Chapter 13. Professional interpreters and their critical role in ensuring communication with other-language speaking patients

Raquel Lázaro Gutiérrez[1]&Francisco Vigier Moreno[2]

[1]Universidad de Alcalá, Madrid
[2]Universidad Pablo de Olavide, Seville
raquel.lazaro@uah.es

Abstract

In our current societies, people from different backgrounds and cultures who speak different languages live together. This rich mixture of cultures and languages also implies some challenges for the functioning of and access to public services, including healthcare, as people who do not speak the official language of the place they live in have the right to access public services in the same conditions as native speakers. The barriers raised by linguistic and cultural disparity become even more obvious when healthcare is considered from a humanistic perspective, as language barriers in healthcare very frequently lead to a lower quality in health services, worse patient health outcomes and greater treatment costs. It has already been proved, however, that the best remedy to overcome these language and culture-based communicative problems is to resort to professional interpreters. This contribution describes a set of case studies that have been extracted from a corpus of real conversations recorded from medical consultations with patients who did not speak the language of healthcare providers. Our aim is to discuss how healthcare interpreters work (and how they should work) in order for communication to be improved and assistance to be enhanced through the intervention of professional interpreters.

Keywords:interpreting, other-language patients.

Theoretical background

The world is witnessing an unprecedented human mobility both within and across national borders. According to the United Nations, "about 1 billion persons, or one in seven, currently live outside their country or region of

origin" (UN System Task Team, 2012: 3), and yet these estimates are rather conservative as they do not consider migration on a temporary or seasonal basis. And it is not only international migration but also mass tourism and supranational political integration (see the European Union, for instance) that are playing a key role in this mobility of people across borders. Subsequently, current societies are no longer monocultural and monolingual entities (if they ever were), but complex multicultural and multilingual assemblages.

This reality is posing unquestionable challenges for public service providers, as public services must cater for all users, regardless of their linguistic, cultural or ethnic background. One of the domains where these challenges are particularly conspicuous and have farther-reaching consequences is healthcare, since "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care", as enshrined in Article 25 of the Universal Declaration of Human Rights. These challenges, obviously, are related to the intercultural and interlinguistic communicative needs encountered by both healthcare professionals and healthcare users when they do not speak the same language. Whereas overcoming these language barriers is way beyond the abilities and qualification of the former, not addressing them may easily jeopardize the medical assistance for the latter.

Subsequently, interpreting plays a "pivotal and responsible role where there is not a shared language" (Corsellis, 2008: 85). Face-to-face (on site) interpreting still seems to be the preferred option by academics and practitioners regarding quality, as it takes account of both verbal and non-verbal communication and allows for an immediate environment of trust and professionalism. Nevertheless, there are also other modalities that are

gaining ground, especially the so called remote interpreting, in which interpreting is provided through telephone or video-conference, with clear advantages in terms of availability (interpreters are always ready to step in whenever needed and it is easier to find an interpreter for a language of lesser diffusion) and cost-efficiency (no travelling expenses must be covered) (Navaza, Estévez & Serrano, 2009).

The provision of healthcare interpreting varies much from country to country. Some have long-established professional frameworks, like Australia and Canada. But much to our regret, most healthcare interpreting is still undertaken by the so called *ad hoc* interpreters, including friends and relatives of the users or healthcare professionals who are somewhat familiar with the user's language, which normally results in a deficient interpreting service and hence a poorer (and more costly on the long run) healthcare assistance. Evidently, these amateur interpreters have not been specifically trained in the ins and outs of the trade, they do not follow any code of professional conduct and no accountability can be claimed. Therefore, it seems to be critical that the interpretation be performed by a qualified professional, who holds specific training and can be taken accountable by peers and society in general.

In this contribution we examine the critical role played by interpreters in healthcare settings. By depicting two real (and archetypal) cases in which no or poor interpreting took place in medical settings, we purport to highlight how important it is that interpretations are carried out by duly trained and qualified professional interpreters in order to efficiently meet current language needs.

Method / Description of the experience

In order to illustrate the communication problems which arise from the lack of professional interpreters, we present two extracts from recorded real conversations. These two conversations were recorded at the Emergency Department of the Guadalajara University Hospital and a healthcare center in the same town, located in the central area of Spain, close to Madrid. They belong to an open corpus of recorded medical conversations which is being compiled from 1998 by the FITISPos-UAH Research Group. Permission for recording was granted from all the participants in the conversation through informed consents and an agreement was signed by the healthcare authorities to carry out the study. Digital audio recorders operated by the researcher were used to register the conversations.

Results

Example 1. A Polish patient (40) has gone to the Emergency Department with what might be appendicitis. He is assisted by a doctor (50), a Medicine student (30) and a nurse (40). […]

> *1. D2: ¿Si le aprieto aquí le duele en algún sitio? ¿Si le suelto?, ahí sí, ¿verdad? ¿Cómo le duele más? [Does it hurt somewhere if I press here? And when I let go? When does it hurt the most?]*
>
> *2. P: Aquí [here]*
>
> *3. D2: ¿Así? [like this]*
>
> *4. P: Sí [yes]*
>
> *5. D2: ¿O cuando suelto? [or is it when I let go?]*
>
> *6. P: Sí [yes]*

7. D2: Bueno pues hay que operarle ¿eh? [Well then, you will have to have an operation]

8. P: Vale (xxx) [ok]

[…]

9. D2: Bueno, pues vamos a hablar con el anestesista, ¿eh? [Then, let's see the anesthetist]

10. P: ¿Anestesista?[anesthetist?]

11. D2: Sí, claro, porque habrá que dormirle [Sure, we'll have to put you to sleep]

12. P: Oh, no, (xxx) yo no dormir poco [Oh, no, I don't sleep little]

13. D2: No, no, no. Para operarle. No, ¿eh? Para operarle hay que dormirle [Just for the operation, we'll have to put you to sleep]

14. P: (xxx) Yo dormiré ya como siempre dormir, no [I will sleep as usual, sleep, no]

15. D2: ¿Eh? [huh]

16. P: (xxx) Mucho duele [¿no?] [it hurts much, right?]

17. D2: [bueno] Hombre, es que si le operamos en vivo sí le va a doler mucho, ¿eh? [If we operate you live, it is going to hurt very much]

In this fragment a Polish patient visits the Emergency Department with a sharp pain in the lower part of his stomach. He is extremely nervous and has serious problems to communicate effectively in the Spanish language. He arrives at the hospital on his own and there are not interpreters available for his language.

As we can see in Example 1, in the first turn the doctor asks where the patient feels pain and whether he feels it more with or without pressure. We

can see how he needs to ask several times until he finally has an answer from the patient. In fact, the second question he utters is a reformulation of the first one and, as he does not receive an answer, he responds on behalf of the patient. Then the doctor asks a different question, but the answer the patient gives in the second turn corresponds to the very first question the doctor asked.

In the third turn the doctor repeats this last question about when the patient feels the pain. This time he applies pressure and asks whether it hurts. The patient answers affirmatively. Then the doctor relieves the pressure and asks again, and the patient also answers affirmatively, but does not indicate whether he feels more pain this time. The doctor has to deduce this from his body language.

In the seventh turn the doctor announces to the patient that he has to undergo an operation, and the patient agrees. However, the patient seems surprised when short time later the doctor tells him that it is necessary to talk to the anesthetist. In the eleventh turn the doctor explains to the patient that it is important that he is asleep during the intervention. However, the patient does not understand and replies that he does not sleep much. This misunderstanding continues during the following two turns, until turn 16, when the patient asks whether the intervention hurts. The doctor then explains again that it will hurt if he is not asleep under anesthetics when the operation takes place.

After 17 turns, though, we cannot be sure that the patient has understood that he has to undergo surgery and that he needs general anesthesia. This is particularly serious because the patient will have to give his consent about the procedure and there surely will not be consent forms available in his

language or someone who can explain it to him. If he does not get operated soon, his condition will worsen seriously.

With the intervention of a professional interpreter this piece of communication would have been much more fluent and effective. The patient would have known what was happening to him and the treatment he was going to receive. He would have also been able to ask whatever question he might have had and his level of anxiety would not have been so high. The doctor would have been able to communicate the information in a faster way. He could have gathered consent from his patient and would not have felt insecure and frustrated because of the lack of communication.

In the following conversation there was an interpreter present, although, unfortunately, she was an *ad hoc interpreter* (to wit, a neighbor of the patient).

Example 2. A Moroccan patient in her 70s is appointed to a pediatric consultation. The pediatrician, in her 50s, is treating her patients' relatives after suspicion of TB. The patient wants to know the results of a Mantoux text and visits the consultation together with her neighbor, in her 20s.

> *1. D: ¿Sabe, si ella ha estao, o ha tenido contacto con la tuberculosis y al darle (xxx) (corte en la grabación)… tuberculosis y para saber si está enferma, le tenemos que hacer una placa de pecho [Do you know whether she has been or has had contact with TB and when given (xxx) (cut)… TB and to know whether she is ill, we have to examine her chest with X-ray]*
>
> *2. I: Sí (xxx) [Yes (xxx)]*
>
> *3. D: ¿Ya se lo sabe ella? [Does she already know?]*
>
> *4. I: Sí [yes]*
>
> *5. D: Pues explíqueselo, por favor [Then explain it to her, please]*

6. I: Sí, pe… pero ella ha venido par que lo haga a… [Yes, but she has come so that you do…]

7. D: Ya, ya, pero (xxx) que se lo explique [OK, OK, but (xxx) you explain it to her]

8. I: Ah, bueno [Alright]

In this example the patient is accompanied by an *ad hoc,* non-professional interpreter: her neighbor. The doctor, in her first turn, utters a long explanation about the tests the patient has to undergo and the treatment she will receive. The interpreter, instead of explaining it to the patient, nods. The doctor, highly surprised, inquires about the reason why the interpreter has not rendered her words and asks whether the patient already knows what the treatment is about. The interpreter only answers 'yes', without further explanation. The doctor is not convinced about this and asks the interpreter to explain the treatment to the patient. The interpreter tries to reply that the patient has only come to the consultation for the results of the tests. The doctor immediately interrupts the interpreter and insists on her explaining the content of her first utterance to the patient. The interpreter finally agrees.

It takes up to eight turns until the interpreter renders the message to the patient. The interpreter not only does not transfer the content of the doctor's words to the patient, but also demands information from her without the patient having asked anything. The interpreter here is speaking with her own voice and the patient is completely left apart. The conversation is not fluent at all and this creates an environment of mistrust. A professional interpreter would have strictly followed her code of ethics and would have rendered everything and no more that the doctor had said, complying with the principle of accuracy.

Discussion

Nowadays, healthcare professionals must provide assistance to an ever increasing number of other-language speaking patients who, for their part, have the same right to medical assistance as the speakers of the language of healthcare providers. As illustrated above with real cases, the lack of linguistic and cultural assistance or the inadequate provision of interpreting may lead to also inadequate medical assistance, with the well known consequences this can entail, not only in terms of health outcomes (including death) but also in economic terms (more and more lawsuits against healthcare providers for inadequate assistance due to linguistic problems).

Professional interpreting does not only protect healthcare users and professionals, but also safeguards the standards of the interpreter profession. As noted by Corsellis (2008: 85), "the medical and legal professions, for example, would quite rightly oppose pressures for doctors and lawyers to be allowed to practise with lower standards in order to increase their numbers quickly or to provide a cheaper service".

Thus, it is cardinal for anyone involved in healthcare settings to become aware of the central role played by the interpreter in ensuring the adequate medical assistance when the users are not fluent in the language used by healthcare professionals and demand that interpretations be carried out by professional interpreters who have been trained and tested to pursue this professional activity and belong to a professional group that monitors their members' performance (and, if need be, can sanction a member's negligent practice). It is only with the recognition of the importance of professional interpreting by both the users and the other professionals (doctors, nurses, healthcare managers, etc.) that current language barriers can be effectively

overcome and proper medical assistance can be provided to other-language speaking patients.

References

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