

Language barriers in health: lessons from the experiences of trained interpreters working in public sector hospitals in the Western Cape

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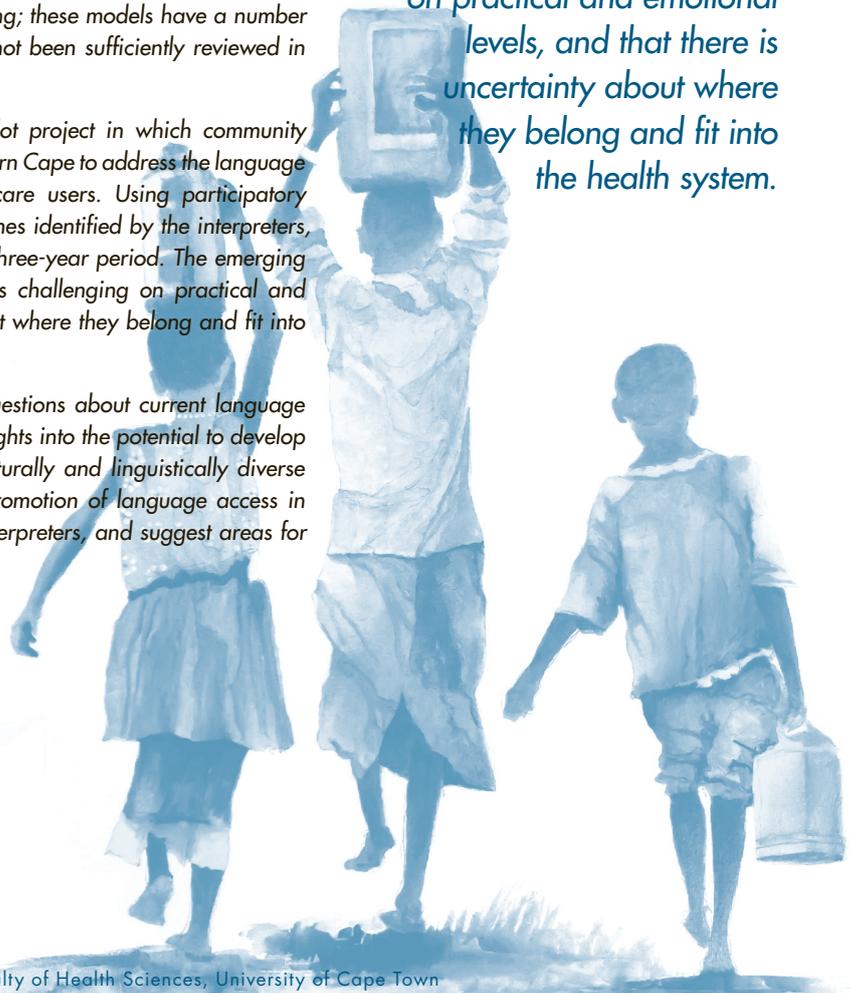
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There has been a longstanding call to employ trained interpreters to address language barriers in health care in South Africa. The international literature shows that while trained interpreters can be effective, the existing sophisticated models of upper-income countries are expensive and contextually inappropriate for low-resource settings like South Africa. In community interpreter models, members of the community are given brief training in interpreting; these models have a number of potential advantages for our context, but have not been sufficiently reviewed in the literature.

In this chapter, we describe the findings of a pilot project in which community interpreters were introduced to hospitals in the Western Cape to address the language barrier experienced by isiXhosa-speaking healthcare users. Using participatory action research methods, we discuss emerging themes identified by the interpreters, from mentor sessions conducted with them over a three-year period. The emerging themes suggest that they experience their work as challenging on practical and emotional levels, and that there is uncertainty about where they belong and fit into the health system.

The experiences of the interpreters raise crucial questions about current language issues in our hospitals, while offering important insights into the potential to develop a multilingual health service for South Africa's culturally and linguistically diverse population. We make recommendations for the promotion of language access in health services, the professionalisation of health interpreters, and suggest areas for further research.

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Introduction

In the 2012/13 edition of the *South African Health Review*, Nadia Hussey¹ suggests that the 'overlooked' language barrier remains a crucial challenge to providing equitable and quality health care in South Africa. She makes an important contribution to a growing body of work on issues of language access in health care over the last three decades,²⁻²⁹ and in her recommendations to improve the situation, echoes a longstanding call to employ trained interpreters in health institutions across the country.

In this chapter, we describe an initiative to heed this call by the Western Cape (WC) Department of Health (DoH), and highlight lessons learnt from the experiences of the trained community interpreters involved in the project. In introducing this work, we offer a brief overview of language access issues in South Africa.

Language in South Africa

South Africa is a multi-cultural and heteroglossic society with 44 living languages (11 of which have official status), and is home to a large number of African refugees. South Africa scores 18th highest worldwide on Greenberg's language diversity index,³⁰ which means that the likelihood of two people meeting at random and sharing the same mother tongue is slim. Although language trends are shifting, particularly with Afrikaans and English no longer being 'white languages',³¹ isiZulu remains the most common home language in South Africa. In the WC, the most commonly spoken languages are Afrikaans (41.4%); isiXhosa (28.7%) and English (27.9 %).

English is only the fourth most-common home language in South Africa,³¹ but is typically the preferred language of healthcare providers, resulting in more than 80% of medical interactions occurring across language and cultural barriers.^{9,18} In exploring language as a barrier to care at a South African paediatric hospital, Levin¹⁵ found that only 6% of medical interviews were conducted partly or fully in the patient's home language despite the patient's preference for the latter. This is a right which is enshrined in South Africa's Constitution and national and provincial language policies.^{32-34,17} According to these policy documents, healthcare users have the right to be informed of and/or use interpreter or translator services "by choice regardless of their ability to communicate in English" (emphasis added).^a However, Williams and Bekker²⁶ found that "knowledge about public-language policy in the State health sector is vague and inadequate" resulting in "little accommodation" for users who prefer using their mother tongue.

The situation in South Africa is such that medical interviews are generally conducted in the healthcare user's second or third language¹ and it is therefore not surprising that the healthcare users in Levin's study¹⁵ experienced language and culture as more of a barrier than South Africa's notorious structural and socio-economic issues. This is in line with international findings where "... the language barrier is the primary challenge for meeting the healthcare needs of the immigrant population",³⁵ except that in South Africa the linguistically disadvantaged population is not made up solely

of minority immigrants but the multilingual population at large.¹⁴ The result is that South Africa essentially has "... monolingual health services in a multilingual society".⁷

There is extensive literature on strategies to manage linguistic diversity in health care in high-income countries with refugee populations. However, Swartz et al.²⁴ have recently shown that the issue of language diversity is in fact greater in many low- and middle-income countries, due largely to high levels of external and internal migration. However, affordable models for making health services available to a range of linguistic communities are scarce.

In South Africa, common language practices to address barriers in health care include linguistic code-switching, the use of a few key terms in the healthcare user's language, and ad hoc arrangements⁵ involving the use of family members, hospital security guards, nurses or household aides as informal interpreters.

While South African researchers have demonstrated both the complexity of informal, ad hoc interpreting, and the potential to improve communication and health care,^{2,19,25} the use of informal or untrained interpreters is more often seen as "not suitable or sustainable."^{1,35,15} Informal interpreting has raised a number of clinical, ethical and human rights concerns. Recent research has shown that in a relatively well-resourced tertiary mental health facility in the WC, where informal interpreting is conducted for isiXhosa-speaking patients on an ad hoc basis, every interpreting error likely to be of diagnostic significance occurred in the direction of making the patient appear more psychiatrically ill.¹²

The lack of linguistic capacity among informal interpreters was demonstrated in two separate informal interpreting community groups.^{8,11} There is also concern that untrained interpreters may find the triadic interpreter-mediated relationship particularly challenging to negotiate, and that the arrangements can have a negative impact on healthcare user autonomy, informed consent and confidentiality. Informal interpreters, for their part, may run the risk of long-term distress due to emotional over-identification with healthcare users.²¹

The need for trained interpreters

Interpreting in healthcare settings is a highly complex process that aims to achieve "a workable interpretation which has use in the clinical setting"²¹ and requires of the interpreter accomplishment in both languages as well as familiarity with the healthcare user's culture, professional jargon,^{36,27} and emotional vocabularies.² Words do not always translate easily or accurately, particularly medical terms,²⁹ and cultural and other socio-political differences (e.g. educational levels) expressed in language through, for example, proverbs, emotional undertones and humour, can prove challenging for even highly trained interpreters.¹⁴

Interpreters also act as "cultural broker(s)"²⁷ or "mediators"¹ providing a 'bridge' between clinicians and healthcare users²⁴ – which adds another level of complexity to the interpreter-mediated clinical encounter. The concept of culture is easily reified, ignoring important differences such as social class, religious beliefs, educational levels, degrees of acculturation, urbanisation and explanatory models of illness between healthcare users and interpreters, and both clinicians and interpreters may mistakenly

^a The language rights of all citizens are enshrined in the Constitution,³³ while the language rights of healthcare users are further elaborated in the National Department of Health's Policy on Language Services³⁴ and the Provincial Government of the Western Cape's (PGWC) Language Policy.³² These policies also govern the establishment of the PGWC Language Unit through which an external interpreter service (telephonic and face-to-face on request) is made available to health establishments in the WC.

assume that the interpreter 'knows' the healthcare user's culture and is able to offer judgments about the user's behaviour.²⁴ Fulfilling this role requires a sophisticated ability on the part of interpreters to hold their own cultural constructions³⁷ while fostering and foregrounding the clinician–healthcare user relationship.^{14,19}

Adding to this complexity is the fact that the interpreter-mediated health encounter reflects deep historical and contemporary socio-political, cultural and economic divisions.^{1,16} The healthcare users who require interpreter services in the health system are frequently among the most marginalised socially and economically,¹⁴ and often have particularly traumatic histories. In public hospitals, untrained interpreters often share the healthcare users' cultural and socio-economic background and may overidentify with them, and may be vulnerable to these unconscious and unspoken dynamics and alliances within the interpreter-mediated encounter, which heightens the emotional impact of the work.³⁸

Furthermore, language itself may be associated with traumatic memories and emotional meaning for interpreters, as suggested by Busch and Deumert.³⁹ This is particularly relevant in the South African context where language continues to play a central role in the political landscape and lived experience, particularly of marginalisation, of ordinary people.

These issues are exacerbated in the context of mental health care, where assessment and treatment of all conditions are strongly based on language. Disordered language and communication are commonly part of the symptomatology of serious mental disorder; where this is the case, the question of communication and interpretation is not simply one of facilitating a discussion between two people (clinician and healthcare user), each being able to communicate well, but in different languages.

The international literature has shown that the use of trained interpreters raises the quality of care and levels of satisfaction for healthcare users with limited English proficiency to approximate that of healthcare users without language barriers.^{40–43} Trained interpreter services are therefore now widely viewed as an essential part of quality health care, and service models in higher-income countries include sophisticated professional interpreter services such as *Mother Tongue* in the United Kingdom.⁴⁴ While there is much to be learnt from these services, they are expensive and contextually inappropriate in South Africa.²⁴

'Community interpreting' models hold more promise for low-resourced, culturally and linguistically diverse settings like South Africa.⁴⁵ Community interpreters are drawn from among the members of the community being served and have received some training in interpreting. Community interpreting is usually done in less formal settings, such as hospitals or police stations, and is usually done in consecutive mode, involving less formal speech.

Community interpreting is cost-effective, offers task-shifting opportunities and, because interpreters usually share the healthcare user's cultural and social background, promotes cultural competence.²⁴ However, questions about whether such low-cost solutions work in practice remain unanswered.

Until recently, dedicated interpreters were employed only in the Department of Justice, despite the reliance on similar accuracy of information by the Health Department.⁷ Furthermore, accreditation through the South African Translators' Institute (SATI) is currently

available only for simultaneous or conference interpreting, and therefore not for community or health interpreting.

It is in this context that the Interpreter Project was implemented. The project is part of a larger action research project exploring a range of issues related to language and interpreting in health/mental health care, including the experience of interpreters (both untrained and trained), clinicians and patients.^{8,10–13,21,24}

An action research method was adopted as such an approach is best suited to a deep exploration of the subjectivities and lived experiences of participants, particularly in research areas with a limited knowledge base.^{46,47}

The Interpreter Project

Following years of grappling with language access and motivating for interpreter posts to be created in hospital establishments, the WC DoH engaged in a collaborative project with the Provincial Government of the Western Cape (PGWC), Extended Public Works Programme (EPWP) and Stellenbosch University (SU) to train and place community interpreters in hospitals in the WC.

In December 2011, 15 first-language isiXhosa speakers with formal schooling to Matric level were recruited as health interpreters on a contract basis by the EPWP. They underwent a three-day intensive training course in Interpreting and Psychiatry by the Departments of Afrikaans and Nederlands, Psychology and Psychiatry at SU. The trained interpreters were then placed in six public hospitals in the WC^b as interns and commenced duty in December 2011. However, in March 2012, EPWP funding was reduced and the interns were re-appointed as administrative interns by the DoH for a period of 12 months from 1 May 2012. At this point, 12 interpreters were appointed due to attrition and resource constraints, with a further interpreter resigning to take up another post shortly thereafter.

By May 2013, the DoH had successfully motivated for the creation of permanent posts and the remaining 11 interpreters were officially employed as interpreters on salary level 4 by the WC DoH. Two interpreters subsequently resigned to take up other posts in the Department of Health, which currently leaves nine interpreters formally employed by the DoH.

All the interpreters are self-identified as African, with five females and four males making up the remaining nine interpreters. The average age of the interpreters is 36 years, with an age range of 27–43 years.

To augment the intensive training course, ongoing mentoring and support for the interpreters was conducted initially every fortnight and later monthly in order to facilitate the placement of the novice interpreters, all of whom were working in health and mental health institutions for the first time. Once the interpreters were absorbed into the health system in 2013, concerns were raised about the time away from the hospitals required for the mentor sessions, and the sessions were eventually reduced to quarterly meetings.

Using practice-based action research⁴⁸ principles, two key meetings were held, giving interpreters the opportunity to explore and develop themes reflecting their experience. Some of the emerging themes are discussed in the following section.

^b Alexandra, Lentegeur, Mowbray Maternity, Somerset, Stikland and Valkenberg Hospitals.

Emerging themes

The experiences of the interpreters in this project are consistent with local and international literature on the subject where the work is described as “complex, challenging, exhausting, and often invisible”.^{6,49,50} Additionally, the “negotiating of blurred role boundaries and competing, often conflicting, expectations was an additional work burden for health care interpreters and contributed to feelings of being exploited, disrespected, misunderstood, or excluded from membership on the health care team”.⁴⁹

A key aspect of the experience of the interpreters in our project is the question of where they ‘belong’, which is not unique to our project. In a similar local community interpreter project^c conducted more than a decade ago, there was also “conflict and disagreement, overt and covert, about where interpreters fit into the new order of things”.⁶ Internationally, Rosenberg et al.⁵¹ also found that this “absence of a place for interpreters in the institution ... [and] not [being] part of the healthcare or the administrative staff” was consistent with research findings.

Another key aspect highlighted by this project is the underutilisation of trained interpreters, which is paradoxical given that the need for such trained capacity is frequently expressed in the literature. While it is possible that this is merely the result of logistical problems resulting from a serendipitously introduced service, or of clinicians trying to do their best in a pressurised, challenging service environment,¹³ local literature suggests that there is more to consider.

Conditions of service

Discussions in the group were dominated by issues related to conditions of service, particularly during the period when the interpreters were transferred to the Health Department. This was not surprising, given that this was the first time that most of the interpreters were employed in government structures, and they knew very little about how the hospital system worked. They used the group space to learn about procedures from each other, and to measure consistency of experience.

Salary levels, job descriptions, performance evaluation and career-pathing all came under discussion at various points over the course of the mentor sessions. The new post of interpreter was created under the authority of the quality assurance manager and the job description included an administrative function. It was clear that the system was ill-prepared for the interpreters, with no clear parameters on the administrative/interpretation split, no standards for performance evaluation and the absence of career-pathing, leading the interpreters to say frequently “... we don’t know where we belong in the system”.

Nature of interpreting and interpreting challenges

The interpreters distinguished between what they referred to as ‘clinical’ and ‘general’ interpreting. Clinical interpreting involved interpreting in a variety of clinical encounters, from individual healthcare user–clinician interviews, to family and group sessions, ward rounds, healthcare user meetings in wards, and telephonic consultations with healthcare users and family members. They described the demands as differing in these contexts, from long and exhausting sessions in forensic wards, to shorter but high volumes of sessions in busier admission units.

‘General’ interpreting involved patient care activities such as helpdesk duties, assisting healthcare users to complete forms, explaining rights and responsibilities, translating medication instructions, conducting healthcare user surveys, and managing complaints and compliments. Helpdesks and queue marshalling in general hospital settings were often experienced as stressful, because of the high number of healthcare users as well as having to deal with healthcare users who were frustrated after long hours of waiting.

Administrative duties varied and included such tasks as data capturing, filling out Review Board forms, recording admission and discharge statistics, delivering incident and periodical reports, and updating the forensic service database.

The issue of where interpreters ‘belong’ in the system arose frequently. Interpreters felt that the nature of their work was largely clinical, and that they should be seen as part of the clinical team in the hospital.

At the same time, they noted that administrative duties ranged between 20% and over 80% of their job descriptions. Interpreters noted that while these functions presented an opportunity to learn new skills and to be more competitive in the job market, there was also the risk of losing their core identity as interpreter. Additionally, this function required that interpreters stand in for absent administrative staff who are remunerated on a higher salary level, leaving some of the interpreters feeling exploited. Interpreters also frequently expressed frustration with being evaluated on tasks that they were not trained to do.

Interpreters battled to reconcile the low utilisation of their services in some areas with the appreciation they received from healthcare users for their services, which led to some questioning whether the low utilisation was related to staff rather than healthcare user need:

The patients do need us, but do the staff?

The staff ... do not treat me as an interpreter ... they treat me as a clerk.

This also raised the questions of access to interpreters. Some clinicians used a booking system, while others expected them to be available when needed. This was particularly difficult in the larger psychiatric hospitals where there are large distances between wards and the interpreters did not have access to transport. Interpreters described instances of arriving at a ward after being called, only to find an informal interpreter being used instead because they could not get to the ward timeously.

^c In 1997, the National Language Project’s (NLP) Community Health Interpreter Training and Employment Programme (CHITEP) trained 20 interpreters and placed them in 10 healthcare sites in the Western Cape. The interpreters were first-language isiXhosa speakers with Matric, and completed a two-month training course.⁶

This was juxtaposed with less frequent experiences of feeling valued and respected by clinicians, as in instances of being called to interpret despite the presence of isiXhosa-speaking staff members, or in linguistically challenging encounters (e.g. Setswana/English-speaking clinician; isiZulu/isiXhosa-speaking client and isiXhosa/English/isiZulu-speaking interpreter).

Lack of in-hospital transport was one of the resources frequently cited by interpreters as an obstacle to meeting their job requirements. Others included access to computers to complete administrative tasks such as minute-taking, and the absence of isiXhosa–English dictionaries to aid them in the translation of more technical terms and difficult concepts. Furthermore, interpreters frequently discussed the lack of on-site supervision, and a lack of referral pathways to interpreters with more experience or better training in scenarios where engagements were difficult to interpret for clients.

A further challenge was that of the interpreters finding themselves in compromising positions between clinicians and healthcare users. These ranged from experiences of healthcare users saying to the interpreter “Don’t tell the doctor ... ” to a clinician reportedly telling the interpreter “Don’t worry about it, he’s talking nonsense” when a healthcare user disclosed sexual assault by another healthcare user during an interpreted session.

Emotional experiences of the work

Much of the emotional experience of the work was initially linked to the precarious position of the interpreters in the system and was expressed as feelings of job insecurity, powerlessness and frustration.

Low utilisation of the interpreter services in some areas, together with the unchecked and ongoing use of informal interpreters, left interpreters feeling undervalued. These feelings were reinforced by the lower salary level assigned to interpreters, and their perception that their administrative functions were more valued than their interpretation services. Some interpreters experienced the administrative tasks as demeaning:

The stuff we get asked to do are what others don’t want to do or there is no-one doing it.

The clerical work is available more than interpreting work.

For one of the interpreters, this was particularly painful after she was unsuccessful in her application for an administrative post:

I am working as a clerk ... but I didn’t get the job ... I’m the joke of the hospital.

The interpreters frequently expressed that the hospital system does not understand their role as interpreter and had unrealistic expectations in this regard, e.g. the focus on patient numbers, and availability.

They also felt unsupported by the lack of access to resources, and the lack of on-site supervision related to their interpreter function. Very few clinicians offered them the opportunity for debriefing following interpreted sessions, and with the mentorship group meeting less frequently, they were often left to find their own supports. They could appreciate the longer-term value in this, but sometimes found acute periods of distress difficult to manage. One interpreter who found a session with a child rapist to be “too close to home” as the child victim was the same age as his daughter, sought support from a fellow interpreter, in addition to the mentor group. Another

interpreter who used the employee assistance agency following a traumatic incident found it unhelpful, but with the encouragement of the group, returned to the agency and worked successfully with a different counsellor.

Feelings of vulnerability were linked to feeling poorly trained to work in hospitals generally, and in psychiatry in particular for those in such settings. Because they entered the hospital system initially as administrative interns, and were later transferred to permanent posts, the interpreters did not undergo the standard induction and orientation programme for new appointees. Despite ongoing requests, only one interpreter underwent the Introduction to Psychiatry course offered in the hospitals.

Interpreters also felt ill-prepared for the effects of listening to the traumatic experiences of healthcare users, and felt that training in counselling skills could help them contain the difficult emotions they were left having to process.

Furthermore, their experiences of different cultural practices led one interpreter to the realisation that “We are all Xhosa, but we are all different”. The interpreters felt that they needed “a course on culture” to help them fulfill their role as cultural broker, the complexity of which became clearer during the discussions in the group.

As interpreters were exposed to various physical and emotional risks, the question was raised of indemnity and protection by their employer. Such risks included exposure to healthcare users who could become aggressive, as well as interpreters witnessing abuse and discrimination. With regard to the latter, one interpreter warned another about formally reporting incidences:

If you write a report, you must protect yourself...it can be used against you.

while another was concerned about the effect on relationships with other staff members:

... because they’ll feel like I’m spying.

Discussion

Despite the legislative ideal, the slow progress in addressing language access in health services in South Africa has led a number of authors to question whether the South African healthcare system ‘silences’ non-English healthcare user voices^{1,3,23} and benefits from constructing them “as voiceless, dependent, powerless, healthcare users.”¹⁰ Elkington and Talbot⁷ add that the healthcare system’s ‘reluctance’ may result from conflating language and race, and thus “ironically further entrenching the notion that indigenous languages do not deserve recognition and conveying to indigenous language speakers that this aspect of their need is unimportant”.

Regardless of the factors that may be at play in mitigating the promotion of language access, the question is: who is responsible for the service? The interpreter-mediated session is traditionally viewed as having three main players: interpreter, healthcare user and clinician. Zimanyi⁵² suggests that “in reality, there are usually more participants, although not always physically present, whose contributions (or non-contribution as the case may be) also greatly affect the outcome of such sessions”. These ‘institutional participants’ include health services, the State and the community. Our project suggests that these levels, particularly those of the health services and

the State, have a direct impact on the provision of quality interpreter services, and dialectically, on the experiences of interpreters.

At State level, the lack of policy guidelines and standards for quality interpreting services, as well as lack of regulation of the language professions⁷ impacts negatively on service development. This is compounded by the lack of recognition of health interpreters by professional bodies and the lack of accredited training programmes available for community interpreters in general, and health interpreters in particular. This leaves community interpreters without the protection of ethical standards and practice guidelines.

At the level of health services, the WC DoH has gone a long way towards operationalising national and provincial policy directives, such as the National Development Plan 2030 (NDP 2030),⁵³ by creating interpreter posts in the Health Department. The project demonstrates what can be achieved through cross-sectoral collaboration and decisive and innovative leadership.

However, as pointed out by Swartz et al.,²⁴ the challenge in growing this fledgling service lies in examining the organisational as well as the linguistic dimensions of the service. This requires a meaningful engagement with questions of how language issues, and interpreters, are viewed at the institutional level, and what the institutional responsibility is for supporting and growing the service. In practice, this means that institutions must take full responsibility for the utilisation of interpreter services, and provide structural support for interpreters to fulfil their roles.^{6,50}

At the level of community, a pertinent issue is the fact that healthcare users are uninformed of their language rights and their right to access interpreter services. Interpreters, however, through their close association with marginalised healthcare users,⁵⁴ represent an opportunity for the healthcare system to “inscribe traces of the excluded other into the dominant language”,⁵⁵ and thereby bring marginalised healthcare user voices into dominant discourses in institutions. As pointed out by Brisset, et al.:⁵⁶

Interpreters are more than communication helpers ... they are witnesses of how our institutions deal with socio-cultural and linguistic diversity. The extent to which interpreters are recognized by those institutions and their voices heard is a sign of how society and its members, particularly healthcare administrators and practitioners, handle differences. Ignoring or depreciating interpreters' contributions to the healthcare process is equivalent to ignoring or depreciating our own diversity.

Conclusion and recommendations

The aim of action research is to influence practice and the conditions under which it occurs, as well as how it is understood.⁴⁸ This exploratory study points to the need for more in-depth research into the experiences of community interpreters in our health settings, and into key gaps at the level of hospital services, policy and training. We offer suggestions to facilitate the integration of community interpreters in health settings at each level.

Hospital services

With the task of providing access to health care and ensuring that

policy is implemented, hospitals must ensure that all staff are familiar with national and provincial language policies and the role that interpreters play in complying with these.

Hospitals should also ensure that healthcare users are informed of their right to express themselves in their mother tongue, and to use interpreter services. In order to improve the interpreting services provided, healthcare users should be invited to provide feedback on the quality of these services.

Utilisation of interpreter services should be closely monitored, with appropriate responses in the case of both under- and over-utilisation. Here, practical responses such as integrated booking systems⁵⁷ or the use of interpreters across centres⁷ could be considered. More importantly, the possible drivers of utilisation patterns should be given adequate consideration at institutional level, keeping in mind the institutional dynamics that may be at play. Courageous conversations of this nature may need to be had, and may benefit from external facilitation.

Supervision and debriefing are crucial for interpreters to function at optimal levels. On-site supervision is also more likely to support ‘team functions’ rather than ‘profession-specific functions’,⁶ thus facilitating integration while responding to the unique dynamics at institutional level. Our intervention has also highlighted the value of peer supervision, and occasional joint supervision with members of the clinical team may also be necessary.

The literature suggests a number of areas that should be addressed in good supervision. These are listed in Box 1.

Box 1: Elements of good interpreter supervision

- ❖ Understanding of emotional, ethical, systems and workload issues
- ❖ Understanding of complex dynamics in teams in different institutions
- ❖ Appreciation of the varying needs of patients in different wards
- ❖ Focus on clarifying professional and personal boundaries
- ❖ Focus on the emotional impact of the work, highlighting problematic reactions in this regard
- ❖ Recognition of the potential growth inherent in interpreting and trauma
- ❖ Recognition of the dangers of one-off sessions with healthcare users who have particularly traumatic histories and presentations
- ❖ Recognising signs of burnout in the interpreter

Sources: Splevins et al., 2010;³⁸ Miller et al., 2005.⁵⁰

Although the issue of healthcare users also needing a clearer understanding of the role of the interpreter⁵ and what to expect from them did not emerge in the project's thematic analysis, we suggest that a pamphlet may be useful to present this information together with guidance on healthcare user language rights and how to access the service.

Evidence-based guidelines and standards of evaluation^{57,58} should be developed to clarify the interpreter function. The question of where interpreters belong in the system should also be engaged with critically at institutional level, taking into consideration that much of the literature recommends integration of interpreters into the multidisciplinary team.^{49,59,60} Williams and Bekker²⁶ go as far as to suggest that there should be an:

acknowledgement of officially trained medical interpreters as a 'related profession' in health services. Such acknowledgement ought to be equal to the status of social worker, psychologist or physiotherapist.

This has implications for the salary levels of interpreters. There have been attempts to address the question of appropriate remuneration levels and utilisation (for example, appointing interpreters as administrative clerks with interpreting as a key job output). While such proposals may be expedient in addressing the issue of salary level, the risk of entrenching the invisibility of language issues would remain.

Policy

All policies should be reviewed in terms of language access issues. For example, the NDP 2030,⁵³ and a number of other key policy documents, do not consider the impact of language barriers on health outcomes.

The accreditation of health interpreters should be addressed, as well as guidelines for practice and ethical standards. In this regard, registration as a 'language practitioner' under the South African Language Practitioners' Council Act⁶¹ may present an opportunity for professionalisation.

Training

There is an urgent need to develop formal training programmes to prepare interpreters to work specifically in health and mental health care in South Africa.⁷

Although not a focus of this intervention, our work in the broader project¹³ suggests that training of clinicians and supervisors/managers would facilitate interpreter-assisted programmes. There is also a need for clinicians to be aware of their profession-specific responsibilities towards healthcare users with limited English proficiency, and the use of interpreters in their fields.

Training on how to "collaborate with (and not ... 'use')"⁵¹ interpreters should be included in the formal training of all healthcare professionals.

Research

The vast majority of studies in this area have been conducted in high-income countries,^{62,56} and while there is a burgeoning body of work in South Africa dating from the 1980s,¹⁻²⁹ there is a clear gap in the literature on the careful description and appraisal of innovative and low-cost ways of attempting to address these issues in South Africa.

The experience of interpreters, and the impact of their personal histories and trauma on their work, are also starting to come under the focus of global research interests.^{38,54,56} This is particularly pertinent to South Africa where, as stated by Penn,¹⁸ "the majority of health interactions ... are mediated by a third party whose role is little understood".

Research is needed to gain a deeper understanding of the interpreter's role, and how to support the integration of interpreters into low-resourced, linguistically limited health systems such as ours.

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