person's day which can then affect everyone else's day.

Delys: Is there any coordination between the interpreting service and the appointment booking service?

Kim: We are all linked. We do block booking wherever we can. We've got a good arrangement with the referral and appointment center and the call center. Anyone making appointments, we try saying: “You've got four of these patients (of the same language), can we try to make them 9am, 10am, 11am and 1pm”. So that we just need one Chinese interpreter who would do the whole lot. Because we are short staffed in our booking office, it's quite hard to keep on top of that. But within the boundaries and the staff we have got, we manage it well. And then of course, at the clinic, sometimes there are shift changes and so staff aren't aware what's happening and of course that's not ideal. But that's the idea: to have block booking.

Delys: What qualifications do you require your interpreters to have?

Kim: We have a minimum qualification of the “Certificate in Liaison Interpreting” which is offered at Auckland University of Technology and Unitec [Institute of Technology]. That's the minimum qualification. Some have obviously the “graduate diploma” and they are highly qualified, and everybody should be like that. But the minimum qualification is that. If it's like an unusual, really-hard-to-find language and they are not qualified and they are proficient in English and they have other skills that would suit healthcare, we would employ them as well. I have only one unqualified and that's that [Dialect A].

Delys: And do you encourage the [Dialect A] interpreter to go and get a qualification?

Kim: No, not for the number of jobs she does. Because there's only one family. She probably does a job a month; that wouldn't be worth it.

Delys: Do you provide training and professional development opportunities?

Kim: Yeah, we do. In-house we have a learning and development center here and we provide “Culture and Linguistic Diversity,” which is a course not only for interpreters but also for service users. And while we don’t really have much in-house interpreting training, there are lots of personal and professional development courses that run. We liaise a lot and work with WATIS [Waitemata DHB Translation and Interpreting Service]. We pay our permanents to go [on professional development courses] but we don’t offer that to our casual interpreters; there’s just no pool of money for that. In terms of professional and personal development for our casual team, it is up to them to upskill.

We also run service-specific workshops. If the service is not getting what they want out of a job with an interpreter, we will look to design a tailor-made workshop specific to that service. I’ve run one recently, co-jointly with the Speech and Language Service. They [speech therapists] were finding it difficult to extract the information they required from their patients. The interpreters needed time to prepare phrases that were linguistically and culturally appropriate for the patient. So in order to improve the quality of interpreting with the assessment and treatment with culturally and linguistically diverse patients, a workshop was designed for the interpreting team. Out of this interpreting group a ‘specialist interpreter’ list was developed, so when the SLT team request a Chinese interpreter, we can look up a list and can go “Oh, you know, Joe’s done that course, we’ll send him, he has done the workshop and is proficient in working with patients with speech and language difficulties”.

Delys: That’s a huge area, isn’t it and really specialized?

Kim: We have what we call our specialists in terminology in each language, so we’ll have one interpreter make sure it’s their job to upskill and knows all the latest terminology, procedures, treatments. They disseminate the information through the team in their language.

Delys: Is there anything you believe needs to be added to the interpreter education that we have in New Zealand at the moment?

Kim: I have made a little list and that includes feedback from some of my interpreters.

- One thing is to keep upskilling and refreshing medical terminology and awareness. I know that my senior team will do that but some of the interpreters are a little bit lax to get that done. Also with that comes refreshing knowledge of treatments, procedures, new equipment, and medical equipment.
- Upskilling in mental health training. There’s not enough people wanting to do mental health training. I cannot push people to do that enough. That’s one of our biggest areas where we probably have the highest incident rate. So that shows me that I have to have interpreters trained more in that area.
- Health and safety, being aware that they need to know how to protect themselves from the exposure to illness because they work in health. For example, radiation and X-ray, being aware when they have to put on scrubs and protective clothing and footwear. They shouldn’t have to be reminded by the theater team that they need to dress appropriately and put scrubs on when they are going into procedures.
- And obviously the Code of Ethics¹¹. I often give them refreshers on the Code of Ethics and reminding them of our visions and values because all DHBs have their own visions and values specific to them.

¹¹ See the New Zealand Society of Translators and Interpreters (NZSTI) Code of Ethics at <http://www.nzsti.org/about/Publications/>

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- I think there should be shadowing for new interpreters. My existing interpreters and my senior interpreters said, “They shouldn’t be limited [to] what they learn in class. They should do more practical interpreting and they should shadow or be hooked up with a mentor.” I know when I get one started here, part of their orientation is to shadow, especially the ones that haven’t done healthcare or haven’t been in a healthcare setting. Until you actually work in a healthcare setting you are really unaware what it’s like and the procedures and policies and the nature and culture of an organization.
- And, ideally I would like them to be evaluated by the person whom is being shadowed. I cannot evaluate and give them feedback, so they need to be critiqued by their mentor.

Delys: Is there any advice that you would give to new graduates?

Kim: It’s just the whole shadowing, do as much practicum as you can because it’s the key, isn’t it?

Delys: What do you think is unique about interpreting in New Zealand?

Kim: The only thing I could think of is we have small communities, and therefore the interpreter is generally known in that community. Take for instance our [Language B] community out here in Counties, the Code of Ethics for interpreters is even more important, because they are in the same church and are also interpreting for them or family members. They are actually their friend because there is no other [Language B] interpreter. We cannot offer you a [Language B] female because we only have a [Language B] male. So we have some problems like this where we cannot meet their total needs.

Obviously we have to assure that person that we know that you are friends, but [our interpreters] are bound by a strict Code of Ethics. That’s part of our professionalism. That is okay, they are aware of that. They know that and they are happy with that, I think that’s the thing that is unique in Counties because we have small communities, so our interpreters are known out in the Counties and they are often held in high regard. They all know what they do out there is also reflected in what they do in here, because you cannot run around and be irresponsible in the community, when the same people are your clients and patients when you come to work.

Delys: Is there anything you want to add?

Kim: The other thing that’s unique in New Zealand is we’ve got a limited number of interpreters, so we share the database with MBIE, that is the Ministry of Business, Innovation and Environment, and other DHBs. And nationally, we share the same, so the people that work for me could also work for LanguageLine, MBIE, for Auckland DHB, Waitemata DHB, courts, and justice—it’s the same interpreter.

And I think, the one thing that I have often wondered about is whether we pay people to get qualifications. That’s something I would be quite keen to do if there was a bigger pot of money with my high-demand languages and that’s mostly for Pacific languages. I cannot find Samoan male interpreters, I cannot find Tongan interpreters. That’s probably because even though I have got people that approach me when I say “There’s a course you need to do”, they sometimes cannot afford to go. At the moment there’s no money; therefore I am not getting interpreters, so I’m still short of Tongan and Samoan interpreters.

Delys: So, even just having scholarships available within the community.

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Kim: That's something they have just started¹² but they started off with the unusual and hard-to-find languages where I think they should have been looking at high demand/required languages. I think they did but Samoan and Tongan were not on the list. Also, the criteria was quite hard to meet. For example, someone I suggested apply [wasn't successful]. Maybe her English wasn't good enough for that. She converses very well on the phone and she was recommended through somebody else, but she had difficulty completing the scholarship requirements. That was quite interesting. She would have made a good interpreter.

Delys: That's excellent, thank you Kim.

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¹² In 2016, the three Auckland-based DHBs, the MBIE, and the Auckland University of Technology (AUT) offered 10 scholarships for applicants wishing to undertake a four-course Graduate Certificate in Arts (Interpreting) at AUT. Two of these were awarded to speakers of languages in the smaller Pacific nations; the remainder to speakers of minority refugee languages.