

Where the interpreter stands

Positioning is the first decision an interpreter makes on an assignment. This brief gathers what professional guidance, rules and interaction research actually say about it

Compiled 11 September 2026 12 sources · healthcare, legal, remote Prepared for Ambar Interpreting

WHAT THE EVIDENCE SUPPORTS

01 There is no single correct seat. The main professional guide in US healthcare interpreting lays out pros and cons for four arrangements and leaves the choice to the interpreter's judgment.	02 Guidance and folk practice conflict. Practitioner advice often calls the triangle "perfect"; the NCIHC warns that sitting in the middle pulls both parties into talking to the interpreter.
03 Gaze does much of the work attributed to seating. Where the interpreter looks selects who speaks next	04 Two settings override preference entirely: signed language, where line of sight comes first, and courtrooms, where placement is set by rule and by the judge.

Why a chair is a clinical decision

The National Council on Interpreting in Health Care published its [Guide to Interpreter Positioning in Health Care Settings](#) as a working paper in November 2003. Its framing is still the one most training programs use: patients and providers tend to speak to the interpreter, because the interpreter is the only person in the room who speaks both languages. The relationship gets stronger when they speak to each other instead, and physical arrangement affects how much they do.

The paper lists the factors that constrain the choice before preference enters: signed or spoken, the physical configuration of the room, the nature of the session, who else is present, the patient's emotional state, and the patient's cultural sense of personal distance.

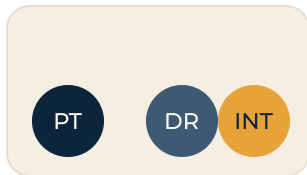
The training article [-Interpreter Training Programs, December 2017](#) - restates the same three-position analysis and credits the NCIHC for it, adding two practical rules: don't sit so close that you crowd the patient, and stay at eye level with both parties.

"The ultimate test, of course, is the outcome of the interaction; if the interpreter went largely unnoticed and the communication went well, the positioning was effective in meeting its goal."

NCIHC WORKING PAPER, 2003

Three seats, three trade-offs

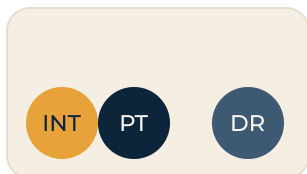
Each arrangement buys one thing and costs another. The pattern below is drawn directly from the NCIHC paper; the diagrams are not to scale.



Next to the provider

The provider looks at the patient rather than at you. Speech from the patient is aimed toward the provider, and you and the provider can both read the patient's face and gestures.

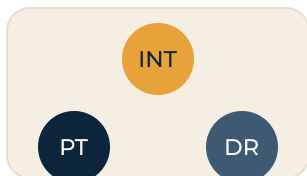
COST A reticent patient may read you as part of the medical establishment rather than a neutral party. You can also end up in the provider's path and standard exam-room chairs often make this seat impossible anyway.



Next to the patient

Tends to promote direct patient-provider talk, and your presence at the patient's side can feel supportive enough to bring out a hesitant patient.

COST The provider may start looking at you instead of the patient. The patient may treat you as an ally, asking your advice, making side comments, or turning around to talk to you rather than the provider.



In the middle

Reads as unbiased to both parties, which is exactly why practitioners like it and it is the arrangement most often described as the "triangle."

COST The NCIHC is blunt: there is a strong tendency for patient and provider to focus on the interpreter instead of on each other, and the position does not encourage direct communication between them.

WHERE SOURCES DISAGREE

The triangle is popular and contested

Agency-facing guidance states it plainly: "the perfect position for the interpreter in a medical setting is the triangle," because all three parties can see and hear each other ([Archway, 2021](#)). The NCIHC treats the same position as the one most likely to break direct patient-provider contact.

WHAT ONE SURVEY FOUND

A nationwide questionnaire of interpreters working in Slovenian healthcare settings found the triangular position was the one untrained interpreters most often took and found most appropriate and reported a considerable gap between what those interpreters thought they should do and what they actually did ([Pokorn, *Translation and Interpreting Studies* 12:3, 2017](#)).

Our reading, not the source's: a position's popularity among untrained interpreters is weak evidence that it is best practice. The survey is self-reported, from one country, and does not measure patient outcomes.

FINDING TWO

The evidence base is thinner than the advice

The NCIHC paper is explicit about its own footing: no empirical research on positioning existed at the time of writing, so most interpreters' opinions rest on personal experience, and the paper offers its pros and cons as a first step toward consensus. Twenty-three years on, we found no study that randomizes seating and measures communication outcomes.

What has grown instead is interaction research on the interpreted triad , conversation analysis, multimodal video analysis, and mobile eye-tracking. That work does not rank seats. It documents how gaze, body orientation and head nods organize an interpreted conversation, and it finds that seating arrangements shape nonverbal interaction: in one therapeutic-encounter analysis, the seating left no stable line of mutual body orientation between doctor and interpreter, which worked against their coordination.

Gaze is the adjustable part

The NCIHC's own remedy for a bad seat is not a better seat. When an interpreter makes direct eye contact with a speaker, that speaker is most likely to keep addressing the interpreter. Averting the gaze, resting it on a spot on the wall or floor while interpreting is a nonverbal reminder that the two parties should be talking to each other, and it helps the interpreter listen while keeping the speaker in peripheral vision for body language.

Note the tension with therapeutic settings: research on mental-health interpreting describes gaze avoidance as a way interpreters limit their own emotional load, with possible costs to managing the session (Wadensjö 2001; Bot 2005, as discussed in [Vranjes et al.](#)).

FINDING THREE

Setting by setting, the room decides

Outside the routine outpatient interview, the NCIHC guidance becomes specific and in several settings it stops being a matter of preference.

INPATIENT BEDSIDE Stand at the provider's side. On opposite sides of the bed, the patient's head swings back and forth between the two of you.	EXAMS AND DISROBING Behind the curtain when privacy is sensitive offered to every patient, not only patients of the opposite sex. If you must stay in the room, move near the patient's head with your back turned.
TRAUMA ROOM AND ICU At the patient's head, moving in and out as equipment requires, and clear of leads and tubing. In the OR, wherever the provider directs typically also at the head.	RADIOLOGY Behind the same screen that protects the technician; if you must be near the patient, a lead apron and throat shield. Interpreters are entitled to the same radiation protection as clinical staff.

PATIENT TEACHING

Stand near the caregiver and the equipment being demonstrated, so the patient can watch the demonstration rather than you.

CLASSES AND FAMILY CONFERENCES

Next to the one or two target-language speakers for whispered simultaneous interpretation, consecutive whispering if you are not trained in simultaneous. Close enough to the provider to hear everything.

FINDING FOUR

Two settings where preference does not apply

Signed language: sight line first

The NCIHC states that in signed interpretation the deaf person's need to see the interpreter's hands and face overrides every other consideration in the paper. Industry guidance says the same in stronger terms: the need of the Deaf person to see the interpreter clearly "should override everything else" ([Globo](#)).

The practical burden falls on the provider too: don't block the line of sight or cover your mouth, and address the patient rather than the interpreter ([Jeenie](#)). Signed interpreting also usually runs simultaneously rather than consecutively, which changes the rhythm of the room.

Courtrooms: placement is a rule

Federal guidance puts the interpreter where they can clearly hear and see the defendant, witness, counsel and judge at all times, and names the usual spot: between the witness stand and the defense table ([Federal Court Interpreter Orientation Manual](#)). At the stand, the instruction is to stand near the witness without blocking the jury's view, keep professional distance, and interpret consecutively as federal law requires ([C.D. Cal. orientation](#)).

State rules codify it. Indiana requires the interpreter to be in full view of the person testifying without obstructing the judge, jury or counsel and lets the judge order a change of position when noise or overlapping speech makes interpreting difficult ([Indiana Court Rules, Rule III](#)). Practice still varies between US courts on whether the interpreter sits beside the defendant or away from them ([Orozco-Jutorán](#)).

FINDING FIVE

On video, positioning becomes the device's problem

When the interpreter joins by video, the choices move to the cart: screen size and height, camera angle, lighting on the patient's face and hands, and whether bed rails, tubing or staff block the view. Vendor and integrator checklists converge on the same items, position the device so patient, provider and interpreter can all see each other, and place the cart without obstructing care ([Frederick Interpreting](#); [Vlcom](#)).

For signed language the bar is higher: the screen must show the interpreter's hands, face and upper body, and the camera must not cut off the patient's hands ([Sorenson](#); [Martti](#)). Sources here are mostly commercial, which is a caveat: they point back to the National Association of the Deaf position statement rather than to independent evidence, and they have a product to sell.

BEFORE THE ENCOUNTER

Both the IMIA guide for providers and Harborview's EthnoMed guidelines put positioning in the pre-session, alongside eye contact and mode of interpretation (a conversation to have before the patient is in the room)

EthnoMed's wording for spoken interpretation is the cleanest summary of the goal we found: position so that **the patient can look at the provider and hear the interpreter** ([EthnoMed](#), rev. 2019; [IMIA](#)).

What this adds up to in the room

A synthesis of the sources above, in the order the decisions actually arrive. The sequencing is ours; each item traces to a source in the list below.

- 1 Settle mode and position in the pre-session, with the provider, before the patient arrives.
- 2 If the assignment is signed or tactile, line of sight wins and the rest of this list bends around it.
- 3 Default to the provider's side in inpatient and bedside work; it keeps the patient's head still and their eyes on the provider.
- 4 Read the patient before choosing proximity. Personal space is cultural, and a hesitant patient may need you beside them rather than beside the clinician.
- 5 Sit or stand to be at eye level with both parties; the choice depends on chairs, room size and how many people are present.
- 6 Use gaze to correct what the seat gets wrong, and offer the curtain before any disrobing or intimate exam.

SOURCES

What we read, and how much weight it carries

Accessed 11 September 2026. Professional guidance and court rules are primary

[Guide to Interpreter Positioning in Health Care Settings](#)

NCIHC Working Papers Series, November 2003. Primarily written by Linda Haffner.

Professional consensus paper; the origin of the three-position analysis. Self-declared as experience-based, not empirical.

[3 Useful Positioning Tips for a Healthcare Interpreter](#)

Yana Fisher, Interpreter Training Programs, 22 December 2017.

Training-provider article; restates NCIHC positions and adds exam and ER guidance. Marketing context for a certificate course.

"There is always some spatial limitation":
Spatial positioning and seating arrangement in
healthcare interpreting

Nike K. Pokorn, *Translation and Interpreting Studies* 12(3), 2017, 383–404.

Peer-reviewed survey of interpreters in Slovenia. Self-reported; no outcome measures. Read via abstract and indexing records.

On the role of gaze in turn-taking in interpreter-mediated dialogue · Affiliation in interpreter-mediated therapeutic talk

Vranjes, Brône & Feyaerts; mobile eye-tracking studies, 2018–2019.

Peer-reviewed multimodal research. Small-N case analysis; describes mechanisms rather than recommending positions.

Guidelines for Interpreted Visits

Elinor A. Graham MD, EthnoMed / Harborview Medical Center. Authored 1995, last reviewed 28 May 2019.

Institutional clinical guidance; strong on the pre-session. Provider-facing.

IMIA Guide on Working with Medical Interpreters

International Medical Interpreters Association, undated PDF. Association guidance. No publication date on the document: treat as current-practice guidance of uncertain vintage.

Federal Court Interpreter Orientation Manual and Glossary · Interpreting at the Witness Stand · Indiana Court Rules, Rule III

US Courts; US District Court, C.D. Cal.; Indiana Supreme Court (current rule).

Binding or quasi-binding rules for legal settings. Highest authority of anything cited here, but jurisdiction-specific.

Globo · Jeenie · Sorenson · Martti · Frederick Interpreting · Vlcom · Archway

Language-service and AV vendors, 2021–2026.

Commercial practice reports. Useful for operational detail on signed-language sight lines and VRI setup; each has a service to sell, and several defer to the NAD position statement rather than to research.

We found no controlled study comparing interpreter positions on communication or clinical outcomes. Anyone claiming one seat is measurably better is going beyond the published record. The defensible position is the NCIHC's: judge the room, then judge by whether you went unnoticed.