

INTERPRETER GUIDELINES FOR HEALTHCARE PROFESSIONALS SERVING REFUGEE AND IMMIGRANT PATIENTS

Effective Communication across Language Barriers

THIS BRIEF GUIDE is designed to support your efforts to work through a professional interpreter to deliver health care services to an individual whose primary language and culture differs from your own. Using an interpreter effectively requires knowledge and skill. The provider who becomes skilled at using an interpreter can reduce the patient's confusion and anxiety and establish the framework to provide the best possible level of communication and cooperation.

Even without a language barrier, a healthcare provider must communicate effectively to obtain an accurate medical history, to explore the patient's symptoms and to evaluate responses to therapy. Quality communication also builds trust and cooperation by establishing an emotional link between provider and patient. However, good communication does not always occur in a healthcare setting. Reasons vary. The provider and patient may be virtual or actual strangers and yet need to share emotionally charged content. There may be a mismatch in the education and life experiences of the persons involved. The patient may be uncomfortable or anxious. Finally the environment may be impersonal, noisy and lacking in privacy.

When the provider and patient *lack a common language and culture* additional and formidable communication barriers exist. Well-meaning attempts to bridge language barriers without a trained interpreter may result in confusion, anxiety and the potential for a poor outcome. In addition, ethical and legal issues arise when patients are unable to understand due to a language barrier.

Understanding the Interpreter's Role

Interpreters vs. Translators An **interpreter** provides an oral communication bridge, whereas a **translator** provides a similar bridge in writing. Some excellent interpreters are not equally skilled in translation, and many translators are not fluent in oral communication. If possible, a healthcare interpreter should provide the patient with *written instructions for aftercare* (if indicated) even though he or she has given the patient the same instructions orally. It is important to understand that effective translation of written materials may need to include modification of the original English language content prior to translation of that content. This effort, to design materials with cultural relevance as well as linguistic accuracy, is hugely important.

The Interpreter's Role(s)

Professional interpreters function in different roles depending upon the environment. In a court of law, the interpreter provides correct content to both listeners but does not advocate for one side or the other. In contrast, a school district or nursing home may employ a bilingual individual to serve as a client advocate as well as an interpreter. Professional health care interpreters function in an environment where they may be called upon to link individuals who not only don't share a language, but may come to the visit with very different understandings of the causes of health and illness. Thus, multiple demands may be made upon the interpreter in a healthcare setting, some before and some even after the actual encounter.

Linguistic Tasks

It can be a confusing experience for the health care provider to hear an interpreter communicate what you have just said in a language you do not know. Your brief comment (such as “I have the results of your biopsy”) may seem to morph into several sentences in a different language. One reason is for this is that English differs from many other languages in both sentence structure and conceptual framework. Word order may also differ. For instance, the common English practice of putting the subject of a sentence before an action verb is quite different from typical sentence structure in French. In addition, the interpreter may be struggling to frame the concept of “biopsy” into something coherent for a patient whose primary tongue doesn’t include the word “biopsy” and doesn’t allow for casual reference to a part of a woman’s body. Thus the interpreter may be engaging in verbal gymnastics to convey a concept that would be rather straightforward in English.

The interpreter as teacher The interpreter is frequently called upon to function as a *cultural educator*. For instance, she may need to stop interpreting in order to provide cultural information that the provider needs to understand in order to follow the patient’s thought process. When this occurs, the interpreter makes it clear that she has stepped out of the interpreter role and is serving as an educator. Most trained interpreters signal the change in role by altering their voice and by using an introductory phrase such as “May I explain...?” Interpreters may raise their hands in a “Stop” gesture as they move from interpreter to educator mode. Once the explanation is complete, the gist of the content is also provided to the patient so she is not isolated from the communication. An example of this would be when a physician examining a newly arrived refugee woman might ask about scaring suggestive of surgery and radiation therapy whether the patient has a history of breast cancer. Given the patient’s negative and horrified response, the interpreter might enter the role of educator with both the patient (stating in her tongue, “good doctors in America ask questions that may seem odd to you at first. I will explain this to your doctor.”) and the physician (stating in English, “Doctor, this patient is from a country where physicians tend to have a different way of handling information regarding illnesses such as cancer with the patient. The word cancer is rarely used and has a connotation of inescapably terminal illness. Even when it is diagnosed, discussion of the implications would normally be held with the appropriate family member, not the actual patient. Given this, Doctor, it is entirely possible that if this woman *was* treated for breast cancer, she could be unaware of the diagnosis and might be more familiar with language regarding a ‘tumor’ or a ‘growth.’”)

The interpreter as advocate

In ideal situations, the interpreter is not positioned to advocate for either the patient or the health care provider, but rather she advocates for quality of communication between the parties. This means that the interpreter acts pro-actively or reactively to promote effective exchange of content with minimal barriers. There are a number of tasks related to this part of the interpreter role. The interpreter might need to volunteer information that would be obvious to the listener if a common language were being spoken, for instance, that a patient’s speech is slurred or that an adult patient is using the syntax of a young child. When this occurs, the interpreter will interrupt the communication tasks by a gesture or statement to both the patient and provider and then provide the critical information. Such side explanations should be kept at a minimum to avoid moving the patient out of the communication loop.

Although not ideal, in some settings the interpreter may be functioning also as a *patient advocate*. If the interpreter is a volunteer from the patient’s ethnic community, she may experience strong internal and external pressure to intervene for the patient. This pressure may interfere with her interpreting role unless she is very well trained and disciplined in her approach. If the interpreter is not a professional and/or is emotionally involved with the patient, the role of advocate may become more important than the role of interpreter. As a result, the interpreter’s wish to serve what she believes is the patient’s best interests could lead her to edit or omit statements made either by the provider or the patient. For example, she might not interpret a statement she considers anxiety provoking for the patient. This is more likely to occur in a cultural mismatch or when the content is emotionally charged. Obviously this can have serious medical, ethical and legal consequences. *Avoid using family members or anyone else emotionally involved as interpreters in a situation involving a document requiring informed consent (or in any case in which the editing of information could lead to misunderstanding.*

Provider Strategies

In a nutshell, the provider should:

- ◆ Familiarize yourself with the role of the interpreter and techniques for effective utilization of interpreter/translators

prior to actually needing to use one for a particular patient.

- ◆ Use lay (rather than medical) terminology in communications. Otherwise the provider is, in effect, asking the interpreter to “translate” medical terminology into the appropriate level of English lay language and then to interpret the lay language into the patient’s language.
- ◆ Engage all your active listening skills to detect the patient’s perspective and find common ground, avoiding assumptions.
- ◆ Seek to provide services at a level comparable to those delivered to your patients without language or cultural barriers. Avoid casting the interpreter in a role of associate health care worker by asking them to engage in tasks (filling out forms, contacting patients with results of tests, etc.) that normally would be handled by you or your staff. Use the interpreter as a bridge, not a substitute for staff.

Be aware that a patient may attempt to shift the interpreter into a provider or staff role. For example, a patient may ask the interpreter to give medical advice or provide triage in an emergency. The provider can help the interpreter avoid this role by letting the patient know beforehand who to contact in an emergency or simply where to get more information regarding her health concerns.

Strategies for Success

A successful interpreted encounter requires planning by the provider and professional skill on the part of the interpreter. Before the event the provider may need to call the interpreter to arrange an appointment or to communicate information to the patient. If the interpreter who arrives for the encounter is unfamiliar to you, spend a few minutes deciding which interpreting method should be used. (If this discussion takes place in front of the patient, the interpreter will share the content with the patient.) The interpreter and patient also may need to determine the most appropriate dialect or select an interpretation method.

Use the most appropriate mode of interpretation

Consecutive Interpretation The consecutive method is the most common method used in health care encounters. The interpreter listens to the speaker utter several phrases or sentences in the first (source) language and then interprets the content into phrases or sentences in the second (target) language. If you are using this method, you need to “package” your utterances in one or two sentences expressing complete ideas and then pause for the interpreter to pass that information on. The interpreter will incline her head in your direction or make eye contact when ready for new information.

If the interpreter feels that she is receiving too much information too fast from you (or the patient) she will signal you (usually by the raising of hands in a “stop” gesture) to provide an opportunity to catch up. It is generally easy to develop a rhythm between the healthcare provider, interpreter and patient in this method. Most interpreters functioning in a health care setting gravitate naturally to this mode of interpretation. On the other hand, *consecutive interpretation puts the most pressure on the interpreter’s memory to avoid content loss*, and may occasionally interrupt the thought flow for the provider or patient.

Simultaneous Interpretation In this method the interpreter vocalizes the target language just a few seconds behind the source language speaker, pitching her voice to slightly override the source language speaker’s voice. There is relatively little delay between speakers. However, this method is very difficult when there is a sentence structure mismatch between the two languages and it requires tremendous concentration on the interpreter’s part. To be truly effective, this method requires skill on the part of both the provider and the patient. Although the listener may hear two people at the same time (the speaker and the interpreter), he must attend to the interpreter for verbal communication and cues and keep his eyes on the speaker for non-verbal cues. Simultaneous interpretation is most effective when the speaker is lecturing to a larger group of people. It may also be useful when the provider is discussing very detailed information with a patient (such as lab results or the nuances of a particular method of therapy) and he wants to reduce the pressure on the interpreter to store and communicated complicated concepts or technical information.

Once the method of interpretation has been determined, the participants in the encounter should position themselves to facilitate communication and minimize distractions.

Set the Stage

The environment The chairs in the room should be arranged in a triangle so that the provider and patient are facing each other, with the interpreter able to see the faces of both individuals from the side. If the patient is lying in bed or on an exam table, the provider should stand or sit to the side of the bed and the interpreter should stand or sit at the foot. The provider should pitch his voice at a level in which he may be heard by the patient and understood by the interpreter. In situations where distraction and noise are inevitable (as in an emergency department) the speakers should move as close to each other as culturally acceptable and pitch their voices to facilitate communication.

Communication techniques The provider should face the patient, make eye contact as culturally appropriate, and speak directly to the patient. For instance, the provider should say (while looking only at the patient), “I have your test results.” The provider should avoid looking at the interpreter and saying, “Tell Mrs. Tran that I have her test results.”

In this manner one-to-one communication between provider and patient is encouraged, and the interpretation process becomes less of a block and more of a bridge. By making eye contact, the provider and patient provide themselves with non-verbal communication cues to support the verbal communication being provided by the interpreter. When successfully performed, this method places the interpreter in the background and spotlights the communication and the emotional link between provider and patient.

Common Problems and Potential Solutions

If the provider finds the interpreter’s accent confusing, he should request that the interpreter speak more slowly and clearly. If the interpreter doesn’t understand the provider’s statement, he should ask the provider to simplify the terminology or to rephrase a complicated idea. As at the end of any healthcare encounter the provider should restate the main ideas and ask the patient to demonstrate understanding by describing what she has understood.

Certain types of encounters are especially complicated. Several of these difficult situations are described here, together with possible solutions.

When the interpreter is not professionally trained Sometimes a professional interpreter is not available. If the potential lay interpreter is truly fluent in both languages, the communication may be effective if the provider is experienced with using interpreters. The provider should outline her expectations up front and then patiently guide the lay interpreter. If the interpreter is not fluent and/or the provider is not experienced with the use of interpreters, the provider should either postpone the encounter or focus only on the most basic concrete material until a skilled interpreter is available.

Warning: The provider should be very cautious when working with a lay interpreter. A professional interpreter contributes far more than facility in the language to the encounter. For instance, in many cultures it is appropriate to nod the head in an affirmative manner to indicate you have *heard* the speaker but it does *not* mean you agree with him or even understand him.

When the encounter is emotionally charged Healthcare providers often see patients who are angry, hurt or confused. The professional interpreter will attempt to convey your utterances to the patient, and hers to you, with as little editing as possible. If the patient says something inappropriate to you, the professional interpreter will repeat this verbatim where possible. If the patient interrupts the interpreter, the interpreter will slip in the patient’s comment. Remember not to blame the interpreter for the patient’s words or behavior. Instead, employ the same conflict resolution skills or crisis intervention techniques used with other patients.

When the patient does not answer appropriately The demented or mentally ill patient may not answer questions coherently. If a patient appears to be answering inappropriately or the responses are meaningless, the provider should employ the same assessment skills he would normally utilize to determine if a patient is psychotic, confused or otherwise neurologically impaired. It is appropriate to ask the interpreter to describe the patient’s speech in terms of fluidness, syntax and clarity. Unless directed otherwise, the interpreter may tell the patient that she is being asked to describe her speech structure.

When the patient seems non-compliant or uncooperative A patient’s apparent lack of understanding or her reluctance to agree with a proposed intervention should be taken at face value. Sometimes, however, it can be due to

poor interpreting. The provider may ask the interpreter if a cultural mismatch might account for the patient's response. The provider may want to ask the patient more questions in order to assess her understanding of what has just been said. It is counterproductive to blame an interpreter for the patient's failure to understand or comply with the provider's expectations.

When the provider is speaking to a group If the provider is talking to a number of people (such as a family), he and the interpreter may need to modify their techniques to ensure understanding and flow. For instance, if several people begin to speak at once, the interpreter may use a gesture to identify the person that he is interpreting for at that instant (pointing to or touching the speaker, if culturally acceptable). In this situation, the interpreter may resort to clarifying introductory phrases such as "he says" in order to reduce the confusion that occurs when more than one person has spoken at the same time.

Risks of multiple conversations The provider should be aware that the interpreter might not hear and interpret important comments if multiple conversations are taking place at the same time. Limiting the number of people speaking simultaneously reduces stress on the interpreter and the risk of content loss or error.

Becoming Aware of 'Cultural Blindness'

A health care provider working with a patient from a very different culture needs to be aware of the potential for confusion generated by his or the patient's natural cultural "blindness". Generally, cultural blindness refers to the difficulty that an individual experiences in attempting to recognize and understand the values and assumptions of someone from another culture. Taken to the extreme, cultural blindness can become *ethnocentricity* illustrated by the belief that only one's own ethnic group, nation, or culture is valid.

The Use of Language in Different Cultures "Cultural blindness" may be particularly evident in understanding how language is used in a particular culture. Most native English speakers use language to describe reality (that is, to define and articulate a given view or circumstance) and to exchange information. Many of us take for granted that our way of using language is the only way (or at least the best way) to give and receive information. The spoken word may have a different role in other settings, however. In many other cultures, words spoken aloud are believed to be capable of influencing or even creating reality. Or, in other cultures, the primary role of communication may be to create or strengthen relationships between individuals with information exchange relegated to a lesser role. If, for example, a Romany woman has been given discharge instructions post a lumpectomy, it would be helpful to list potential problems requiring a return to the surgery center *impersonally* by saying, "Rarely patients may experience bleeding (or whatever symptom) and need to return for further care." Avoid saying, "After this surgery you might experience bleeding and you would need return." The second statement may falsely convey your belief that this patient is *likely* experience the symptoms. This is a confusing message.

Non-language Barriers To Communication Language is only one of the barriers that may exist between the patient and the provider. Many cultures have markedly different beliefs about individual autonomy, the relative value of science/medicine/technology, the role of spirituality and the responsibilities of healer and patient. Even if an individual has studied English extensively in her native country, she rarely makes the leap to a Western model of healthcare immediately upon arrival in the United States. In fact, the amount of time that the patient has spent in the United States is a poor predictor of her level of understanding or her comfort with the Western model of healthcare. Some new arrivals acculturate to a Western model of care completely. Other people integrate beliefs and behaviors of their adopted country even as they retain strong basic ties to their primary culture—ties that are likely to affect them in the stress of a health crisis. Others never seek to adopt Western models of healthcare.

If the provider knows that he is going to have intense or frequent encounters with individuals from a particular culture, it's important to learn more about how members of that culture perceive health and illness, how they define the patient role and how they formulate their expectations of healthcare providers. In addition, understanding of basic communication patterns is helpful. An interpreter familiar with the potential areas of cultural mismatch can be a crucial bridge. She can offer explanations and if necessary refer the provider to someone who can be of assistance.

Summing Up

Nearly all communication in clinical settings requires some element of cultural bridging. It is hard enough for American

born patients and their families to understand the complex and intimidating sphere that encompasses healthcare in the United States. The additional challenge of cultural and linguistic mismatch makes it even more difficult for new arrival families. However, the practitioner who sincerely seeks to bridge these barriers through the expert use of a professional interpreter opens the door to good health for many of our nation's newest Americans.

INTERPRETER GUIDELINES FOR HEALTHCARE PROFESSIONALS (August 2000) was developed by Barbara Bogomolov, RN, Manager, Department of Refugee Health Service, Barnes-Jewish Hospital, St. Louis, Missouri. This edition was created as a service to the Susan G. Komen for the Cure, St. Louis affiliate.