

anxiety and depressive disorders as well as the lack of formal education during time spent in internment camps.

The internment camp experience also has a significant impact on an individuals' physical health. Lack of proper sanitation and close quarters in camps can lead to rampant spread of infectious diseases which both sicken the immigrant and those who come in contact with him or her after release. Harsh climates and lack of access to medical practitioners, medications, and equipment can lead to lack of diagnosis and proper treatment of chronic medical conditions and poor prenatal care that can have long-term negative health consequences. A 2006 study by Hahn et al. showed an increase risk of cardiovascular diseases including hypertension and chronic ischemic heart disease in such populations.

One of the main physical consequences of internment is malnutrition. During wartime, resources are frequently scarce and those who have already been identified as a potential threat to the State are typically of low priority for dwindling food supplies. Immediate consequences of long term, severe malnutrition can include refeeding syndrome in which the body is unable to properly metabolize nutrients during the first several days of food availability resulting in fluid and electrolyte disturbances. If not properly treated, this can lead to seizures, coma, or death. Malnutrition can also increase ones susceptibility to infectious disease including active tuberculosis. Longer-term sequelae of malnutrition can include osteopenia and osteoporosis with its associated increase in risk of bone fractures as well as overall increased mortality rates. Malnutrition in childhood has also been associated with lower educational achievement. Even in internment camps where food is adequate, if the diet is lacking in specific essential nutrients individuals may have mental impairment, heart disease, or bleeding disorders, and pregnant women may give birth to children with birth defects.

In summary, the consequences of internment both on physical and emotional health are significant and should not be overlooked. The 1949, the Geneva Convention outlined appropriate treatment of internees, giving special attention to issues of hygiene, access to food and medical attention. Public criticism of internment has grown since World War II. In the USA,

attempts were made to address the “significant human suffering” caused by the internment of ethnic Japanese during World War II. On August 10, 1988, President Ronald Reagan signed a law issuing reparations payments of \$20,000 to those Japanese-American citizens and permanent residents who had been subject to the internment process. Additional monies were set aside to fund education programs related to these experiences.

Related Topics

- ▶ [Holocaust](#)
- ▶ [Posttraumatic stress disorder](#)
- ▶ [Survivor syndrome](#)
- ▶ [Trauma exposure](#)

Suggested Readings

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- Children of the Camps, The Documentary Website. <http://www.children-of-the-camps.org/history/health.html>. Accessed February 16, 2010.
- International Committee of the Red Cross (ICRC). *Procedural principles and safeguards for internment/administrative detention in armed conflict and other situations of violence*. <http://www.icrc.org/Web/eng/siteeng0.nsf/html/review-858-p375>. Accessed February 16, 2010.

Interpreter Services

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When compared to patients who share the same language with their providers, language-discordant

patients experience lower quality of care, including but not limited to worse interpersonal care, less communication, and lower patient satisfaction even in areas unrelated to language. Translators (i.e., individuals who work with written documents) and interpreters (i.e., individuals who provide oral communication) often are considered the standard solutions to provide culturally appropriate and sensitive care. Interpreter Services, which may be a contracted independent agency or a division housed within a health care organization, often provide services for both medical translation and interpretation.

Medical interpreting is not only well organized but is also extensively studied in various multiethnic societies (e.g., Australia and Canada) and in countries that represent a destination of intensive immigration (e.g., Denmark, Germany, the Netherlands, Spain, Switzerland, the United States, and the United Kingdom). In the United States, starting from the late 1970s, there have been federal and state legislative efforts to require physicians to provide interpreters for patients with limited English proficiency (LEP). At the federal level, the White House issued an Executive Order on *Improving Access to Services for Persons with Limited English Proficiency* on August 11, 2000, which resulted in written guidelines being provided, by the Department of Health and Human Services in 2003, to health care providers to ensure language assistance for persons with LEP. The guidelines were rooted in the Title VI of 1964 Civil Rights Act, which prohibits discriminations on the basis of race, color, or national origin by any recipient of federal financial assistance. In short, health care providers who do not provide interpreter services will be cut off from federal reimbursements, including Medicare, Medicaid, and the State Children's Health Insurance Program. Because by law the cost for interpreters cannot be transferred directly to the patients, health care facilities often struggle to find sufficient funding through federal/state-level sources, insurance companies, and private funds. In early 2009, California became the first state in the United States to pass a law requiring health insurance organizations to pay for interpreting and translating services. Although the American Medical Association (AMA) and health maintenance organizations often raise concerns about the high costs of interpreter services, recent studies have demonstrated that providing interpreter services

as a part of standard care often increases the overall number of immigrant patients, resulting greater revenue for the hospitals.

As of 2010, many national and regional interpreter associations in the United States have advocated for a national certification although a standardized process is still a work-in-progress. A national survey in 2010 showed that nationally certified American Sign Language interpreters are better compensated than spoken language interpreters in health care settings. The efforts to push for national certification reflect the interests in recognizing medical interpreters not only as bilingual go-betweens but also as health care professionals. The local certification requirement for medical interpreters often differs from state to state. In states where the certification tests are required, they often are limited to a few languages (e.g., Spanish). As a result, there are no federal or state regulations in place that prohibit the use of noncertified/professional interpreters in health care settings.

The cultural and linguistic diversity of patients make it unrealistic for health care organizations to provide professional interpreters in all languages at all times and/or all points of contact. The AMA, in fact, has provided guidelines to providers for the effective and appropriate utilization of different types of interpreters, including on-site professional interpreters, telephone interpreters, ad hoc interpreters, family interpreters, bilingual staff, and bilingual health care providers. Professional interpreters are typically defined as individuals who have received a minimum of 40 hours of training in medical interpreting. Different health care organizations may have additional requirements, including intern hours or (internal) certification. Several recent reviews have found that on-site professional interpreters appear to raise LEP patients' satisfaction and quality of care to approach or equal that for patients without language barriers. However, researchers have also found that even in states that institute interpreter legislation, health care providers often underuse on-site professional interpreters, citing time constraints and lack of availability of interpreters as primary reasons. On-site professional interpreters can also be unrealistic if the patient population cannot support such services.

Most health care facilities also use other types of interpreters, which are not without flaws. For example,

telephone interpreters do not have access to other speakers' nonverbal cues and tend to have concise talk that centers on medical information (as opposed to rapport-building). Ad hoc and family interpreters, including bilingual children, may not understand complex medical procedures, pose additional risks to malpractice lawsuits and patient privacy, and/or experience unanticipated stress. Bilingual staff and providers need to manage other institutional roles and responsibilities that may conflict with that of interpreters.

It is important to note that providers and patients do not share the same preference for interpreters. Generally speaking, both providers and patients prefer on-site professional interpreters; however, they do not share the same attitude for other types of interpreters. Other issues (e.g., trust, interpreter availability, and specific tasks) may influence their preferences. For example, patients may prefer family interpreters because they can assist them after medical encounters and have their best interests in mind. In addition, in small immigrant communities where privacy can be a concern, minority patients may feel reluctant to disclose information to individuals outside of their social network, including a professional interpreter. In contrast, health care providers often are concerned that family interpreters may side with patients and become a liability in malpractice lawsuits. Many providers argued that in situations that require emotional support (e.g., disclosing poor prognosis), they prefer nonprofessional on-site interpreters over professional telephone interpreters. Some providers cited the convenience, medical knowledge, and institutional role of bilingual staff and colleagues as reasons why they are preferred choices in the absence of on-site professional interpreters. Several researchers recently have noted that family interpreters can be very valuable for specific tasks (e.g., obtaining medical history and patient advocacy). Finally, although providers generally are satisfied with medical encounters conducted through their (limited) second language skills, patients often find the interaction biased toward the providers' informational needs and does not allow them to communicate freely.

In addition to different types of interpreters, health care facilities also have introduced various modes of medical interpreting, including video medical

interpreting, computer-based preprogrammed screening, and remote simultaneous medical interpreting. These interventions primarily aim to improve interpreting services to rural areas and emergency rooms, which traditionally have difficulties in providing on-site professional interpreters at all hours. Although the different types of interpreters and modes of interpreting are not interchangeable as they each have their own distinctive strengths and weaknesses, they serve as valuable resources in complementing and/or supplementing on-site professional interpreters' services.

By recognizing the variety of interpreters and modes of interpreting available in health care settings, researchers have explored their corresponding impacts on patient satisfaction, provider expectations, patient–interpreter relationships, institutional costs, and clinical consequences. It is important to note that researchers and providers have shifted away from the argument that only professional interpreters should be used in health care settings. Rather, they have proposed that the ability of providers to work with different types of medical interpreters is critical to the efficiency, quality, and informal economy of bilingual health care. For example, for routine care, providers may feel comfortable to communicate through nonverbal communication, limited second language skills and/or family members; however, they should use on-site professional interpreters for interactions that may be complex or have high stakes. Recent studies on medical interpreters have centered on identifying the contextual factors and guidelines that allow providers to develop effective and appropriate strategies when working with different types of interpreters.

Currently, there is no standardized code of ethics for medical interpreters although many interpreter associations and health care organizations have proposed various forms of code of ethics for interpreters. Reviews of the codes of ethics for medical interpreters have concluded that many of the codes emphasize a mode of interpretation that calls for an objective and neutral role for interpreters. Professional medical interpreters are trained with a default role, which is often called the conduit model. In the conduit model, interpreters assume a passive and neutral role, faithfully transferring information from one language to another without any agency or distortion. The

prevalence of the conduit model also is reflected in the public's and providers' attitude and expectations for interpreters, envisioning interpreters as neutral translating machines. Interpreters often viewed the conduit role as a mechanical, robotic performance in which interpreters are prohibited to intervene in the interactions or to have personal opinions. Although professional interpreters often identify strongly with the conduit model, they also report significant dissonance and/or distress if they believe a strict adherence to the conduit model may lead to, if not worsen, miscommunication, prejudice, bias, and/or problematic care.

The research and health care communities, as a result, increasingly have recognized the complexity of interpreters' functions, which is reflected in the emerging trends in reexamining and expanding interpreters' roles and code of ethics. Researchers have demonstrated that interpreters do not assume a passive or neutral role as prescribed by the conduit model. Rather, they are active participants who systematically adopt purposeful strategies to improve a patient's health literacy, to protect institutional resources, to reduce the cultural gap between the provider and the patient, to reconcile provider–patient conflicts, to reinforce provider–patient relationship, and to ensure the quality of provider–patient interactions. Many researchers have concluded that the complexity of bilingual health care makes the conduit model impractical, if not unrealistic. As researchers noticed interpreters' active involvement in the communicative process, however, they also have questioned interpreters' ethics and raised concerns about how some of their communicative strategies may infringe on providers' authority or patients' autonomy. It is important not to romanticize interpreters' active role in interpreter-mediated medical encounters and examine their performance and communicative strategies critically.

There is a growing attention on viewing medical interpreting as a goal-oriented activity (i.e., achieving optimal care for patients). Interpreters are not necessarily expected to remain passive or neutral. Rather, they should actively shift between various roles (e.g., from the least intrusive role of conduit, to clarifier, to culture broker and finally, to the most intrusive role of advocate) in response to the tasks, issues, and contexts emerged during medical encounters. Interpreters are

encouraged to actively evaluate other speakers' communicative goals and to modify their strategies and role performances accordingly. Interpreters, thus, are a part of a health care team and share the responsibilities in ensuring the quality of care.

A successful interpreter-mediated encounter is a coordinated accomplishment of all individuals involved. All participants (e.g., the provider, the interpreter, the patient, and even the family members) in the interpreter-mediated medical encounters can influence the process and quality of bilingual health communication. Interpreters can play a significant role in this process by overtly and covertly enhancing the patient and/or provider communicative competence. For example, to ensure effective and appropriate provider–interpreter interactions, interpreters may conceal the providers' problematic behaviors or ask questions on behalf of the patient. One study found that, when interpreters are friendly and emotionally supportive, Latino patients are more receptive to providers' suggestions of amniocentesis. A neutral/slightly cheerful interpreter can act as a buffer to the patient in reducing the negative moods caused by a despondent therapist. In fact, interpreters actively provide emotional support by noting the needs to bridge cultural differences and to ensure quality care. Conversely, interpreters' behaviors may compromise other speakers' communicative competence. For example, when interpreters focus on medical information and ignore providers' rapport-building talk, providers may appear emotionally detached. These studies highlight the fact that medical interpreters play a critical role in patients' health care experiences and in shaping provider–patient communication and relationship.

Providers' communicative behaviors may create dilemma for interpreters in managing medical encounters. For example, providers often feel comfortable in saying things that they would not have said during a monolingual medical encounter (e.g., showing confusion about the actual diagnosis or making disrespectful comments about the patients) believing that the patient would not understand them anyway. An interpreter may feel obligated to relay such information but fear that doing so may worsen the provider–patient relationship. In addition, interpreters may be motivated to bias toward providers (as opposed to patients)

and to accomplish providers' communicative goals (e.g., pressuring patients to accept the providers' treatment suggestions) due to the lack of job security. Both interpreters and providers have reported instances in which an interpreter was sanctioned or even fired because they fail to meet the providers' expectations. The hierarchy of health care teams privileges physicians' status and perspective. As a result, researchers have argued that successful bilingual health care requires providers to create an environment in which others (e.g., interpreters and patients) are comfortable to voice their opinions without fear of retribution (e.g., getting fired or reprimanded). In other words, both providers and interpreters should feel empowered to challenge each other's perspectives and derive mutually acceptable solutions based on open discussion of the optimal utilization of their medical, cultural, and/or linguistic expertise.

This is a perspective that has been neglected in the conceptualization of bilingual health care until very recently. Traditionally, interpreters are believed to be the persons who are solely responsible for the success of an interpreter-mediated medical encounter, which is accomplished through their neutral, faithful, and accurate relay of information from one language to another. The emerging perspective, however, highlights the importance of providers' and patients' roles in contributing to a successful medical encounter. Many health care organizations now offer workshops on cultural competence and interpreter-mediated interactions to providers and/or patients, aiming to improve their communicative competence in cross-cultural health care.

A national survey in 2006 found that roughly 50% resident physicians reported no training on adapting their communicative strategies when working with interpreters and 67% reported no training to manage situations in which they suspect the interpreter has misinterpreted. The lack of training can lead to provider–interpreter miscommunication and problematic collaboration. When providers are familiar with interpreters' practices (e.g., first-person, emotionally detached, and/or simultaneous interpreting style), they can understand the purposes of interpreters' specific behaviors and, if necessary, negotiate with interpreters about other alternatives to achieve optimal care. In 2004, New Jersey became the first state in the United States to adopt a law requiring medical schools to include cultural

competency into curriculum, which include working with medical interpreters. Cultural competency education also was required for physician relicensure. Since then, many other states have also adopted laws or introduced bills on similar topics. These legislative efforts provide strong support to recognize successful bilingual care as a coordinated accomplishment between the provider, the interpreter, and the patient.

Related Topics

- ▶ [Access to care](#)
- ▶ [Cultural competence](#)
- ▶ [Cultural humility](#)
- ▶ [English as a Second Language](#)
- ▶ [Language](#)
- ▶ [Language acculturation](#)
- ▶ [Language barriers](#)
- ▶ [Limited English proficiency](#)
- ▶ [Medical interpretation](#)
- ▶ [Telephone interpretation services](#)

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Suggested Resources

- Certification Commission for Healthcare Interpreters. <http://www.healthcareinterpretercertification.org/>
- International Medical Interpreters Association. <http://www.imiaweb.org>
- Occupational Outlook Handbook (2010–2011), Bureau of Labor Statistics, USA: <http://www.bls.gov/oco/ocos175.htm>
- The National Board of Certification for Medical Interpreters. <http://www.certifiedmedicalinterpreters.org>

Intestinal Parasites

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Infections with intestinal parasites are one of the most common medical conditions observed among immigrant populations coming from endemic areas. Although many individuals report to have little or no symptoms, intestinal parasitic infections may lead to severe health problems if left untreated. Commonly detected pathogenic intestinal parasites through routine stool examinations are: *Entamoeba histolytica* (*Amoebiasis*), *Giardia intestinalis*, *Ascaris lumbricoides*, *Trichuris trichiura*, hookworm, *Strongyloides stercoralis*, *Schistosoma mansoni*, *Schistosoma haematobium*, and tapeworm (*Taenia* species). Some parasites may be less frequently observed in stool samples, but instead, detected through an elevated number of eosinophils in response to the infection. Prior to departure, presumptive therapy is recommended for immigrants originating from endemic areas, for example, Middle East, South/Southeast Asia, and Africa. Respective oral drug regimens of albendazole, ivermectin, and praziquantal are provided. Pre-departure treatments have reduced parasitic infections among newly arrived immigrants. Special considerations are recommended

in administering presumptive treatment to the following populations: infants, under five children, pregnant women, women who are breastfeeding, and immunocompromised individuals. Despite treatment during medical screenings, some intestinal parasites can persist years after resettlement. Comprehensive health exams are recommended post-resettlement to detect persistent infections and prevent more serious complications from developing.

Commonly Detected Intestinal Parasites

Commonly detected intestinal parasites fall under two general categories: protozoa or helminth. Frequently observed pathogenic protozoan infections are *Giardia Lamblia* and *Entamoeba histolytica*. Helminth infections are further classified into three main groups: nematodes, flukes, and tapeworms. Nematodes are intestinal parasites transmitted through oral-fecal route or skin penetration with infective larvae. These parasites include hookworm (*Necator americanis*, *Ancylostoma duodenale*), *Trichuris trichiura*, *Ascaris lumbricoides* and *S. stercoralis*. Flukes are parasites that require an intermediate host and are associated with chronic infections contributing to severe mortality and morbidity. Infections with the *Schistosoma* species are frequently diagnosed in immigrants originating from sub-Saharan African countries. Transmission occurs via skin penetration by infective larvae resulting from exposure to water sources proliferating with infected intermediate hosts, that is, snails. Infection with tapeworms (*Taenia* species) occurs through the human consumption of eating undercooked beef, pork, or fish with the parasite larvae.

Risk Factors

While infections with intestinal parasites are common medical diagnoses among newly arrived immigrants, these infections are preventable and easily treated with access to medical services particularly the availability of oral medications. A significant risk factor for the presence of intestinal parasites is residence in areas with high disease burden for parasitic infections. Contributing to the disease burden, these areas are located in resource-poor countries in which access to clean, protected water sources, sanitation facilities, and medical services is limited or nonexistent. These infections