Working With Interpreters

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DR. ROBERT DRICKEY *(Medical Director, Family Health Center, San Francisco General Hospital):* Today's Grand Rounds concerns working with interpreters. In the Family Health Center, including the Refugee Clinic, between 50 and 90 percent of our medical encounters are cross-cultural, and many of these encounters require an interpreter. Interpretation requires great skill, and good communication with the interpreter is essential for a successful patient-provider interaction. Ms. Shotsy Faust, a family nurse practitioner who works in the Refugee Clinic–Family Health Center, will lead our discussion today. Ms. Faust holds a master's degree in community health care nursing. Her master's thesis concerned aspects of cross-cultural communication in health care. She has extensive experience working with refugees in the United States and Southeast Asia.

SHOTSY FAUST *(Family Nurse Practitioner):* Health care providers working cross-culturally often need interpreters in order to communicate with patients. The purpose of this session is to focus on issues that arise in the provider-interpreter interaction and the impact this relationship has upon the patient. Many times providers and interpreters may feel uneasy or unsure of each other, but rarely do they have the time or place to discuss their interaction or issues that arise about interpretation. Today we will explore that interaction and some of the issues.

Even when they share language and culture, communication between the provider and patient is fraught with complexity, arising from differing expectations, backgrounds, educational levels, age, and class among other factors. When the interpreter joins the interaction, communication becomes even more complex. The interaction among the provider, patient, and interpreter is called the PPI triangle (Figure 1).

As illustrated in Figure 1, the PPI triangle can also be viewed as sets of dyads, or communication partners. The patient-interpreter, the interpreter-provider, and the provider-patient dyads all have distinct roles that can be altered to enhance or detract from communication. By recognizing the dyads, it is possible to address the relationship of each participant to the other. The provider and the patient have only nonverbal communication as a means of expression. The provider and interpreter have both verbal and nonverbal communication as well as the shared "culture of medicine." The interpreter and the patient have verbal and nonverbal communication as well as the bond of culture or language. These dyads represent a shift in authority, since the patient comes to the clinic seeking the consultation of a medical expert but may communicate mostly with an interpreter. The power or authority may shift from provider to interpreter depending upon the role definition as viewed by both provider and interpreter. Since all verbal communication must be channeled through

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that are not familiar with western medical jargon and may have their own healing systems, often thousands of years old. The substance of this interaction may be inexact, incorrect, or insufficient.

INTERPRETER AS PATIENT ADVOCATE

Many interpreters see themselves in the role of advocate for the patient, and some view themselves as clinic or provider advocates. As advocate, the interpreter may interject questions that the patient may not know to ask or may take extra time to discuss concerns with patients or significant others.

INTERPRETER AS CULTURE BROKER

In this role the interpreter sees him or herself primarily as either a broker of western medicine to patients of another culture or as a broker of the cultural ways of the patient to the western provider.

PARTNERSHIP BETWEEN SPECIALISTS

This ideal relationship occurs when the provider embodies nursing and medical expertise while the interpreter provides cultural and language expertise. Development of this approach takes sensitivity and skill. The following are some suggested techniques for the development of this partnership:

1. Choose a trained interpreter whenever possible. A background in medical terminology and experience with patient encounters are invaluable to the accuracy of the interaction and enhance patient cooperation.

2. If you cannot locate a trained interpreter, work with someone (hospital staff, community member) who is not a member of the family. Fluency in language does not imply fluency in medical terminology or skill in working with people seeking health care.

3. Least desirable, but sometimes necessary, is to work with a family member or friend as an interpreter. The family member most proficient in English is often a younger school-aged child. Interpreter accuracy and confidentiality are difficult to maintain in this situation. Age, ability, and emotional involvement of the family member or friend may affect the ability to interpret, especially regarding areas of intimacy or serious illness.

4. Choose an interpreter of the same sex and of comparable age or older than the patient when possible. In many cultures age signifies authority and trustworthiness and will alleviate anxiety and promote compliance. An interpreter of the same sex will be able to inquire appropriately about issues of a sensitive or intimate nature.

5. Negotiate briefly with the interpreter to form a team approach. Introduce yourself and the patient and provide a brief patient history, if known.

6. Establish a positive context for the interaction by (1) using a quiet unhurried approach, (2) having all participants sit down, (3) providing clues to one's identity as a health care provider for easy patient identification (eg, white coat or stethescope), and (4) learning a few key words, such as "hello" and "how are you," in the language of the patient to aid in the joining process.

7. When speaking or listening, watch the patient, not the interpreter.

8. Address questions to the patient as "you" rather than through the interpreter as "she" or "he."

9. Use short simple statements. Minimize jargon and avoid idioms or metaphors.

10. Do not expect sentences or concepts to be translated word for word but rather interpreted as culturally appropriate concepts.

11. Expect long conversations between interpreter and patient, but do not accept "yes" or "no" as a response. Ask for an interpretation of the substance of the conversation.

12. Ask the interpreter for a "cultural interpretation." What expectations does the patient have for the clinic visit (medications, a cure, reassurance)? What meaning do symptoms, tests, or treatments have for the patient?

13. Use the physical examination not only as a diagnostic measure but as a means to communicate nonverbally with the patient and to demonstrate your intent to seek the cause and to allay the symptoms of the illness.

14. Provide written information for patients literate in their own language.

15. Realize that the first visit is the longest but

is an invaluable investment in the future relationship with the interpreter and patient.

DR. DRICKEY: Joining us today are interpreters from our hospital and clinic to present the interpreter perspective and to answer questions from health care providers. With us are Kakada Au from Cambodia, who speaks Cambodian; Tieu Chow, Vietnamese and English; Galo Tobar from Ecuador, who speaks Spanish and English; and Elizabeth Wierzbianska, who speaks Polish, Czech, Spanish, French, Italian, and English.

MS. FAUST: What training do interpreters receive to interpret cross-culturally?

MR. GALO TOBAR *(Interpreter)*: We receive training in medical terminology and some time working through issues in patient–provider-interpreter situations.

MS. ELIZABETH WIERZBIANSKA *(Interpreter)*: Some of us have worked with refugees, and this was our initiation into interpreting. Repeated contact with patients helps us to continue to develop our skills.

MS. KAKADA AU *(Interpreter)*: I have been working with refugees for four years, and I feel proud of being here because the situation in my country is so difficult. There are only doctors in the big cities in Cambodia. Sometimes it is hard to interpret for my people who come from the rural areas and have never seen a doctor; there are so many levels of speaking, and it is hard to find the right words for many different patients. When I first came to this country, I went to the doctor and was told to take off my clothes. I was scared and did not know the reason for this. I had with me an 8 year-old to interpret because I did not speak English. I would not do it, and I left the clinic because I did not understand and was embarrassed.

MS. FAUST: This brings up the issue of the interpreter as the patient advocate as well as use of a family member or untrained interpreter.

MR. TOBAR: When I work with the patient and provider, I tend to side with the patient because he or she is in the most precarious position and is sick. There is a lot of uncertainty for the patient, not only because of sickness but also because the patient is not able to communicate. Also, in my country you must have money to see the doctor and to buy the medicine, and patients worry for this reason.

MS. FAUST: Would you, as interpreters, feel comfortable correcting the provider if you felt that there was cultural insensitivity or if the information was too complex or too much in quantity to translate?

MS. WIERZBIANSKA: I would feel comfortable correcting a provider if it's done in a tactful way. At times I have had to stop the provider from asking questions that may be embarrassing for the patient and may be better asked later in the interview in a different context, especially when asking questions of a personal nature too early in the interaction.

MR. TOBAR: I try to explain to the provider why the patient may be confused or why the question may be inappropriate. For instance, if the provider asks the sexual preference of a male Latino, I will spend time with the patient explaining why the doctor needs to know. The doctor must understand the cultural reasons why the patient and I must have a long conversation about a simple question like this.

MS. FAUST: How do you handle it if the provider and the interpreter are the opposite sex of the patient?

MS. AU: Sometimes for the patient it can be very embarrassing (even if she is married). I tell the providers that they can get more done with a female interpreter. Female patients won't say anything to a male interpreter. The patients sometimes even get mad at me if I ask the questions for the doctor. In this country a woman can be unmarried and have sexual relations, but in my country if a woman is unmarried it is accepted that she is a virgin. The unmarried woman therefore needs an explanation about why the doctor wants more information about her sexual history than only that she is unmarried.

MS. FAUST: How much do you feel interpreters need to know about the illness of the patient?

DR. DRICKEY: I've noticed that when working with experienced interpreters, they sense the direction of interview and frequently anticipate my question. They learn a lot about the disease process in ongoing work with patients.

MR. TOBAR: Interpreters need to know enough to understand the responses of the provider or to ask for clarification if there is some

question. Also, we must be able to respond to the questions of the patient, although in my experience the patient does not often come seeking a lengthy explanation or diagnosis but mostly wants to feel well again or to get medicine or reassurance.

MS. FAUST: Do you think that providers need to know about traditional therapies or alternative therapies being used by the patient in addition to medicines that the provider prescribes?

MR. TOBAR: Many of the patients still use traditional or folk remedies, but often they have exhausted these means, and that is why they have come to the clinic.

DR. DRICKEY: The provider needs to keep in mind that other remedies have been and may still be in use. You may not need to know exact details, but it is important to know that other methods have been tried.

MS. FAUST: How much do patients need to know about disease process?

MS. AU: Many of my patients don't understand about cancer, liver diseases, high blood pressure, and so on. They never knew that they had these in my country. People died of fever, old age, or weakness, but not like here. Sometimes when the medicine or treatment makes the patient feel worse, such as with chemotherapy or blood pressure medicine, the patient loses faith in the doctor. He or she blames both the doctor and the interpreter for the illness. They won't come back unless we spend the extra time needed to help them understand what is happening.

MS. WIERZBIANSKA: I sometimes find the opposite with my patients. They are from "advanced countries," where they see the doctor frequently, even for minor things or about excuses for work. They are also accustomed to being given a great deal of detail about their medical conditions. These patients often challenge the provider by asking, "What haven't I been told?" "Why is the provider so young?" It is hard to know whether all of this needs to be conveyed to the provider, since I believe that it comes from a sense of insecurity or threat of being in a new culture.

MS. FAUST: In some situations the interpreters may have more information about the patient than is elicited during the clinic visit. Do you share this additional information with the provider?

MS. AU: Sometimes it takes a little longer, but if I know certain things, such as whether there is another illness in the family or whether the husband has left the home, things like that, I try to tell the provider, especially if the problem is sadness or depression or family matters.

MS. WIERZBIANSKA: It is important to establish a relationship between the interpreter and the provider so that each can check with the other during the clinic visit about all of these questions. This helps us to work as a team and to work better with the patient.

MS. FAUST: In closing, what do you think are the most common or serious problems that providers and interpreters have in working together?

MS. WIEZBIANSKA: Time constraint is one of the most difficult issues. It takes extra time to convey thoughts cross-culturally as well as bilingually. In an effort to include all that is necessary, the provider often tries to include too much in a sentence, or there isn't time to explain all that the provider says. The patient often leaves overloaded with information and with too many things to remember or to do.

The inappropriate use of interpreters is also an issue. In one instance, a Chinese woman had been diagnosed with cancer and her husband was being used as the translator. The patient sat silently as the provider gave a tremendous amount of information to the patient's husband, whose English was not fluent. Occasionally the husband would nod to the wife. In this instance the provider was using a relative too emotionally involved and was overloading the individual with information. The provider had not established a relationship with the patient, only with the husband.

MR. TOBAR: The problem that I have encountered most often is difficulty in the provider staff not understanding the cultural background of the patient. It has happened that the patient refuses to give blood because he believes that he has a limited amount or that giving it will make him weak, and the provider became impatient and didn't understand the reason or appreciate the time that I needed to assist the patient's understanding to get the patient's cooperation.

MS. AU: Patients from my country hold the physician in high respect. They will say "yes" to what the physician orders or to the physician's

questions about medicine they are taking because they respect authority and don't want to let the physician down. It is hard for them to speak up, to disagree. Rather, it is better to say "yes" and save face for both physician and patient. It is important for the provider to know that this can happen, to ask questions, and to reassure the patient that the provider will not be angry or personally disappointed.

Second, it is often hard to know when to stop the patient from talking too much. They may have many years of problems and have never seen the physician, so they want to talk about all of it at once. Sometimes the patient and I talk for a long time in Cambodian, and the physician doesn't know what we are saying. During this time I try to integrate western and eastern approaches to medicine, changing from western medical ideas to eastern. I try to explain to the provider what I have been talking about, and I try to tell the patient to talk of only one problem at a time.

DR. DRICKEY: We have had an opportunity today to hear from both providers and interpreters about roadblocks to better communication and common problems that we encounter when we work together cross-culturally. I hope that this discussion will cause all of us to examine the patient–provider-interpreter encounters in which we are involved with an eye toward improving those relationships.

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