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SPECIFIC CHARACTERISTICS AND CHALLENGES OF MEDICAL INTERPRETING (EXEMPLIFIED ON THE GERMAN LANGUAGE)

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Abstract

The paper analyzes the specific characteristics and challenges of medical interpreting. It establishes the critical differences between the competences of non-professional and professional interpreters. The necessary conditions for the successful work of a medical interpreter, as well as the factors causing translation mistakes, are considered in the current study. The paper summarizes most mistakes made by non-professional interpreters taking place in bilingual communication between a physician and a patient, and also emphasizes the crucial features of their consequences for the health and life of patients because they are the main source of medical mistakes. The authors substantiate the need to attract professional interpreters to improve the quality of medical care in connection with the growth of international labour migration in the context of globalization. In the case of mediated communication involving an interpreter, the reasons for the communication disruption may be due to incompetent actions of the interpreter, causing serious mistakes. These include eliminating, "false fluency", non-equivalent replacement of words and statements, "correction" of statements with the inclusion of the translator's own opinion, the addition of words or phrases missing from the original message.

Keywords: Bilingual communication, German language, globalization, international labour migration, medical interpreting, translation mistakes.

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1. Introduction

Medical interpretation is considered to be one of the most popular and the most complex, time-consuming and responsible types of translation, being at the same time a sufficient young field of interpretation: the need for it arose in the 80s of the XX century due to the fast growth of world migration and the need for providing health care to foreigners.

The participants of such type of communication are, as a rule, physicians (doctor, nurse, laboratory assistant) and patients (and/or family members) in different situations, whether connected with medicine and human health, including:

- in the doctor's office (clinic, hospital, psychiatric hospital, sanatorium);at doctor's visiting patients at home (district doctors, ambulance);
- in pharmacies;
- in social security institutions and insurance companies;
- during significant sporting events.

2. Problem Statement

In the recent past, most interpretation services for immigrants were provided by family members or friends voluntarily. Besides, the role of non-professional (casual/untrained/unqualified) interpreter can take on:

- a bilingual medical officer who is temporarily removed from his or her primary duties to perform some interpretation services;
- a bilingual individual in a reception ward of a clinic who has volunteered his services as an interpreter;
- a student of a linguistic course.

Recently, the situation has changed dramatically: due to the concerns about the poor quality of non-professional interpretation, which ultimately leads to a decrease in the quality of medical services provided, the legislation of some countries imposes a financial burden on medical institutions to cover the costs of professional translation or interpretation. For example, in the United States, clinics receiving government subsidies are required to provide interpretation services at their own expense. In Japan, medical interpretation is included in the range of services provided through telemedicine.

According to German law, the cost of a professional interpreter is not covered by the health insurance funds. Any medical institution can meet a patient's wish and pay for an interpreter or include his/her translation services in the patient's account (Berner, 2018). However, more and more often in recent studies (BDÜ Infoservice, 2017; Bechmann, 2014; Borowski, 2018; Flores et al., 2003; Menz, 2018; Meyer, 2004; Weber et al., 2018) there has been the idea that the only possible approach to ensure the effective communication between a physician and a patient is to seek some professional medical interpreters, and the amateur interpretation is not only undesirable but also is dangerous.

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3. Research Questions

According to researcher Mityagina (2017), the translator does not act as a "passive transformer of the text", but as an active "designer" of transcultural communication and the translation process is a transformation of "complexes of communicative actions into the complexes of other actions which are more adequate in the implementation of the current interaction in the target culture" (pp. 31-32).

An absolute answer to the expected question “Should a medical interpreter have a medical education?” does not exist. The translators/ interpreters with medical education believe that it is indispensable to practise this activity, but the translators/interpreters with lack of it see no reason to have it. Basic medical knowledge is certainly necessary to understand the subject of translation/interpretation. It is also obvious that a doctor who speaks a foreign language, also cannot be a good interpreter, because a translator/interpreter is a different profession that needs to be studied.

4. Purpose of the Study

The paper summarizes most mistakes made by non-professional interpreters taking place in bilingual communication between a physician and a patient, and also emphasizes the crucial features of their consequences for the health and life of patients because they are the main source of medical mistakes. The authors substantiate the need to attract professional interpreters to improve the quality of medical care in connection with the growth of international labour migration in the context of globalization.

5. Research Methods

In a clinical study (Borowski, 2018; Flores et al., 2003) with three comparison groups (professional interpreter, casual interpreter and the lack of an interpreter), it was found: a medical interpreter makes fewer mistakes (12%) compared to a non-professional interpreter (a medical professional who speaks the patient's native language or the relative of the patient) (22%). Another conclusion is striking: if there was no interpreter, and the doctor communicated with the patient "on the fingers" (to use hand gestures), there were fewer errors (20%) than in the case when the translation was carried out by a non-professional interpreter. It is quite natural to conclude that the number of errors in the translation was inversely proportional to the number of hours of special training in the field of medical terminology. The main factor positively influencing the number, type and clinical consequences of mistakes is the volume of vocational training.

Thus, this study showed that medical interpretation should be provided by professionals who have received special training, while casual translators can make mistakes fatal to the patient.

6. Findings

The uniqueness of the competencies required for a medical interpreter is indisputable. According to the "IMIA Guide on Medical Translation" (Txabarriaga, 2009, p. 3), a medical interpreter must be fluent in the native and foreign languages, have analytical skills and a good understanding of the cultural characteristics of the peoples with whose languages he deals with. At the same time, he must be familiar with medical

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terminology and be able to use special dictionaries, as well as improve his skills, constantly being in search of the best equivalent in the language into which the translation is carried out.

Violations of communication between the doctor and the patient, which are relevant for monolingual interactions (Bührig & Meyer, 2009), in bilingual interactions are aggravated by the language barrier, as well as due to cultural and biomedical differences. The problem of the language barrier when communicating a patient of foreign origin with a doctor is the main problem, which is noted by the staff of medical institutions (Dreißig, 2005). They can occur already during the first examination in the clinic, if the patient does not speak German at all or his/her knowledge is insufficient to describe the symptoms of the disease. Often, doctors have to use hand gestures, empathy, or to seek the patients' relatives help as interpreters. Indistinct descriptions of symptoms, complicating the communication process at the stage of case history taking and diagnosis making, inevitably lead to the fact that such patients are classified by medical staff as non-cooperative. Lack of awareness of the health care system, a lower educational level, and the desire to avoid hospitalization for fear of losing their jobs are also reasons that migrants can falsify symptoms, give inadequate complaints and thus complicate the communication within the health facility.

The consequences of a lack of understanding between the physician and the patient are extremely serious. In the absence of adequate communication between the participants of the medical interaction, the provision of medical services is either terminated or occurs with mistakes, poor quality and a significant risk to the patients' health.

Language and cultural barriers lead to excessive tests, inability to understand medical forms, follow doctor's instructions, misdiagnoses, medication errors, longer hospital stays and the risk of re-hospitalization, and consequently to a sharp increase in the cost of medical services.

Thinking about the translation mistakes in the medical field, it is important to pay attention to the following fact: 80% of medical mistakes occur not because of lack of professional qualities of physicians, but because of communication failures both between medical workers and patients and between physicians themselves (Baller & Schaller, 2017), that in the conditions of precise specialization in the medical field can lead to critical situations.

The following 5-question memo (5 Ws) can help you avoid mistakes to transmit the relevant information:

> Wer? Who? (Name, Age, Major diseases)
> Warum? Why? (Reason for hospitalization: disease, accident, surgery).
> Was? What? (Diagnostic and treatment activities that have been carried out)
> Wie? How? (Current state of the patient and the types of therapy used)
> Wohin? Where? (Where should the patient be transferred? What does the further treatment/diagnosis plan include?) (Schrimpf et al., 2017, p. 134).

Just as a violation of a certain algorithm of actions can lead to a critical mistake due to the loss of relevant information in direct communication between the doctor and the patient, the loss or misrepresentation of information in the translation process can also have clinical consequences.

In the above-mentioned study (Borowski, 2018; Flores et al., 2003), several of the most common translation mistakes were found: elimination (52%), false fluency (16%), non-equivalent replacement of words

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and statements (13%), "correction" of statements with the inclusion of the interpreter's own opinion (10%), addition of words or phrases that were not spoken by the participants of the dialogue (8%). 63% of all mistakes had potential clinical consequences, for example, the elimination of the question about the presence of drug allergy, the information about the dose and duration of antibiotics, the adjustment of information about the method of application of hormonal ointment (not only on the face, but also on the whole body surface), etc.

It happens very often that the first and last phrases in the message are eliminated. In a medical dialogue, this can be fraught with consequences both psychologically (the last phrase usually contains the most important information) and medically. In this case, an interpreter who eliminates some information risks inadvertent murdering by filtering out the information which is vital to the patient.

A crucial point is inadmissibility of eliminating information that may seem to be irrelevant, absurd or unacceptable for ethical reasons (indecent, causing a sense of shame). A specific feature of medical interpretation is that such statements can, for example, help to make a psychiatric diagnosis or to assess the psycho-emotional state of the patient, and therefore they are completely necessary for analysis.

One of the reasons for the information eliminating may be the wrong choice of the type of translation. Interpreters often practise simultaneous interpretation, while the standards recommend using consecutive interpretation as a method of translation for most medical interactions, that is, when an interpreter hears the message, understands it and accurately translates into the target language during a pause. Due to simultaneous translation, the interaction proceeds quickly, doctors believe that the translation process was successful, but most of the translated message may be lost, and the result may be unacceptable for each of the three participants (Rebrina & Malushko, 2017).

For example, an interpreter cannot synchronously transmit the message "Entschuldigung, dass ich Sie habe warten lassen, aber ich habe gute Nachrichten: Ihr MRT ist ok."("Sorry to keep you waiting, but I have good news: Your MRI is fine!"). The interpreter must transmit three main points: apologies for the delay, good news and MRI results. If he had practised simultaneous translation or information eliminating, the meaning of the message might have been lost.

Medical interpreters are also discouraged from resorting to summarizing, as this compromises the accuracy of the translation process. To achieve accuracy, an interpreter must be a good listener and avoid eliminating, filtering, or adding information.

Often, the interpreters who are unfamiliar with the designation of any manipulation/procedure or diagnosis can make another serious mistake: keep the word of the source language, add the appropriate ending and/or suffix to it, and pronounce it with the accent of the target language, thus creating a word that does not exist. This mistake is called "false fluency" and inevitably leads to misunderstanding and misinterpretation: as a result, the patient begins to believe that he has a mysterious disease with a terrible name, while he could get a clear picture of his/her condition if the interpreter tried to find an exact equivalent. A common example of this mistake is often incorrectly translated borrowed word *Adipositas* (from Lat. adeps "fat"), which literally means "obesity, obeseness".

The guidance for interpreters also contains some criteria which are necessary to ensure quality translation:

1. The position of the interpreter should be chosen so that eye contact can be established between the doctor and the patient (the interpreter should be outside the doctor-patient line). Maintaining good eye contact helps to establish a trusting environment during the conversation, and, conversely, poor

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eye contact can cause difficulties in communicating with the patient. Besides, the eyes give the key to human emotions and therefore can help the doctor to determine the psycho-emotional state of the patient more accurately.

2. The using of the first person while interpreting (it allows to partially neutralize the effect of indirect interaction). Violation of this recommendation creates an undesirable barrier and leads also to clutter of the syntactic structure.
3. Too long replicas must be interrupted for the interpreting.
4. If some ambiguities arise, the interpreter should clarify them through additional questions, translating the latter.
5. After the conversation, it is necessary to inform the doctor about the features of the dialogue (inadequate or aggressive speech behaviour of the patient) (Flores et al., 2003; Weber et al., 2018).

Since a medical interpreter is faced in his/her work with life and death issues, human emotions, and medical secrecy, he/she often faces some ethical dilemmas (Malushko et al., 2016). The first professional code of ethics for medical interpreters was developed in 1987 (IMIA, 2008), and subsequently, many professional communities supplemented and corrected its provisions. However, the main ethical requirements for a medical interpreter were and remain the requirements of confidentiality, completeness and accuracy of translation, refusal to perform work beyond their professional qualifications, the level of language proficiency or special training, impartiality, protection of the interests of patients, consideration of intercultural differences and continuous improvement of their skills. The essential role of a medical interpreter is to advocate for the patient and to be a cross-cultural facilitator, offering the health professionals and the patients some explanations of cultural differences and traditions only when it is appropriate and necessary for the good communication process.

7. Conclusion

Sometimes, arising problems in communication between a doctor and a patient in the framework of monolingual interaction, which can lead to medical mistakes and cause serious harm to the patients' health and life, in the framework of bilingual communication are aggravated by the language barrier and socio-cultural differences of communicants. In the case of mediated communication involving an interpreter, the reasons for the communication disruption may be due to incompetent actions of the interpreter, causing serious mistakes. These include eliminating, "false fluency", non-equivalent replacement of words and statements, "correction" of statements with the inclusion of the translator's own opinion, the addition of words or phrases missing from the original message. The problems of effective communication between physicians and patients become even more urgent in the context of a sharp increase in international migration. The response to increasing migration should be the professionalization of the medical interpretation environment and the associated improvement in the quality of services provided.

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