



International Journal of Human Rights in Healthcare

Medical translation: the neglected human right

Bradley Dalton-Oates,

Article information:

To cite this document:

Bradley Dalton-Oates, (2017) "Medical translation: the neglected human right", International Journal of Human Rights in Healthcare, Vol. 10 Issue: 4, pp.228-238, <https://doi.org/10.1108/IJHRH-01-2017-0004>

Permanent link to this document:

<https://doi.org/10.1108/IJHRH-01-2017-0004>

Downloaded on: 19 November 2017, At: 09:00 (PT)

References: this document contains references to 32 other documents.

To copy this document: permissions@emeraldinsight.com

The fulltext of this document has been downloaded 74 times since 2017*

Access to this document was granted through an Emerald subscription provided by emerald-srm:387340 []

For Authors

If you would like to write for this, or any other Emerald publication, then please use our Emerald for Authors service information about how to choose which publication to write for and submission guidelines are available for all. Please visit www.emeraldinsight.com/authors for more information.

About Emerald www.emeraldinsight.com

Emerald is a global publisher linking research and practice to the benefit of society. The company manages a portfolio of more than 290 journals and over 2,350 books and book series volumes, as well as providing an extensive range of online products and additional customer resources and services.

Emerald is both COUNTER 4 and TRANSFER compliant. The organization is a partner of the Committee on Publication Ethics (COPE) and also works with Portico and the LOCKSS initiative for digital archive preservation.

*Related content and download information correct at time of download.

Medical translation: the neglected human right

Bradley Dalton-Oates

Bradley Dalton-Oates is an Adjunct Professor at the Facoltà di Farmacia e Medicina, Università degli Studi di Roma La Sapienza, Rome, Italy.

Abstract

Purpose – The purpose of this paper is to highlight that the lack of a specific right to a medical translator under International Law can be considered an outlier when viewed within the context of the copious legislation regarding translation in general. Given the lack of specific legislation guaranteeing the right to a medical translator under International Law, the paper further aims to highlight the resulting effects on medical providers and patients.

Design/methodology/approach – The paper opted for a detailed historical legal analysis regarding the history of translation under International Law in general, as well as specific international, intranational, and regional legislation regarding the right to a translator in medical settings. The data were complemented by a thorough review of documentary analysis of existing scholarship, detailing the experiences of medical providers and patients.

Findings – The paper provides insights as to how international legislators have traditionally viewed medical translation: whether as a matter of international relations, access to care, discrimination, or as a fundamental part of the Right to Health. The paper finds that differing views on the subject have resulted in nations, regions, and medical providers having great discretion in deciding which patients are provided with a translator. The paper finds that such decisions are often made on a basis other than that of patient health.

Research limitations/implications – Because the provisioning of translators in medical settings currently inevitably falls to a nation or single institution, research into which patients receive a translator and why lacks generalizability (because empirical data are not available for every region of the world). Researchers in future are encouraged to further develop the empirical evidence found in their regions with a more quantitative approach, documenting the non-provisioning of translators in their areas and categorizing the motives behind the decisions of medical providers in a given area.

Practical implications – The paper includes implications for patients who have suffered adverse events after miscommunication (or lack of communication) with their medical providers. The paper aims to investigate in what venue may they seek legal remedy, and on what grounds. The paper also has implications for national and regional governments. Given the lack of binding International Law regarding medical translation, national and regional governments attempt to guarantee the provisioning of translators to some patients and not others. Such decisions may become political and have unintended consequences for medical providers and patients alike.

Social implications – The paper includes implications for international legislators and national legislators. The paper also includes implications for medical providers and patients, as language barriers are becoming a more common feature in medical facilities around the world due to globalization and migration. The rate of patients suffering adverse events after not being provided with a competent medical interpreter is bound to rise.

Originality/value – This paper fulfills a need to examine medical translation in the context of other types of translation under International Law. This paper fulfills a need to study how the lack of specific International Legislation guaranteeing the right to medical translation has implications for national/regional legislators, medical providers, and patients alike. This paper fulfills a need to discuss the legal remedies available to patients who have suffered adverse medical events after not being able to communicate with their medical provider.

Keywords International law, Human rights, Migration, Public health, Patient safety, Language barrier, Medical translation, Translator

Paper type General review

Introduction: the Right to Health

Language barriers between patients and medical professionals are becoming an increasing feature of many healthcare systems around the world (Meeuwesen *et al.*, 2011; Quan and Lynch, 2010). Many communities are facing a growing number of immigrants in hospitals and clinics, and the issue

Received 30 January 2017
Revised 17 February 2017
20 April 2017
Accepted 29 April 2017

extends to ethnic minorities who speak other languages. Hearing-impaired and visually impaired citizens also commonly face language barriers. Healthcare professionals themselves are ever more likely to practice far from their home communities, which often implies that they have to communicate in another language. Those circumstances may result in a barrier to accessing care, medical error, or an outright denial of care for a patient: as such, the right to a translator in healthcare settings would seem to be given under International Law. Furthermore, the denial of proper translation has proven to lead to denial of preventative care, maiming, and even death (Price-Wise, 1998; Kelly, 2010).

Both the 1948 Universal Declaration of Human Rights (UDHR, art. 25)[1] and the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR, art.12 (2)(b,d)[2] specifically mention the Right to Health. The 1946 Constitution of the World Health Organization[3] preamble outlines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

The UDHR guarantees “medical care and necessary social services” as a human right, whereas the ICESCR goes further by guaranteeing “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” which includes “the creation of conditions which would assure to all medical service and medical attention in the event of sickness.” The United Nations’ Office of the High Commissioner for Human Rights further commented on the issue of access to care in 2000[4], outlining four distinct dimensions of accessibility: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility. To quote the attorney Natalie Huls (2004) (US Occupational Safety and Health Review Commission): “Most international human rights law tends to overlook access to health because the right to health indirectly addresses how that right is to be fulfilled. The right to health states that everyone should have access to health, but does not address the specific issues of access, guarantees to access, and does not explain what access entails.”

The result is that a wronged patient seeking redress may feel that article 25 of the UDHR or article 12 of the ICESCR may not be the most practical grounds with which to bring suit before an international court, and decide to “forum shop” by appealing to other international bodies (e.g. The European Court of Human Rights), “grounds shop” (by filing using a legal basis other than the Right to Health), or simply file a case nationally.

In the year 2000, The Office of the High Commissioner for Human Rights published General Comment number 14, which sought to clarify what the Right to Health entails. The (non-binding) General Comment notes that the Right to Health includes both freedoms and entitlements, including “the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health,” and of the statement that “the highest attainable standard of health” in article 12.1 takes into account both the individual’s biological and socio-economic preconditions and a State’s available resources.” It also stresses the importance of accessibility, which should encompass non-discrimination (“health facilities, goods, and services must be accessible to all, especially the most vulnerable or marginalized sections of the population”), and information accessibility (“accessibility includes the right to seek, receive, and impart information and ideas concerning health issues). Perhaps most importantly, General Comment 14 outlines that “States parties have immediate obligations in relation to the right to health, such as the guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and the obligation to take steps (art. 2.1) toward the full realization of article 12. Such steps must be deliberate, concrete, and targeted toward the full realization of the right to health.” It also notes that States should move toward “progressive realization,” that “retrogressive measures taken are not permissible,” and that the State “has the burden of proving that [retrogressive measures] have been introduced after most careful consideration of all alternatives [...] in the context of the full use of the State party’s maximum available resources.” Most importantly, article 14 highlights deliberate action of the state: “Violations of the obligation to respect are those State actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality [...].” It notes that “In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12.” Suffice it to say that the Right to Health should create a Positive Obligation on the part of the State, as it is a supreme Human Right.

A rich history of the right to translation under International Law

To a casual reader it may not seem odd that language, translators, and translation as regards the Right to Health were not specifically envisioned by the drafters of the ICESCR in 1966, or the Office of the High Commissioner in 2000. This is surprising, however, given the emphasis on language and translation in other spheres of legislation. In fact, the lack of an explicit article guaranteeing the right to a translator in medical environments may be seen as an outlier in the field of Human Rights, for translation enjoys a long history under International Law.

Translation in an international context is probably most widely associated with the Nuremberg trials of 1945-1949. Headphone-clad translators proved vital in the criminal proceedings. In modern times, denial of a translator in a legal context (either nationally or internationally) is often enough grounds for appeal. The right to an interpreter for criminal defendants is guaranteed by Article 14(3)(f) of the International Covenant on Civil and Political Rights[5], Article 6(3)(e) of the European Convention for the Protection of Human Rights and Fundamental Freedoms[6], and Article 8(2)(a) of the American Convention on Human Rights[7]. Furthermore, guidelines have been issued specifying the particulars of who is to be guaranteed a translator, when, and by whom. In 2013, The UN published the United Nations Principles and Guidelines on Access to Legal Aid in Criminal Justice Systems, which notes that the “interests of justice” require a “fair and public hearing,” and as such guarantees that anyone “detained, arrested, suspected or accused of, or charged with a criminal offence be guaranteed certain rights by States.” Guideline 3 (43- (c) and (f)) ensures that “States should introduce measures [...] To inform all foreign detainees and prisoners in a language they understand of their right to request contact with their consular authorities without delay [...] [...] To provide the services of an independent interpreter, whenever necessary, and the translation of documents where appropriate[...] [8].” Marginalized groups are guaranteed additional rights to match their specific needs in Guideline 2, 42(a). The European Union has drafted even more exacting guidelines for translation in a legal context. The Directive 2010/64/EU of the European Parliament and of the Council on the Right to Interpretation and Translation in Criminal Proceedings[9] specifically addresses translation, and created a “Roadmap for strengthening procedural rights of suspected or accused persons,” which outlined five measures for implementation. Measure A involves the right to translation and interpretation. The “common minimum rules to be applied in the fields of interpretation and translation” include that Member States gauge whether an individual comprehends the language used in court (item 21), that the quality of interpretation is the responsibility of the Member State (item 24), that a Member States replace a sub-adequate interpreter when necessary (item 26), that “certain documents” should always be translated (item 30), and that Member States should “facilitate access to national databases of legal translators and interpreters” (item 31). Furthermore, the Directive establishes that translators be provided at all phases of criminal proceedings during police interrogations, court hearings, and interim hearings (article 1), and that people with hearing or speech impediments have “appropriate assistance” (article 3). Member States are expected to cover the costs of translation, and ensure its quality (articles 4 and 5). To this end, “Member States shall endeavor to establish a register [...] of independent translators and interpreters who are appropriately qualified.” Local authorities are also required to train as to how to communicate with people with the assistance of an interpreter (article 6). The aforementioned features of International Law that have been introduced as regards legal translation would be welcome additions in healthcare settings as regards medical translation, but do not currently exist.

The evidence above does not exhaust all the references to translators and interpreters under International Law, however. Both article 32 of The Hague Conventions of 1899[10] and article 32 of The Hague Conventions of 1907[11] guarantee the presence of an interpreter when declaring a truce among combatants. More recently, article 9 of the 2006 Convention on the Rights of Persons with Disabilities[12] requires that States provide access to interpreters to disabled persons, specifically mentions medical facilities, and is very precise in its definition of the kind of interpreting services (“guides, readers, and professional sign-language interpreters”) that are to be provided.

While international legislation specifically addressing oral translators and interpreters has thus far been discussed, it is important to note that the CRPD (article 2) also makes strides in defining the

term “language” with great specificity (including repeated mention of Braille for those with visual impairment). CRPD not only discusses language inasmuch as it involves access, but also discusses the issues of culture and linguistic identity (Articles 24.3(b), 24.4 and 30.4). In reality, the provisioning of translators in medical settings can often be viewed through the lens of both culture and linguistic identity (as discussed in the following), but it is important to first to pause and make a distinction between legal translation and medical translation in the kinds of legislation reviewed above.

The key distinction is that although it has been established that translation and translators have enjoyed a long history under International Law in various contexts, there is a difference between the relationship between a State and another State (i.e. legal translation), and a State and the individual (i.e. medical translation). A translator accompanying a flag of truce after defeat in a battle will serve as an intermediary between a State and another State. This is also the situation for translators used in the police and legal proceedings previously discussed. The English criminal defendant, for example, who does not receive an English-speaking translator in another country while being the subject of criminal proceedings may seek some level of protection from the British Government. There is thus an interest to be served between a State and another State in guaranteeing the provisioning of translators in legal settings: this is more or less explicitly stated in the wording of some of the legislation itself. The Directive 2010/64/EU of the European Parliament and of the Council on the Right to Interpretation and Translation in Criminal Proceedings states that “The implementation of the principle of mutual recognition of decisions in criminal matters presupposes that Member States have trust in each other’s criminal justice systems.” In this seven-page document the words mutual recognition are mentioned nine times, trust (between Member States) seven times, but individual rights are mentioned only twice. Herein lies the very prickly issue for the international legislator: it is one thing to “strengthen cooperation between Member States,” and quite another to issue prescriptive and binding rules as to the necessary behavior between a State and an individual.

In contrast, the relationship between a given State and an individual in healthcare settings involves a series of actors with sometimes complicated incentives and motivations. Without greater specificity or binding guidelines under International Law regarding medical translation, just who decides whether a patient in need of a medical translator receives quality medical translation? This decision can be affected by any number of entities, including the State, region, medical facility itself, medical staff within the facility, budgeting factors, and/or translators themselves.

Dynamics affecting the provisioning of translators: language discrimination vs language bias

Linguistic discrimination

Many countries have national histories of promoting official national languages and suppressing others. Linguistic discrimination can be either “positive” or “negative.” For many years Turkish was officially promoted by the State as the *lingua franca* of public administration. The Centre for Social Policy and Intervention Studies noted that effective communication between healthcare staff and the Kurdish community in the East and South East of the country was nearly nonexistent. In a report published in 2011, they noted: “Signs on the walls of clinics and hospitals instructed citizens to ‘speak Turkish’ and, at the peak of the armed conflict in the East between the Turkish army and the separatist PKK, health-workers were punished for nonetheless trying to communicate with their patients using Kurdish” (Meeuwesen *et al.*, 2011). However, linguistic discrimination does not necessarily mean suppressing the use of a language. In 1987, Norway implemented laws protecting the rights of an indigenous group, the Sami. Kale and Syed (2010) highlight the fact that “The Sami and Norwegian languages are equals, and the Sami people have an extended right to use their language in healthcare and social service sectors.”

The promotion or restriction of certain languages is institutional by nature. Perhaps the most researched cases in healthcare translation involve hearing-impaired communities. It has become more and more common for countries to enact legislation guaranteeing rights of signed-language translators in public administration to the hearing-impaired. Swabey and Nicodemus (2011) have discussed the history of translation in healthcare environments for American citizens,

citing the landmark legislation of 1990, The Americans with Disabilities Act, which guaranteed hearing-impaired Americans the right to a translator. Reeves *et al.* (2002) note that similar rights were guaranteed to British citizens under the 1996 Disability Discrimination Act. It is important to highlight that in these cases national legislation has come before international legislation, with The United Nations Convention on the Rights of Persons with Disabilities being only adopted in 2006. However, while national legislation has been binding in the UK and USA for two decades, International Law has lagged behind: The United Nations Convention is a non-binding Optional Protocol pending ratification.

Not all language barriers in medical settings start with a patient being unable to speak the official language used in a hospital or clinic. In 2008, a German doctor, Dr Daniel Ubani, caused the death of the patient David Grey on his first shift in a British hospital (House of Commons Health Committee, 2010). The error was judged to be gross negligence on the part of Dr Ubani, and prompted the coroner involved in the case, Dr William Morris, to issue a list of 11 recommendations to the British Department of Health (Meikle and Campbell, 2010). Morris recommended, *inter alia*, that doctors' language skills be verified with Britain's National Health Service. Dr Ubani had originally applied to practice medicine in the city of Leeds. Upon being informed by Leeds PCT that his application would be unsuccessful due to his very low IELTS test scores, Ubani withdrew his application and immediately reapplied in a different region in the UK that only vetted the language skills of doctors coming from non-EU nations (Gammell, 2010). After David Grey's death, Ubani returned to Germany and continued to practice, while Grey's family filed a case with the European Court of Human Rights seeking to extradite Ubani back to the UK. The family's request was rejected by the court, and Ubani was ultimately prosecuted in Germany (Connolly and Meikle, 2009).

An outcry on the part of the British public on authorities caused the General Medical Council to require an English language proficiency test for all foreign physicians including those from The European Union, which necessitated a change in The European Union's freedom of movement rules. All regions in the UK now have uniform language standards for physicians. Several foreign physicians already practicing in the UK have had their licenses revoked after MPTS hearings, some with IELTS scores as low as 4.5/9 (Meikle and Campbell, 2015). As of November 2015, over half of the doctors seeking employment in the UK (900) could not attain a license, as they could not prove their language skills. In 2014, a third of physicians licensed in the UK had done the bulk of their medical training outside the UK, and 10 percent of the physicians working in the UK had qualified in countries within the EU.

The conclusion is that linguistic discrimination is an institutional policy that removes the element of discretion on the part of the medical provider as to whether or not a medical translator must be provided for patients. Both national and regional entities have sought to protect languages over the years. Another notable example is Wales, which passed The Welsh Language Act in 1993, and the Welsh Language Measure in 2011 (Vacca, 2011) encouraging medical staff to ask if a patient's first language is Welsh, and what language they would prefer to speak in during medical consults. In 1986, the province of Ontario, Canada, passed the French Language Services Act promoting the French language in public administration (Hagan *et al.*, 2013).

In principle, it may seem beneficial to leave language legislation to a national or regional authority. Empirically speaking, as there is no binding International Law explicitly covering the right of a patient to a translator (or to translation) in medical settings in force, medical translation might be seen not as a Human Right but perhaps a Civil Right to be dealt with on a national level. Sadly, medical translation cannot be considered a Civil Right either, and leaving it to national legislators is problematic. The issue is that while the State may be incentivized to promote legislation protecting its citizens, it cannot assume that citizenship or nationality is equivalent to language. Thus by promoting the use of one language or other, a nation can only hope to aid subgroups of citizens speaking the promoted language. Because language is related to culture, which groups are left protected or vulnerable can become a charged one for national legislators (and budgets). From the perspective of a patient, the need of a medical translator has the effect of shifting essentially a medical issue (the need of a patient to communicate clearly with their physician) into a political issue (whether the language the patient speaks is part of the "in group" of protected languages). The outcomes may be quite arbitrary. In practice, the Norwegian

Government might provide a medical translator to a member of the Sami community (and Norwegian citizen), whereas the Turkish government may choose not to provide a translator to a member of the Kurdish community (and Turkish citizen). An English-speaking American or Canadian citizen would be benefitted by the UK's language requirements for foreign doctors practicing in the UK. In this way whether patients-in-need receive care in their language is a matter of luck. Patients needing a medical translator due to their language not being expressly sanctioned under national law thus fall into a gray category, and a number of other factors will dictate whether they receive a translator. This leads to the phenomenon of language bias.

Language bias

If there is no State or regional policy regarding the patient's language, the decision to provide a translator will be under the discretion of someone, often a member of medical staff. Language bias is a result of multiple factors determining whether a medical professional seeks out a translator. Nationality has long been contemplated to be a possible source of bias between medical provider and patient. The Third Geneva Convention of 1949 specifically stipulates that it is preferable that members of one nationality be treated by medical staff of their same nationality in POW camps. Whether or not a doctor or nurse shows an overt bias toward treating a member of their own nationality in a more favorable way, many cases have illustrated that medical staff are often unable to deal with the complexities that language barriers present. A study published by the School of Public Health at the University of California at Berkeley noted that medical staff often incorrectly conflate a patient's ethnicity with the language they speak (Quan and Lynch, 2010). Medical providers who have learned another language at school may prefer to communicate directly with their patient and "get by" with their own limited ability, even when the resources of the medical facility would permit hiring a medical translator. This was judged to be a factor in the death of eight-year-old Victoria Climbié in 2000 as a result of extreme child abuse and torture while under the care of her guardian. Climbié had only been in the UK a year, and her native language was French. Yet she was never provided with a professional translator, with the physician opting to speak with Climbié's guardian using the physician's own limited French. In a 2003 inquiry, when the physician was asked if she would be able to capture linguistic nuances "speaking English to a woman whose mother tongue was French," the physician replied that "sometimes when [...] I did not know the words, I would use the English things to try and see if there was something equivalent" (Laming, 2003). Strangely, however, it seems that physicians may opt not to use an interpreter even when the patient has requested an interpreter and the interpreter is already present on-site (Brueck *et al.*). Brueck analyzed 142 medical assignments searching for "person-related factors that were perceived as either beneficial or detrimental to the interpreting situation." The sign-language interpreters categorized their interactions with physicians as "positive," "negative," or "neutral." A total of 22 of the cases studied were ranked as negative (15 percent). In 15 of the 22 cases, interpreters commented that doctors' attitudes made the difference. In one case, an interpreter was told that the treating ophthalmologist did "not need an interpreting service. So far it's always gone pretty well. [...] She can lip-read perfectly. Are you family?" As the consultation progressed, the interpreter noted that the patient did not, in fact, understand communication given to the patient: "[The doctor] draws close to the patient's face and speaks in telegraphic style. The patient does not understand at all and looks at me. I interpret. The ophthalmologist looks at me, copies me, and seems to be proud. He stops speaking and uses only gestures to communicate." In another case, an interpreter was mocked about there being too many people in the room: "Oh, I have two Ms. Millers here, do I?" The interpreters also noted that they were not "under the impression that negative experiences were caused by a lack of [the doctors'] confidence in their abilities," but instead noting time pressure, institutional pressure, lack of empathy, lack of experience with translators, moody/willful behavior, and whether the doctor had had contact previously with the patient as contributing factors that led to negative interactions.

Doctors who would prefer to use an interpreter may face other hurdles which effect the eventual procurement of a translator. Sometimes their choice will depend on whether they have an available interpreting service, and who would pay for such a service. The Centre for Social Policy and Intervention Studies provided an outline of the *de facto* situation as it currently exists in five countries (Meeuwesen *et al.*, 2011). They noted that Germany has no official policy regarding

healthcare interpreting, and that physicians must rely on NGOs to provide them. The UK is listed as guaranteeing “no formal right” to interpreters with “statutory and NGOs in health service” filling the gap. Patients in both Italy and the Netherlands have a formal right to an interpreter, but in Italy the administration of this service falls under the purview of municipalities (meaning there is “poor use” of the interpreting service, “where it is active”), whereas in the Netherlands there is a service called TVcN that is free and paid for by the government (meaning that “professional interpreters are used”). As these examples illustrate, there is very often a difference between official policy and daily practice in medical facilities around the world.

According to a study by the School of Applied Language and Intercultural Studies at Dublin City University, the provisioning of medical interpreters to patients can become a political issue (Phelan, 2012). Local voters and taxpayers often have less than positive sentiments about migrants, and even countries that have traditionally been friendly to migrants can balk at the high costs associated with providing translation services. When national budgets find it difficult to pay for basic medical services for citizens, services to refugees and migrants are often cut. As the Dublin City study found, “In 2011 the Danish government announced that from June it would no longer cover the costs for medical interpreters for patients who had been living in Denmark for more than seven years. The Dutch Ministry of Health followed with an even more draconian approach; from 1 January 2012, the cost of translation and interpreting would no longer be covered by the state. These two announcements led to widespread concern about whether or not there is a legal foundation for interpreter provision in healthcare” (Phelan, 2012).

The practical implications for patients and healthcare systems

Just what happens when patients do not receive quality language translation in healthcare settings is a subject with wide-ranging ramifications. It is already known that a language barrier alone may cause residents of a given community to delay seeking preventative care: this has been the case with immigrant communities for some time (Woloshin *et al.*, 1997; Scheppers, 2006). Immigrant communities in some places have seen funding for medical translators for their language eliminated following cuts in healthcare budgets in general in their communities. Many cities that face an influx of migrants, economic migrants, and refugees are especially affected because unlike more stable immigrant communities, these patient populations are more mobile and present unique challenges for medical staff.

In the future, this may be an issue of epic proportions for researchers. In some metropolitan cities, it is estimated that 8-30 percent of the local community does not speak the language most commonly spoken by medical staff in the region (Kale and Syed, 2010; Meeuwesen *et al.*, 2011). In the USA, a study conducted by the University of California at Berkeley identified 35 legal cases filed in the State of California from 2005 to 2008 in which language barriers “may have resulted in harm to the patient” (Quan and Lynch, 2010). The cumulative total paid out in damages was approximately \$2.3 million, with an additional \$2.8 million in legal fees. In the USA, medical error at large (meaning medical error in general, not only owing to language barriers) has been recently estimated to be the third leading cause of patient death, and there have been calls for better reporting of such cases (Makary and Daniel, 2016). Some estimates have put the number of deaths in the USA due to medical error generally at 44,000-98,000 yearly (Kohn *et al.*, 2011).

There are many documented cases of patients who have suffered adverse, irreversible health effects due to the lack of a qualified interpreter in hospitals and clinics around the world. This may be due to poor translation when an unqualified interpreter is provided. This has sometimes been the case when patients’ family members are used as *ad hoc* translators, including minor-aged children (Meeuwesen *et al.*, 2010, 2011; Downing and Roat, 2002; Russell, 2015; Kale and Syed, 2010). There have also been cases of providers using bilingual non-medical hospital staff to translate on an *ad hoc* basis. Many “professional” translation services contracted by medical facilities do not have any kind of certification process for medical translators: there have even been reports of security guards and cleaners moonlighting as medical translators (Hagan *et al.*, 2013). As reviewed above, often patients in need of translators are given no translator at all. The cases of adverse patient events resulting from poor medical translation or no translation at all are truly disturbing.

What legal remedy might a wronged party seek after suffering an adverse event? From a patient's perspective (or that of their surviving family members), the legal remedy sought after might vary greatly depending on what "subgroup" the person belongs to. Without an explicit right to a medical interpreter outlined under International Law, an injured party faces a queer and often perverse path to justice. Wronged patients in countries with privatized systems of healthcare might find it advantageous to sue their medical provider on the grounds of malpractice; however, frequently these cases do not reach the criminal legal system and become an issue for an insurer to deal with (either the medical facility's insurer or the individual physician's; Quan and Lynch, 2010). Similarly, patients who suffer adverse health effects due to the lack of written translation in medical packaging (e.g. visually impaired patients who were not provided instructions in Braille, patients who received leaflets that were not in their mother tongue, or patients who were not given leaflets in plain language) may file suit against a private entity such as a pharmaceutical company (Ved, 2010).

Patients who suffered a negative health outcome in the country in which they reside and are citizens face fewer hurdles in seeking legal recourse, provided their language (or right to a translator more generally) is also protected under national law (as is the case in countries that provide rights to hearing-impaired patients). However, even in these cases the way to proceed is sometimes unclear. In the case of *Szjjarto v Hungary*, a Hungarian Roma woman underwent a procedure for a miscarriage (Women's UN Report Network, 2006). She was asked to sign a consent form on the operating table authorizing a tubal ligation, but did not understand the technical word for sterilization. Only after the procedure did Szjjarto understand that she would not be able to conceive children in future. She filed a case in the Town Court of Fehérgyarmat, which did not rule in her favor, and eventually appealed in Szabolcs-Szatmár-Bereg County Court. Neither case was decided in her favor. Instead of pursuing a claim in an international venue on the legal basis of the Right to Health under Article 12 of ICESCR, however, she filed a claim against Hungary internationally, accusing it of being in violation of Articles 10(h), 12 and 16(1)(e) of the Convention on the Elimination of All Forms of Discrimination against Women (the case was adjudicated by the CEDAW Committee). The CEDAW Committee ruled in her favor. In this way Szjjarto's case turned a medical issue into a gender issue.

The case of *Vo v France* presents similar issues. Mrs Vo was a French national of Vietnamese origin who did not speak French. She was in her sixth month of pregnancy when she attended the doctor for a routine check. Sadly, hospital staff confused her for a different patient with a similar name, and Mrs Vo underwent an unnecessary medical procedure that resulted in the death of her fetus. In French courts, Mrs Vo sought to have the doctor charged with, *inter alia*, unintentional homicide. Eventually she filed a case in the European Court of Human Rights, using not the legal grounds of the Right to Health, but of Article 2 of the European Convention on Human Rights. The case centered less on the damage done to Mrs Vo herself, but sought to resolve whether the unborn fetus was subject to the right to life under Article 2 of the ECHR (Plomer, 2005). Furthermore, it has been suggested that involuntary sterilization should be considered tantamount to torture (Sifris, 2010), which refocuses the matter from one of health to something rather different: a women's rights issue, a reproduction issue, or a torture issue.

This is a dangerous precedent to set. Certainly a male patient who suffered irreversible damage during a medical procedure due to miscommunication with his physician would be no less deserving of a legal remedy. Perhaps the more relevant question is whether persons who have suffered an unwanted or unnecessary medical procedure after not being able to communicate with medical personnel should consider torture as a legal basis for filing claims in international venues, given that the Right to Health as it currently stands lacks specificity.

Conclusion

Notwithstanding the long history of translation under International Law, no explicit right to medical translation is currently expressly guaranteed as regards the Right to Health. What was once simply a void may become a vacuum as language barriers between medical staff

and patients become an ever more common reality in medical facilities around the world. International legislators may balk at issuing prescriptive rules as to how States manage their patient pools and public health systems; however, the real-world effects of not having clear legislation are likely to increase. Lacking the specific guidance that international legislation would provide, from a provider's perspective, the provisioning of translators may involve factors other than those purely of the patient's health. The lack of guidance may also mean that patients who suffer adverse events after not being able to communicate with medical staff are incentivized to not file claims in international venues, or to file on grounds other than the Right to Health. It is thus that a patient's Right to Health can only continue to be conflated with any number of other issues, which may not continue to be tenable given current global realities.

Notes

1. www.un.org/en/universal-declaration-human-rights/
2. www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx
3. www.who.int/about/mission/en/
4. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), 2000, www.ohchr.org/Documents/Issues/Women/WRGS/Health/GC14.pdf
5. www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx
6. www.echr.coe.int/Documents/Convention_ENG.pdf
7. www.oas.org/en/iachr/mandate/basic_documents.asp
8. www.unodc.org/documents/justice-and-prison-reform/UN_principles_and_guidelines_on_access_to_legal_aid.pdf
9. <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2010:280:0001:0007:en:PDF>
10. http://avalon.law.yale.edu/19th_century/hague02.asp
11. http://avalon.law.yale.edu/20th_century/hague04.asp
12. www.un.org/disabilities/documents/convention/convoptprot-e.pdf

References

- Connoly, K. and Meikle, J. (2009), "UK Fury as Germany prosecutes Daniel Ubani, GP who gave fatal dose", *The Guardian*, available at: www.theguardian.com/society/2009/dec/14/uk-germany-doctor-ubani-row (accessed November 14, 2016).
- Downing, B. and Roat, C. (2002), "Models for the provision of language access in health care settings", National Council on Interpreting in Health Care and Hablamos Juntos, CA, pp. 1-23, available at: www.pacificinterpreters.com/docs/resources/ncihc-working-paper-models-for-provision-of-language-access.pdf
- Gammell, C. (2010), "German doctor who killed patient avoided English test", *The Telegraph*, available at: www.telegraph.co.uk/news/health/news/7045267/German-doctor-who-killed-patient-avoided-English-test.html (accessed October 10, 2016).
- Hagan, S., Swartz, L., Kilian, S., Chiliza, B., Bisogno, P. and Joska, J. (2013), "The accuracy of interpreting key psychiatric terms by ad hoc interpreters at a South African psychiatric hospital", *African Journal of Psychiatry*, November 2, Vol. 16 No. 6, pp. 424-29, doi: 10.4314/ajpsy.v16i6.54.
- House of Commons Health Committee (2010), "The use of overseas doctors in providing out-of-hours services", available at: www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/441/441.pdf (accessed November 12, 2016).
- Huls, N. (2004), "Review digest: human rights and healthcare", Graduate School of International Studies, University of Denver, CO, p. 20, available at: www.du.edu/korbel/hrhw/researchdigest/health/health.pdf
- Kale, E. and Syed, H.R. (2010), "Language barriers and the use of interpreters in the public health services. A questionnaire-based survey", *Patient Education and Counseling*, Vol. 81 No. 2, pp. 187-91, doi: 10.1016/j.pec.2010.05.002.

Kelly, N. (2010), "The value of a single word", *The BMJ Blogs*, available at: <http://blogs.bmj.com/bmj/2010/09/15/nataly-kelly-the-value-of-a-single-word/> (accessed September 21, 2016).

Laming, H. (2003), "The Victoria Climbié inquiry", available at: <http://dera.ioe.ac.uk/6086/2/climbiereport.pdf>

Makary, M.A. and Daniel, M. (2016), "Medical error – the third leading cause of death in the US", *The British Medical Journal*, Vol. 353, p. i2139, doi: 10.1136/bmj.i2139.

Meeuwesen, L., Twilt, S. and Ani, E. (2011), *If You Don't Understand what I Mean: Interpreting in Health and Social Care*, Centre for Social Policy and Intervention Studies, Utrecht.

Meeuwesen, L., Twilt, S., ten Thije, J.D. and Harmsen, H. (2010), "'Ne Diyor?' (what does she say?): informal interpreting in general practice", *Patient Education and Counseling*, Vol. 81 No. 2, pp. 198-203, doi: 10.1016/j.pec.2009.10.005.

Meikle, J. and Campbell, D. (2010), "Doctor Daniel Ubani unlawfully killed overdose patient", *The Guardian*, available at: www.theguardian.com/society/2010/feb/04/doctor-daniel-ubani-unlawfully-killed-patient (accessed December 11, 2016).

Meikle, J. and Campbell, D. (2015), "GMC calls for tougher powers to check European doctors' skills", *The Guardian*, available at: www.theguardian.com/society/2015/nov/17/gmc-calls-tougher-powers-check-european-doctors-skills (accessed December 11, 2016).

Phelan, M. (2012), "Medical interpreting and the law in the European Union", *European Journal of Health Law*, Vol. 19 No. 4, pp. 333-53, doi: 10.1163/157180912X650681.

Plomer, A. (2005), "A foetal right to life? The case of *Vo v France*", *Human Rights Law Review*, Vol. 5 No. 2, pp. 311-38, doi: 10.1093/hrlr/ngi017.

Quan, K. and Lynch, J. (2010), *The High Costs of Language Barriers in Medical Malpractice*, School of Public Health, University of California Berkeley, Berkeley, CA, available at: www.pacificinterpreters.com/docs/resources/high-costs-of-language-barriers-in-malpractice_nhhelp.pdf

Reeves, D., Kokoruwe, B., Dobbins, J. and Newton, V. (2002), "Access to primary care and accident & emergency services for deaf people in the North West", a report for the NHS Executive North West Research and Development Directorate, Manchester, pp. 69-110.

Russell, B.R. (2015), "Using children as informal interpreters in pediatric consultations", *International Journal of Human Rights in Healthcare*, Vol. 8 No. 3, pp. 132-43, doi: 10.1108/IJHRH-07-2013-0009.

Scheppers, E. (2006), "Potential barriers to the use of health services among ethnic minorities: a review", *Family Practice*, Vol. 23 No. 3, pp. 325-48, doi: 10.1093/fampra/cmi113.

Sifris, R. (2010), "Conceptualising involuntary sterilisation as severe pain or suffering for the purposes of torture discourse", *Netherlands Quarterly of Human Rights*, Vol. 28 No. 4, pp. 523-47.

Swabey, L. and Nicodemus, B. (2011), "Bimodal bilingual interpreting in the US healthcare system", *Advances in Interpreting Research: Inquiry in Action*, Vol. 99 No. 1, pp. 241-57.

Ved, J.K. (2010), "Package inserts in India: need for a revision", *International Journal of Pharma Sciences and Research*, Vol. 1 No. 11, pp. 454-6.

Woloshin, S., Schwartz, L.M., Katz, S.J. and Gilbert Welch, H. (1997), "Is language a barrier to the use of preventive services?", *Journal of General Internal Medicine*, Vol. 12 No. 8, pp. 472-7, doi: 10.1046/j.1525-1497.1997.00085.x.

Women's UN Report Network (2006), *Hungary – Roma Woman Sterilization Case – CEDAW*, WUNRN, Geneva, available at: www.wunrn.com/2006/11/hungary-roma-woman-sterilization-case-cedaw/

Further reading

Dingfelder Stone, J. (2012), "Assessing the Existence of the Right to Translation under the International Covenant on Civil and Political Rights", in von Bogdandy, A. and Wolfrum, R. (Eds), *Max Planck Yearbook of United Nations Law 2012*, Vol. 16, Martinus Nijhoff, pp. 159-81, available at: www.mpil.de/files/pdf4/mpunyb_04_Dingfelder_Stone_161.pdf

Kohn, L.T., Corrigan, J. and Donaldson, M.S. (2000), *To Err is Human: Building a Safer Health System*, National Academy Press, Washington, DC.

Nicodemus, B. and Metzger, M. (Eds) (2014), *Investigations in Healthcare Interpreting. Studies in Interpretation*, Vol. 12, Gallaudet University Press, Washington, DC.

Paul, C. and Thomas, J. (2010), "Safer out of hours primary care", *The British Medical Journal*, Vol. 341 No. 1, pp. 25-7.

Transcript of Ruby Schwartz's Evidence in the Victoria Climbié Inquiry (2002), available at: www.victoria-climbié-inquiry.org.uk/Evidence/Archive/Oct01/121001latestp2.htm (accessed November 9, 2004).

Vacca, A. (2013), "Llei de la llengua gal·lesa (Gal·les) 2011, l'ús del gal·lès a l'Administració pública: un pas endavant?", *Revista de Llengua i Dret*, Vol. 59 No. 1, pp. 131-8.

Wise-Price, G. (1998), "Language, culture, and medical tragedy: the case of Willie Ramirez", *Health Affairs Blog*, available at: <http://healthaffairs.org/blog/2008/11/19/language-culture-and-medical-tragedy-the-case-of-willie-ramirez/> (accessed June 17, 2015).

Corresponding author

Bradley Dalton-Oates can be contacted at: bradleydaltonoates@gmail.com

For instructions on how to order reprints of this article, please visit our website:

www.emeraldgroupublishing.com/licensing/reprints.htm

Or contact us for further details: permissions@emeraldinsight.com