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European Forum of Sign Language Interpreters

"What's up Doc?" Interpreting in the Medical, Mental and allied Health Care Settings

Proceedings of the 25th efsli Conference

Toulouse, France, 9th-10th September 2017

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EFSLI 2017

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Diagnosing Healthcare Assignments: Medical Interpreting for Deaf People in Europe

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Abstract:

This article presents the insights of five practicing signed language interpreters into the conditions and factors that characterize professional interpreting in the medical field in Austria and Germany. To this purpose, a total of 142 healthcare assignments, completed by the five interpreters in 2012, and 59 medical encounters in 2017, were documented and analyzed. We discuss recurrent features of medical encounters between deaf patients and hearing doctors that involve a signed language interpreter. The data presented here suggest that, more often than not, interpreters will encounter conditions that are conducive to the satisfactory outcome of healthcare assignments. We then present the results of a workshop conducted with 11 interpreters in Austria about their experiences in medical interpreting. We also add the contributions of interpreters from other European countries that had been added at the conference.

Keywords:

Health care interpreting, deaf patients, sign language, Austria, Germany

1. Introduction

This contribution presents the results of a piece of practice research on health care interpreting in Germany and Austria, conducted in 2012 and 2017, by five respectively three working interpreters and Prof. Jens Hessman from Magdeburg-Stendal University of Applied Sciences.

Furthermore, it looks into the results of a workshop conducted with the staff interpreter of a clerical hospital, Lisa Wipplinger on the same topic in Linz, Austria in spring 2017 where 11 interpreters talked about their experiences in medical interpreting. Finally, we present the contributions of the interpreters at the conference to add other countries' perspectives to justify our audacious title "Health Care Interpreting in EUROPE".

2. The study

The foundation of our study on health care interpreting was an investigation into the working experiences of five sign language interpreters in Germany and Austria conducted in 2012. For a whole year, the five interpreters did reflective logs of their medical assignments and recorded them in diary fashion; we logged basic data (e.g. patient´s age and gender, medical condition, etc.), duration of assignment, number of people involved, details of each medical assignment, gave a sketch of "how it went", and also commented on non-linguistic aspects that might have helped or hindered the success of the assignment (e.g. level of familiarity amongst the patient, doctor, and interpreter; doctor´s attitudes, background knowledge of the medical staff, as well as what transpired in the waiting room).

Data were organized to collectively identify various conditions that the interpreters experienced as being either supportive of or hindering to interpreter-mediated healthcare.

The main goal of this study was to enable the participating practitioners to reflect on the experience of professional sign language interpreters in the healthcare system and identify conditions that they experience as supportive of their practice as opposed to those factors that can make their work difficult or stressful. The results of this field research were published in Nicodemus and Metzger (2014).

From January to June 1917, the study was repeated to check its validity. Data were collected by three of the five interpreters of the initial study and analysed the same way as in 2012.

We kept a log of all our health care assignments. These notes were entered into a data base and evaluated with regard to ten recurring features that we considered as distinctive components of medical interpreting assignments. While the triad of patient, doctor and interpreter is at the centre of medical consultations, further components contribute to the overall progression and success of an assignment.

In 2012 we had 142 assignments with 60 different patients, in 2017 we analysed 59 assignments with 30 patients. The difference might be due to the fact that the second period is only half a year and would have been higher if we had looked into another full year as the deaf patients tend to use the same interpreter for all their health care assignments. The urgency of the assignments is generally "normal": 64% (2017: 77%), only 18% of the assignments are of high urgency (2017: 5,2%). As to the location of the medical encounters, the majority took place at doctors' offices 67,6 % (2017: 58%), only 30% (2017: 40%) at clinics.

The fact that 96% (2017: 93%) of all assignments are with medical specialists is striking. This may be due to a number of reasons, including the fact that deaf patients may prefer to use an interpreter

when seeing a specialist to avoid miscommunication but use other ways of communication with their general practitioners. In both data sets, the four main areas are gynaecology, internal medicine, paediatric care and ophthalmology although not in the same ranking and proportion.

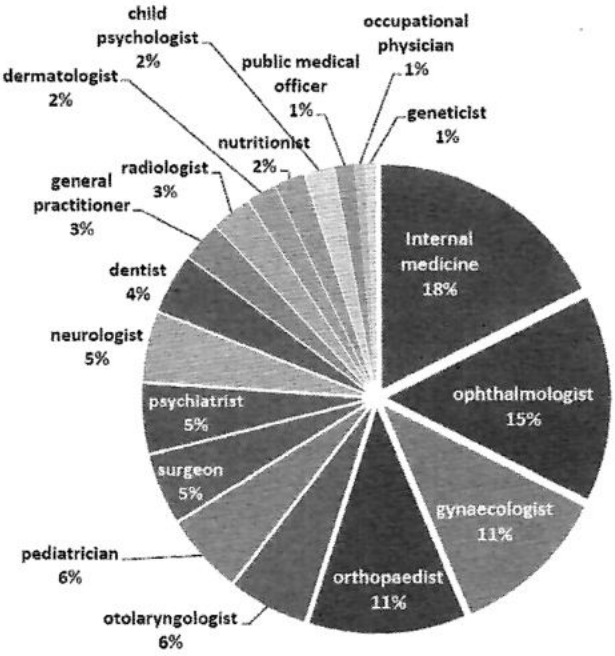

Diagram 1: medical fields of interpreted assignments in 2012

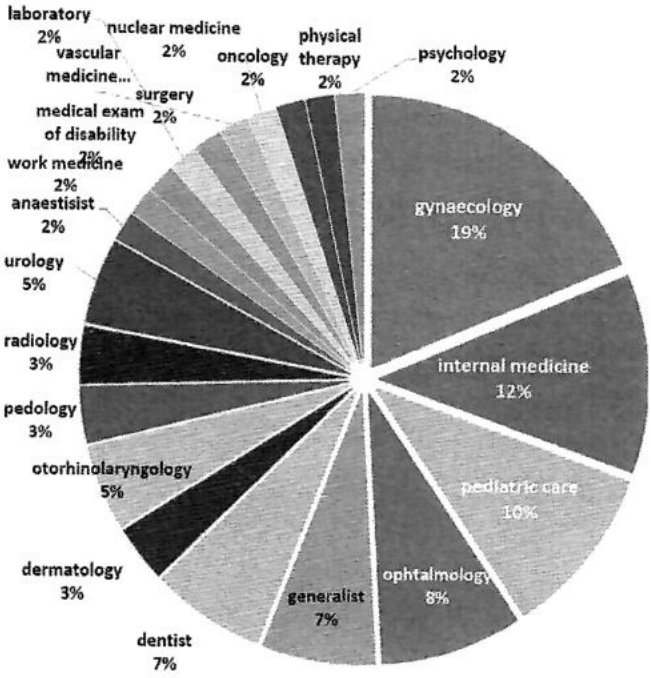

Diagram 2: medical fields of interpreted assignments in 2017

In both years, there are more women attending medical services than men, although the disproportion is really striking in the data from 2017: 22 women opposed to two men, whereas in 2012, the relation was 28:21.

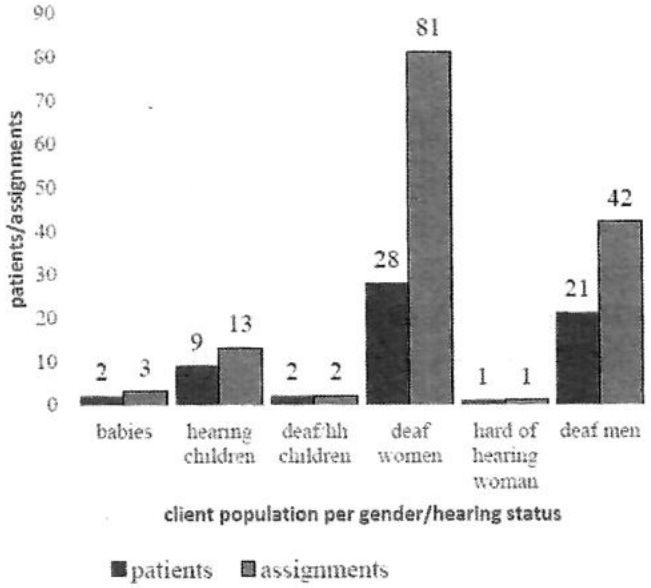

Diagram 3: patents and assignments 2012 by gender and hearing status

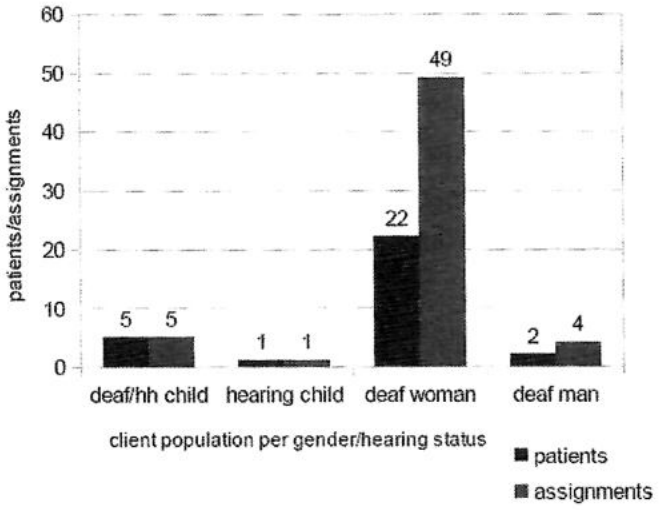

Diagram 4: patients and assignments 2017 by gender and hearing status

2.1 Results

2.1.1 Procurement

Someone has to "bring in" an interpreter. In Austria and Germany, this is done mostly by the deaf customer her/himself. They prefer to call an interpreter they trust and have known for some time. Some assignments were organized by others, such as family members, caregivers, social workers, or other sign language interpreters. Very few assignments were organized by hearing doctors or their staff.

2.1.2 Waiting room interaction

More often than not, even with an appointment, patients have to wait before they can see the doctor. This time is rarely idly spent but rather may allow for crucial interaction between deaf patients and interpreters. It is about briefing the interpreter by procuring vital information and about developing the rapport between deaf clients and interpreters.

2.1.3 Medical staff

In most cases, the initial contact at the clinic or at the doctor's office is made with a receptionist. Their attitude may have a considerable impact on the doctor's attitude and on the climate and tone of the consultation.

In more than one third (37%, 2017: 79%) of all assignments receptionists were perceived as friendly, polite and helpful by the interpreters. Some communicate directly with the client.

2.1.4 Doctors

All the doctors in this study were hearing. Obviously, their attitudes and behaviours contribute crucially to the success of the interpreted interaction. Unfortunately, the pressure on doctors

exerted by institutional structures or lack of time are detrimental to the success of medical consultations. In positively rated assignments, doctors were often familiar with the overall situation and knew either the deaf patient (34,5%, 2017: 52,5%) or both the deaf patient and the interpreter (23,9%, 2017:33,9%). But respectful behaviour does not depend on familiarity; attitudes appear to be crucial, as we found some doctors unfamiliar with deaf patients or interpreters treating their patients with respect and adjusting to the patients' needs (e.g. using visual material for explanations). On the other hand, lack of empathy with the patient and disrespect made few doctors misuse the interpreter as a bearer of bad news (by asking them to explain the negative diagnosis outside of his office) or a caregiver of a patient in despair (by leaving the interpreter to deal with the emotional reaction of the deaf client).

2.1.5 Deaf Patients

All the patients in this study were deaf (including a small number of patients who might be considered hard of hearing in audiological terms). In a number of cases, deaf clients accompanied their deaf or hearing children.

We identified three main reasons for dissatisfaction with the assignment of deaf patients:

- confusion about the flow of communication and roles of people present,
- interaction that lacked explanation (e.g. a diagnosis was given without sufficient clarification), and/or
- the patients' misguided expectations (e.g. doctor did not prescribe their preferred medicine).

The interpreters considered it helpful if the patients took initiative and tried to control the communication, this included quite

ordinary behaviours, such as introducing themselves and their interpreters, asking questions, etc.

Even proactive deaf patients were not always successful in their attempts to get what they wanted, and sometimes it took great assertiveness to elicit answers out of a doctor. It can be problematic if the agenda of the assignment is ignored, e.g. patients who repeatedly interrupted the doctor, or would not stop talking, even after the doctor had clearly brought the consultation to a close. Sometimes patients complained and made demands, without acknowledging that the doctor had already made an effort to accommodate their wishes. Another difficult situation arose when a deaf patient refused to cooperate with the doctor, came unprepared, questioned the usefulness of the procedure and did not accept the doctor's advice.

Occasionally, lack of signing skills or unskilled use of fingerspelling can also cause problems if the interpreter does not understand or cannot be understood by the deaf patient.

2.1.6 Interpreters

The situation may prompt interpreters to react or get involved in different ways. Generally, there is more involved than simply rendering messages. Generally, the interpreter's intervention is necessary to create suitable conditions for the interpreting tasks. Thus, the interpreter may ask for a change in the position of a chair, intervene to shorten the waiting time, or instruct medical staff about how to proceed during an examination. We found that interpreters intervened

- • when faced with ignorance on the part of a doctor or staff member concerning deaf patients or the interpreting process
- • the interpreter tried to stop patronizing or dominating behaviour by the hearing doctor or staff member

- • when s/he felt the need to advocate for the deaf customer because of the diffidence or insecurity of the deaf person in interacting with hearing people or the doctor
- • because of an inconsiderate use of technical jargon to make sure to understand the message to be conveyed.

2.2 Drawbacks

Level of detail that was recorded varied between interpreters, and in some instances, it proved difficult to verify particular aspects of the assignment from memory at a later date.

3. Workshop on Healthcare interpreting in Linz, Austria, in VI/2017

Patricia Brück, a freelance interpreter, and Lisa Wipplinger, a staff interpreter at a Clerical Hospital in Linz, conducted a workshop to look more closely into the Austrian situation. The nine participant interpreters plus the two presenters represented several federal countries; the range of individual professional interpreting experience was from 1 to 20 years. After the presentation of the study of 2012, the interpreters took a vote on the ten features of healthcare interpreting analysed in the study and chose four to be examined in more detail. The method applied was brainstorming where the interpreters were given time to put down their ideas, problems, memories on cards that were subsequently presented to the whole group and clustered on pin boards.

The four features chosen were: waiting room interaction, deaf patients, examinations/treatments, debriefing.

3.1 Waiting room

Time in the waiting room is put to good use. We attend to our customers to reduce their stress or fear, we listen to their

complaints, keep the time and remind the HC staff of their deaf patient, we are briefed for the consultation, interpret forms or written explanations.

The problems mentioned were: is it my duty to make small talk or listen to complaints about foreign refugees or political parties? The privacy of a communication in sign language was questioned as more and more hearing people learn sign language.

3.2 Deaf patients

As to deaf patients, the interpreters mentioned problems that make their work difficult:

- Lack of knowledge: general, health, medical and some deaf patients do not even know their own health status
- There are deaf patients with little sign language competence and without skills in fingerspelling
- Many do not know how to properly communicate with doctors/nurses and do not know how much they should share (life story?)
- They lack a clear picture of the work of an interpreter
- Some deaf patients are a source of embarrassment for the interpreter
- And how do we not intrude into their privacy?

3.3 Examinations or treatments

When it comes to examinations or treatments, the SLI does not only interpret, but:

- Explain the situation and the needs of patients and SLI to the doctors and nurses
- Make arrangements for communication if SL cannot be used (ophthalmologist with USHER patients)
- Give support to the deaf anxious patient

The problems mentioned were position, lightning, protection of doctor or interpreter (e.g. face mask), time restrictions, and the very presence of the interpreter embarrassing the deaf patient or crowding the narrow space of the examination room.

3.4 Debriefing

When debriefing, the interpreter has to take on a lot of tasks:

- Repeating the instructions given by doctor
- Reexplaining some instructions/facts
- Organising next assignments/replacement
- Passing on of information

  there is no harm in sharing information with another free-lance interpreter as s/he is still bound by her/his professional confidentiality. It may be problematic, if the interpreter is a staff interpreter and may have to divulge information that the patient would not like to be known by the doctor who was not present at an examination or consultation with a colleague.

The problems mentioned were: the interpreter usually is no medical expert and does not feel secure when repeating the doctor's instruction or explaining medical facts. As the time of the debriefing is not considered to be part of the assignment, interpreters are usually not paid for their additional time and effort.

These results were put into a mindmap that we will provide upon request but the language used is German. There is a second part of the workshop planned for this November where we want to examine more features and explore controls to the demands identified.

4. Contributions of other European countries

Belgium

Belgium has three interpreting agencies. VRI is little used. The contributing interpreter is a staff interpreter. Being a staff interpreter has the advantage of continuity, but the disadvantage of the Deaf patient not being able to choose who is going to interpret for her/him. If staff interpreters are not available, free lancers are brought in. The contributing interpreter does not do a lot of VRI, only a small percentage (5%) of her work load, as she does not like it because of the big chance of misunderstandings.

Usually it is the deaf person bringing in the interpreter, not the doctor. The medical staff often is not informed about sign language interpreting and there is no briefing or debriefing time planned. It is possible to bring in a deaf intermediary. In the southern part of Belgium, there is good health care service with deaf intermediaries. Nevertheless, the status of deaf interpreters is unclear.

Croatia

The situation is similar to that of Austria and Germany, but interpreters are employed. When working in health care, they have to face the fact that doctors and medical staff lack patience, they expect the interpreter to explain the problem/the symptoms of the patient and not the patient her/himself.

France

There are 15 services for deaf patients providing sign language or sign language interpreting and even deaf intermediaries if needed.

The contributing interpreter reports about consultations in difficult cases like cancer patients. S/he asks the question how to find the right register for a deaf child that may be involved.

Ireland

The Irish contributor reports of problems with having no information of the gender of the patient that is not divulged by the booking agency because of confidentiality issues. There was a case of a deaf woman explicitly asking for a female interpreter but the agency sent a man. The assignment had to be referred.

Lithuania

The contributor reports about long waiting hours at health care services. The interpreters had asked the deaf association for support. They addressed the municipality responsible for health issues. These authorities have ruled that deaf people with interpreters have now priority to be admitted.

Macedonia

There are big problems in the medical area e.g. with mental health. The diagnoses of mental problems are very superficial. The deaf patients do not understand their diagnosis. The interpreters have advocated with the government for access to medical information and have explained about the short time of medical appointments as deaf people do not have enough time to explain their situation or really understand what the doctors tell them.

Norway

There is an interpreter service provided for the Deaf community. In contrast to Germany and Austria, interpreters have been instructed not to sit in the waiting room with the deaf patient. The reason for this is a research study conducted by Katharina Cecilia Williams

about medical consultations. She found that Deaf people talking in the waiting room with their interpreters before the appointment did not talk to the doctor afterwards because they were expecting the interpreter to relay the information to the doctor as they had already explained everything in the waiting room.

Romania

There is a severe lack of understanding about the role of the sign language interpreter among the medical staff. The contributing deaf interpreter was working for a deaf blind mother when the doctor asked her/him to leave the room not to disturb the privacy of the patient without understanding that he had no way of communicating without the interpreter being present.

UK

Deaf patients cannot choose their interpreters as interpreters are booked by agencies who do not respect the deaf customers' needs or wishes (e.g. the same interpreter for follow-up appointment). They often do not convey enough or complete information e.g. the preferred gender or the department (problem with informed choices – not all interpreters like to take mental health appointments). Sometimes the interpreters are not informed about the name of the patient (possible conflicts of interest!). Sometimes scarce interpreter resources are wasted because two departments of the same hospital book interpreters for the same day. Some agencies have been known to engage untrained, unregistered and unqualified interpreters for health care settings.

What has been presented here are only glimpses into an important and delicate area of sign language interpreting in Europe. We are convinced that it is high time to look into health care interpreting in more detail and we would very much like to see more research into the practice of other European countries. We believe that providing successful sign language interpreting is one of the most

important means to give deaf people access to knowledge about health issues and health care in general.

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5. References

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