Medical Interpreting in a New Member State
A Plea for a Proactive Approach

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The article focuses on Slovenia, which has seen one of the highest increases in immigration in the last few years among new EU member states. It argues that Slovene public institutions still seem unaware of the problem and do not place any value on community interpreting. The legislation regulating public service interpreting is confusing and unclear, revealing ignorance of the basic competences needed for working as an interpreter in the public sector. Two cases are profiled, showing that there is no network providing medical interpreting to medical personnel, leaving them without any support and forcing them to improvise. The article concludes with a plea for a proactive approach that would respond to the need and set up medical interpreting and public service interpreting in new member states.

By population, Slovenia is the fifth-smallest EU member state; with 0.4% of the total EU population it outranks only Estonia, Cyprus, Luxemburg and Malta. However, considering the percentage of migrants in its population, Slovenia leaves one third of the EU member states behind. In 2006 and 2007, Slovenia’s 2.7% of migrants may not have reached the high of 19% of migrant population in Latvia, but it did surpass the Czech Republic, Hungary, Lithuania, Slovakia, Bulgaria, Poland and Romania. Moreover, the trend is definitely upward: Slovenia’s 127% immigration increase from 2006 to 2007 was second only to the rates for the Czech Republic (141.8%) and Denmark (131.7%) (Vertot 2009:64-72).

Slovenia had experience with immigration even before joining the EU: from as early as the late 1970s, economic immigrants employed in the construction industry or as seasonal workers arrived from other Yugoslav republics; since 1992, when Slovenia became an independent state, the intensive immigration from former Yugoslav republics has continued. The statistical data thus show that in 2007 the majority of immigrants from non-EU states still came from the republics formerly belonging to Yugoslavia (85.4%), among these, most were from Bosnia and Herzegovina (45.4%), Serbia (including Kosovo) and the Former Yugoslav Republic of Macedonia (ibid.). Such immigrants usually do not represent a major linguistic
problem, since the majority of the Slovene population can speak or at least understand Serbian, Croatian and Bosnian (or better, Serbo-Croatian, which functioned as an unofficial lingua franca in the otherwise officially trilingual Socialist Republic of Yugoslavia). However, the Albanians from Kosovo, whose knowledge of Serbian is diminishing, and immigrants from other EU member states represent an increasing problem. In 2007, for example, already every third immigrant from other EU member states came from Bulgaria and every fifth immigrant from Slovakia (Vertot 2009:71) – that is, from linguistic groups that were traditionally not represented in Slovenia and might present a problem for Slovene speakers. Slovenia, like many other new member states, is thus a country that has had almost no experience with immigration that represented a linguistic challenge, but the dramatic change in the immigration flow and the new linguistic groups of immigrants now demand swift response.

The fact that Slovenia has long stopped being a country of emigration and has become a country of considerable multilingual immigration is not reflected in research or public awareness of the issue. Although interpreting for healthcare institutions is not only well organized but is also extensively studied in various pronoucedly multiethnic societies such as Australia (for further reference see Merlini and Favaron 2007/Ozolins 1998) or Canada (for further reference see Abrahma and Fiola 2006). It is also investigated in countries that represent a destination of intensive immigration such as the US (for further reference see Angelelli 2004/Angelelli 2007/Angelelli et al. 2007/Schweda Nicholson 1994), the UK (for further reference see Cambridge 2008), Germany (for further reference see Allaoui 2005/Bahadir 2000/2004/2008/Meyer 2004/Otero 2008), the Netherlands (for further reference see Bot 2007), Denmark (for further reference see

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1 The official languages in the Socialist Yugoslavia were Slovene, Serbo-Croatian and Macedonian. Slovene was the official language in the Republic of Slovenia, and Serbo-Croat was only one of the subjects taught for a year to ten-year olds in Slovene schools. However, the language used for commands in the Yugoslav military (in which every adult citizen of Yugoslavia was supposed to serve for a year), was only Serbo-Croat. It has been 18 years since the last Slovene served in the Yugoslav army, and so greater linguistic problems might be expected in contacts with Serbs, Croats and Bosniaks in the future.

2 Immigration from other countries is almost negligible: despite fairly high numbers of asylum seekers (e.g., in 2000 more than 9,000 asylum applications were recorded), from 1991 to 2007, the status of conventional refugee, refugee for humanitarian reasons and subsidiary protection was granted only 159 times altogether. Moreover, in the last few years Slovenia has some of the lowest refugee-recognition rates in Europe, with just one asylum seeker recognised as a refugee in 2006, and two in 2007.
Dubslaff and Martinsen 2007), Spain (for further reference see Gutierrez and Garcés 2008/Sanchez-Reyes et al. 2004/Valero Garcés 2007), and Switzerland (for further reference see Leanza 2007). The issue is also being extensively discussed in neighbouring countries such as Austria (for further reference see Grbić and Pöllabauer 2006/Pöchhacker and Kadric 1999/Pöllabauer and Prunč 2003) and Italy (for further reference see Amato 2007/Buri 2008); however, it is strangely almost completely ignored by the new member states, the only exception being Tryuk’s discussion of community interpreting in Poland (2007/2008), and Sauvêtre’s (2000) description of migratory flows in Central Europe. This lack of research reflects the fact that in many of the new member states there is no awareness of the need for healthcare interpreting and therefore also no organised healthcare interpreting service. The statistical data provided by Eurostat (cf. Vertot 2009:67) show that at least in the Czech Republic and Slovenia the dramatic increase in immigration flow does not allow passivity any longer.

An interview with the only fully employed interpreter at the only Slovene immigrant detention centre (Umek 2008) reveals that in the case of a medical emergency the in-house interpreter or other interpreters contracted by the Ministry of Internal Affairs accompany the asylum seeker to the hospital. Because these interpreters have not received any additional training in medical interpreting, it is interesting to examine the selection procedures for contracted interpreters. The legislative act regulating employment of interpreters in asylum procedures is the International Protection Act (IPA, Zakon o mednarodni zaščiti), which was written in accordance with various EU legislative acts and adopted in December 2007. A closer look at the third paragraph of Article 11, which defines the selection procedure for interpreters by the Ministry of Interior Affairs, is a telling example of the unawareness of the nature of public service interpreting work in Slovenia and it reveals a deep misunderstanding of community interpreting and the demands that community interpreters must meet in their work. The paragraph states:

(3) Za tolmača je lahko izbran, kdor izpolnjuje naslednje pogoje:
- je vreden zaupanja;
- je poslovno sposoben in ima splošno zdravstveno zmožnost;
- aktivno obvlada slovenski jezik;
- ima ustreza dokazila o pisnem in ustnem znanju jezika, za katerega tolmači;
- ima kot oseba, ki tolmači v svojem materinem jeziku, dokazila o uspešno zaključenem šolanju v tem jeziku;
- ima ustreza dokazila o dosedanjem opravljanju tolmačenja;

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(3) Persons can serve as interpreters if they:
- Are trustworthy;
- Are professionally competent and have general medical
  (interpreting) ability;
- Are fluent in Slovene;
- Have proper certification of written and spoken knowledge of the language for
  which they interpret;
- (as persons who interpret in their mother tongue) have certification of training
  in this language;
- Have proper certification of past interpreting experience;
- Can also provide interpreting services on Saturdays, Sundays,
  national holidays and other holidays;
- Can be available within two hours if there is a need for interpreting service;
- Can provide written translations in at least five days;
- Formally declare that they do not provide interpreting services for
  the embassy or consulate of the country whose language they interpret;
- Have no criminal record and are not involved in any criminal procedure for a
  crime being prosecuted ex officio that could be penalized with six months or more of
  incarceration.3

The bullet points marked in bold are the most problematic part of these provisions. For example, the proviso that interpreters can provide “proper certification of written and spoken knowledge of the language for which they interpret” is not clear: Does the phrase “language for which they interpret” mean “the language they interpret from” or “the language they interpret into”? The authors of the law probably meant both, but it remains unclear which certifications are meant and which level of knowledge of the language(s) is required.

The next bullet point states that candidates for interpreters should “(as persons who interpret in their mother tongue) have certification of training in this language”. Again, it is not clear here whether the law insists that interpreters be only Slovene native speakers who know some other foreign

3 Translation into English and emphasis are by the authors of this article.
language and native speakers of some other language who know Slovene, but not interpreters who can interpret from one foreign language into another (e.g., a Macedonian native speaker who can also interpret from Bulgarian into Slovene). The wording also does not make it explicit whether interpreters should provide certificates for training in their mother tongue or in their foreign languages.

The bullet point stating that interpreters should provide “proper certifications of past interpreting experience” discriminates against interpreters working with peripheral languages (see Linn 2006 for the distinction between peripheral and central languages). It is not difficult to provide a proof of interpreting experience with English, German, Italian, Spanish or French, but it is currently impossible to provide certificates for Roma or Turkish – and these are languages that will be needed in the asylum procedures.

The last bullet point, like all the previous ones, shows that the authors are not really familiar with interpreting or translation practice. It states that interpreters should be able to “provide written translations in at least five days” but does not define the number of pages or the direction of translation. Such an open obligation should never be imposed on any interpreter or translator.

This short example shows that legislation in Slovenia regarding public service interpreting is incoherent, unclear and written by people who are unfamiliar with interpreting work and are unaware of the competences needed for such work. It reflects the fact that there is very little public awareness of the necessity for such linguistic support. The inevitable result is that medical personnel who have to treat patients that do not understand or speak Slovene, Croatian, Serbian or Bosnian, or any of the central languages such as English, German, French or Italian, are left to fend for themselves without any support provided.

In 2006 a 14-year-old Romanian came to the outpatient clinic at the Department of Infectious Diseases, University Clinical Centre Ljubljana. He had a skin and lymph node infection and was accompanied by his family. The only languages he and other members of his family spoke were Romanian and Roma. The medical doctor treating the patient tried to use various languages such as English, German, French, Croatian, Slovene, but to no avail. Finally, they managed to establish some feeble communication in a combination of Italian and Latin.

Another example showing how communication between patients and medical doctors depends solely on the ingenuity of the medical personnel and their personal enthusiasm and dedication is shown in the following case.
On 17 December 2008, a 15-year old refugee from Afghanistan was admitted to the Department of Infectious Diseases, University Clinical Centre Ljubljana, due to a severe medical condition with high fever, enlarged lymph nodes and extreme wasting. He was accompanied by a female Slovene guardian, assigned to him by the detention centre, who spoke English with him and provided the medical personnel with some basic information on the personal history of the patient: his parents were killed in Afghanistan, in September 2008 he managed to escape to Europe following his four brothers, who have recently found asylum in Finland. His journey through Pakistan, Iran, Turkey and Greece lasted seven months, during which he acquired some basic English.

The diagnosis was tuberculosis of the lymph nodes and tuberculous meningitis. Immediate treatment with oral antituberculous drugs was introduced as well as parenteral rehydration and nutrition. However, from the very beginning the patient refused all medical procedures and refused to communicate with healthcare providers who tried to speak to him in English.

After a few days, during which the medical personnel had to struggle with him to take blood or administer a pill, his behaviour changed abruptly: he became apathetic, lost all motivation to live and expressed a desire to die. He completely refused to take prescribed medicine which might eventually endanger his life. The treating physician was convinced that the patient would need someone to explain the risks to him but was unable to communicate with him effectively. It would have been possible to sedate the patient and force treatment on him because he was minor, but the treating female physician decided to try other ways to motivate the patient.

Because no support is provided to medical doctors in such cases, the treating physician first called the guardian originally assigned to him by the detention centre, but the guardian was unable to persuade him to undergo the treatment. Then his brother in Finland was called to try to reason with him, but was not successful. A psychiatrist recommended mild antidepressants, which the treating physician was reluctant to administer. The treating physician thought that the patient’s resistance to treatment might be due to the fact that he was being treated by a female doctor, so a male Slovene doctor was asked to talk to him – again to no avail. The next step taken was to contact the Islamic representatives in Slovenia for help, but an urgent call from his non-English-speaking brother, interpreted into English by an official Finnish interpreter, reminded the medical personnel that he and his brother were Shiites, and that a Sunni cleric might not be welcomed. And because the Muslim community in Slovenia is Sunni, the help of the mufiti was declined.
In an almost hopeless situation, the treating physician contacted the Ministry of Defence because she knew that Slovenia has representatives at the NATO base in Afghanistan. The ministry allowed her to establish connection with the Afghan interpreter working for the Slovene mission. The interpreter, who by chance was a pharmacologist by profession, had a long telephone conversation with the patient in his native language – and was eventually able to change his mind. The patient started to take the prescribed medications and eat solid food. In the following days his mood picked up and his medical condition improved remarkably. This case ended well, but only because of some good fortune and the immense dedication and ingenuity of the medical doctors treating the patient.

To conclude, action is demanded by recent increases in immigration flows that have proven to be particularly dramatic not only in the traditional immigration EU countries but also in the majority of the new member states. The situation in Slovenia, a new EU member state with one of the highest increases in immigration in the last few years, shows that public institutions still seem to be unaware of this problem and do not place any value on community interpreting, including medical interpreting. The legislation regulating public service interpreting is confusing and unclear, revealing numerous misconceptions and ignorance of the basic competences needed for working as an interpreter in the public sector. The two cases profiled here also show that there is no network providing medical interpreting services to medical personnel, leaving them without any support and thus forcing them to improvise and fend for themselves. So far, no case has been documented in Slovenia in which malpractice could be charged due to a lack of interpreting in a medical setting, but one should not wait for something bad to happen before acting. Public institutions should be made aware that language barriers are not only a human rights issue, but should be considered from a risk-management perspective as well, because patients could sue for damages if interpreting is not provided, especially those from EU countries.

Let us therefore act before it is too late. The first step is for translation and interpreting training institutions in Slovenia and other new member states to start offering programmes aimed at training qualified public service interpreters and thus contribute towards heightened awareness among public institutions about the need to professionalize not only medical interpreting, but also public service interpreting in general.
References


