

Public Service Interpreting in Healthcare: There is no such thing as a Routine Conversation

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Abstract: Doctors and nurses throughout the United Kingdom will have to communicate across language and culture at some time in their careers. When this occurs, the picture is more complex than they often believe. It is not enough simply to send for an interpreter. All health care staff should have some orientation training in working effectively in such circumstances. Doctors themselves have often pointed out that they have neither adequate training nor easily available protocols for arranging and running bilingual consultations. The difficulty for many is that there is a plethora of different training schemes and certificates currently in use. It is consequently almost impossible for a clinician to know, when an interpreter is engaged, what level of competence they have achieved in any of their languages or what the clinical team can reasonably expect them to be able to do. As professionals in diverse but collaborating professional disciplines we are often at cross-purposes with each other, because we use jargon which has prevented us from thinking clearly about what we mean. This paper will look at some of the dangers and challenges that face clinicians and interpreters as they collaborate to provide safe and effective health care for foreign patients.

Key words: Medical interpreting, nomenclature, language of distress, Multidisciplinarity, hidden agenda, briefing, debriefing, role boundaries.

Background

In Healthcare services in the UK, and to some extent the rest of Europe, the current situation of interpreting services is one of widely differing standards. The health sector tends to see itself as having different needs from those of the criminal justice system, where standards of interpreting are predicated on practitioners having a degree-level specialist qualification and being listed on the national register of public service interpreters¹. Interpre-

Resumen: En algún momento de su carrera, todo médico o ATS del sistema sanitario británico se encuentra con pacientes de otras lenguas y culturas. Con frecuencia dichos profesionales no son conscientes de la complejidad de este tipo de situaciones. No se trata simplemente de llamar a un intérprete sin más. Todos los profesionales sanitarios requieren algún tipo de formación u orientación para garantizar el trabajo efectivo en dichas circunstancias. Los propios médicos han señalado en numerosas ocasiones que no disponen ni de la formación necesaria ni pueden acceder fácilmente a protocolos que les proporcionen pautas de actuación en consultas bilingües. La dificultad radica en el gran número de certificados y cursos de formación para intérpretes. Esto hace que sea imposible, cuando se contrata a un intérprete, que el clínico sepa cuál es el nivel de competencia adquirida en las lenguas de trabajo y cuáles pueden ser las expectativas con respecto a las funciones que debe realizar /cuál es el nivel de desempeño profesional que se le puede pedir. Como profesionales de campos distintos pero llamados a colaborar los unos con los otros en ocasiones surgen malentendidos, porque empleamos jerga que nos impide pensar con claridad en el significado de nuestros enunciados. Este artículo examinará algunos de los peligros y desafíos con los que se enfrentan los médicos y los intérpretes durante su trabajo conjunto al intentar ofrecer una atención sanitaria segura y eficaz a pacientes extranjeros.

Palabras clave: interpretación médica, nomenclatura, lenguaje de la angustia, multidisciplinarietà, agenda oculta, información previa/posterior, límites del papel.

ters have little influence on the design of language services in health and social care, and evaluating the cost of service provision, or the lack of it, is limited to looking at interpreters' fees and charges. No comparisons appear to have been done on the relative cost to the system as a whole of, say, keeping a patient in hospital for an extra day and night for observation versus paying an interpreter for an hour in order to make a competent assessment of their fitness for discharge home.

Health and social care service personnel continue to take the view that interpreters in hospitals have no need of professional qualifications. They will acknowledge that the criminal justice agencies might incur legal difficulties if they accepted lower standards but are fond of believing that medical interactions are often "routine conversations". It may be "routi-

¹ See http://www.cps.gov.uk/legal/section16/chapter_c.html for details of the National Agreement on the provision of interpreters in the Criminal Justice System (currently under review)

ne” to the doctor, but it is nothing of the kind to the patient. Nor is it routine, linguistically, to the Interpreter who is managing medical and vernacular language; idiomatic expressions and jargon; culturally laden references and non-verbal aspects of the communication relay all at once.

Nomenclature

A lack of clarity in nomenclature leads to confusion and allows inadequately trained personnel to be deployed inappropriately, to the detriment of safe medical practice. We have to be completely clear about the difference between an interpreter and a bilingual worker with proper respect accorded to both. Jones and Baylav provide a discussion of these roles. (Jones and Gill, 2003:17, Baylav and Fuller 2003:18). Bilingual workers conduct conversations with the patient or client in a shared mother tongue, to impart or elicit information at Reception for example; or as a ward clerk, auxiliary nurse or other worker. These conversations often draw on a limited lexicon. They will subsequently report or record these conversations in the dominant language. That is not interpreting, and can often be done at level 3 of the National Occupational Standards in Britain (CILT, 2006) which do not describe a person as an interpreter below degree level (Level 6, see below). This is the minimum level at which reliably accurate transfer of meaning can be expected. Using the wrong title encourages the cost-conscious to press untrained reception staff into acting as an interpreter when they are not qualified to do so. It is not good practice to ask any specialist personnel to act outside their role; just as no nurse would consent to give physiotherapy to a patient, so the specialist activity of interpreting should be left to trained interpreters.

Interpreters in British hospitals

Training for interpreters working in UK healthcare is patchy at best and non-existent at worst. Many hospitals and primary care services continue to engage members of the family or friends, including children, to relay complex and potentially life-damaging information across language and culture. The questionable ethics of this are ignored on the grounds that ‘patients prefer it; they trust the family member’. (Jacobs *et al*, 1995:10) The most obvious issues: confidentiality, impartiality and reliability of transfer, are subjugated to the patient’s uninformed and unchecked preference. The Climbié case, in which a child of 8 was systematically abused until she died, is simply the extreme tip of a very large global iceberg. The report by Lord Laming on his enquiry into the failures of the relevant health and social care services to protect the child stops short of requiring interpreter training. In his recommendations, Lord Laming states the following:

When communication with a child is necessary for the purposes of safeguarding and promoting that child’s welfare and the first language of that child is not English, an interpreter must be used. In cases where the use of an interpreter is dispensed with, the reasons for so doing must be recorded in the child’s notes/case file”. (Laming, 2003:1)

Unfortunately, he fails to define the word ‘interpreter’, and so untrained, untested practitioners can continue to obtain work with vulnerable members of the public. Worse, clinical staff will often “manage without”, and believe this to be perfectly safe. This is mostly driven by cost, not only because professional interpreters, taking professional responsibility, ask for commensurate fee levels; but also due to the cost of training, sitting examinations, and annual registration. It is easy, but dangerous, to assume greater knowledge of the dominant language than the patient can actually deploy in stressful circumstances. Trying to communicate in pidgin, with gestures that may be meaningless or even insulting to another cultural group, is tantamount to practicing veterinary medicine on human patients. Patients cannot reasonably be asked to trust clinical staff under such circumstances and the practice certainly displays scant respect for them. Their fears are reflected in such phrases as: “If the staff don’t understand me maybe they will do something by mistake” (Hennings, 1996:101), and:

“They are not good at explaining are they? They just assume that you are dumb and you don’t understand anything. They don’t bother explaining. They just assume that we are like all the rest of the women who go in who don’t speak English, they assume we are like them”. (Hennings, 1996:106)

Another detrimental effect of the various trainings and certifications that have grown up is that there is no coordinated benchmarking system in use, so each is claimed by its supporters as being different and better than all the others. There may be some truth in this in terms of properly evaluated and nationally benchmarked tests of linguistic and interpreting skills. However, the resulting confusion means that national occupational standards in interpreting (CILT, 2006) are not widely observed and many individuals working as interpreters have no training at all. It is ironic, therefore, that in legal areas (where service providers imprison, rather than bury their mistakes) the nationally accredited testing requirement for interpreters is higher and more stringently applied².

² (See http://www.cps.gov.uk/legal/section16/chapter_c.html retrieved 23.06.2003, for details of the National Agreement on interpreter provision in the Criminal Justice System.)

Uptake of interpreter services in British hospitals

The British are, lamentably, not a nation of linguists. Because we do not, for the most part, speak more than one language well, we have very little understanding of the challenges involved in switching meaning from one linguistic system to another. If we accept that communication is at the core of all successful medical practice, and that poor communication is at the root of the majority of complaints made by patients against doctors, then it becomes apparent that the skill and reliability of the interpreter are critical to the positive outcome of any bilingual consultation. According to Francis Szekely of The Medical Defence Union "communication problems are an issue in almost every single claim and complaint against a doctor." (Szekely, 2003)

Interpreters are still not seen as professionals, by other professionals

Most Primary Care Trusts (PCTs) in England and Wales have established some form of interpreting service in their area, in response to recent domestic and EU legislation on Human Rights. Some of these are housed within the hospital itself, and offer either part time or full time services, with less frequently required languages sourced from outside, often from a city council service. Many rely completely on the city council's service or the services of a charity to provide them with interpreters, who may or may not have some form of certification, usually at NVQ level 2 or 3. Under the QCA calibrations these are equivalent, roughly, to GCSE grades A-C (an exam taken by schoolchildren at the age of 14 to 19) and A level (the school-leavers' examination which precedes university entrance). National Occupational Standards (CILT, 2006) do not describe a person as an interpreter until they attain NVQ level 4. Expert interpreters are described as level 5, in this system. It should be noted that the Qualifications and Curriculum Authority (QCA), which regulates public and professional examinations in the UK, calibrates the Diploma in Public Service Interpreting as Level 6, on a par with an honours degree (e.g. a B.A.) in line with national occupational standards. Conference interpreters will be trained to MA level.

This history of 'coping' and the climate of confusion mean that doctors and nurses often do not know how to access linguistic resources appropriate to their needs, or else they think their department cannot afford to pay for them. Therefore, in the moment of crisis, when no planned language service has been provided,

they turn gratefully to relatives, cleaners, and other members of staff (Pöchhacker, 2000). Anybody who sounds fluent in a strange language is presumed to be competent for the job. The result is that trained interpreters are not employed, either because doctors have no familiar or easily accessible protocol for doing so or because they genuinely believe that this use of amateurs is acceptable practice. "We manage", they say, waving their hands about in the belief that the patient's smile means "Ah, of course! I understand you". Actually, it is more likely to mean "I have no idea what you mean, but I'm too terrified to complain".

Box 1: An interpreter is called out by the police to attend a spanish-speaking car crash victim at the hospital. When she arrives at the emergency department, she is greeted by a doctor who tells her to go home because the patient's friend has arrived, and is spanish. The doctor views the friend as the ideal interpreter. The professional interpreter replies that she has responded to a call, and will therefore have to be paid whether she stays or not. She therefore suggests speaking to the patient to ask if she wants her friend to interpret in what may become a somewhat intimate situation. She is led reluctantly to the bedside, where she says, in spanish "hello, I'm a professional interpreter ...". Before she can say more the friend cries out "thank god for that! I've only been in this country four months and I don't understand a word these women say - they're al speaking Welsh". Actually they were speaking Englisj, but with a welsh accent. To put this incident in perspective, the patioent had been brought to hospital strapped to a spinal board, and turned out to have afractured sternum.

uncommon to hear administration personnel saying things like "we don't tell them interpreters are available because then they would want to use them and they're expensive". It is difficult to understand why no comparative costings seem to have been done which consider, for example, the cost to the hospital of keeping a patient in a ward for an extra day for observation, against the cost of a professionally interpreted assessment conversation, which might have meant them being safely discharged home instead.

Hidden Agendas

The issue of risk to the patient has been explored elsewhere. (Jacobs *et al*, 1995) (Cambridge, 1999). What is less often considered is the matter of professional risk

to the clinician and to the institution. Untrained, unregistered interpreters can completely de-skill the most highly trained doctor without his or her knowledge, and are unlikely to carry any kind of insurance. In any case, if things go wrong, proving what was actually said in the other language will be almost impossible. When an interpreter is not called because a particular family or community member always attends with the patient, to 'interpret', there is risk to all parties. Impartiality and confidentiality will be compromised and normal family dynamics distorted. There can be few circumstances when the comfortingly familiar family or community member could not stay and provide support in the shared mother tongue, as well as reassuring the patient that the interpreter is doing a good job, so long as it is genuinely the patient's wish that s/he be present. For there to be no qualified interpreter present puts the patient at risk of a hidden agenda, (cf Victoria Climbié).

Another example of a hidden agenda is the child who wants the parent to stay in hospital, in a phenomenon that has come to be known in Britain as "Granny Dumping", as follows:

Doctor: "I don't think you need to stay in hospital Mrs Bloggs. Your ankle is only sprained, and I think you can safely go home."

Patient's son: (interpreting to Mother) The doctor says you shouldn't think of going home because you wouldn't be safe on your bad ankle.

Patient: (actually says) "I'm very keen to go home, Doctor. I'm quite safe on my own. My son helps me out, you know, he lives quite near me"

Patient's son: (acting as interpreter) "Mother says she doesn't want to go home. She doesn't feel safe any more. She wants to stay in hospital or go into the Elder Home."

Professional interpreters must relay the content of what was said truthfully, and their personal feelings must not interfere, as this son's seem to be doing. It is unlikely that the doctor above would allow this decision to be made without proper consultation and consent. It is to be hoped that he would bring in a professional interpreter once he realized the risks to the patient.

Expense and delay

Poor internal communications can cause unnecessary extra expense and delay, and are sometimes due to interpreters being called, but not treated as professionals: no briefing, no debriefing, no accommodation of the interpreting process, no awareness of our professional codes. The incident below resulted from a clinic clerk, who had insufficient relevant information available, phoning to book an interpreter.

Box 2: An interpreter receives a phone call from someone at the main general hospital asking her to attend a Spanish woman the following Thursday in Clinic G. The interpreter tries to gain enough information to prepare for the job but is thwarted. The person phoning is a clinic clerk, and can only offer the patient's name (which she spells, it turns out, incorrectly) and the date and time of the appointment. She cannot even say what sort of clinic it will be, only that it's on the third floor. On arrival the patient turns out to be a man, considerably older than the female interpreter, and is Italian. The interpreter doesn't speak Italian. The specialty is urology. It turns out that on the previous visit the doctor tried out his holiday Spanish and waved his hands about a lot. The man had no idea what was going on, but nodded here and there, being completely bemused. So the doctor wrote in the record: "this man needs a Spanish interpreter." The interpreter, having no alternative, went home and sent in her invoice, leaving the patient's daughter to try to interpret. How the patient and his daughter felt about being forced into this situation is open to conjecture.

Booking, briefing, understanding our techniques and professional needs

Once hospital authorities decide to set up interpreting services, they need to have clear in their minds that occupational standards offer a benchmark for safe entry to professional interpreting practice. If we take nursing as an analogy, newly qualified interpreters are equivalent to D grade nurses, and will rise up the grades with experience in practice. junior nursing staff are safe to carry out basic tasks reliably, but need supervision and further training for more technically complex work. Interpreters who enter the profession with qualifications will improve their skills even further with experience. However long habit, of itself, does not create competence and training is indispensable.

Clinical and other front line staff cannot be expected to know what interpreting involves or how to set about engaging and deploying interpreters. There should be a widely publicized and easily available protocol published for doing this, which recognizes the professional status, codes of ethics and guides to good practice that professional interpreters adhere to. Since these include a clear commitment to confidentiality there should be no difficulty with giving them sufficient advance information to prepare adequately for the job. It is easy, but unrealistic, to assume that what seems to the clinical professional to be a routine clinic encounter, will necessarily be a "routine conversation" from a linguistic standpoint. Whoever makes the booking must therefore be able to provide, not only the date, time, place and person to ask for, but also information about the nature of

the consultation. Staff should be discouraged from writing on the notes which language is appropriate, unless they have checked with the patient.

Problems with input signals always pose a threat to high quality output in interpreting. If we think about the input signals individually, we must consider sight and sound, as well as disturbances in the signals. Sighted listeners gain a very large amount of their understanding through their eyes. In a busy major injuries section of the emergency department it is unlikely that there will be any acoustic insulation. Not only do patients have very little privacy, and staff will speak quietly to try to compensate for that, but interpreters suffer from multiple extraneous aural input such as crying, shouting, mechanical noises and so forth which can cause confusion leading to error. It certainly makes concentration difficult. It can be helpful to use a piece of equipment such as a Trantec for Interpreters³ though this would not be appropriate in situations such as coronary care since it involves radio receivers and microphones; but it has the advantage of allowing an interpreter to hear properly without being in the way, stepping on the catheter tube, or setting the alarms off. When everyone is in a hurry, they can forget to speak clearly and finish sentences. When men wear a full beard or anyone is wearing a clinical mask they are much harder to understand. Rush can lead to the interpreter being interrupted before s/he has completed the relay. Spanish, and Urdu as just two examples, are longer than English, making most things significantly longer to say. The key phrase may be at the end. This is especially true when technical terms or terms with no cultural equivalent have to be explained. The challenge for the clinical members of the team is to remember, in a very fast-moving environment, to allow for the interpreting process and to offer the patient sufficient opportunity to ask questions or tell them things.

What can you expect your interpreter to do?

The interpreter should act as the 'alter ego' or other self of each speaker in turn. They should relay the whole message, without alteration to the meaning, in as closely as possible the style of the original. That is the ideal. In situations of great stress, where the patient is frightened, anxious or angry, this can be very difficult. In situations of rapid change and urgency, such as often occur in the emergency department, it can be equally difficult. Staff can be cryptic to the point of being unintelligible outside their own work team. The interpreter is not, in that sense, a member of the

work team and does not have access to their spoken codes and short forms. The patient may well resort to the comforting language of childhood and mother, in other words to idiolect. It can be difficult to hear, and hard to ask the patient clarifying questions to establish meaning, as in the following example: "make sure they cover my lalas nurse. You will, nurse, won't you?" Actually, this was an English speaking patient, but the interpreter would still have to stop her and ask for clarification.

Roles and boundaries

Interpreters are linguists. They are not auxiliary nurses, care assistants, or clerks. They are there to serve the communication needs of the patient, and the clinicians. They are not there to run errands. One example might be staff assuming, in spite of her *ÍD* badge, that the interpreter is a member of the patient's family. This may be partly because the patient has been at the hospital for several hours already, and has moved from the OPD clinic to X-ray, and on to ECG. At each move, the interpreter would have to re-explain her role to the staff. She may not always be given that opportunity, however, which can result in the group administering this test not understanding who she is. Their failure to understand her role boundaries may result in attempts to shift a part of the nurses' responsibilities onto her such as helping a patient to undress, because they see her as a family member.

The interpreter's duty to relay meanings does not stop until the patient has actually left. Box 3 contains an example of "the door handle technique", to show that interpreters must not stop relaying messages until the patient is out of the doctor's earshot.

Box 3: A patient consults her GP about difficulty sleeping, and frequent waking in the night. There is much inconclusive talk about worry, anxiety, foods that should not be eaten late at night, hot baths and milky drinks. Relaxation techniques are discussed. At what appears to be the end of the consultation, following the farewells, the patient opens the door. Door handle in hand, she says to herself "mind you, it's not the worry that wakes me, it's the sweating", and she keeps walking.

This type of situation is familiar to doctors, and an alert GP (whose alert interpreter had relayed this apparently throwaway comment) will call the patient back. There could be some chronic infection that should be investigated, such as tuberculosis, or malaria for example and blood tests are called for. For healthcare interpreters, nothing is ever "throwaway" that is a judgment for a doctor to make. Nothing is ever "routine".

³ Trantec RX8 for interpreters

question? Trained clinical staff can draw inferences from the questions that lie beneath the surface. The very fact of having asked it can reveal the patient's secret anxieties, or gaps in his or her knowledge that should be dealt with. Interpreters are not trained as clinicians. Box 4 offers a small illustration.

Box 4: An interpreter has been asked to help at a 20-week scan. The patient is a first time mother, and arrives for the scan alone. Once the patient is settled on the couch, the nurse says to the Interpreter, "I've forgotten the gel, I'll be back in a minute. Just explain this procedure to her, will you?" She leaves, but the interpreter does not offer explanations and instead sits quietly and exchanges general pleasantries. When the nurse returns she explains that she is not trained as a nurse, and this is not her patient. She could not give explanations, as requested, because she is not competent to answer questions reliably. Later, on her way to the car park, the interpreter meets the young mother again, who asks her where to catch the bus for town. Now in her role as spanish-speaking passerby with local knowledge, the interpreter points out the right bus stop. (She does not offer the lady a lift!).

You will perhaps notice a significant difference in the interpreter's activities shown in box 4, compared to the way s/he would behave in a police custody suite or in court. The golden rule in those situations is "never be left alone with the non-English speaking client". That is because an indiscretion on their part can compromise your impartiality or put you in a real quandary over confidentiality. In the worst-case scenario, the detained person in a police cell says something like, "well, I'll admit to this one. I did commit the last offence, you know, but don't tell him that!" The interpreter will have to take the officer, who was not present to be interpreted to at a critical moment, aside and tell him or her what was said. S/he must then withdraw from the case. This is expensive for the interpreter who will lose income by it, but necessary because s/he is now a potential witness and cannot claim to be impartial. On the other hand, to withhold that information from the officer could make the interpreter guilty of an offence such as obstructing the police, conspiracy to pervert the course of justice, or conspiracy, according to the case. In a hospital or primary care situation, it is not feasible or helpful to remove oneself. If a patient is sitting in a waiting room, there is no reason not to make pleasant conversation. It would be foolish to offer personal details, since one is there as a professional linguist, not a friend. The Interpreter's duty to impartiality can only be fulfilled if both parties perceive them as being impartial. This perceived impartiality is an attribute that a professional must

always protect. However, general chat, and perhaps the offer to sight translate any public notices that seem relevant, can pass the time. If there will be long hours of waiting it is wise to take some work to do, or something to read.

Multidisciplinary teams – role boundaries, debrief, freelancing

Multidisciplinarity is a fact of life in the hospital environment. For the team to be effective, all the members must accept each other as professionals, know what each member's role is, and understand how the team is led. From the interpreter's point of view, the important thing to know is that each speaker in turn must be represented accurately and that only opinions on issues of language and culture are permissible. Clearly, this can throw up ethical dilemmas, and a good knowledge of the interpreters' codes of ethics and guide to good practice will be important to the language practitioner. Proper intervention in the process by the interpreter is always a delicate judgment call.

For example, supposing an interpreter comes to believe that the young woman being interpreted for is pregnant, but is choosing not to tell the doctor so. It is tempting to think that there is a duty to the (supposed) unborn child and the doctor must be told what the interpreter thinks. But what makes the interpreter believe this? Is it something the woman has said? If so, and if s/he has been interpreting fully and accurately, then the doctor has the same information as the interpreter does, and can make up his or her own mind. Indeed he or she may already have done so and be pursuing a particular line of questioning for that reason. Maybe the matter has already been discussed, in a previous interview, through another interpreter, and is a sensitive issue for the woman. Sometimes a collection of unwitting signals, often culturally embedded, adds up to a single item of potential information that must then be explored to be confirmed. This "collection" is not accessible to the doctor, but briefing would have resolved the question as to whether pregnancy had been suspected or canvassed at an earlier appointment. Briefing is something, as I have said, that is rarely given.

Debriefing

In medical interpreting the potential for upsetting interviews is very high. We can be as professional as anyone could wish at the time but when the assignment is over, the injuries we have seen, or the emotional distress we have witnessed gets under our guard. It is unhealthy to suppress our emotions for too long and in any case will distract us from the details of the next assignment. It is

very important to ask for a short debrief with others who know the details of the case, or failing that with someone at the commissioning agency; someone, at least, who shares the same commitment to confidentiality. It is quite possible in such circumstances not to say anything which would identify the patient involved. The debriefer does not need to know where in the country the events took place or any personal details about anybody. What the interpreter concerned needs to talk about is how they feel, knowing that the listener will respect confidentiality. Freelancing means that one will often feel the need to ring a professional colleague and say, "I've had a terrible day, I feel awful, can I have ten minutes in confidence?" What is needed, as a rule, is not that the interlocutor should 'fix' anything, but simply that they listen.

Freelancing means isolation

Freelancing also means that you find your own work, and are running a small business. Interpreter training very rarely includes instruction on commercial aspects of the job. If you do undertake charitable or pro bono work, such projects should be chosen with care. Freelancing in medical interpreting will often mean traveling all over the city to attend 3 or 4 assignments in one morning. Each employer will try to pay only for the half hour the interpreter spent on their premises unless the interpreter has negotiated a reasonable rate of pay beforehand. In the UK several trade unions⁴ will allow freelance interpreters to join which helps a lot. Necessary skills include being adept at finding your way to hitherto unheard of health centres, on the basis of completely inaccurate directions. This costs unpaid time, however, and it is therefore harder to earn a living in PSI work than in office work or nursing.

Transactional discourse across culture and patient expectations

I have already discussed the special nature of transactional discourse in medicine (Cambridge, 2003) and will only sum it up here.

- 1) Transaction has three main characteristics (Cheepen and Monaghan, 1990:12):
 - a. Asymmetry of power – in most transactions, the customer has the power because they have the money. In medical discourse, knowledge is power, and the patient is relatively supplicant and power-less.

- b. Social distance – where there is a difference of opinion, the least powerful participant will usually defer to the other.
 - c. External goal – a purpose beyond the conversation itself, such as a purchase, or enhanced wellbeing.
- 2) Inverted dynamic of discourse in medicine – the interaction is supplier led, not client led (1.a).
 - 3) There is scant common ground (Clark, 1996).
 - a) Feeling heard – if no explanation is given of the cultural norms of conversation in this setting, patients will feel alienated and vulnerable to censure.
 - b) 'Face' — patients will lose face if their contributions to talk are rejected because they unwittingly break the 'rules'.
 - c) Questioning strategies – may be quite different in the two cultures involved and those in the dominant culture will be unfamiliar to the patient.
 - d) Knowledge of 'the system' – patients with no experience of the British healthcare system are likely to have expectations of treatment and outcomes based on the system in their home country, which can easily lead to misunderstanding.
 - e) Bi-cultural knowledge – only the interpreter is likely to have much of this, and will need to deploy great skill in spotting and responding to misunderstanding.

It is the interpreter who is constantly treading this tightrope and attempting to negotiate meaning without compromising his or her ethical principles and codes of conduct. They must always keep all parties informed of whatever is said in the hearing of the patient, and alert everyone present to issues that arise from the influence of the special discourse style used.

Conclusions

"Each culture (and to some extent each gender, social class, region and even family) has its own language of distress, which bridges the gap between subjective experiences of impaired well-being and social acknowledgement of them. Cultural factors determine which symptoms or signs are perceived as abnormal; they also help shape these diffuse emotional and physical changes into a pattern that is recognisable to both the sufferer and those around them." (Helman, 2000:85).

The language of distress is at the very heart of the interpreter's business and is a culturally specific form. The first stage of interpreting service provision is to set up a service. This will involve planning, and the planning should include knowledgeable members of the interpreting profession. Clinical staff should know that interpreters need

⁴ The National Union of Professional Interpreters and Translators (NUPIT) part of the Amicus Union, UNISON and GMB.

briefing, may need debriefing, and that interpreting is itself a process that must be accommodated.

Provision for the use of technology should be made wherever possible; but beware of over reliance. Telephone interpreting is possible in many cases, but desirable and fully reliable in relatively few. It should be used with caution and should never be a substitute for face to face interpreting by suitably qualified professionals unless there is no alternative.

Training for both interpreters and key clinical personnel should be mandatory in order to preserve the integrity of the multidisciplinary team. Not every bilingual needs to be an interpreter. The word is overworked, and many organisations, especially hospitals, will benefit from having bilingual staff at key early contact points such as reception. These people are not interpreters, but are invaluable and still need training to carry out their routine job in a shared other language with the client, while reporting in the dominant language (English in the UK).

Bilingual medical staff who consult and treat patients in the shared other language and report in the dominant language, are obviously ideal but there will never be enough of them to meet the whole need.

It should be recognised that interpreters are highly skilled professionals who can find it very difficult to earn a living in the unregulated and fragmented market that currently exists. They need a great deal more support from collaborating professionals than they usually get. This is not a plea for kindness to interpreters; it is a statement of fact concerning the wellbeing of the vulnerable end user: the patient.

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Sources of Further Information

<http://www.harpweb.org.uk/> Help for Asylum Seekers and Refugees Portal Many resources (in English) of practical help as well as multilingual information and help packs. UK site.

<http://www.ncihc.org> National Council on Interpreting in Healthcare (US site). Research and information, in the USA.

www.iol.org.uk The Chartered Institute of Linguists – professional membership body. You will find details of the Diploma examinations (DPSI) and qualification for bilingual workers, the Certificate in Bilingual Skills (CBS)

www.iti.org.uk The Institute of Translation and Interpreting, professional membership body for all professional translators and interpreters.

www.nrpsi.org.uk The National Register of Public Service Interpreting, professional register and professional standards body.

www.qca.org.uk The regulatory body for public examinations and publicly funded qualifications, including the DPSI and CBS exams run by the CIL. See national qualifications framework.

www.cilt.org.uk The National Centre for Languages, the Government's recognised centre of expertise on languages. See National Occupational Standards for Interpreters.

www.qca.gov.uk The Qualifications and Curriculum Authority. See National Qualifications Framework for comparison of levels among accredited national examinations.

PLAB TESTING

What is PLAB?

The PLAB test — set by the Professional and Linguistic Assessments Board — is for overseas qualified doctors who want to practice medicine in the UK under limited registration. The test is designed to assess a doctor's ability to work safely in a first appointment as a senior house officer (SHO) in a UK National Health Hospital (NHS).

The PLAB test consists of two parts — PLAB Part 1 and PLAB Part 2. Candidates may not sit Part 2 until they have passed Part 1 and must take Part 2 within three years of having passed Part 1. There is no limit on the number of attempts at PLAB Part 1, and candidates may have up to four attempts at Part 2.

Composition of the PLAB Part 1 exam

PLAB Part 1 is a three-hour exam, with 200 questions comprising 140 Extended Matching Questions (EMQs) and 60 Single Best Answer (SBA) questions divided into themes.

Composition of the PLAB Part 2 exam

PLAB Part 2 takes the form of Objective Structured Clinical Examination (OSCE), which includes an assessment of clinical and communication skills.

Taken from http://www.plabeasy.com/what_is_plab.htm
23rd June 2006

International English Language Testing System (IELTS)

Exams can be taken through the British Council in many countries, prior to arriving in the UK to work. Medical graduates coming to the UK to work must take this test and gain an overall level 7 pass in order to get work. Under EU law however, exceptions to this rule include nationals of member states of the European Economic Area (EEA) other than the UK. See http://www.gmc-uk.org/doctors/how_to_register/language_proficiency.asp#2

