IMPLICATIONS FOR THE TEACHING OF COMMUNITY INTERPRETING: FIELD EXPERIENCE IN AN AUSTRALIAN HOSPITAL

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INTRODUCTION

The Health Care Interpreter Service was established in Adelaide (South Australia) in 1979 within the Ethnic Affairs Commission following a Commonwealth Government invitation to the South Australian Government to enter a cost sharing arrangement for the provision of interpreting and translating services in the health area.

At present only two hospitals, the Royal Adelaide and the Queen Elizabeth are provided with interpreters by the South Australian Ethnic Affairs Commission. Seven staff members are employed with three full-time and one part-time interpreter located at each hospital. The interpreters in these hospitals render their services Monday to Friday both to outpatients and inpatients and are easily contacted by hospital staff.

The Royal Adelaide covers such languages as Italian, Greek, Ukranian, Serbian, Croatian and Vietnamese. The Queen Elizabeth covers Italian, Greek, Vietnamese, Chinese, Polish and German.

The following notes were taken from reports of field supervision conducted at the Royal Adelaide Hospital in 1989 and are outlining some of the difficulties encountered in community interpreting in the medical field. Most aspects seem to underline the inherent relationship between interpreting performance and psychological factors present in the environment at the time of the interpreting situation. These factors have a direct influence on the interpreter’s skills and can affect negatively his/her otherwise excellent language proficiency.

EFFECTS ON INTERPRETER’S PERFORMANCE (caused by the behaviour of medical staff)

It is common knowledge that migrants feel insecure and isolated because of language barriers. These feelings can be further aggravated by the practitioner's incorrect use of the interpreter. When a person is talked at rather than talked to, a feeling of isolation and misunderstanding can develop with consequent deleterious effects on the communication process.

The majority of practitioners talk to migrants in the third person, many don’t even look at the patient while they are talking about them. They simply don’t realize that they are dealing with people of perhaps low education and perhaps of no great social standing, but who are nevertheless sensitive and attuned to other people’s attitudes. This is more common with older, perhaps more experienced practitioners than with some younger professionals who seemed to be more sensitive towards both the migrant’s needs and the correct use of interpreters.

The practitioner sometimes believes that the presence of an interpreter will smooth over any communication problems. This is not always the case and it should be taken into consideration that people are not only different because of the language used but also because of the way they act or think. One typical example is the reluctance of some migrant women to remove their clothes before an examination. It would be appropriate at this time to take a little extra care. The hospital staff should realize that they are dealing with someone who is probably shy, usually elderly, conservative and who is with . . . probability
ashamed of getting undressed before people she does not know. This situation can be further aggravated when female migrants are asked to strip in the examination room only to be left there alone for long periods of time before the doctor arrives. This type of situation can be found fairly distressing by anyone, but in the migrant's case this distress is exacerbated by the heightened feeling of vulnerability due to the combination of the above mentioned problems with added communication problems (further aggravated by the situation).

In some instances, the interpreting service is not fully utilized because of attitude differences between staff members and these usually have a detrimental effect on the interpreter's performance. For example, a nurse, due to her negative attitude towards the use of interpreters, would always ring the interpreting office at the last minute to make an appointment in the hope that the interpreter was not available. Even worse, a doctor may openly state that he does not want to use interpreters for the simple reason that he believes that all migrants should be able to understand and speak English and hence the use of interpreters should be abolished.

The quality of interaction between medical staff and patients has inevitably a strong influence on the quality of the interpreter's performance. The following list includes some of the problems faced by an Anglo-Australian health professional when treating non-English speaking patients:

- failure to recognize normal and abnormal reactions due to patient's culture and traditional upbringing;
- failure to understand or note non-verbal communications;
- tendency to see patients as "racial stereotypes;
- failure to recognize the role and importance of the extended family in time of crisis;
- hostility towards patients due to racial prejudices;
- failure to recognize the importance of interpreters.

EFFECTS ON INTERPRETER'S PERFORMANCE (caused by the behaviour of patients)

The co-operation of the migrant is of great importance for the interpreter in acting as an effective communication bridge. This often does not happen due to shyness, fear and disorientation. Lack of privacy is also hindering total co-operation from the migrant: the cases where the interpreter is alone with the patient and the doctor, without the presence of nurses, other patients, orderlies etc, are quite rare.

The most common problem is talking too fast. The migrant feels that giving the greatest amount of information possible in the shortest time possible is the right approach to the situation. Sometimes the interpreter is interrupted before the previous sentence has been fully translated in the target language. This highlights the importance of having control of the situation, to take quick and prompt action in establishing the pace and the length of each interaction, to create some order to avoid confusion and frustration.

Often migrants will repeat the same concept or question over and over again to assure themselves that their words are being heeded and this can create a fair amount of confusion both for the interpreter and the practitioner.

The intermittent use of source and target language is also a very common problem often combined with the use of incorrect English and a pidgin variant of the other language. In extreme cases, the migrant talks his/her own type of idiolect and the interpreter may understand some of what has been said by keeping the context of the situation in mind, but it is impossible to prevent some loss of information unless the interpreter is very familiar with the migrant's way of speech and has interpreted for the same person many times before.

Sometimes migrants use the interpreter mainly to reassure themselves. It may be that they are rather proficient in English, but in a stressing and unfamiliar situation they revert to the mother language, or have more difficulty than usual in communicating in English and the presence of an interpreter leads to more detailed and precise explanation of the migrant's state of health and an accurate diagnosis can be formulated. In these circumstances the use of the interpreter is not confined to a verbal role, but becomes also a psychological crutch, a symbol of reassurance for the migrant, definitely appreciated by the patient but not necessarily by the practitioner who often is inclined to doubt the need for an interpreter.

Another fairly common misuse of the interpreter includes the migrant giving the professional irrelevant information especially when the patient misunderstands the question and therefore gives a totally irrelevant answer. Most doctors are very busy and hence have not time to spare. They prefer that the interpreter repeat only the information relevant to the question. An interpreter according to ethics should interpret everything that is said to the best of his/her ability, but this can not always be done in hospitals where time is precious. For example, a doctor can ask the interpreter to extract only the relevant information from the patient who is not
answering the question at hand but rather repeating himself. It is not the interpreter's job to decide what is or is not relevant but rather to repeat absolutely everything that is said. This may cause a dilemma for the interpreter who has to choose whether he/she should satisfy the doctor's request or adhere to professional obligations.

In many cases the migrant will talk about irrelevant subjects that are out of context in the dialogue, such as complaints about other members of the family, anxiety about work situations etc. Often the migrant waits to refer this information only to the interpreter because he/she feels better understood by a person of the same ethnic background. During situations such as these one can realize the importance of keeping the interpreter in a neutral position with no risk of personal involvement (i.e. leave the room when the practitioner is not there, and avoid contact outside the work environment).

LANGUAGE

Although the majority of practitioners use non-technical language when explaining surgical or examination procedures to the patient, often both medical subcode and register have to be toned down in translation in order to make the migrant understand. The implication here is that the interpreter has to be aware of all possible linguistic variants for a specific semantic concept and this embraces various dialects and dialectal influences on standard expressions.

However it is appropriate to remember that the majority of future community interpreters are usually recruited from the pool of language students with ethnic origin and that the (ethnic) interpreter may not have sonic recall and yet has a bank full of data which once had meaning and really is his/her basic language.

It is unethical to abruptly interrupt either the practitioner or the patient while they are speaking and sometimes the length of the speech can jeopardize a correct interpretation. A good interpreter has to master the ability to interrupt the flow of the conversation at the right moment, that is, interrupt the staff member or patient without cutting them short. Clearly there is a need for both medical staff and patients to be briefed on the correct use of interpreters.

SCHEDULE

A poor administration of provided services can put the interpreter under stress and hinder his/her efficiency. For example an interpreter may have been booked for a certain time and various contrentemps eventuate such as:

1) The interpreter arrives on time to find that he/she has to wait, sometimes for long periods, because the doctor is running late or has not yet finished with other patients or is awaiting documentation.

2) The interpreter arrives on time but half of the interview has already taken place without his/her presence.

3) The interpreter arrives at the clinic at the prearranged time. The interview begins but at a certain time the doctor leaves to search for health records, chase up analysis results or consult with other professionals. The interpreter is left to wait for extensive periods of time in order to continue and finish the interview.

4) The interpreter arrives at the clinic at the prearranged time to find that no interview has taken place; the patient has just walked out or alternately the interview has taken place without the help of the interpreter as he/she was not considered necessary.

CONCLUSION

Community interpreting in "real life" situations is altogether different to the interpreting sessions in class. In cases where staff members and patients are not familiar with working with interpreters, the interpreter's task is made more difficult than what it already is.

An interpreter in the medical field must cope with highly stressful, difficult and extreme situations. Often he/she would feel somewhat intimidated and disoriented by the sheer largeness of the hospital environment, by never-ending interferences (difficult to re-create in the classroom) and the amount of suffering that takes place there, but must have the ability to shut off the humane and highly emotional side of some interpreting situations and to concentrate on his/her role as a communicative tool.

APPENDIX 1

CODE OF ETHICS (SOUTH AUSTRALIAN ETHNIC AFFAIRS COMMISSION)

1) To act at all times in accordance with standards of conduct and decorum appropriate to the aims of the profession.

2) To interpret and/or translate only in the language(s) for which they are accredited and have been registered.

3) To refuse work if it is beyond their technical knowledge of a subject or their recognized linguistic capacity or if there is a conflict of interests within their field of employment.

4) To treat any information that may come to their knowledge in the course of their work as
a professional secret not to be divulged to any third party.

- Such information may only be revealed for:
  a) purely professional or statistical purposes provided that the identity of the parties involved as well as the specific contents of the interpretation and/or translation remain protected by professional secrecy; or
  b) the necessity of the administration of justice.

5) To endeavour to the best of their abilities to be accurate by ensuring that the true meaning of words, concepts, statements and bodily expressions is conveyed to the persons for whom they are acting. Also to admit and to promptly rectify interpreting or translating mistakes of which they become aware.

6) To observe impartiality and objectivity in all professional situations and not to permit personal opinion to influence the performance of their work.

7) Not to take personal advantage of any information obtained in the course of their work. If they have an interest other than the professional one in an assignment, they must disclose such an interest to all parties concerned before accepting the assignment.

8) Not to take advantage of the fact that the identity and/or interests of parties have become known to them, particularly with regard to soliciting work directly from the parties concerned, while employed by the South Australian Ethnic Affairs Commission as Interpreters and/or Translators.

9) Not to sub-contract interpreting and/or translating assignments without formal approval by the South Australian Ethnic Affairs Commission.

10) Not to engage in other interpreting work while on a specific assignment for the South Australian Ethnic Affairs Commission.

11) Not to, in any circumstances, accept any reward, favour or otherwise from parties while in the employment of the South Australian Ethnic Affairs Commission.

12) To be strictly punctual since no start can be made in their absence.

13) To always dress neatly since a good appearance enhances professionalism.

14) To assist and to co-operate with other members of the interpreting and translating profession in every practicable way.

15) To constantly seek to improve their skills and knowledge within the profession.

16) To be guided by the recommended scales of fees or remuneration for professional services established by the South Australian Ethnic Affairs Commission.