Interpreting in Emergency Services: Challenges for Face-to-Face and Telephonic Interpreters

Healthcare interpreters, both face-to-face (onsite) and telephonic, are presented with unique challenges as they interpret during Emergency Services encounters. These encounters may take place in the emergency department or trauma bay of a hospital, by phone in the field, on board an ambulance with an E.M.S. (Emergency Medical Services) worker, over the phone with a 9-1-1 dispatcher, or over the phone with a poison control center. This article is intended to give interpreters and managers of language service programs some insight into these challenges, and to present some possible suggestions and solutions for practical use. The challenges or difficulties faced by interpreters to be considered include the following:

- Positioning
- Multiple providers
- Critical time frame
- Flow of communication
- Excessive background noise
- Highly emotional nature of the encounter
- Personal protective equipment (PPE)
- Unique needs of family members
- Telephonic interpreting/equipment

**EMERGENCY ROOM (E.R.) / TRAUMA CENTER**

In the most common encounters, face-to-face/onsite interpreters (hospital staff interpreters, contractors, or agency interpreters), as well as telephonic interpreters, are called to the bedside as a Limited English Proficient (LEP) patient arrives in the E.R./Trauma Center. As the team assembles and the patient arrives, the interpreting encounter begins immediately. The first task of the emergency treating team is to find the mechanism of injury, such as motor vehicle crash, auto-pedestrian accident, or auto-bicycle accident. A trauma leader is generally assigned to supervise the assessment and subsequent treatment of injuries. The trauma leader may be a trauma surgeon, or another physician or staff member in the Emergency Department. Next, the primary survey is conducted by the trauma leader with the assistance of an interpreter. The primary survey consists of the following 5 factors using the letters A, B, C, D, and E:

1. Airway – is the airway intact?
2. Breathing – are lung functions normal?
3. Circulation – are pulses/heart rate normal?
4. Disability – are motor functions normal?
5. Exposure of injury – remove clothes/backboard to expose injuries

Also, the following basic questions may be asked:

1. What was the mechanism of injury/location/approximate time of injury?
2. Was a seat belt/helmet worn? Did the airbag deploy? Was the injury self-inflicted?
3. Are there any special needs (LEP, hearing, sight)?
4. Identification of the patient (name, date of birth, gender, weight, etc.)?
5. When was the last meal eaten?
6. Are there any allergies?
7. Is the patient taking medications currently?
8. What is the patient’s medical history?

As questions are asked, the interpreter may be interpreting for a patient, or for a family member if the patient is unconscious. As the trauma leader continues to ask questions, the recording nurse records the information in the patient’s chart. From the very beginning of the encounter, the interpreter must be sure to identify and make contact with the trauma leader and the recording nurse in order to manage the flow of communication.

Positioning
A common challenge for interpreters in the emergency room/trauma bay (as well as in some other clinical areas) is positioning. Where should the interpreter stand or sit for maximum efficiency? For the interpreter, proximity to the patient is critical for effective communication. Interpreters struggle with the “ideal” position nearest the head of the bed without obstructing others. However, other high-priority functions occur at the head of the bed (anesthesiology/intubation, respiratory therapy, insertion of chest tube/central line, medication administration, etc.).

Multiple Speakers and Fast Pace
The fact that multiple providers from multiple medical specialties are present may also cause difficulties for the interpreter (surgery, nursing, anesthesiology, respiratory therapy, radiology, chaplaincy, social work, EMS, police and others). Also, in extremely urgent cases, the trauma leader and other providers may begin the primary survey even before the interpreter arrives or before a telephonic interpreter is contacted, and critical background information may be lost to the interpreter. The fast pace of the trauma room may also affect communication, and the interpreter may be forced to modify his or her technique in some cases. As multiple providers work quickly to complete their assessments and interviews, the interpreter may be pulled in many directions at the same time. Providers may shout out questions simultaneously. Interpreters must strive to control the flow of communication, asking providers to speak one at a time, in consecutive mode whenever possible; however, critical, time-sensitive situations may force the interpreter to switch into simultaneous mode.

Background Noise
The nature of the E.R./trauma room itself also creates excessive background noise that may affect communication and/or distract the interpreter. These noise factors may be intensified by the following: multiple providers, loud volume of speech (e.g., shouting), equipment/monitors, pain/emotional state of the patient (e.g., crying, shouting), or adjacent family members/other patients.

Stress and Emotional State
The emotional nature of many E.R./Trauma Center encounters may affect the interpreter’s performance; near-death situations can drastically increase stress and anxiety. The following questions should be considered: Are the interpreter, patient, and/or family distraught? Are children involved? Are the physical injuries disturbing to view? Moreover, interpreters may be required to wear Personal Protective Equipment (PPEs) during a trauma (mask, face shield/goggles, gown, gloves, leaded apron (x-ray), etc.). The use of PPEs may also become a stressor for some interpreters and could affect performance. During and after E.R./Trauma Center encounters, family members may be faced with special needs that involve the interpreter: contacting friends/family by phone, contacting clergy or other religious support, conversations with law enforcement, conversations with chaplains and social workers, end-of-life/funeral arrangements, etc.

TELEPHONIC INTERPRETING CONSIDERATIONS
The use of telephones and telephonic interpreters can also create unique challenges. With the use of speakerphones, sound quality may be affected, so proximity of the phone equipment is crucial. Volume of speech in the trauma room must be maintained, and background noise becomes an even more critical factor. Telephonic interpreters also face challenges during 9-1-1 emergency calls with LEP patients. During extremely high-stress 9-1-1 calls, callers may not provide the information to the dispatcher in the order in which questions are asked. Telephone interpreters must triage what they hear and then provide the most
critical information to the dispatcher first. In more extreme cases, it may even be necessary to use summary interpretation when time is critical (outside the National Standards of Practice recommended by the NCIHC). A tone of voice that is appropriate for the emergency situation must be used. The interpreter should also report and interpret any background observations, sounds, or conversations that may be important to the dispatcher. Telephonic interpreters may also be used in the field with first responders (at accident scenes, at crime scenes, in the LEP patient’s home, or on board an ambulance), and cell phones/EMS radios may be used to connect with the interpreter. Similar to 9-1-1 calls, telephonic interpreters may also be used to communicate with LEP patients who call Poison Control Centers. Specialized terminology (household chemicals, poison plants, poisonous insects and reptiles, etc.) may be necessary in these cases.

TIPS FOR SUCCESS

In conclusion, here are some key factors for a successful interpreting encounter in Emergency Services:

- The interpreter should clearly identify himself or herself when entering the room/trauma bay.
- Identify the trauma leader – the interpreter must be sure to know who the trauma leader is.
- Identify the recording nurse – the interpreter must also be sure to know who the recording nurse is and establish a connection from the beginning of the encounter.
- Control the flow of communication among multiple providers, requesting one question at a time to the interpreter.
- Recognize that the most experienced interpreters will perform the most efficiently under stress.
- Understand that novice interpreters may need repetition and clarification, and that time may not allow for this.
- Investigate the development of additional interpreter training specific to Emergency Services.
- Educate the trauma team – let them know that things will work differently with an interpreter.

Interpreting for Emergency Services, whether onsite or over the phone, poses extra challenges. These unique encounters may also push interpreters to their emotional and professional limits. Striving to work within the National Standards of Practice and National Code of Ethics recommended by the NCIHC is always a must, but adapting to the changing dynamics of the situation is sometimes necessary. Giving special consideration to these challenges before and during emergency encounters can increase the number of positive health outcomes, reduce the risk of miscommunication, and help to manage the inherent stress for providers and interpreters alike.

REFERENCES


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