

LANGUAGE BARRIERS IN CROSS-BORDER
HEALTHCARE:
QUALITY TRAINING OF TRAINERS THROUGH
COLLABORATION

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HEALTHCARE INTERPRETING AND TRANSLATION IN EUROPE

- *Angelelli, C. 2015. Study on Public Service Translation in Cross-border Healthcare: Final Report for the European Commission Directorate-General for Translation. (language policies in healthcare in Germany, Greece, Italy, Spain, the UK)*
- “[w]ith alarming frequency, healthcare institutions **do not provide any formal language services** and ad-hoc language brokers are called upon to perform translation, interpreting and language/cultural mediation without compensation” (Angelelli 2015: viii).

Do we need to train translators and interpreters, or can untrained bilinguals and healthcare specialists be used for these communication purposes?

HEALTHCARE PROFESSIONALS WITHOUT INTERPRETER AND TRANSLATOR TRAINING

- Elderkin-Thompson et al. (2001) analyzed 21 Spanish-speaking patients communicating with the help of **nurse interpreters**. They found that approximately **half the encounters** resulted in serious miscommunication, compromising the physician's understanding of the symptoms and undermining the credibility of the patient's concerns.

AD-HOC INTERPRETERS AND TRANSLATORS

- inaccuracy of the transfer (omissions and additions), the lack of impartiality and confidentiality.
- often introduce their own opinions, challenge the statements made by the patient, guide answers or answer questions on behalf of the patient, and often engage in other tasks outside the interpreted conversation (Cambridge 1999, Martínez-Gómez 2014; Lesch and Saulse 2014).
- Flores et al. (2003) audiotaped and transcribed 13 paediatric encounters in a hospital outpatient clinic:
 - in 6 encounters professional Spanish interpreters were used, in 7 encounters ad hoc interpreters
 - 396 errors were noted, with 63% of these errors having potential clinical consequences, such as omitting questions about drug allergies
 - errors committed by *ad hoc* interpreters were **significantly more likely to be errors of potential clinical consequence** than those committed by hospital interpreters (77% vs 53%).

CONSEQUENCES: MISTRUST

- ad-hoc interpreters and translators can introduce mistrust in the communication.
- FFP7 European project MIME – “Mobility and Inclusion in Multilingual Europe” (2014–2018), research carried out among the asylum seekers in Slovenia in 2016:

“The official translators and interpreters that translate the papers, yes, they are qualified. But the others that are just interpreters... Some of them, they didn’t study, most of them, they didn’t study in this field, so they just... Because they just know the language, they come to work. [...] It has happened that there was a **misunderstanding** among the people, or **mistranslating** among the people.” (33-year-old man from Iran, Pokorn and Čibej 2018)

CONSEQUENCES: HIGHER COSTS IN HEALTHCARE (DAMAGES)

- the use of untrained bilinguals may lead to inadequate diagnosis or misdiagnosis and delayed or incorrect medical treatment which can also result in complaints and litigation.
- Quan and Lynch (2010) report that in four US states between 2005 and 2009 there were 35 claims totalling **\$2,289,000** in damages or settlements and **\$2,793,800** in legal fees due to failure to provide appropriate language services in healthcare settings.

CONSEQUENCES: HIGHER COSTS IN HEALTHCARE (HOSPITAL STAY)

- Lindholm et al. (2012) analysed the records of 3071 LEP patients at a hospital in the US between 2004 and 2007.
 - patients who did not receive professional interpreting had an average stay **of 0.75 to 1.47 days longer** than patients who had an interpreter at both admission and discharge.
 - Slovenia: the average cost for day in hospital in Slovenia in 2018 was €1380, while the average fee for a sworn interpreter was €70 an hour.
 - an interpreter would have to spend 20 hours before the costs of interpreting exceeded the costs of the saved time in hospital.

POLICY IMPLICATIONS

- public service interpreting and translation **should be financed by the state** and provided to newly arrived migrants in high-risk situations, in particular in legal, police and healthcare settings.
- The stakeholders should consider to:
 - Subsidize **training for healthcare professionals**, with a focus on acquiring interpreting and translation competences;
 - Provide **training for bilinguals** with a focus on acquiring thematic competence (i.e. focus on the field knowledge), interpreting and translation competences, and professional ethics;
 - Create **affordable training** so that migrants can enter the profession of community interpreting and translation.

THE ROLE OF HIGHER EDUCATION INSTITUTIONS

- HEI with an experience in educating translators and interpreters should establish close working relationship with institutions responsible for public health promotion, institutions training healthcare workers, NGOs and specialists in social sciences helping migrants to access and benefit from primary healthcare.

TRAINING NEWLY ARRIVED MIGRANTS FOR COMMUNITY INTERPRETING AND INTERCULTURAL MEDIATION

- Erasmus+ project **TRAMIG** (www.tramig.eu): University of Ljubljana, University of Trieste, Oslo Metropolitan University, Aristotle University of Thessaloniki, the National Institute of Public Health of the Republic of Slovenia and the Local Health Authority of Reggio Emilia with an aim:
 - to **train the trainers for community interpreting and/or intercultural mediation courses**.
 - define **the profile** of two different professions: that of an intercultural mediator and that of a community interpreter
 - **share the know-how** we have in interpreter and translator-training institutions and train the students from the communities we traditionally do not reach, and thus eventually contribute to a **successful inclusion** of newly arrived migrants into the **linguistic and economic mainstream of the host country**

THANK YOU FOR YOUR
ATTENTION



Training
newly arrived migrants
for community interpreting
and intercultural mediation

REFERENCES

- Angelelli, Claudia V. 2015. *Study on Public Service Translation in Cross-border Healthcare: Final Report for the European Commission Directorate-General for Translation*. <https://publications.europa.eu/en/publication-detail/-/publication/6382fb66-8387-11e5-b8b7-01aa75ed71a1/language-en>
- Cambridge, Jan. 1999. Information Loss in Bilingual Medical Interviews through an Untrained Interpreter. *The Translator* 5(2), 201–219.
- Elderkin-Thompson, Virginia, Cohen Silver, Roxanne and Howard Waitzkin. 2001. "When nurses double as interpreters: A study of Spanish-speaking patients in a U.S. primary care setting." *Social Science and Medicine* 52, 1343–1358.
- Flores, Glenn, M. Barton Laws, Sandra J. Mayo, Barry Zuckerman, Milagros Abreu, Leonardo Medina and Eric J. Hardt. 2003. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* 111(1), 6–14.
- Lesch, Harold M. and Bernice Saulse. 2014. Revisiting the interpreting service in the healthcare sector: a descriptive overview, *Perspectives* 22/3: 332-348.
- Lindholm, M., Hargraves J.L., Ferguson W.J., Reed, G. 2012. "Professional language interpretation and inpatient length of stay and readmission rates." *Journal General Internal Medicine*, 27/10: 1294–99.
- Martínez-Gómez, Aída. 2014. Criminals interpreting for criminals: breaking or shaping norms? *The Journal of Specialised Translation* 22: 147-193.
- Pokorn, Nike K. and Čibej, Jaka. 2018. Interpreting and linguistic inclusion - friends or foes? Results from a field study. *The Translator* 24/2: 111-127.
- Quan, Kelvin and Lynch Jessica. 2010. *The High Costs of Language Barriers in Medical Malpractice*. 2010. University of California: School of Public Health, The National Health Law Program. <http://www.healthlaw.org/publications/the-high-costs-of-language-barriers-in-medical-malpractice#.Vj78naR-QhY>