

Ad-hoc interpreting in health care

Authors:

Akgul Baylav, UK

Francesca Cesaroni, IT

John Eversley, UK

Trish Greenhalgh, UK

Hans Harmsen, NL

Ortrun Kliche, DE

Ludwien Meeuwesen, NL

Bernd Meyer, DE

Barbara Schouten, NL

SOCRATES GRUNDTVIG 2: LEARNING PARTNERSHIPS

Project: BiCom – Promoting bilingual and intercultural competencies in public health

Ancona, Hamburg, London, Utrecht

July 2007

Foreword

This text is one of the concrete results of a Grundtvig II learning partnership, which is named the *BiCom project – Promoting bilingual and intercultural competencies in public health*. This project was initiated in 2005 by Ortrun Kliche of dock-europe, Hamburg. Partners of four European countries took part in the project during a period of two years. The members were from Germany, Italy, Netherlands and the United Kingdom, and all having different backgrounds. This means that university professors, adult education trainers, researchers, physicians, linguists, interpreters and mediators (often several professions were represented in one person) have had different input, interests and aims.

In the Grundtvig II learning partnership, the partners organized several workshops where Turkish health and social care providers as well as ad hoc- and professional interpreters from the four European countries were brought together and exchanged their experience, concrete expertise, and especially expressed their needs and requirements, regarding bilingual and intercultural competencies, relevant to improve communicative interaction in health and social care contexts. This has resulted in a list of needs for the different target groups, which forms the basis for designing the specific training strategies for the target groups.

Bilingualism of migrants is often regarded as a deficiency rather than a competence. But in a multilingual society, bilingual people are needed as ad hoc interpreters in all kind of social situations. The training of ad hoc interpreters and mediators in their informal language skills will contribute to the improvement of both: competencies of their mother tongue as well as of the language of their host country. Linguistic diversity – one of the main aspects of a multicultural Europe - will be assured, also in health and social care, by providing interpretation and mediation; this in turn will provide access to health care for all language groups.

The different topics and aims, discussed and examined in the Grundtvig II – learning partnership, have resulted in several contributions, which are put together in this report. This report is also put on the bicom-website, as a booklet, see www.bicom-eu.net.

The authors
July 2007

Table of contents

1. Introduction	3
2. Role of bilingual advocacy in communication	5
3. The position of the physician in multilingual communication	8
4. Ad-hoc interpreting in hospitals	9
5. Training for ad-hoc interpreters in public health	11
6. Forum theatre	14
7. The science and the art of interpreting: Using forum theatre to give voice to child interpreters	16
8. Which research methodologies are useful for promoting bilingual and cultural competencies in public health?	17
9. Final words	19

1. INTRODUCTION

Despite the fact that the European Union recognises only 23 official languages, it is well-known that in most European countries hundreds of different languages are spoken by people of various different ethnic groups. As a result of this diversity, a significant proportion of healthcare consultations concern interactions of health care practitioners with people from ethnic minority communities speaking diverse languages and having diverse cultural backgrounds. Research has clearly indicated that in such intercultural medical consultations the communication process is often less than adequate: miscommunications and misunderstandings are common and patients are often dissatisfied with the care they receive. Ultimately, the poor quality of the communication process might have negative consequences for the health of those whose linguistic and cultural backgrounds differ from their doctor. To counter these problems, strategies aimed at improving the communication process between health care providers and patients are desperately needed. One viable strategy is to foster and enhance the linguistic and cultural competencies of healthcare professionals and relatives of the patient, who act as ad-hoc interpreters during healthcare consultations with non-native patients.

During a two-year learning exchange process, healthcare professionals, scientists, public health experts and ad hoc-interpreters have reflected on the theory and practice of ad-hoc interpreting in health care through group discussions, lectures, workshops and so on. Different perspectives on ad-hoc interpreting have been explored and existing practices in a number of European metropolitan areas investigated. The results of this quest are summarized in seven papers, each describing different aspects of the issue of ad-hoc interpreting. In the contribution of Akgul Baylav's "*role of bilingual advocacy in communication*", the conceptual difference between ad-hoc interpreting and bilingual advocacy is highlighted and described. Her main argument is that bilingual health advocates can help bridge the power gap between patients and healthcare providers and that advocacy services are essential in delivering good quality of care to patients who do not speak the same language and have a different cultural background than the healthcare provider. In the second paper, "*position of the physician in multilingual communication*", Hans Harmsen outlines the need for physicians to be aware of cultural differences with non-Western migrant patients. Apart from removing linguistic barriers, which requires the help of an interpreter, physicians have an obligation to be culturally aware. In raising their awareness, better mutual understanding with their patients, and as a consequence, better care, can be achieved. Bernd Meyer's paper on "*ad-hoc interpreting in hospitals*" starts with a case of a Turkish patient in a German hospital, illustrating the common practice of ad-hoc interpreting in healthcare and the lack of policy when it comes to making use of the linguistic competencies of interpreters. He makes a plea for the development of policies with regard to the linguistic rights of migrant patients and ends his paper with a number of recommendations on how to develop these. In the paper of Ortrun Kliche, "*training for ad-hoc interpreters in public health*", proper training for ad-hoc interpreters to improve the quality of interpreted conversations is stressed. She describes several aspects such trainings could encompass, such as the mutual exchange of experiences, empowering interpreters and Forum Theatre. The paper by Frances Rifkin and John Eversley, "*Forum Theatre*", describes this last tool in more detail. The theoretical background and key ideas about Forum Theatre are reviewed, and the practice of this "theatre of the oppressed" is briefly summarized. How Forum Theatre can actually be used in practice, is outlined in the paper by Trish Greenhalgh and colleagues, "*the science and the art of lay interpreting: using forum theatre to give voice to child interpreters*". This paper describes and reflects the results of an international workshop in which child interpreters enacted their experiences as ad-hoc interpreters. Last but not least, Ludwien Meeuwesen's paper, "*which research methodologies are useful for promoting bilingual and cultural competencies in public health?*", gives a clear overview of research

methodologies that can be employed in the study of promoting bilingual and cultural competencies in health care. She concludes her paper by stating that in choosing a particular research strategy, the aim of the project and the specific questions to be answered should serve as the main criteria.

All in all, the seven papers presented here highlight various relevant aspects of the theory and practice of ad-hoc interpreting and shed more light on the issues at stake. They also demonstrate that there are no easy answers to this complex issue, and that for every answer, more questions can be raised. Hence, the quest for more knowledge, insight and wisdom continues. Hopefully, the BICOM project will be regarded as a starting point in this respect and will stimulate others to take the lead and proceed on the information gained during the last two years. One thing has become evidently clear though: to improve the quality of care for non-native patients, all parties in the patient-doctor-interpreter triangle have to be taken into account. So, it looks that in this particular case Nietzsche was wrong when he said that it takes two to make a truth. It takes three.

Barbara Schouten

2. ROLE OF BILINGUAL ADVOCACY IN COMMUNICATION

Bilingual Health Advocates help bridge the gap of inequality and power between patients & service providers.

Throughout the United Kingdom there are a number of workers employed, on a paid or unpaid basis to provide a link between health professionals and patients who, for various reasons, encounter barriers in accessing public services, notably health and social care. These workers have a number of different titles, "Linkworkers" and "Bilingual Health Advocates" being perhaps the commonest.

Historically, the concept of having someone to act as the patient's advocate began in the United States of America in 1950's and 1960's, primarily for disabled people, people with learning difficulties and mentally ill people. In the UK, the first patient advocates were for similar groups, with the addition of older people as a care group for whom advocacy workers were employed.

Early 1980s saw the emergence of the concept and practice of Bilingual advocacy which catered for people from minority ethnic communities and who speak different languages and have different cultural traditions than the service providers. The practice started in maternity services in hospitals and in 1987, it was transferred to primary care and other community based services.

Bilingual advocacy = Interpreting?

Interpreters and translators have existed for centuries, but Bilingual Advocacy is a relatively new practice that is in the process of being recognised as a 'profession' in its own right. Bilingual Linkworkers/ advocates, interpreters, community interpreters and translators are all titles for bilingual workers who are most commonly employed for providing language support to the users (both from the minority ethnic communities and from the health and social care agencies).

Although these terms are used interchangeably as all these workers are employed to overcome the so-called "language and cultural barriers", they differ from each other substantially, both in the ways they operate and in the way they address the issues. Furthermore, as is the case with most new and developing concepts, these terms and practices are not always understood and applied in the same way by the different parties involved, e.g. both the community members and providers of health and social care services. Discussions and debates are continuing in different relevant circles to clarify these concepts and their definitions in relation to bilingual communication. As yet, these discussions have not resulted in a common understanding of the terms, but they have nevertheless helped to highlight some of the complexities of the issues involved. This is to be expected when dealing with such dynamic concepts the use and understanding of which very much changes by whoever uses them and for what purpose.

As a rule interpreters work to a defined brief restricted to language support and cannot interfere beyond it, especially when they experience or observe discrimination towards their clients or communities.

A bilingual advocate, however, works to a brief that makes it possible for them to negotiate on behalf of, but in partnership with, their clients, and challenge discrimination if/when needed. Advocates can act independently of the clinical providers and as such, they are accountable, first and foremost, to their clients and communities. This level of quality

intervention brings the health professionals and their patients to an equal level where they can negotiate the available options and outcomes of care for the patient.

The roles of an advocate

Bilingual health advocates are trained professionals who

- Act on behalf of their patients and help them to communicate their needs to health and social care providers;
- Help service providers to understand fully the symptoms that patients express;
- Facilitate linguistic and cultural communications;
- Inform patients of services and choices available;
- Work with individual patients or groups of patients;
- Assist with promoting good health and well-being.

Bilingual health advocates carry out their role in a number of ways such as by:

- Educating health care staff about their culture and background, the socio-economic conditions and the health care needs of their patients and communities,
- Supporting patients within consultations through interpreting and explaining what is taking place and why,
- Informing patients about possible choices for the management of their condition,
- Encouraging their patients to ask questions and ensuring that their needs and concerns are dealt with,
- Informing patients about their rights within the system and its institutions,
- Challenging practices within the system which discriminate against their client group, by challenging institutional racism or, indeed, racist attitudes and practices by individuals,
- Helping to change and improve the services and systems through consistent and open feed-back from the patients and their communities.

Principles of advocacy

Although still in the process of being worked out in a systematic way, experience has shown that there are a number of principles underpinning the provision of advocacy services. The principles of advocacy within health care are somewhat similar to those in legal settings – basically, advocates are there to represent the patient's interests to the health service. So, being a "patient-centred" or "patient-led", non-judgemental; and confidential service, independently set up and managed from the care providers and accountable to the patients and their communities are some of the key principles of advocacy. These principles, together with the accessibility and availability of the service, training and support of staff and involving the users in the development of services form the basis of Advocacy Service Standards necessary to establish and maintain high quality advocacy services.

Models of working

As the local conditions and patient profiles change from one locality to the other, there is no one model that would be applicable to all settings in all localities. The main models of providing advocacy services within health care settings are:

a. Locally based services: Personal, face to face advocacy services provided from a local site, be it in the hospital, health centre or a local office/base. Advantages are: familiarity with the service and service providers as well as with the local communities and agencies - good for appropriate referrals to local networks/agencies for additional support, on-call during

office hours, easily accessible and readily available, particularly in emergencies, outreach/support at home when needed.

b. Dedicated sessions: These are regular (usually weekly) sessions where advocacy is provided on a regular basis from one service site for a specific group of patients. They are pre-arranged for mutual convenience and can be on or off-site, i.e. in community centres, mosques, patients' homes etc. If organised well, they can be extremely cost-effective in that valuable time and resources (beds, medicines, test materials etc) are saved by clinicians and patients communicating effectively.

c. Specialist services: These are sessions where advocacy support is provided for a specific service. The advocates are based within the service (e.g. maternity, cardiology, TB or diabetes clinics) and work only with the users and providers of that specialist service. This gives them a good working knowledge of specialist terminology and familiarity with the services, helps to establish trust between themselves and users (both community members and providers of health services), and also establishes a continuity of service for them. In different specialist set ups, the role of the advocate may change focus to have a:

- Health management function (e.g. Maternity, Cardiology, TB, Diabetes)
- "Counselling" and support function (e.g. HIV/AIDS or Haemoglobinopathies) or
- Very specialist function as in Mental Health settings.

Service specifications should reflect the specialist requirements of these different functions and settings where services will be provided.

Conclusion

Providing a valuable and much needed advocacy service that truly acts on behalf of and in partnership with patients to improve their health and access to health care presents numerous challenges, both at individual and organisational levels. Nevertheless, when someone is faced by a large, complex organisation where the quality of care is variable, advocacy is a very important role. Where the patient and health care professional do not speak the same language, bilingual advocacy is essential - if patient care is to be more than guesswork and valuable resources to be saved. For both the health professional and the patient, the presence of an advocate not only provides interpreting, but assistance with more subtle areas of possible conflict, and support and help when dealing with them.

Akgul Baylav

3. THE POSITION OF THE PHYSICIAN IN MULTILINGUAL COMMUNICATION

The physician's professional concerns are first to gather the correct information for adequate diagnosing and secondly to advise the patient in a understandable way.

A common language with good proficiency of both physician and patient is necessary. Multilingualism (both of physician and patient) is a benefit in this connection. Very often the mediation of a multilingual person is necessary to bridge the gap in understanding between patient and physician. The use of interpreters varies. Very often it is a family member or acquaintance, sometimes a multilingual colleague or other healthcare professional and some countries have free professional interpreter services. The use of informal interpreters (in a GP setting mostly family members) has some advantages. They are immediately and easily available mostly and therefore save time in practice. They are familiar with the physician and have a great commitment with the patient. But in complicated diseases and treatments or relationships it can also be a disadvantage. As a result professional interpreting is required.

Language is not the only barrier in contact and mutual understanding. The cultural context of a person defines their views on health and illness, expectations towards healthcare and also the general accepted communication rules, as Arthur Kleinman¹ has demonstrated so clearly. So for the medical consultation in a multiethnic patient population especially the way healthcare issues are communicated should be subject of attention. Patient's communication needs are also different. The shared decision-making model, as a standard of good patient-physician communication during the consultation, may be applicable to the well-educated western patient but not be good patient centred communication for all (especially the non-western) patients. This requires cultural awareness of the physician, attentiveness for misunderstanding and linguistic barriers. So even the use of interpreters does not release the physician from being aware of cultural gaps. A mutual understanding between physician and migrant patient is the key word for bridging barriers in the consultation. Experiences with training physicians in multicultural communication shows that is a willingness to bridge the gaps but also lack of knowledge and often lack of competence to do so. Training of physicians has proven to be effective in improving mutual understanding between physician and patient. But also patients should be empowered to express their needs to physicians and not accept misunderstanding. Differences in patterns and perceptions of multiculturalism and multilingualism in western European countries in their impact on problems with and problem solving of are interesting and should be explored more. They extend the view over the border of the national healthcare system and its' 'national cultural' solutions. In this respect it offers the opportunity to come to more cultural diverse input of solutions. Shared international solutions can be tested in their efficacy and efficiency for the local situation. This process empowers a common European approach of multiculturalism and multilingualism in healthcare and is therefore already interesting.

1) Kleinman MA. *Patients and Healers in the context of culture*. London: University of California Press, 1980.

4. AD HOC-INTERPRETING IN HOSPITALS

What is ‘ad hoc-interpreting’?

Consider the following case: A patient with a Turkish background comes to the hospital because of heart problems. He has lived in Germany for more than 30 years and is now retired. His German is good enough for his daily affairs, but a hospital visit is, usually, not a daily affair. The hospital visit takes a certain time during which time he gets frequent visits from his family, including his oldest son, who was born in Germany and speaks German and Turkish equally well. Right from the beginning, the hospital staff noticed that the patient doesn't speak German very well, but they make do – in most cases. This patient is able to communicate his needs and understands more or less what the staff members want him to do. However at certain moments, the communication with him is noticeably difficult and that's where the son comes in: he explains treatment decisions, diagnosis, or risk information to his father. After a short while, the staff members start making appointments with the son when they have to talk about difficult matters to the patient.

Thus, the son gradually starts acting as an interpreter for his father. Maybe he doesn't even think about it, and maybe he is acquainted with this task because he is doing it since childhood. Nevertheless, his role changes: he is not just visiting his father any more, like other family members do with their relatives. Rather, he significantly facilitates the work of the hospital employees, especially that of the medical staff. Without this bilingual person, it would have been much more difficult to proceed with the treatment, otherwise crucial information would not have been delivered to the patient because of the language barrier.

Therefore, ad hoc-interpreting is typically the spontaneous, relatively unprepared engagement of people with language skills in communication with non-native patients, be they employees with a migrant background, tourists, or business travellers from abroad. Ad hoc-interpreters don't get paid for their services. The service is usually perceived as a kind of social or moral duty – by themselves and those around them. Some hospitals provide lists of staff members who are willing to act as interpreters on an ad hoc basis, but often staff members don't know about the linguistic resources of their colleagues and simply have to find out who is speaking other languages when communication with non-native patients breaks down.

Who can act as an ad hoc-interpreter?

Everybody who is present or within reach and speaks the language of the patient and the physician. That can be a nurse or a relative, or a gardener or a taxi driver waiting outside. Usually, communication problems become obvious in cases of emergency, when time is short and solutions need to be found rapidly. Therefore, people mostly don't care about the professional, educational, cultural, and linguistic background of the interpreter. This is not wise, but as long as nobody complains, all involved parties believe that it works. The interpreters are usually those who notice the difficulties more clearly than others, because only they know what has been said and what actually has been translated.

Is ad hoc-interpreting good or bad practice?

It depends. By definition, ad hoc-interpreters are not trained for this job, and they don't get paid. Therefore, the activity is almost completely non-institutionalized and lacks any feature of professional work. However, as communication problems with migrant patients are not that rare, some staff members may acquire a high level of interpreting competence simply on the job. I remember a Hungarian health worker with Russian as his second language who worked in a German-speaking hospital for twenty years – for some reasons he was the only person who was acting as an interpreter for these languages in this hospital, and he had achieved a certain level of expertise and reflection without any formal instruction. Similarly, many professional interpreters outside hospitals who work with so-called exotic languages

never had any formal training and learned how to interpret simply by doing it. Therefore, it is not true that all ad hoc-interpreters necessarily perform badly or are unprofessional. Rather, competence depends largely on the professional and educational background, the type of bilingualism (successive or simultaneous), and the motivation of the interpreter. Furthermore, family members often show greater ability to address the patient adequately, by being not too technical or too direct. However, if one is looking for a good interpreter, the topic of the talk should also be considered – for some topics it might be good to have someone who is not linked to the family, while in other cases, it might be crucial to have someone who knows the family from inside. If doctors are in doubt, they should ask the patient – and not only then. For patients it is equally important to communicate through someone they can trust in, as it is for doctors. However, children under-age are usually ruled out – for ethical reasons, not because they are necessarily bad interpreters.

What are the main difficulties in ad hoc-interpreting?

One big problem is the lack of preparation and regulation for ad hoc-interpreting as such. It starts with the detection of language problems – usually nobody systematically checks whether migrant patients have sufficient linguistic skills for medical communication. From the moment they are admitted at the hospital they are treated just like other patients. Thus, the problem is usually detected by chance, and then the search for an interpreter is not organized and regulated. Doctors are not trained to handle this situation, just as they are not trained to communicate via an interpreter. Similarly, ad hoc-interpreters are often not consciously taking the role of an interpreter by organising the interaction and steering the flow of talk. They don't know how to stop the doctor if the talk is getting lengthy, and they don't slow down the patient if he is looking for more support than the interpreter is willing or able to give. However, typical problems of ad hoc-interpreting in hospitals entail medical topics and technical terms on one hand, and the purposes of medical talk on the other. It's not just knowing that inscrutable medical language, but also knowing why doctors talk about certain things in certain ways: "one can take a sample then" is not equal to "they will take a very small sample", and "we would like to do an ultrasound" is not equal to "they will do an ultrasound". Thus, communication sometimes depends on inconspicuous linguistic forms which ad hoc-interpreters tend to disregard.

Should ad hoc-interpreting be abolished?

No. Although some alternative models exist (telephone interpreting, patient advocates), ad hoc-interpreting will continue to play an important role in providing medical care to migrants – despite all problems. However, it would be a great step ahead if hospitals would develop policies regarding the linguistic rights of migrant patients. This includes:

- The duty for all hospital employees to address the language issue whenever they feel that it could be a serious problem.
- Training for bilingual hospital employees who are willing to act as ad hoc-interpreters.
- Training for medical staff in working successfully with interpreters.
- Acknowledgement and remuneration for bilingual hospital employees who are willing to act as ad hoc-interpreters.
- Development of internal accredited interpreting services for hospitals which have a high percentage of migrant patients.

References

Bührig, K. & Meyer, B. 2004. Ad hoc interpreting and achievement of communicative purposes in briefings for informed consent. In: J. House & J. Rehbein (eds.) *Multilingual communication*. Amsterdam: Benjamins, 43-62.

Interpreting – International Journal of Research and Practice in Interpreting, Vol.7, No.2,
2005. Special Issue on Healthcare Interpreting: Discourse and Interaction.

Bernd Meyer

5. TRAINING FOR AD HOC-INTERPRETERS IN PUBLIC HEALTH

An interpreted medical setting is no better or worse than a dialogue between physician and patient without interpreter, it is different. This difference is challenging and gives new or other possibilities for communication.

Background

Medical care for non-native patients with limited national language skills causes serious problems in hospitals - for the patients, for work procedures and for giving and receiving correct diagnoses. Taking Germany as example, it has to be said that hospitals and surgeries only rarely solve their linguistic problems with patients with the help of professional interpreting services for medical purposes. The necessity of bilingual health advocates (as described in *Role of Bilingual Advocacy in Communication*) is not yet seen at all.

The vast majority of health care providers solve their linguistic problems spontaneously, with the help of ad hoc-interpreters, i.e. bilingual staff members (with or without a health care background) or relatives of the patient. These persons solve the problems of communication by spontaneous interpreting and try to mediate between physicians and patients. Thereby, they contribute – off the cuff – an invaluable part in medical care.

Unfortunately, ad hoc-interpreting is not without risk and does not always lead to the wanted results (see *Ad hoc-interpreting in hospitals*). Misunderstandings and extended dialogues in the triangle of physician - patient - interpreter interfere with the work routine, but above all with satisfying examination results for the patients. The interpreters are often overburdened by the spontaneous situations and the additional work that has to be done and the issues they have to deal with. Despite all the problems ad hoc-interpreting will continue to play an important role in providing medical care to migrants. The question is how can we improve this situation?

Training for ad hoc-interpreters

Without abandoning (and repeating) the main demand – that of a professional, bilingual health advocate for every patient with limited national language skills – at least a certain quality of ad hoc-interpreting should be guaranteed where possible. This is realistic for a group of ad hoc-interpreters who easily can be addressed to: health care staff in hospitals, surgeries or other health care facilities, e.g.: nurses, ancillary staff or administrative personnel.

Training is necessary for bilingual hospital employees, acting as ad hoc-interpreters, as well as for medical staff, who are working with interpreters to improve interpreted conversation, to make use of the advantages a three-part-conversation can have and to raise consciousness about the issue of “multilingualism” in general. Moreover, a well- trained ad hoc-interpreter will appreciate the own language performance and will more be self-confident if it is recognized as additional professional work by colleagues and superiors.

Training for Ad hoc-Interpreters in Public Health includes linguistic and (trans)-cultural knowledge as well as the experience and the practical background of ad hoc-interpreters and medical staff themselves. At the same time, the training is a field of research in itself . It analyses how translated dialogues between patients and physicians function from a practical as well as from a linguistic and communicational perspective. Furthermore, the need for further training for ad-hoc-interpreters and clinic staff will be assessed.

Methodical approach (“Everybody is an expert”) and contents

Fundamental for the training is the experience that every ad hoc-interpreter has gained at work as well as his or her skills, be they informal (E.g. very often linguistic skills, as a mother tongue) or formal (knowledge of health care issues etc.). Mutual exchange of experiences of possible problems and solutions that have worked in practice, are an important part of the training. The role of the trainer is mainly that of a facilitator of knowledge, which the training gives room for.

From concrete successful or unsuccessful interpreting situations, the participants of the training have experienced, analyses are made of what went wrong or well and why, and recommendations for a better performance are developed and discussed. In order to bring in the knowledge and experience of the ad hoc-interpreters and to work out feasible solutions, active and dynamic methods are required. Methods that really involve the participants of a training, are extremely useful, as e.g. role plays but particularly the Forum Theatre (see: Forum Theatre).

The analyses focus on the three interlocutors of the communication triangle (physician – patient – interpreter) and explore their different contributions to the progress of conversation. But besides the interlocutors’ roles and actions, language itself (its possibilities but also its limits) is also object of a critical reflection.

I do not want to go deeper into the contents that are part of all training for interpreters, such as interpretation techniques, communication skills and the question of technical terms, but would like to go on to another point that is particularly important in the training for ad hoc-interpreters: empowerment.

Empowerment

Medical settings do not take place in a kind of social vacuum but right in the middle of our society which raises a lot of questions:

What role does multilingualism play in our society? What about language hierarchies? Do ad hoc-interpreters normally experience their bilingualism as a value or do they meet with disapproval because of e.g. an accent? And what does this mean for a health care setting interpreted by an ad hoc-interpreter with a migratory background?

Training for Ad hoc-Interpreters in Public Health has to consider these questions and has to strengthen the ad hoc-interpreter’s role – both as interlocutor in the communication triangle and also as colleague and employee.

In a conversation no interpreter (neither professional nor ad hoc) is a mere tool for comprehension. The training helps fulfil the role as ad hoc-interpreter with more self-confidence. The questions are - how to influence on the conditions of an interpretation setting, how to influence – if necessary – on the ongoing conversation, how to deal with the increasing responsibility, but also how to reject the unsaid obligation to help with ones language competence. These are important issues to reflect upon, and the list is not complete.

Insofar, training for ad hoc-interpreters includes a meta-level that raises consciousness. The question of providing language support in public health is a political issue in several aspects:

Multilingualism is a fact in our societies and consequently public health cannot deny its responsibility to provide language support.

Bilingualism is a competence, regardless of the language that is spoken.

Ad hoc-interpretation is additional work that has to be recognized as such.

Ad hoc-interpreters must somehow be remunerated for their work.

Training is necessary to help bilingual staff members gain interpretation competencies.

To encourage and promote bilingual competencies of staff members helps them to contribute their linguistic knowledge in a professional way.

Conclusion

Training for Ad hoc-Interpreters in Public health provides professional communication skills that are indispensable for good medical care for non-native patients. At the same time it sensitizes for the social value of informal skills, such as bilingualism or cultural skills. It supports ad hoc interpreters, who often have a migrant background, to develop confidence in their own capacities, which is an important aspect of empowerment. In these respects training is part of a political debate about multilingualism in societies with migrant populations.

References

- Dagmar Domenig (ed.): Professionelle Transkulturelle Pflege. Handbuch für Lehre und Praxis in Pflege und Geburtshilfe. Bern, Göttingen, Toronto, Seattle, 2001.
- Peter Saladin (ed.): Diversität und Chancengleichheit. Grundlagen für erfolgreiches Handeln im Mikrokosmos der Gesundheitsinstitutionen
- <http://www.ethno-medizinisches-zentrum.de/>

Ortrun Kliche

6. FORUM THEATRE

Background

Forum Theatre is a participatory theatre form, one of the elements of “Theatre of the Oppressed.” It was developed in Latin America by Augusto Boal as a way of working with theatre to tackle the overriding problems experienced by ordinary people.

Significantly for the BICOM project it specifically developed in a context where people were described as ‘illiterate’ because they were unable to express themselves in a particular language, in this case Spanish. (Boal, 1979).

It has been seized on, developed and adapted all over the world. Currently practitioners are applying it internationally and in the UK in Health Promotion, Theatre for Development, Community action and development, work in prisons, work in health, Theatre in Education (TIE) and schools work, Drugs and HIV awareness, in consultative projects and in many other areas. It has developed into various strands – though they are often intertwined – Legislative Theatre (policy-making), the Rainbow of Desire (therapeutic) and Forum Theatre (educational). Education in this context is used in the way that Paolo Freire used the term – education as liberation (Freire, 1972).

Theory

Forum Theatre explicitly draws on theories about the theatre and education. Consciously or (more often) not it also draws on theories about policy-making and management of change too. There are several key ideas:

Oppression

Boal reflects on the way in which people may be neither free nor externally repressed. Boal commented that after the visible, physical repression he had seen in Brazil:

“In Lisbon, in Paris there appeared oppressions that were new to me ‘loneliness’, impossibility of communicating with others’ fear of emptiness...I was ... asking, mechanically, ‘where are the cops?’” (Boal, 1995)

The cops, he decided were in the head -hence the development of the therapeutic techniques. The concept is very similar to that of Franz Fanon’s internalised oppression (Fanon, 1967).

Language

From Boal’s earliest experiments in Peru and Brazil he was acutely aware of the way that language was a tool that could be used to reinforce or change power relationships. Physical imagery and photography have been used by Boal to overcome the restrictions of language. He says ‘...By learning a new language, a person acquires a new way of knowing reality and of passing that knowledge to others...’ (Boal, 1979).

Reframing

Unlike role-play in which a ‘part’ is acted out as if there is a consensus on how the role is perceived, Forum Theatre specifically explores conflict. In this it takes after Goffman’s understanding of human interactions (Goffman, 1986) and Schon and Rein’s understanding of policy controversies (Schon and Rein, 1994). The techniques for reframing draw on the tradition of Bertolt Brecht of making the familiar strange – *Verfremdungseffekt*.

Reflection

Core to Paolo Freire's approach to learning was that it needs to be drawn out of the learners by a process of reflection rather than drawn from the 'bank' of an "expert" (Freire, 1972). Forum Theatre came into being while working with Freire when a member of an audience went on stage after actors failed to convey image on stage that she wanted them to. The transition from spectator to participation as 'spectators' is important. The idea that reflection is more than a mechanical process is also in management theory (Schon, 1991).

Although it is not a conscious part of Boal's thinking, Schon's distinction between 'Espoused Theory' - what people think they are supposed to think - and 'Theory-in-Use' is a useful one.

Two techniques are particularly used by Forum Theatre to achieve this: extrapolation of everyday experience into the imagination and unrestrained context of theatre and the use of metaphors. Again this fits with management theory (Morgan, 1997).

Transformation

Reframing and Reflection are combined in Forum Theatre to (re)construct reality (Berger and Luckmann, 1972). The idea that small or every-day events can 'cause' much bigger transformations is shared with contemporary writers on the management of organisations and change (Morgan, 1997). 'Flux and transformation' have a much longer history (going back to Heraclitus) and wider applications in theoretical physics (quantum mechanics) with ideas of small changes being capable of setting off much bigger ones and post-Darwin biology with ideas of systems that are not separable from their environment - ecology or autopoiesis.

Forum Theatre's techniques for promoting transformation often involve small change to what someone does or says which sets off a change in a train of thought or action.

The practice

A typical session begins with exercises and games aimed at initiating a playful, creative approach to what may be serious issues. A scenario or a set of images or tableaux is prepared by the group around what is of interest and importance to them. When the work is shown to an audience or worked within the group, everyone is encouraged to intervene to change the situation or resolve the problems. It is a theatre form that is entirely determined and developed through participation.

A classic Forum session involves the replacement of the principal character in a scenario, the one who represents the group, by members of the audience. Thus, take turns to be in someone else's shoes and experience life through their eyes. This is called by Boal "pluralisation" and is central to the reflexive processes of Forum and Theatre of the Oppressed as a whole.

The "Spectators", practise or rehearse change by exploring the alternative courses of action open to the protagonist of the piece and carrying the experience through into everyday life.

A facilitator who becomes the "Joker" for the Forum, the enabler or mediator for the group, conducts the session.

"The nature of the society is reflected in its smallest cells. The great themes are inscribed in the smallest personal themes." (Augusto Boal.)

Its use in the BICOM is discussed elsewhere.

Bibliography

- Berger, P and Luckmann T (1972) *The social Construction of Reality*. Penguin.
- Boal, A (1979) *Theatre of the Oppressed* Pluto
- Boal, A translated by Jackson, A (1995) *Rainbow of Desire*, Routledge.

- Fanon, F (1967) *Black Skin White Masks*. Grove Press, New York.
- Freire, P (1972) *Pedagogy of the Oppressed*. Penguin
- Goffman, E (1986) *Frame Analysis*. Northeastern University Press.
- Morgan, G (1997) *Images of Organization*. Sage.
- Schon, D (1991) *The Reflective Practitioner*. Avebury.
- Schon D and Rein M (1994) *Frame Reflection – Toward the Resolution of Intractable Policy Controversies*. Basic Books.

Frances Rifkin & John Eversley

7. THE SCIENCE AND THE ART OF LAY INTERPRETING: USING FORUM THEATRE TO GIVE VOICE TO CHILD INTERPRETERS

Introduction

Like it or not, children are often used as interpreters in clinical consultations. This has often been seen not merely as substandard practice, but as having serious ethical problems. Yet the few empirical studies that have been done on child interpreters reveal a different story: children are often very good at interpreting for their family members; they gain fulfillment and satisfaction from it; and it introduces them to role models that may inspire a future career as doctors or nurses. But the role of child interpreter is nevertheless an ambiguous and challenging one, with complex power relationships and (often) high intellectual and social demands on the child.

Methods

As part of the BICOM partnership we recruited six child interpreters who were now aged 16-17 but who had been interpreting since age 7. The children were all participants on a pre-medicine summer school for pupils from deprived socio-economic backgrounds. They worked with two specialists in forum theatre to develop scenarios based on their past experiences. They enacted these as unfinished theatre dramas at an international workshop attended by participants from different EU countries, and drew members of the audience into the different stories. The background to Forum Theatre is described elsewhere.

Results

The young people presented a powerful and evocative picture of the experience of the child interpreter. They expressed multiple and conflicting emotions through their enacted scenarios, confirming that the role of interpreter in medical consultations has both positive and negative effects on the child. Themes raised included pressure of time, lack of sympathy or understanding from clinicians about the demands of their role, confusion with specialist medical terminology, lack of health literacy in the relative for whom they were interpreting, and the difficult responsibility of breaking news that was likely to engender anger or sadness in their relative. Audience participation promoted engagement with the children's experience, and demonstrated that there are no easy answers to this complex issue.

Conclusion

Forum theatre is an effective way of exploring complex social situations, and especially for giving voice to individuals who lack power in such situations.

Trish Geenhalgh

8. WHICH RESEARCH METHODOLOGIES ARE USEFUL FOR PROMOTING BILINGUAL AND CULTURAL COMPETENCIES IN PUBLIC HEALTH?

The choice of a specific research strategy is highly dependent on the aim of the study. There are innumerable strategies that may vary on a continuum, depending on the level of (political) action, and the importance attached to changing the situation. On this 'high action' end of the continuum the focus is more on giving a contribution to the empowerment of people, to consciousness- raising. In that sense it shows overlap with political and or educational aims: the basis is one of a normative action, or of a certain policy.

On the other end of the continuum, the emphasis is just on the "gathering of information" in a systematic way, which seems to be more neutral, with aims like "to gain insight into...", e.g. the percentage of informal interpreters use in health care. This information may be used to change a situation, but from a research perspective this is not the first aim.

The presented list of strategies do not pretend to be exhaustive nor are the listed strategies mutually exclusive. Along the continuum there are countless combinations possible. The list is just meant to give an idea which strategies might be relevant for BICOM.

1. Action research is based on Kurt Lewin's field theory: insight is gained by changing the situation. If you change the situation, the problem becomes visible (e.g. women's refugee houses, emergency telephone-line for children). If the policy in hospitals for interpreter services is changed, we can observe and describe the experiences and opinions of the several groups involved (professionals, patients, (in)formal interpreters).

2. Theatre forms (like forum theatre or role playing) enable us to explore complex social situations, and to give voice to individuals who lack power in such situations. It can contribute to empowerment and consciousness- raising of people.

3. Process evaluation is based on different data gathering methods, with the aim of giving a convincing description of 'good practices'. These may be educational tools and methods, a new treatment, etc. The process of the treatment or methods is described in detail, and from different perspectives.

4. Intervention studies are aimed to demonstrate an effect of a training or treatment. E.g. what is the effect of training in bilingual or intercultural competencies of health care providers on the level of mutual understanding between provider and patient? For example:

Harmsen, H. et al. (2005). The effect of an educational intervention on intercultural communication: Results of a randomised controlled trial. *British Journal of General Practice*, 55, 343-350.

5. Interviews (group, individual) are meant to study opinions, attitudes and behaviour, and they may contribute to change these opinions etc. as well. By applying group interviews (focus groups, Delphi method), the participants may learn from each other. At the same time, relevant information is gathered. For example

Green, J. et al. (2005). Translators and mediators: Bilingual young people's accounts of their interpreting work in health care. *Social Science and Medicine*, 60, 2097-110.

Greenhalgh, T., et al. (2006). Communicative and strategic action in interpreted consultations in primary health care: A Habermasian perspective. *Social Science and Medicine*, 63, 1170-87.

6. Field work, participant observation makes also use of different gathering methods, but the researcher just describes what he/she observes. Fieldwork is frequently used in anthropology for performing site studies.

7. Observation studies are also descriptive and based on discourse analysis, conversation analysis. Audio- or video recordings, and transcripts of natural conversation are used to detect specific communication patterns, e.g. in intercultural and or bilingual settings. For example, to give a description of linguistic misunderstandings or to describe differences in communication patterns between different ethnic groups. Examples include:

Bürhig, K., & Meyer, B. (2004). Ad hoc interpreting and achievement of communicative purposes in briefings for informed consent. In J. House and J. Rehbein (eds.), *Multilingual communication* (pp. 43-62). Amsterdam: Benjamins.

Meeuwesen, L., Harmsen, H., Bernsen, R., & Bruijnzeels, M. Do Dutch doctors communicate differently with immigrant patients than with Dutch patients? *Social Science and Medicine*, 63, 2407-2417.

8. Survey research/ questionnaires are meant to gather information, to show different pattern in behaviour, to develop questionnaires, e.g. on cultural views, or to evaluate the quality of health care services regarding migrant issues (communication, interpreter use, prejudice treatment expectations, etc., cultural knowledge).

Harmsen, J.A.M. et al. (2006). Cultural dissimilarities in general practice: Development and validation of a patient's cultural background scale. *Journal of Immigrant and Minority Health*, 8, 115-124.

9. Epidemiology generates data of large groups showing trends (linguistic competencies; education, work; subjective health; diseases etc.). Epidemiology refers to the story of the statistics. These data may be relevant to support health policy. For example: the percentage of immigrants taking their own interpreter with them is very high– which is contrary to public health policy (the right to make use of public interpreter services).

10. Review studies present the state of the art regarding a specific issue, perform a meta-analysis, give an inventory of knowledge.

Mayhew, L., Eversley, J., & Harper, G. (2007). Neighbourhood knowledge management pilot project: Making neighbourhood knowledge accessible. London: ppre Ltd, Mayhew Associates and London Borough of Tower Hamlets.
<http://www.nkm.org.uk/publish/Knowledge%20management%20pilo4%20.pdf>

Schouten, B.C., & Meeuwesen, L. (2006). Culture and medical communication: A review of the literature. *Patient Education and Counselling*, 64(1-3), 21-34.

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review*, 62, 255-99.

Conclusion: For the purpose of promoting bilingual and cultural competencies, the strategies most applicable seem to be to ones grouped on the “action” end of the continuum, especially process evaluation (description of best practice), and consciousness raising forms such as focus interviews or forms of theatre. However, also the other strategies may be very useful too. As always it will depend on the aim of the project.

Ludwien Meeuwesen

FINAL WORDS

“The **Charter of Fundamental Rights** adopted in 2000 places an obligation on the Union to respect linguistic diversity (Article 22) and prohibits discrimination on grounds of language (Article 21). Respect for linguistic diversity is a fundamental value of the European Union, in the same way as respect for the person, openness towards other cultures, tolerance and acceptance of other people.” (http://www.europarl.europa.eu/facts/4_16_3_en.htm)

The partners of the Grundtvig2-Learning Partnership BICOM put their work in this context, to be taken literally. They will try to continue their cooperation. The application for a Grundtvig – Multilateral project has been submitted.

Ortrun Kliche