Working With Interpreters During International Health Responses

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ABSTRACT

Health care providers face multiple difficulties in providing care to a disaster-stricken community. Training, preparation, and a good attitude are important, as is adequate logistical support. An often-ignored issue is the difficulty encountered with language barriers during a response, and how using interpreters affects the quality and impact of the health care provided. This article reviews the use of interpreters and focuses on how they may affect an international health care response.

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Key Words: disaster, language, interpreter, translator, communication

International disaster response is a chaotic logistical nightmare; even the most prepared workforce should expect difficulties in transportation, housing, and worksites. The workforce should also expect difficulties in communication because of cultural and linguistic barriers. There are approximately 7000 languages in the world, and it is impossible to have skilled, prepared interpreters for every potential locale.[1] As an example, even though Haiti is only 500 mi from the United States, only 1 American in 500 speaks the dominant language of Haiti, Creole.[2,3] Hundreds of agencies in the health sector responded to the 2010 earthquake in Haiti with thousands of expatriate staff.[4,5] Although some of these groups had local language speakers, many of the providers were unable to communicate verbally or were dependent on interpreters.[6-8] One in-country source for bilingual personnel was deportees from US prisons, a choice that may have been functional but with the potential for significant problems.[9]

International aid responses often address the needs of the most disenfranchised and impoverished people,[10] which typically means poorly educated linguistic and ethnic minorities. These are the populations that are most likely to need outside health care assistance and the least likely to have Western-educated bilingual members. In those instances in which interpreters are available, the problem of logistical and financial limitations of moving staff internationally remains.

Without bilingual staff, it will be necessary to acquire local staff to provide interpretation. These interpreters will likely be of varying quality and motivation. Their ability to work effectively and appropriately with the affected community is critical, yet difficult for an outsider to assess. Frequently, interpreters remain intimately involved with the provider team for days, developing strong personal relationships with the providers, but their goals and expectations may not be the same as the providers or the community. They often acquire disproportionate power and authority, controlling communication and access. The evolution of roles and unmanaged power can affect the nature and quality of the health care response and also lead to unintended consequences.

There is substantial academic literature examining the role of interpreters for non-native language speakers seeking care in the Western world, but little has been written about the use of interpreters by expatriate providers working outside their home country. Moreover, nothing in the literature, to the author's knowledge, has examined the unique and evolving role of interpreters involved in health care disaster response or humanitarian aid programs. This article addresses some of the language, cultural, and personnel issues that occur when providers need interpreters for international disaster response, and how these issues evolve over time. The list below addresses these issues briefly:

Technical difficulties of language interpretation
- Ability to speak local or translated language
- Poor understanding of local idiom or culture
- Ability to translate health concepts to local understanding

Interpreter-based issues
- Difficulty in admitting limitations
- Interpreter interprets to fit perceived desires of providers
- Ethnic, cultural, social, or sex-based biases
- Assumption of power and control of the health mission

Provider-based issues:
- Jargon-based language
- Unrealistic expectations
- Impatience

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A PubMed search of the terms *interpreter* or *translator* produced 1120 unique articles; however, not a single one examined the utilization of interpreters in disaster response, and only 1 article addressed interpreter usage in complex emergencies.[11] Multiple articles discussed issues regarding communication with non-native populations through interpreters and the perceptions and roles of interpreters. In addition, articles discussing the role of interpreters in foreign research projects were reviewed. Finally, the author drew upon personal experience and informally collected information from colleagues who have been involved in multiple international disaster responses.

UNDERSTANDING TRANSLATION AND INTERPRETATION

Most of us have noted communication problems among seemingly indistinguishable native speakers. Not only may words be interpreted differently based on life experiences and mood but also interpersonal communication comprises a vast number of nonverbal components. All of these are pieces of how we interact and communicate.

The terms *translator* and *interpreter* are an example of how native speakers may use words differently, because these 2 words are interchanged commonly. To follow standardized usage, a translator rephrases sentences from one language to another, as is typically performed with legal documents, thereby working solely with the written or verbal word; whereas an interpreter not only translates but also adjusts language so that it is meaningful to all of the participants.[12-15] To be an interpreter requires extensive cultural knowledge in addition to linguistic and communication skills.[16,17]

A common expectation of health care practitioners is that interpreters will attempt to be neutral and faithfully replicate what is said between the parties involved—the "interpreter as conduit" concept.[18-22] This expectation is unrealistic for many reasons. First, the complexity of medical and health care jargon is often confusing to the non–health care professional, which is likely to include the interpreters. Second, many Western medical concepts do not have literal translations or just do not make sense to those affected.[11,12,23-26] For example, Western medicine often uses organ-based descriptions of illnesses, which requires the affected population to know their anatomy. "Yellow eye disease" may make sense, whereas "hepatitis" does not.[27] Similarly, non-Western responses may make little sense to the Western health care provider.[19,26] In addition, even if there were nearly identical terms, there is also the possibility that the language learned has significant affects on the cognitive process.[28,29]

INTERPRETER USE IN WESTERN HEALTH CARE FACILITIES

Communication with one's peers is problematic enough[21]; adding linguistic and cultural gulfs adds significant chance for error.[30-33] Our relatively affluent Western health care facilities often use ad hoc or professional interpreters to assist staff, but studies have demonstrated that this has a negative effect on the quality of interaction and care.[34-37] Professional interpreters, preferably with specialized training in medical interpretation, may decrease communication errors,[14,26,33,35,38] but this ideal is rarely achieved in the best of times,[36,39-43] and even when it is, errors in communication are common.[16,37,39,44] In addition, despite the fact that Western health care workers often use interpreters, few have formal training in working with an interpreter and usually learn on the job.[40,42]

SOURCES OF INTERPRETERS IN INTERNATIONAL RESPONSE

Many ethnic groups needing emergency care are linguistically isolated and are less likely to be educated in Western languages. The available multilingual individuals typically are better educated, descendants of émigrés, or outsiders who have made an effort to learn the language. Bilingual native speakers have often achieved that skill at the cost of losing some measure of their roots, affecting the quality of the interaction. Those who have left home for formal education or are second- or third-generation émigrés may have lost familiarity with village life or left cultural beliefs in the homeland. Predominant local concepts of health, healing, and religion may not be something that the interpreter has ever learned or is able to communicate. Formal schooling or a Western education also may make an interpreter feel awkward or embarrassed about beliefs that seem "ignorant," affecting the fidelity of communication.

Those who are the most skilled at interpretation are often local health care personnel with their own duties. Once a health care team has traveled thousands of miles, it is easy to rationalize that using local health care providers as interpreters will provide added training for local staff (who may be motivated to be associated with a Western medical team). This, however, may monopolize the time of those most proficient at providing immediate and direct health care to the local community.

Another common source of help may be religious missionary groups; some have foreign missions with bilingual personnel. Although they may have vast cultural and religious gaps with the local population, the author has found them to be useful in humanitarian aid situations. That said, there may be ethical questions about using faith-based groups,[45] and linking with them implicitly endorses their activities. In addition, they commonly have other responsibilities that may divert their attention, including times that they are unavailable.

Many areas have English-language schools and the teachers often "volunteer" themselves and their students. These students may have limited skills, and in some instances pay their teachers for the opportunity to learn a Western language with a native speaker. The student's abilities and expectations may be a poor match for the required interactions. Even when seemingly qualified interpreters make themselves available, it is vital to remember that speaking a common language is no guarantee of social compatibility; many wars have been fought among groups that are indistinguishable to outsiders.

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EVOLUTION OF RELATIONSHIP

Repeated interactions should lead to trust.[24] Interpreters commonly become embedded within response teams, and over time, relationships tend to evolve. Repetitive translations or interpretations of the same simple set of demographic or triage questions frequently become initiated by the interpreter without input from the provider. Thus, the role of health care provider and interpreter can be partially reversed, creating what has been called role reversal.[46-48] How role reversal affects an aid situation is unclear, and it should be remembered that the providers may be overwhelmed. The expanded role of the interpreter may be worth the tradeoff of decreased communication and personal interaction. Interpreters also may find themselves taking sides,[49] either acting in ways to support providers[49-52] or becoming patient advocates.[19,20,53] Patients may expect the interpreter to become their advocate.[49] These roles may become more dominant as time passes, especially for an interpreter who is socializing and eating with the provider team or who is significantly involved with the affected community.

UNINTENDED CONSEQUENCES

As noted above, the interpreter is vital to communication, and with time the interpreter's role may evolve. Controlling communication gives vast power to the interpreter, creating a state of dependency.[46] Power has the potential to be abused, and the interpreter is in a potential position to control the flow of aid or influence to the community. Abuse of power can include favoring ethnic subgroups, steering money to relatives, or failing to report information that may reflect badly on the interpreter. Any of these actions may anger the local community. In an effort to maintain the favor of the health care provider, information may be slanted to appeal to the interests of providers. It is useful to note that these negative results may be caused by subconscious actions or by honoring cultural norms on the part of a well-meaning interpreter. An example of the latter is the failure to adequately understand problems of a patient of a different sex. These are some of the reasons that patients may mistrust an interpreter.[19,54]

Providers may also undermine local society by their use of interpreters. Hiring health care providers is common, but as mentioned above, time spent interpreting is time away from reestablishing the health care system. If the health care provider appears to be demeaning the interpreter, then the relationship may cause the interpreter to lose face and standing with the community.

In summary, poor communication may undermine program development and confidence in aid providers, and hidden ethnic or cultural tensions with interpreters may alienate the affected population.[11]

RECOMMENDATIONS FOR WORKING WITH INTERPRETERS

No formal guidance exists for emergency health care providers using interpreters in foreign settings, but there are widely known concepts that are reasonable to remember when traveling abroad,[11,46,55-58] including the following:

- Establish a relationship with the interpreter; clarify expectations in advance
- Use simple words; avoid jargon
- Back interpret (rephrase and repeat to ensure accuracy)
- Talk directly to the patient
- Look for nonverbal communication cues
- Be sensitive to issues regarding gender

A disaster response, complex emergency, health care surveillance, immunization, or focused treatment program likely will have a number of specific language and interpretation issues not addressed in the above list.

Just as the skill set of the interpreters may be beyond the responder's control, having an adequate number of interpreters may also be problematic. The ideal ratio of interpreters to providers depends on the situation. If a program is something that can be managed through simple algorithms, then it may be that 1 interpreter can provide cascade training for others to search for specific syndromes or cases. A screening program that must sort through multiple complaints, such as would be seen by a postdisaster medical clinic, may need more than 1 interpreter. A focused, surgically oriented team may need only a few interpreters to manage intake and postoperative communication.

More specific recommendations for the international responder follow:

- Be sensitive to the differences between your interpreter and the affected population (eg, socioeconomic, ethnic, religious); ask the interpreter and others about potential difficulties.
- Look to see whether certain populations appear to be excluded by the interpreter.
- Be wary of the increasing power and autonomy of the interpreter.
- Look for opportunities to vary who you use as an interpreter; consider a policy of alternating or rotating interpreters among staff to avoid establishing adverse patterns.
- Have an understanding of the future role and duration of services.
- Try to learn some number of locally important health-related words.
- Continue to train local staff in medical interpretation.

CONCLUSIONS

An international health care response may have many complexities and is likely to be filled with unanticipated surprises. Technical skills, attitude, proper equipment, and logistical sup-

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port are all of value, but the ultimate goal is to provide care to the affected population. Good communication is vital and will likely require the assistance of an interpreter to understand the culture and to properly communicate. The interpreter may become the critical link to success. It is important that the provider be prepared to optimize the relationship with the interpreter and be aware of potential pitfalls. Perhaps equally important is to understand that the interpreter is often stressed[23] and may not feel appreciated by providers.[54] Ultimately, the interpreter will have significant power and may serve both as a "cultural broker"[12,17,49] and a consultant.[30]

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