

## **Concept Paper**

**CLAS Theme:** Language Access Services

**Title:** *Language access in healthcare:  
Domains, Strategies and Implications for Medical Education*

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Purpose: Quality communication lies at the core of cultural competency. The domains outlined below are intended as outlines and tools to organize, teach, and assess health care training programs around issues related to communications, class, culture, language and power.

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## General

*"The goal of medical interpreting should not be on maintaining distant neutrality, but on building shared meaning."*<sup>1</sup>

Communication lies at the core of cultural competency. The domains outlined below are intended as outlines and tools to organize, teach, and assess health care training programs around issues related to communications, class, culture, language and power. The assumptions (in building domains for a subcategory focused on language, health care interpreting and communications)<sup>2</sup> are based on the model created by Meekin, et al, for the assessment of palliative care education. These domains and strategies are consistent with other guidelines, standards and models currently under assessment. These include the CLAS Standards, developed with funding from the OMH,<sup>3</sup> the Association of American Medical College's current effort to define, assess cultural competence in medical education,<sup>4</sup> the Society of Teachers of Family Medicine (STFM) Core Curriculum Guidelines<sup>5</sup> and a training program prepared for the Royal College of General Practitioners.<sup>6</sup> The materials provided are intended as a step beyond guidelines and will hopefully provide teaching staff, clinicians and trainees with specific, focused material intended to stimulate change in the way language issues are addressed in teaching and patient care. The text and appendices that follow are based on the outline below.

### **Domain I: Core concepts - communication across barriers of language, class and culture.**

- A. Inequities in Care Based on Language and Ethnicity.
- B. Language Use
- C. The Role, Training and Working Standards of Interpreters in Health Care
- D. Dealing with Disparate Ethical Systems
- E. Patient's Rights and Standards

### **Domain II: Core Skills**

- A. The Triadic Interview
- B. Power, Bias and the Development of Trust in Clinical Process
- C. Trained vs. Untrained Interpreters
- D. Stress Reduction and Focused Interview Techniques
- E. Understanding Different Modes of Interpretation

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<sup>1</sup> Solomon MZ: From what's neutral to what's meaningful: reflections on a study of medical interpreters. **J of Clinical Ethics** 1997;8:88-93, p 91.

<sup>2</sup> Meekin SA, Klein JE, Fleischman AR and Fins JJ: Development of a palliative education assessment tool for medical student education. **Academic Medicine** 2000;75:986-922.

<sup>3</sup> Department of Health and Human Services, Office of Minority Health; National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care. Federal Register, Vol 65, No. 247, December 22, 2000 pp 80865-80879.

<sup>4</sup> Gamble VN and Danoff D: Medical Education and Cultural Competence: A strategy to eliminate racial and ethnic disparities in health care. Commonwealth Fund Project, AAMC, 2000-03.

<sup>5</sup> Like R, Prasaad R and Rubel A: STFM Core Curriculum Guidelines: Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent health care. **Fam Med** 1996;28:291-7. Available at <http://www.stfm.org/corep.html>.

<sup>6</sup> Kai J (Ed): Valuing Diversity: A Resource for Effective Health Care of Ethnically Diverse Communities. London, The Royal College of General Practitioners, 1999.

## Teaching Strategies

- A. Weaving Culture and Cross-cultural Communication into Core Curriculum
- B. Teaching Rounds, Case Conferences
- C. Implications for Undergraduate and Graduate Medical Education

## Domain I: Core concepts

### A. Inequities in care

*"The lower likelihood of having a usual source of care .. found among Hispanic children is largely attributable to those whose parents have difficulty communicating in English."*<sup>11, p1773</sup>

In the broad literature about inequities in healthcare, researchers have generally sorted between poverty, race, ethnicity, lack of health care insurance, and differences in compliance, education and understanding. Language also counts. Lee et al found that "adult patients who did not speak the same language as their primary EP (emergency physician) had a greater chance (about 70% greater) of being admitted to the hospital." Furthermore, Lee notes "the risk of admission to the hospital decreased with the presence of an interpreter. Although there was no professional interpreter service available, interpreters somehow positively affected the outcome; that is an interpreter was associated with less risk for hospital admission."<sup>7 p88, 89</sup> Additionally, in children and young adults undergoing Emergency Department (ED) care for an asthma attack, the presence of a language barrier is a significant marker for risk of intubation.<sup>8,9</sup>

*"Evidence that language barriers have a direct effect on health care delivery is growing."*<sup>10</sup>

Patients with limited English proficiency (LEP) have diminished access to primary care,<sup>11,12</sup> are less likely to receive follow-up appointments after ED visits,<sup>13</sup> are less likely to understand their diagnoses, medications and follow-up instructions,<sup>14,15</sup> are less satisfied with care,<sup>16</sup> and do not receive equivalent levels of preventive

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<sup>7</sup> Lee ED, Rosenberg CR, Sixsmith DM, Pang D, Abularrage J: Does a physician-patient language difference increase the probability of hospital admission? **Acad Emerg Med** 1998;5:86-9.

<sup>8</sup> LeSon S, Gershwin ME: Risk factors for asthmatic patients requiring intubation. I. Observations in children. **J Asthma** 1995;32:285-94.

<sup>9</sup> LeSon S, Gershwin ME: Risk factors for asthmatic patients requiring intubation. III. Observations in young adults. **J Asthma** 1996;33:27-35

<sup>10</sup> Betancourt JR, Jacobs EA: Language Barriers to Informed Consent and Confidentiality: The Impact on Women's Health. **JAMWA** 2000;55:294-5.

<sup>11</sup> Weinick RM et al: Racial/ethnic differences in Children's Access to Health Care. **Am J Pub Health** 2000;90:1771-4.

<sup>12</sup> Hu DJ, Covell RM: Health care usage by Hispanic outpatients as a function of primary language. **West J Med** 1998;144:490-3.

<sup>13</sup> Sarver J, Baker DW: Effect of Language barriers on Follow-up Appointments After an Emergency Department Visit. **J Gen Intern Med** 2000;15:256-264.

<sup>14</sup> Shaw J, Hemming JD, Nieman P and Naismith NW: The comprehension of therapy by non-English speaking hospital patients. **Med Jour Aust** 1977;2:423-427.

<sup>15</sup> Crane JA: Patient comprehension of doctor-patient communication on discharge from the emergency department. **J Emerg Med** 1997;15:1-7.

<sup>16</sup> Carrasquillo O, Orav EJ, Brennan TA, Burstin HR: Impact of language barriers on patient satisfaction in an emergency department. **J Gen Int Med** 1999;14:82-7

care.<sup>17, 18</sup> In one study it was clear that Hispanics were twice as likely to receive no emergency department analgesia for long bone fractures and in that study it was ethnicity rather than LEP status that accounted for most of the difference.<sup>19</sup>

In spite of Title VI of the Civil Rights Act of 1964, and subsequent Office of Civil Rights (OCR) rulings, multiple studies demonstrate that LEP patients frequently are recipients of care without adequate language assistance in publicly funded institutions.<sup>20, 21, 22</sup> In Baker's study, for "52% [of Spanish-speaking] patients an interpreter was not used but thought to be necessary by the patient."<sup>22, p 783</sup> Hampers study in a university hospital pediatric ED documented that an interpreter was not called in 24% of cases in which a language barrier was believed to exist. Additionally, both studies were carried out in hospitals that used ad hoc, untrained interpreters "including nursing or clerical staff, family friends, or even other individuals present in the waiting room."<sup>21, p 1256</sup> In Lee's university based ED study only "52% had an interpreter available" and all of these were ad hoc interpreters.<sup>7</sup> Recordings and analysis of interpreter-assisted encounters reveal that untrained ad hoc interpreters induce communication errors by incorrectly interpreting 23 to 52% of the words and phrases in the discourse.<sup>23</sup>

The findings of Baker, Hampers and Lee parallel and support Woloshin et al's 1995 report:

"While common in other environments, professional interpreters are rarely available in health care. New York City, which has one of the largest limited-English-speaking populations in the country, does not employ professional interpreters in its public hospital system. Instead, as in most of the United States, patients and clinicians rely on one of three sub optimal mechanisms: 1) their own language skills, 2) the skills of family or friends, or 3) ad hoc interpreters (bilingual strangers from the waiting room, or employees like a clerk, aide or custodian called away from regular job responsibilities to be an interpreter)."<sup>20, p 724</sup>

Effective clinical process relies on good communication: "What a scalpel is to a surgeon, words are to the clinician ... the conversation between the doctor and patient is the heart of the practice of medicine."<sup>24</sup> And we are left with the question: What happens when a third person, an interpreter, is added to the conversation between the doctor and patient? We will start by considering language use in clinical encounters.

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<sup>17</sup> Naish J, Brown J, Denton B: Intercultural consultations: investigation of factors that deter non-English speaking women from attending their general practitioners for cervical screening. **BMJ** 1994;309:1126-8.

<sup>18</sup> Woloshin S, Schwartz LM, Katz SJ, Welch HG: Is language a barrier to the use of preventive services? **JGIM** 1997;12:472-7.

<sup>19</sup> Todd KH, Samaroo N, Hoffman JR: Ethnicity as a risk factor for inadequate emergency department analgesia. **JAMA** 1993;269:1537-39.

<sup>20</sup> Woloshin S, Bickell NA, Swartz LM, Gany F, and Welch HG: Language barriers in medicine in the United States. **JAMA** 1995;273:724-728.

<sup>21</sup> Hampers LC, Cha S, Gutglass DJ, Binns HJ, Krug SE: Language barriers and resource utilization in a pediatric emergency department. **Pediatrics** 1999;103:1253-56.

<sup>22</sup> Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K: Use and effectiveness of interpreters in an emergency department. **JAMA** 1996;275:783-88.

<sup>23</sup> Ebden P, Bhatt A, Carey OJ, Harrison B: The bilingual consultation. **Lancet** 1988;13:347.

<sup>24</sup> Tumulty P: What is a clinician and what does he do? **NEJM** 1970;283:20-24, quoted in Woloshin, 1995.

## B. Language

*“The physician speaks a strange and often-unintelligible dialect [which] creates a communication gap between physician and patient that is acknowledged by neither.”<sup>25</sup>*

Disparate perceptions of meaning and intent play a role in all clinical encounters and they are magnified by boundaries of culture, class and language. Since a major goal of clinical encounters is shared understanding, the interpreter and provider may need to bridge major gaps in language usage. Clinicians need to recognize differences between lay and professional language, folk terminology as well as complex terms and referents in the patient's culture. Even dreams and hallucinations have meanings in many cultures that lie outside of Western definitional process. Lack of linguistic equivalency is a major issue and trainees need exposure to common examples of this problem. Terms like allergy, anxiety, bacteria, mental health, and stress (to name a few) are absent in the lexicon of many cultures. Lack of linguistic equivalency is, in fact, a two-way street. Groups such as Native Americans, Asian-Pacific Islanders, and individuals from rural or impoverished areas often have rich terminology that lacks a parallel basis in English. This is illustrated in the first figure.

Hmong Term	Translation	Causes	Symptoms
siab phem	'ugly liver'	Congenital, early learning, spiritual causes, natural disaster (e.g., lightening), injury, great personal loss.	Destructive behavior, verbal abuse, inability to verbalize, disorientation
nyuab siab	'difficult liver'	Loss of family, status, home, country, or any important item.	Excessive worry, crying, confusion, disorganized speech, loss of sleep, poor appetite, delusions
tu siab	'broken liver'	Loss of or quarrel with spouse, sweet-heart, family member or friend	Grief, worry, loneliness, guilt insecurity
siab luv	'short liver'	Hereditary, early experience, trauma, severe illness	Extreme temper, violent behavior, restlessness, sweating, flushed appearance
kho siab	'murmuring liver'	Separation, loss of loved one, guilt	Nervous habits (e.g., whistling, pacing, humming, eccentric or deviant actions
lwj siab	'rotten liver'	Stressful family relations, unfulfilled goals	Memory loss, short temper, delusions

Historically, Hmong is an unwritten language. The Hmong terms are written in Arabic characters using a missionary-developed system that is not strictly phonetic (the last consonant is silent and indicates the tone in which the work is spoken).<sup>26</sup>

If a Hmong patient references a problem with siab phem (ugly liver, above), how should an interpreter frame the comment to an English-speaking provider? What if the provider needed to describe hepatitis to a Hmong patient?

<sup>25</sup> Kimball CP: Medicine and dialects. *Ann Intern Med* 1971;74:137-39.

<sup>26</sup> Modified from Bliatout, Table 229.2, Putsch and Joyce, *Language in Cross-Cultural Care*, 1990, p 1061.

Remember, language use is not equivalent across all patients or all cultures.<sup>27</sup> For example, individuals from a variety of backgrounds may use language as if it were imbued with power. When a white middle class ex-US Marine drill instructor comes back from a colonoscopy, learns that it was entirely negative and says:

"I'm really lucky, I was afraid I was going to hear the 'C' word," he's using language in a concrete fashion, one that says that talking about or naming something may cause it to happen. Concrete language use has major implications around issues such as truth telling, informed consent or advanced directives. Interpreters often play a key role in end-of-life decision-making and disclosure of "bad news," or in negotiating informed consent. An interpreter may find his/herself caught between a patient and/or family that opposes disclosure and a clinician who believes that openness and discussion of dangerous issues is an essential norm.

Confronted with disparate communication styles interpreters often hear words and phrases that they fear may be misinterpreted by the either the provider or the patient. For example, when an interpreter hears the provider initiate talk about a dangerous diagnosis, or a major risk, s/he may need to shift roles from a message passer to a culture broker and discuss that concern before continuing. This problem works in both ways; for example, when a patient references a belief that provider may not understand or may mistake for an abnormal thought or behavior.

### **C. The role(s), training and working standards of interpreters in health care**

The interpreter is "the man in the middle with some obligations to both clients and these obligations may not be entirely compatible."<sup>28</sup>

"Traduttore, traditore" - Translators, traitors.<sup>29</sup>

A Cambodian health care interpreter was speaking about her work at a national conference: *"When I arrive and find that the family is waiting and the doctor is not yet ready, I visit with them in the waiting room. This way I can learn many things about them, whether they are a rural family, what news they've had from [our country]. It helps me do a better job when we meet with the doctor."*

The program director of a university hospital-interpreting program jumped up and interrupted: *"No, no, you should never meet separately with the client...you enter the room when the doctor arrives and you leave when he or she leaves. You don't visit with the patient!"*<sup>30</sup>

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<sup>27</sup> Putsch RW: Language in cross-cultural care. In Walker, HK, Hall, WD, and Hurst, JW (Eds): **Clinical Methods**. Boston, Butterworths, pp. 1060-1065, 1990.

<sup>28</sup> Anderson RBW: Perspectives on the role of the interpreter. In Brislin RW (Ed): **Translation: Applications and Research**. New York, Gardner Press, 1976, pp. 205-25.

<sup>29</sup> Caccamise WC: Traduttore, Traditore - translators - traitors. (Letter) **JAMA** 1986;255:2600.

While the above quotations represent widely disparate views of interpreters and interpreter functions, the last exchange highlights early, 1990's disagreements about the "interpreter in a historically traditional neutral role" versus the "interpreter with varied responsibilities in health care and in her community."<sup>30, p1</sup> The literature about communication has emphasized language and culture as "barriers." Interpreters or bilingual healthcare workers are usually represented as ancillary members of the healthcare team who simply enable clinicians and patients to communicate using mutually intelligible terminology and concepts. Most accounts emphasize the need for the neutrality, completeness and accuracy of interpreters. Some researchers, however, have recognized these interpreting guidelines "often fail to take into account issues of class, power, disparate beliefs, lack of linguistic equivalence, or the disparate use of language."<sup>31</sup> Discussion about the dynamics of power in this triadic relationship describes the interpreter as a gatekeeper with the ability to elicit, clarify, interpret, omit, or distort messages.<sup>323334</sup>

A broad spectrum of commentary on the roles, interpersonal relationships and meanings generated in triadic interviews is outlined in the figures of Appendix A (page 21-22).<sup>35</sup> The commentaries adjacent to the figures speak to affective and interpersonal relationships, the quality of message passing, team function, expanded interpreter roles and the general characteristics of recorded, back translated discourse through an interpreter. Medical school teaching staff and clinicians, who teach about cross-cultural communication and deliver cross-cultural care, need to familiarize themselves with these issues. An outline of current agreement on the role of the interpreter, summarized by Avery, is described in Appendix B (page 23).<sup>30, p 12-13</sup> Avery's descriptions of interpreters are well constructed. They encompass a breadth of detailed programs in which interpreters have formally described advocacy roles,<sup>3637</sup> act in well described functions as cultural mediators,<sup>38</sup> as case managers,<sup>39</sup> and solely as professional interpreters in health care. A transcript of an interpreted interview reveals the ways in which some of these independent, coworker roles play out (see Appendix C, page 24-25).<sup>31, p 79.</sup> The transcript records an interview in which a trained interpreter plays an independent role in obtaining clinical history, as well as in obtaining consent for a procedure. It illustrates multiple issues in interpreted interviews and implies the risks inherent in systems that lack clearly described roles for providers and interpreters.

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<sup>31</sup> Kaufert JM, Putsch RW: Communication through interpreters in healthcare: Ethical dilemmas arising from differences in class, culture, language and power. **J Clinical Ethics** 2000;8:71-87, p 72.

<sup>32</sup> Lang R: Orderlies as interpreters in Papua New Guinea. **Papua New Guinea Medical Journal** 1975;18:172-177.

<sup>33</sup> Launer J: Taking medical histories through interpreters: practice in a Nigerian outpatient department. **BMJ** 1978;2:934-935.

<sup>34</sup> Putsch RW: Cross-cultural communications: The special case of interpreters in health care. **JAMA** 1985;254:3344-3348.

<sup>35</sup> Putsch RW: Cross-cultural communication in Health Care Delivery. (unpublished paper) Presented at the 1992 Refugee Health Conference, University of Wisconsin, Milwaukee, 9/21/92

<sup>36</sup> Kaufert JM, O'Neil JD, Koolage WW: Culture brokerage and advocacy in urban hospitals: The impact of native language interpreters. **Santé Culture Health**, 1985;III(#2);3-9.

<sup>37</sup> St Boniface Hospital, Native Services, undated brochure, in use - 1997. Personal contact, Margaret Lavalée, director, Services to Native Peoples, University of Manitoba Medical Center, 1997.

<sup>38</sup> Jackson-Carroll LM, Graham E, Jackson JC: Beyond Medical Interpretation: The role of Interpreter Cultural Mediators (ICMs) in building bridges between ethnic communities and health institutions. Community House Calls Program, Harborview Medical Center, Revised edition, January, 1998.

<sup>39</sup> Case management roles are discussed in Jackson (cited at #38 above), Westermeyer (1989, see appendix A) and exemplified in clinical services at many community clinic sites around the country.

#### D. Dealing with disparate ethical systems

*"Bioethics [has an] extreme reliance on the principle of autonomy and sometimes naive, overly positivistic assumptions about the nature of truth and truth-telling."*<sup>1, p 1</sup>

Cross-cultural clinical encounters are rife with disparate views of truth telling, and informed consent. Discord in clinical communications around these issues has been described in literature about Navajos,<sup>40</sup> Italians,<sup>41</sup> Japanese,<sup>42</sup> and Aboriginal Canadians.<sup>43</sup> Autonomy is a fundamental principle for Western biomedicine. It arises from the notion of "respect for persons" which "has become almost synonymous with the principle of self-determination."<sup>1</sup> In contrast, on a worldwide basis major ethical systems operate on the basis of communal process. Some ethicists suggest that clinical dilemmas arising from disparate perspectives can be readily mediated "by using strategies that allow the patient, family members and providers the opportunity to clarify their values."<sup>31</sup> Kaufert points out that these mechanisms (which often imply that mediation works) may be of limited use in emergency and palliative care situations.<sup>31</sup> Interpreters often find themselves caught in the middle of these discordant ethical perspectives.

It is useful to use a case presentation methodology to see how these issues play out in interpreted health clinical settings. The family of the patient in Appendix D (page 26-27) operated on a communal ethic insisting that the information regarding a potentially lethal diagnosis belongs first to the family, and that truth telling to the patient (as well as informed consent) is dangerous and should be avoided. The case also speaks to the dilemma of dealing with individuals or families that refuse the involvement of a professional interpreter. Discussion of this case as a teaching tool promotes a wide ranging commentary on views held by the staff, on legal and ethical ramifications, on negotiating between disparate ethical systems, and CLAS standards regarding the patient's (or family's) right to refuse an interpreter. Finally, the case raises fundamental issues regarding the meaning of "respect for persons."

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<sup>40</sup> Carrese JA, Rhodes LA: Bridging cultural differences in medical practice: The case of discussing negative information with Navajo patients. **JGIM** 2000;15:92-6. In traditional Navajo culture, thought and language have the power to shape reality. There is a widely held traditional view that discussion of dangerous problems such as the risks of medical treatment may, in fact, bring them about. The study by Carrese and Rhodes raises important questions about dilemmas for patients, health workers and interpreters around these issues. They may find themselves caught between institutional and legal imperatives (both of which are culture bound) and service that is appropriate within a culture and to the individuals and families involved. These dilemmas touch on issues of culture, power and human rights.

<sup>41</sup> Gordon D, Paci E: Disclosure and cultural narrative: Understanding concealment and silence around cancer in Tuscany, Italy. **Soc Sci Med** 1997;44:1433-52., Surbone A: A letter from Italy: Truth telling to the patient. **JAMA** 1992;268:1661-2, and Grassi L, Giraldi T, Messina EG, Magnani K, Valle E, Cartei G: Physician's attitudes to and problems with truth telling to cancer patients. **Support Cancer Care** 2000;8:40-5.

<sup>42</sup> Delvecchio Good, MJ, Good BJ, Schafer C, Lind SE: American oncology and the discourse on hope. **Cult Med Psych** 1990;14:59-79.

<sup>43</sup> Kaufert JM, Putsch RW, Lavalée M: End-of-Life decision making among Aboriginal Canadians: Interpretation, mediation and discord in the communication of "Bad News." **J Pal Care** 1999;15:31-38.

R. Putsch:

## E. Patient's Rights and Standards

*"No person in the United States shall, on grounds of race, color, or national origin, be excluded from participation in, be denied benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." Title VI of the US Civil Rights Act of 1964*

Title VI of the Civil Rights Act of 1964 has been "consistently interpreted as requiring the provision of language services."<sup>44</sup> The National Health Law Program (NHeLP) has provided a clear outline of the "OCR's Bottom Lines for Linguistic Accessibility."<sup>44</sup> (Appendix E, page 28) The NHeLP list is a great resource, outlining the fundamental steps, procedures and structures that must be in place for an organization to meet its responsibility to LEP patients. Additionally, in December 2000, the Office of Minority Health (OMH) published National Standards on Culturally and Linguistically Appropriate Services (CLAS) in health care. Sections 4, 5, 6 and 7 of the class standards reflect mandatory federal requirements for all recipients of federal funds (Figure 2).<sup>45</sup> According to CLAS, "A first preference (is) the availability of bilingual staff who can communicate directly with patients/consumers in their preferred language. When such staff is not available, face-to-face interpretation provided by trained staff or contract or volunteer interpreters is the next preference. Telephone interpreter services should be used as a supplemental system."<sup>46</sup>

### **Figure 2. CLAS standards 4-7 relating to language services of LEP populations.**

4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreter and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

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<sup>44</sup> Perkins J, Simon H, Cheng F, Olson K and Vera Y: **Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities**. January, 1998, Henry J Kaiser Family Foundation, Menlo Park, Ca, p 21.

<sup>45</sup> Federal Register, Vol 65, No. 247, December 22, 2000 pp 80865-80879.

<sup>46</sup> U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH): National Standards for Culturally and Linguistically Appropriate Services in Health Care, March 2001, Standard 4, p 8.

## Domain II - Core Skills

### A. The triadic interview

*"Cross-cultural interpretation ... requires special training and highly developed ... skills. Just any bilingual person, chosen at random, is not sufficient."<sup>47</sup>*

Current best practice suggests that interpreter dependent interviews include attention to:

- An emphasis on shared meaning and understanding,
- A precession,
- Positioning to encourage direct interaction between the provider and patient,
- Unobtrusive posturing and eye contact by the interpreter,
- Strategies to maximize provider-patient interaction,
- Use of first person by the interpreter,
- Control by the provider,
- Interpreter management of cross cultural/cross-language message flow, or Incremental intervention by the interpreter,
- Maintaining transparency,
- Inviting/soliciting the patient's view, and
- Debriefing post interview when appropriate.<sup>48</sup>

**Shared Meaning** - Traditions in professional interpreting have emphasized neutrality. In a purely neutral role, the interpreter is unobtrusive, non-relational and is "not an active player in the social encounter occurring between the patient and the provider."<sup>30, p4</sup> In health care, differences in class, culture, language, expectations and power dictate that for **meaning to be preserved and shared understanding encouraged**, the interpreter must play an active role (see management of ... or incremental intervention below).

**A precession** - A brief meeting before the interpreted interaction allows the interpreter and the provider to clarify the purpose and goals of the visit, as well as to establish necessary ground rules.

**Positioning, posturing and eye contact** - Interpreters are encouraged to be as unobtrusive as possible, to sit beside or just behind the patient and to avoid distracting eye contact. This serves to **maximize direct interaction between the patient and provider** and to avoid having the interpreter become the main focus of both conversants' speech.

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<sup>47</sup> Young RW: **English as a second language for Navajos: An overview of certain cultural and linguistic factors**. Albuquerque, Bureau of Indian Affairs, 1968, p 17.

<sup>48</sup> These best practices are based on a materials taken from Avery (2001), The NCIHC Code of Ethics; Hardt E and Cashman R: **The Bilingual Medical Interview - I**. Boston Area Health Education Center, 1989 (Video); Hardt, E: Discussion Leader's Guide for The Bilingual Medical Interview I and The Bilingual Medical Interview II: The Geriatric Interview. Boston Area Health Education Center, 1991; Roat C: **Communicating Effectively through an Interpreter**. Cross Cultural Health Care Program, Seattle, Wa. 1998 (video); Putsch RW: Cross-cultural com-munications: The special case of interpreters in health care. **JAMA** 1985;254:3344-3348; and Solomon MZ: From what's neutral to what's meaningful: Reflections on a study of medical interpreters. **J Clin Ethics** 1997;8:88-93.

**First person speech** - Interpreters are encouraged to use first person speech, as though the interpreter were the voice of the person speaking. "For example, if the patient says: 'my stomach hurts,' the interpreter says (in the second language): 'my stomach hurts,' and not 'she says her stomach hurts.'"<sup>49</sup> The interpreter's use of first person speech promotes direct communication between the principle speakers. Interpreters in some languages object to this practice and use honorific forms of address like "The doctor says, ...," or respectful address as in, "grandmother, the doctor says ...". In these instances, interpreters reference need for maintaining respect and appropriate address. This pattern varies and some interpreters use first person speech in one direction, say to the provider, and third person speech to the patient.

**Control by the provider** - Control by the provider can be accomplished within a narrow frame of choices. These include suggesting proper positioning and insisting on transparent speech (defined below) by reminding the interpreter to interpret any sidebar conversations or questions that arise in either direction. The need for transparency includes simple things like providing an explanation for a comment made by either the provider or patient, interruptions in the visit (for example, leaving the room to find a record) and actions to be undertaken, etc. Additionally, when untrained interpreters speak for the patient and/or express his/her own opinions or versions of the patient's history: "She says she's been ill for a month," or "It's her stomach that's hurting," providers should insist that the interpreter only repeat what the patient has to say and put aside his/her own opinions of the patient's history, view or concerns.

**Management of cross cultural/cross-language message flow,<sup>50</sup> or incremental intervention by the interpreter<sup>51</sup>** - These two medical interpretation roles have been articulated during the 1990's. "The primary role of the interpreter is to facilitate understanding and communication .. with a primary focus on clarity." Incremental intervention, "which is quite similar to management of cross-cultural message flow," articulates a clear need for the interpreter to use transparency when s/he moves between the roles of message passer and advocate (Figure 3). Needless to say, either role demands that the provider see the interpreter as a legitimate team member and an active participant in a triadic relationship.

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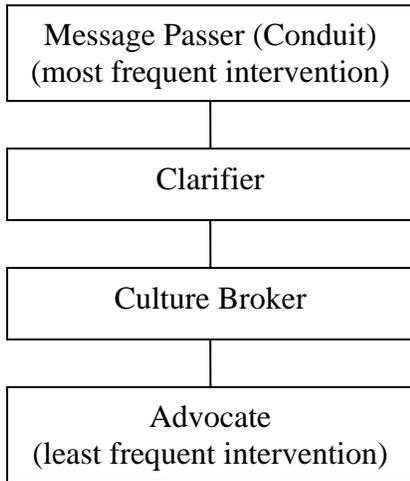
<sup>49</sup> National Council on Interpreting in Health Care: The terminology of health care interpreting: A Glossary of terms. NCIHC, Working paper series, volume 3, Oct 2001, available at <http://www.ncihc.org>.

<sup>50</sup> This conceptualization is most closely tied to that described in the Medical Interpreter Standards of Practice developed by the Massachusetts Medical Interpreters Association and Education Development Center, from Avery (2001), p 7. For full descriptions of these conceptualizations see Avery, p 7-10.

<sup>51</sup> This conceptualization originated by Cynthia E. Roat, MPH, and is the basis for Bridging the Gap, a 40 hour training for medical interpreters (CCHCP, Seattle, Wa., 1998), from Avery (2001), p 9.

**Figure 3. The management of message flow via incremental intervention by the interpreter.**<sup>52</sup>

The range of Incremental Interventions by the interpreter:



It should be clear that the majority of the interpreter's time is spent as a message passer. As the discourse or language differences become more complex, the interpreter shifts to clarify, to see if both sides truly understand each other's meaning and/or intent. The roles of culture broker and advocate are undertaken least frequently. These latter roles often provoke strong responses among professional interpreters many of whom have been trained in legal, business and/or conference interpreting. Health care interpreting, however, is seen as warranting these roles. First, health care is a non-adversarial arena in which shared understanding is a major goal. Second, disparities in class, education and expectations often come into play between health care conversants. Third, interpreters in health care may witness care and events that warrant interpreter advocacy on the part of the patient.

**Maintaining transparency** - Transparency is maintained when everything said by any party present, including the interpreter speaking for his/her own self, is interpreted into a language that others present can understand. Whenever the interpreter has reason to enter into a conversation by speaking directly to either party in either language, the interpreter must subsequently interpret his/her own speech and that of the party spoken to, for the benefit of those present who do not understand the language used.

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<sup>52</sup> Roat C (Ed): Bridging the Gap: A basic training for medical interpreters, 40 hours. Version III, Seattle, Wa., 1998, Cross-Cultural Health Care Program.

**Inviting/soliciting the patient's view** - Communication across boundaries of language, class and culture involves a significant chance of misunderstanding. Although multiple styles of interviewing are used in health care, a patient centered approach will lead the provider to check back, to see if the patient understands, and to inquire about patient concerns. Patients as well as interpreters often need cueing or an explanation as to the meaning and intent of this approach - especially if either expects (due to prior life or cultural experience) the provider to act in a directive, unilateral fashion. At least two reports have examined patient centeredness in cross-language, interpreter-dependent care. Rivadeneyra et al conclude that "Spanish-speaking patients were less likely to receive facilitation from their physicians and more likely to have their comments ignored."<sup>53</sup> Henbest on the other hand felt that the approach worked well across the 8 languages in three South African clinics studied.<sup>54</sup> Various means of eliciting and negotiating around the patient's view have been proposed.<sup>55</sup><sup>56</sup><sup>57</sup>

**Debriefing post interview when appropriate** - Certain circumstances warrant post interview debriefing with the interpreter. These include: discussions around death and dying, telling bad news, family conferences, mental health visits and visits with patients who's complaints seem unusual or hard to sort out. Strategies for next steps often arise out of these debriefings. The interaction simultaneously serves to validate the interpreter's role and participation, allows for clarification and elicits the interpreter's view of the language exchange. An effective, well-trained interpreter can serve as both the provider's mirror and window in cross-cultural work.

## **B. Power, Bias and the Development of Trust in Clinical Process**

*"Provider dominance can serve to impede rather than improve communications. Failure to recognize this can block the practitioner's ability to consider the patient's views and role in the illness process."<sup>57, p 1050</sup>*

Trust, continuity and relationship building are major issues in health care. These issues have generally gone unattended in describing or designing interpreter systems in health care. Although health care systems are quite prepared encourage provider continuity, they often balk at providing interpreter continuity - even in setting such as primary care for refugees, mental health or in the care of complexly ill patients. Furthermore, "almost all communication between physicians and Non-English-speaking patients is concerned with symptomatology to the exclusion of feelings, causes, or patient questions." As a result patients feel devalued and "are at risk for not developing trust."<sup>58</sup>

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<sup>53</sup> Rivadeneyra R, Elderkin-Thompson V, Silver RC, Waitzkin H: Patient centeredness in medical encounters requiring an interpreter. **Am J Med** 2000;108:470-4.

<sup>54</sup> Henbest RJ, Fehrsen GS: Patient-centredness: is it applicable outside the West? Its measurement and effect on outcomes. **Fam Pract** 1992;9:311-7.

<sup>55</sup> Berlin E, Fowkes W: A teaching framework for Cross-Cultural Health Care. **WJMed** 1983, 139:934-38.

<sup>56</sup> Kleinman A et al: Culture Illness and Care: Clinical lessons from anthropologic and cross-cultural research **Ann Int Med** 1978;88:251-258. Kleinman's description of explanatory models, outlined in this paper, has provided the background for works describing teaching and patient care methods including the STFM Core Curriculum Guidelines and The Royal College of General Practitioners' Resource for Effective Health Care of Ethnically Diverse Communities.

<sup>57</sup> Putsch RW: Methodology in cross-cultural care. In Walker, HK, Hall, WD, and Hurst, JW (Eds): **Clinical Methods**. Boston, Butterworths, pp. 1050-1059, 1990. "Methodology" describes specific interviewing interventions to elicit the patient's view and alternative explanations for illness.

<sup>58</sup> Elderkin-Thompson V, Silver RC, Waitzkin H: When nurses double as interpreters: a study of Spanish speaking patients in a US primary care setting. **Soc Sci Med** 2001;52:1343-58, p 1344

Cross-cultural communication is further complicated by a provider-dominant relationship that drives the reality of clinical work and discourse across boundaries of language and culture. Consider that:

- the provider has been asked to help, diagnose, counsel, treat and often to certify the patient as “sick” in a socially approved fashion;
- the provider organizes the discussion, directing it in a fashion that will be optimally relevant to the patient’s complaints and situation;
- the provider molds the patient responses and findings into recognizable, manageable patterns;
- the provider determines which portions of the material will be regarded as significant a decision that is often made unilaterally independent of the patient’s views; and
- the provider then describes the diagnostic and therapeutic actions to be taken.<sup>57, p 1050</sup>

These steps are driven by the methodologies of biomedicine and psychology and are further complicated by levels of skill, time, and the personal bias/expectations of the provider. In interpreted health care, these factors can be dealt with by training both providers and interpreters to maintain a patient centered approach, and to learn its role in triadic interviewing.<sup>59</sup> Developing the skills necessary to visit, interact and listen to patients is necessary for effective work across boundaries of language, class and culture. Evidence that provider bias clearly operates in cross cultural care<sup>19,60,61</sup> requires that systemic change and self reflective process<sup>62</sup> must be woven into the fabric of health care delivery and training systems.

Not only is limited development of trust at stake, but interpreters, confronted with difficulties passing complex messages have “expressed that professionally their first allegiance was to the medical system that employed them to send a message. The asymmetry of knowledge and status clearly determined (at least for the interpreters) whose reality should be conveyed when one is unable to find a conceptual and experiential equivalence.”<sup>63</sup> This commentary about allegiance to the powerful side of the interaction parallels Elderkin-Thompson’s findings. Nurses acting as ad hoc interpreters “slanted information congruent with clinical expectations but not congruent with the patient’s comments, [and] .. slanted the interpretations reflecting unfavorably on patients and undermining the patient’s credibility.”<sup>58, p1343</sup>

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<sup>59</sup> The notion that patient centeredness is applicable across all cultures has been challenged in a thoughtful paper by Skelton JR, Kai J, Loudon RF: Cross-cultural communication in medicine: questions for educators. **Med Education** 2001;35:257-61. "There is a western presumption that patient-centered medicine - essentially a construct of western research - is 'good.'" (p261) None-the-less, earlier work by Berlin EA, Fowkes WC: A teaching framework for Cross-Cultural Health Care. **WJMed** 1983, 139:934-38, proposed a process-oriented model (LEARN) for eliciting the patient’s view as well as for discussing and negotiating around social, cultural and personal information relevant to an illness. Kleinman’s (1978, cited at 56 above) and my own (1990 cited at 57) work suggested that methods to elicit the patient’s view are useful and may themselves need to be adapted to given situations.

<sup>60</sup> Todd KH, Deaton C, D’Adamo AP, Goe L: Ethnicity and analgesic practice. **Ann Emerg Med** 2000;35:11-16. This was Todd’s second article about the selective use of analgesics in emergency rooms and it led to an editorial in the same journal: Goldfrank LR, Knopp RK: Racial and ethnically selective oligoanalgesia: Is this racism? (editorial) **Ann Emer Med** 2000;35:79-82.

<sup>61</sup> Schulman KA, et al: The effect of race and sex on physician’s recommendations for cardiac catheterization. **N Engl J Med** 1999;340:618-626.

<sup>62</sup> Tervalon M, Murray-Garcia: **J Health Care Poor Underserved** 1998;9:117-25 (fully cited at 89).

<sup>63</sup> Jackson JC, Rhodes LA, Inui TS and Buchwald D: Hepatitis B among the Khmer: Issues of translation and concepts of illness. **JGIM** 1997;12:292-98, p 297

Finally, constant changes in interpreters may serve to block effective communication about important problems. Choosing the appropriate interpreter for a given situation may vary depending on patient choice, on gender issues and on the nature of the patient's illness or concerns. These steps are especially relevant for immigrants who have mental health issues, who have been traumatized, or have complex, difficult illness.

### C. Stress reduction and focused interview techniques

*"I was annoyed beyond my capacity to remain civil. I was waiting at 6:30 PM for the on-call intern to show up and relieve me ... when he finally arrived, he wanted a most excruciatingly detailed sign-out conceivable. Finally, I shouted at him, 'look, you're just here for the night! I'm not telling you anything more about these patients' social problems.'"*<sup>91, p 741</sup>

The Royal College of General Practitioners guide suggests that there are "several immediate and practical things health professionals can do to improve the communication process. These include: reducing stress, simplifying your English, learning the client's language and learning to use an interpreter well."<sup>64</sup> "Stress reduction" is focused on the notion that visits to physicians effect patient language use by lowering both the ability to concentrate and level of language use. This is drawn from the work of Mares, et al.<sup>65</sup> Interestingly, stress also operates on the practitioner since "a language barrier disarms a communicant's ability to assess meanings, intent, emotions, and reactions and creates a state of dependency on the individual who holds the keys to the entire process - the interpreter."<sup>34, p3344</sup> Residents in training identify language barriers as a key source of stress<sup>66</sup> and providers not only "have less confidence that the work they are doing with patients is helpful, [but also] express discomfort in seeing patients when there is a language barrier."<sup>67</sup> Conferences with trainees (medical students and resident trainees) as well as practitioners reveal open expressions of mistrust directed at interpreters and raise wide-ranging discomfort about what interpreters actually do.

The Royal College of General Practitioners' guide (1999) offers useful suggestions for interventions by health workers that can reduce stress and these (in the form of training overheads) are reproduced in Appendix F (page 29-30). These guidelines include suggestions such as "try to ensure that the patient always sees the same staff" and it is clear that for many patients continuity of both provider staff and interpreter are important. The importance of checking back is emphasized, including avoidance of questions to which the answer is "yes." This reflects current literature about patient centeredness and earlier suggestions to invite corrections or "induce the discussion of alternatives: 'Correct me if I'm wrong, I understood it this way...' or 'Do you see it some other

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<sup>64</sup> McAvoy B: Enhancing communication with patients, in Kai, J (Ed): Valuing Diversity: A Resource for Effective Health Care of Ethnically Diverse Communities. London, The Royal College of General Practitioners, 1999, Section 7.3.

<sup>65</sup> Mares P, Henley A, and Baxter C: Health care in multi-racial Britain. Health Education Council/ National Extension College; Cambridge, 1985 (cited in Kai J, 1999, Section 7.5)

<sup>66</sup> Chalabian J, Dunnington G: Impact of language barrier on quality of patient care, resident stress and teaching. **Teaching and Learning in Medicine** 1997;9:84-90 cited in Bowen S (2001).

<sup>67</sup> Bowen S: **Language Barriers in Access to Health Care**. Health Canada, Health Systems Division, Health Policy and Communications Branch, Limited Edition, 2001, p 89.

way?"<sup>34, p 3347</sup> Both of these interventions may be difficult in institutional settings which do not formally acknowledge and validate the interpreter's role.

#### D. Trained vs. Untrained Interpreters

*Interpreter: You're telling us that the stools are watery and that they're hard! Do you think we're playing with you? We ask you if they're watery and you say yes. We ask you if they're hard and you say yes. Which should we take of these two?*<sup>33, p 935</sup>

Launer recorded the above argument "about the veracity of the [patient's] history" in a Nigerian outpatient clinic. The orderly, acting as an interpreter was untrained in interpretive techniques. Recording and back translation of discourse using untrained interpreters has a long history. Lang (1975)<sup>32</sup>, Launer (1978)<sup>33</sup> and Marcos<sup>68</sup> have also recorded multiple examples of interpretive problems and distortions:

#### Examples of Bad Paraphrasing: (two cases from Launer)<sup>33, p 935</sup>

**1<sup>st</sup> Patient:** It's my ear that's hurting me. It's blocked and I can't hear with it. The head and neck are hurting and I've got a fever.

**Interpreter:** She says she's suffering from ear pain and headache.

**2<sup>nd</sup> Patient:** This leg. There's pain inside it in the night. In the afternoon I can't walk around freely. If I bend it, I can't straighten it due to pain.

**Interpreter:** He has pain in the right leg. Right inside the bone.

#### Distortions associated with interpreter competence: (two cases from Marcos)<sup>68, p 173</sup>

**MD to 1<sup>st</sup> Patient:** What kind of moods have you been in recently?

**Interpreter:** How have you been feeling?

**Patient:** No, I don't have any more pain, my stomach is fine now, and I can eat much better since I take the medication.

**Interpreter:** He says he feels fine, no problems.

**MD to 2<sup>nd</sup> Patient:** What about worries, do you have any worries?

**Interpreter:** Is there anything that bothers you?

**Patient:** I know, I know that God is with me, I'm not afraid, they cannot get me [pause] I'm wearing these new pants and I feel protected. I feel good. I don't get headaches anymore.

**Interpreter:** He says that he's not afraid, he feels good, he doesn't have headaches anymore.

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<sup>68</sup> Marcos LR: Effects of interpreters on the evaluation of psychopathology in non-English speaking patients. Am J Psychiatry 1979;136:171-74

These examples of message change and distortion by interpreters serve to demonstrate the risks inherent in using ad hoc, untrained, or lay interpreters (these three terms are often used interchangeably in the literature). In Marcos's second example, the speech of a psychotic patient is normalized, a distortion that could lead to misdiagnosis. This problem is well documented with untrained interpreters in mental health.<sup>69</sup> A recent study demonstrated a high frequency of similar distortions when bilingual nurses act in the role of ad hoc interpreters. "Two-thirds of the uncomplicated cases did not contain errors that jeopardized the diagnosis and treatment of the patient. However, one-third of the uncomplicated cases and two thirds of the complicated cases, i.e., those with multiple possible etiologies, experienced communication problems that resulted in errors or significant omissions."<sup>58, p 1354.</sup>

Currently multiple institutions use ad hoc interpreters. Video demonstrations of how they function (presented in teaching formats) are available. The oldest, scripted by Hardt and Cashman comes from the Boston City Hospital. Tapes I and II contain a number of interviews which are particularly well suited for training<sup>70,71</sup> A more recent tape scripted by Roat and her coworkers,<sup>72</sup> demonstrates how a provider can maintain control over an interview conducted through an ad hoc, bilingual employee acting as an interpreter.

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<sup>69</sup> Vasquez C, Javier RA: The problem with interpreters: communicating with Spanish speaking patients **Hosp Comm Psychiatry** 1991;42:163-65.

<sup>70</sup> **The Bilingual Medical Interview - I.** Boston Area Health Education Center, 1989 (Video), and Hardt, E: Discussion Leader's Guide for The Bilingual Medical Interview, 1989.

<sup>71</sup> **The Bilingual Medical Interview - II:** The Geriatric Interview. Boston Area Health Education Center, 1991 (Video). Three episodes in Hardt's tapes are particularly well suited for teaching; the Haitian man with Gaz, a resident who overestimates her Spanish speaking skills, (both in Tape I) and an excellent, non-scripted home visit with a Cape Verdian Creole speaker and his family (Tape II).

<sup>72</sup> **Communicating Effectively through an Interpreter.** Cross Cultural Health Care Program, Seattle, Wa. 1998 (video).

## E. Understanding different modes of interpretation

*Recently, I was approached by a trained interpreter with whom I had worked on several occasions. She told me that I would soon receive a request to examine a Portuguese-speaking patient [and] asked me to specifically request her [to] interpret. I thought little more of it and [subsequently] called the interpreter to meet me on the ward.*

*The patient was in her first trimester of pregnancy with depression, hyperemesis gravidarum, and ambivalent feelings about her pregnancy. I arrived on the ward before the interpreter and was met by the head nurse who told me that the patient's social worker, who also spoke Portuguese, could interpret for me. When I replied that an interpreter had already been arranged, the nurse asked me to meet with her and the social worker in private, immediately. There I was advised that the interpreter should not participate in the interview they felt that she had difficulty communicating with the patient. I thought this peculiar in previous interviews the interpreter had seemed quite competent.*

*I [then] learned that the interpreter, following a previous interview with the patient, had stated at the nursing station that the patient was not able to accept the pregnancy and should have an abortion...staff members disagreed and were concerned that the interpreter because of her personal views, might be able to influence the patient or my assessment. Later I asked the interpreter why she had wanted to interpret for this particular patient. She expressed concern that because the patient's social worker had strong, personal, proscriptive views on abortion, the social worker might minimize the patient's symptoms and block discussion of the issue of abortion.<sup>73</sup>*

Trained interpreters, ad hoc interpreters, bilingual employees, these are part of the broad descriptions and definitions of those called upon to interpret in health care. It is important to remember that the code of ethics for health care interpreters includes a section on impartiality.<sup>74</sup> Earlier work, based on a compilation of Codes from around the country stated that "interpreters should disclose any real or perceived conflict of interest that would affect their objectivity in the delivery of service."<sup>75</sup> The letter to editor cited above (Friend, 1991) clearly demonstrates the need for such a code and for training.

A number of terms are used to describe the interpreting styles and settings of trained interpreters. The commonest form is on-site, or face-to-face **consecutive interpreting** in which the interpreter is present with the provider and patient and uses pauses between speech by the two conversants to pass the message. **Simultaneous interpreting** can be done face-to-face or remotely (through phone sets). In simultaneous interpreting the interpreter converts the speaker or signer's message into another language while the speaker or signer continues to speak. Some sites rely on bilingual workers, including providers, to either provide direct care or to interpret. In many of these instances, the workers are neither trained nor tested for proficiency in the languages in which they self-identify as being proficient.

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<sup>73</sup> Friend WC: (Letter to the editor) Problems with Interpreters. **Hosp Comm Psych** 1991;42:856-7.

<sup>74</sup> National Council on Interpretation in Health Care: A draft Code of Ethics for Health Care Interpreters, October 2001, available at

<sup>75</sup> Kaufert JM, Putsch RW: **J Clinical Ethics** 2000;8:71-87, p 76.

**Telephonic** and **remote interpretation** styles (using headsets, speaker phones, etc) are in use and are undergoing testing in numerous sites around the country.<sup>76</sup> Remote interpreting projects have resulted in literature reports.<sup>77</sup> It is hard to gauge patient satisfaction with these systems since many have been installed in sites that lacked pre-existing, well-run face-to-face interpreting systems. In some hospitals, speakerphone systems have been in use for a number of years.<sup>78</sup> Some clinical services in sites with remote interpreting available insist on face-to-face interpreting. The rationale for this kind of provider driven decision making has not been studied. It is generally accepted that remote systems rob the interpreter of the ability to assess non-verbal cues and meaning. Scholars estimate that the majority of emotional meaning is transmitted non-verbally<sup>79</sup> and that "verbal components [carry] less than 35% of the social meaning of a situation, and more than 65% is carried by the non-verbal component."<sup>80</sup>

Other terminology references **staff interpreters** (on-site, bilingual employees who's sole work is focused on interpreting), **contract interpreters** (interpreters provided by interpretation agencies under contract, usually in less common languages) and **bilingual employees** (bilingual staff who may be called upon to interpret, but have other primary responsibilities). It is important to know whether these different interpreters are trained and/or certified and to recall that few hospitals have set up testing systems to assess the skill levels of bilingual employees.<sup>81</sup> Contracted American Sign Language interpreters (ASL interpreters), on the other hand, are generally certified. The level of training of ASL interpreters is generally high and they have extensive, well-developed codes of conduct and ethics as well as systems in place for their clientele to register complaints.

Finally, there are two further terms that warrant commentary: certified interpreters and sight interpretation. **Certified interpreters** are professionals who are certified as competent by a professional organization or government entity through rigorous testing based on appropriate criteria. Interpreters who have had limited training or have taken a screening test administered by an employer, health facility or interpreter agency are not considered certified. Additionally, some state certification tests are not specifically focused on medical knowledge or on health care interpretation. Although there has been a great deal of concern focused on certifying the skills of medical interpreters, bilingual workers, including physicians, have received far less attention. Only a few systems actually test the skills of physicians and nurses who claim to fluency in a target language. **Sight interpretation** is carried out when an interpreter is requested to convert a written document into spoken language during an interview. It requires a great deal of skill and often puts the interpreter in a position of having to not only explain the meaning and intent of a document but also to change the register to make it understood by the patient.

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<sup>76</sup> Two such sites are Seattle's Harborview Hospital and New York's Gouverneur Hospital.

<sup>77</sup> Hornberger J, Gibson C, Wood W, Degueridere C, Corso I, Palla R, Block DA: Eliminating language barriers for non-English Speaking Patients: a randomized control trial. **Medical Care** 1996;34:845-56

<sup>78</sup> Personal contact, Alberto Garcia, Director of Interpreter Services, Santa Clara Valley Medical Center.

<sup>79</sup> Mehrabian A: Nonverbal Communication. Hawthorne, NY, Aldine Publishing Co, 1972.

<sup>80</sup> Birdwhitsell RL: Kinetics and Context. Philadelphia, University of Pennsylvania Press, 1970, cited in Kai, J (Ed): Valuing Diversity: A Resource for Effective Health Care of Ethnically Diverse Communities. London, The Royal College of General Practitioners, 1999, section 7.9, handout 1, p2.

<sup>81</sup> Stanford Hospital is an exception. Bilingual staff are tested and advised whether they can do limited interpretive work or actually interpret for patient-provider interactions (requiring a higher complexity of skill).

## Teaching Strategies

*Often in the hospital setting I feel I intrude into people's lives, take what I want, and move on.*

*---Third year medical student<sup>82</sup>*

### A. Weaving culture and cross-cultural communication into core curriculum

Teaching about language and communications across linguistic boundaries has taken a variety of forms. The sections on "Enhancing Communications with Patients," and "Working with Interpreters and Advocates," in Kai (1999) offer excellent examples of tying video materials, interactive discussion formats, and role-plays. These approaches have been woven into interviewing courses in which interpreted interviews with standardized patients are woven into student trainee experience.<sup>83</sup> The three training videos cited earlier<sup>84</sup> offer rich examples of video training materials. In addition, it may also be necessary to train faculty mentors and administrators about these issues. Since major metropolitan training centers lack adequate systems to facilitate cross-cultural communication, it is a mistake to assume that faculty members or administrators understand the width and breadth of these issues in clinical care.

### B. Case Conferences, teaching rounds

*"Clinicians who speak medical language fluently may rely on medical speech exclusively. In doing so, they can lose track of whether they are in biologic reality or the socially situated reality of a patient's daily life."<sup>63</sup>*

Case conferences offer a superb opportunity to weave issues of language and interpreter dependent care into educational process and especially conferences in which the interpreters participate. This approach is illustrated in a video entitled "Peace has not been made,"<sup>85</sup> in which residents, staff and interpreters all participate in discussions of a trouble case. Trouble cases as well as routine care offer excellent sources for training sessions. A recent example, recorded during the 24<sup>th</sup> Annual Meeting of the Society of General Internal Medicine, illustrates how clinical material, the patient's voice and that of the practitioner can be woven into a training program.<sup>86</sup> Similar approaches can be woven into grand rounds and even rounds dedicated to cross-cultural issues in training programs.<sup>87,88</sup>

It is useful to incorporate multiple voices and perspectives in teaching rounds and cross-cultural training. These can bridge medical specialties such as family medicine and psychiatry but also

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<sup>82</sup> Feudtner C, Christakis DA: Making the Rounds: The ethical development of medical students in the context of clinical rotations. **Hastings Center Report** 1994;25:6-12, p 6.

<sup>83</sup> Goldstein E, personal contact (2001). Two of four standardized patient interviews in the second year course at University of Washington School of medicine are interpreter dependent.

<sup>84</sup> Hardt 1989 and 1990, and Roat (1998) cited at 70,71 and 72 above.

<sup>85</sup> Yang D, Finck J, O'Neill P and Fagan M: **Peace Has Not Been Made**. A case history of a Hmong family's encounter with a hospital. The State of Rhode Island and Providence Plantations, Department of Social and Rehabilitative Services, 1983.

<sup>86</sup> McFee SJ: Caring for a 70-year old Vietnamese Woman. **JAMA** 2002;287:495-504.

<sup>87</sup> Seattle's Harborview and Providence Hospitals have each sponsored as popular series of monthly cross-cultural rounds for trainees in family and internal medicine, students, MSW's and RN's. A similar program, at Oakland's Childrens' Hospital, has been sponsored monthly by their program in multicultural education.

<sup>88</sup> Culhane-Pera KA, Reif C, Egli E, Baker NJ, Kassekert R: A curriculum for multicultural education in family medicine. **Educ Research and Methods** 1997;29:719-723

should include specialists in ethics, death and dying, anthropology, linguistics, interpreter training, where appropriate.

### C. Implications for Graduate and Undergraduate Education

*"Student dilemmas frequently delve into some deep and unresolved tensions between the actual experiences of providing medical care and our cultural ideals of doctor and patient attitudes and behavior...education must move from an over-reliance upon philosophical analysis to a candid scrutiny of medical social structure and culture."*<sup>88, p 11.</sup>

Tervalon points out the inappropriateness of treating cultural competence as yet another "theoretically finite body of knowledge [in] physician education."<sup>89</sup> Unless faculty validate, observe and teach around issues of self-awareness, language, culture, and responsibility to others on a regular basis, the issues go unattended. Consistent with this observation, multiple programs have proposed and/or adapted training principles that include attention to self-awareness, responsibility to others, team functions, how bias and racism operate.<sup>90</sup>

Christakis and Feudtner point out that "modern teaching hospitals shape and mediate relationships between people" and are all part of the culture of medicine itself.<sup>91 92 93</sup> Since inequities based on language and communications issues derive, in part, from medical training environments training programs must include attention to systemic, structural issues in training environments as well as to interpersonal issues.

Skelton et al have pointed out three ongoing challenges to medical educators and researchers: 1) Almost all communication skills research in medicine has a western setting, and it is not known whether conclusions based on this research are generalized, 2) Research is needed in such key areas as the cross-cultural transferability of such concepts as patient centeredness, the language of illness and the provision of successful opportunities for learning, and 3) Teachers working in culturally diverse societies must be sensitive to the potentially varied expectations and requirements of patients from different cultures.<sup>94</sup>

Finally, there are pragmatic, structural issues to contend with. Many training institutions lack adequate interpreter services or even the means to identify the language needs of their registered patients. This fact is well demonstrated by the literature cited above. In these institutional settings teachers, trainees and clinical mentors are placed in a position of teaching about culturally competent, optimal methods of care in systems that are operationally dysfunctional.

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<sup>89</sup> Tervalon M, Murray-Garcia: Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. **J Health Care Poor Underserved** 1998;9:117-25.

<sup>90</sup> Kai (1999, #6 cited above), Like (1996, #5 cited above), Tervalon (1998, #89 cited above).

<sup>91</sup> Christakis DA, Feudtner C: Temporary Matters The ethical consequences of transient social relationships in medical training. **JAMA** 1997;278:739-43.

<sup>92</sup> Feudtner C, Christakis DA: **Hastings Center Report**, 1994;25:6-12, cited above at 88.

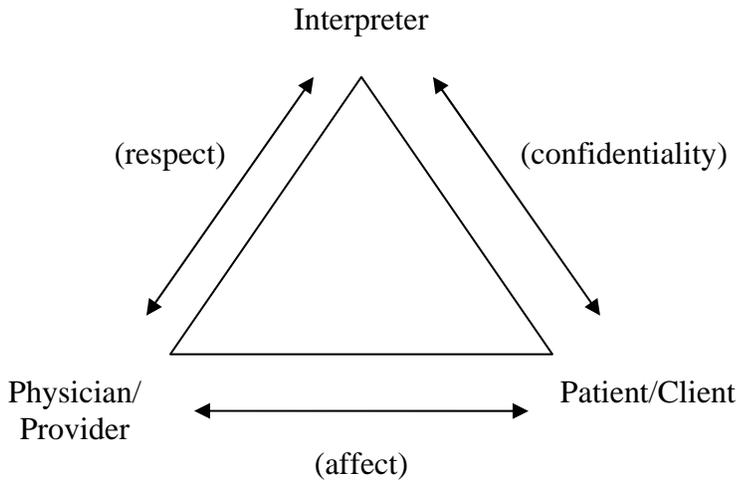
<sup>93</sup> Feudtner C, Christakis DA, Christakis NA: Do clinical Clerks Suffer Ethical Erosion? Students' perceptions of their ethical environment and personal development. **Acad Med** 1994;69:670-79.

<sup>94</sup> Skelton JR, Kai J, Loudon RF: Cross-cultural communication in medicine: questions for educators. **Med Education** 2001;35:257-61.

# Appendix A

## Interpreter training and styles: Different Models of Medical Interpretation<sup>1</sup>

Hardt's description of the bilingual triad focuses on basic themes that he sees operating between the participants. Hardt and Cashman created the following model<sup>2</sup> and comment that:



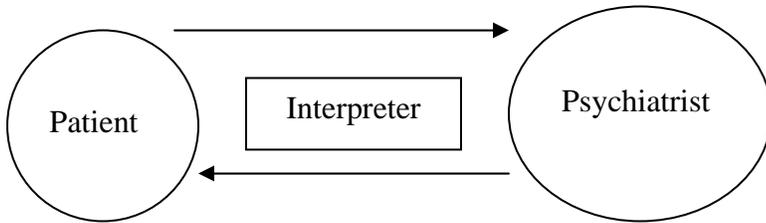
"between the patient and physician, the relationship is often based on affective issues. For both the patient and interpreter, the crucial issue is often confidentiality (if the interpreter is untrained or new to the field, confidentiality cannot be an assumption). Between the physician and the interpreter, the relationship hinges on mutual trust and the professional respect that comes with proper training."<sup>3</sup>

<sup>1</sup> The material presented in Appendix A is adapted from Conference Proceedings, University of Wisconsin, Milwaukee, 9/21/92, Putsch RW: Cross-Cultural Communication in Health Care Delivery.

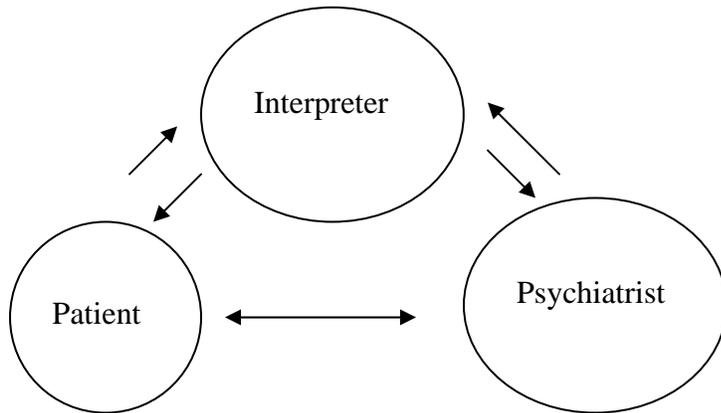
<sup>2</sup> Hardt EJ and Cashman R: Discussion leaders guide for the Bilingual Interview I and Bilingual II: The Geriatric Interview, Boston Area Health Education Center, 1991, pp. 50-51.

<sup>3</sup> The triadic model presented in Hardt's "Discussion Leaders Guide" parallels a model developed by Evelyn Lee, Executive Director of Richmond Area Multi-Services Center in San Francisco. Her work on this model is found in an unpublished manuscript: "Working with Interpreters in Mental Health," 5 pages, undated. The material was used in the 1990's for training interpreters at San Francisco General Hospital, Department of Psychiatry.

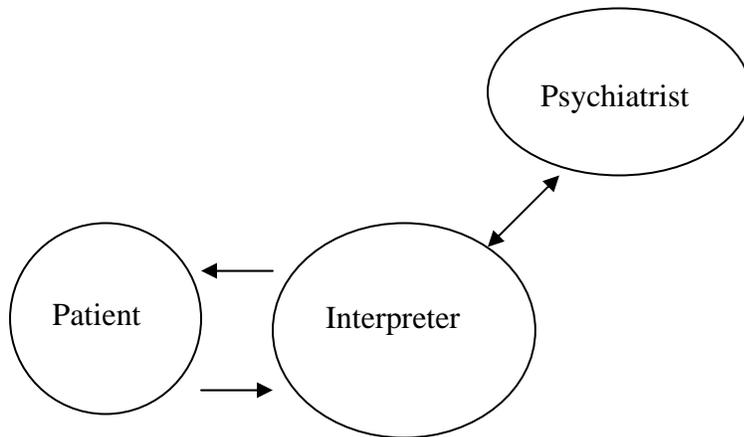
There are widely disparate ideas regarding the interpreter's role, perceptions of how interpretation works, and how training should be focused. Joseph Westermeyer, a psychiatrist, describes the "black box" model, a model "which is sought after in multilingual conferences and international meetings."<sup>4</sup>



"This model (on the left) treats the interpreter as a word unscrambler, (the model) reflects how many psychiatrists and interpreters, new to this clinical task, perceived their mutual roles." Westermeyer points out that this model is unsatisfactory. He sees experienced clinicians and systems moving to the "triangle model," or even what he calls the "junior clinician" model.



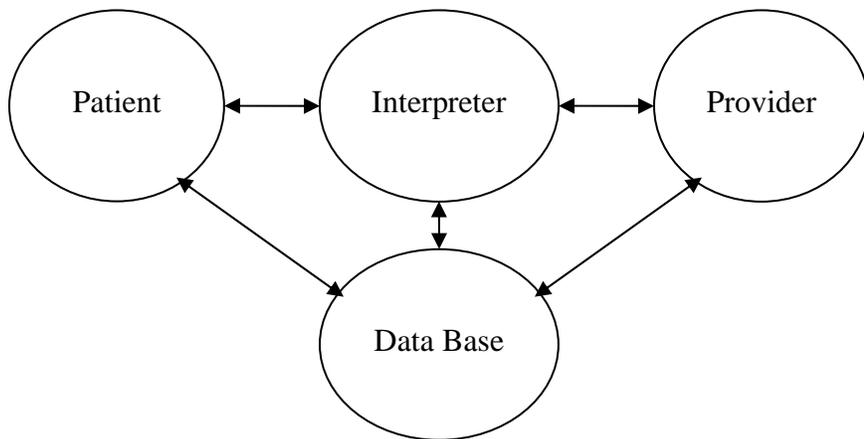
The "triangle model" (on the left) focuses on trust and relationships that take understanding of each others skills and work into account. This clearly calls for team function in triadic interviewing. For those who are interested, Westermeyer's text deals further with specific issues related to triadic interviewing in mental health work.



In Westermeyer's 'junior clinician model' (on the left) the psychiatrist "abandons all attempts to deal with the complexities of interpretation assigning the bilingual worker to a status of a 'junior clinician'...The psychiatrist then supervises the bilingual worker but does not see the patient." Both Westermeyer's work and that of Hardt and Cashman consider team functions as well as broadening the roles and work of interpreters in medical care.

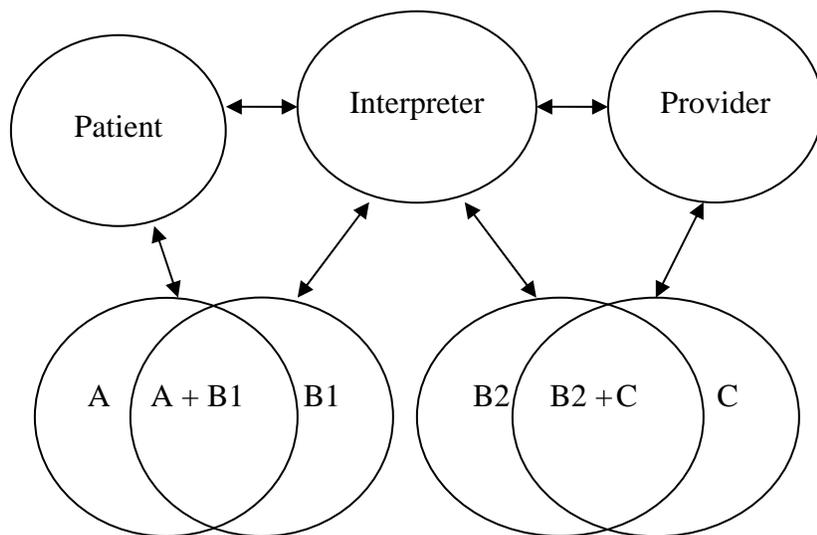
<sup>4</sup> Westermeyer, J: Psychiatric Care of Migrants: A Clinical Guide. Washington, DC: American Psychiatric Press, 1989, pp. 77-78.

My own focus has been on meaning and shared understanding in tradic interviewing. If it were possible that both parties received and understood the same messages, then Westermeyer's "Black Box" model might apply. The following diagram represents the wished-for "clean" exchange of information: (5)



The single circle at the bottom of the left hand diagram reflects the wished-for unity in under-standing. Frustration in our own lives by misunderstanding/disagreements over "who said what" teaches us that this model often doesn't hold for communication between individuals speaking the same language! Each party is likely to have a unique view of what was said, what they heard, or what was agreed to, etc.

"One data base is shared by the patient and the interpreter, a second by the interpreter and the provider....Note that each participant also has an independent view of the transaction (represented by the nonover-lapping areas marked A, B1, B2 and C). At issue is the degree to which areas A+B1 and B2+C are equivalent." "A number of issues interfere "with the generation of equivalent messages. Many information transfer problems are linguistic: bad paraphrasing, lack of linguistic equivalency, substitution or addition of terms, incorrect names and numbers and garbling of the message. Other issues include interpreter beliefs, biases, emotions, disparate views of meanings (of events, terms and trans-actions),<sup>5</sup> and the personal image of the interpreter."



<sup>5</sup> 77-78.(5) Adapted from Putsch, RW and Joyce, M: Language in Cross-Cultural Care. In Walker HK, Hall WD and Hurst, JW (Eds): Clinical Methods. Boston: Butterworths, 1990, pp. 1060-65.

## Appendix B

### The Interpreter's Role in Healthcare

The following is a conceptualization of the interpreter's role in health care that has arisen after six years of deliberation at a national level. This summary is quoted from Avery, writing about the work of the national working group on interpretation in health care, now the National Council on Interpreting in Health Care (NCIHC).<sup>1</sup>

"The basic function of the health care interpreter, as in other interpreter-mediated settings, is to provide a linguistic conversion from one language system into another in such a way that meaning is maintained.

Accuracy and completeness are professional standards that underscore the practice of interpreting. In the health care setting, however, fidelity to meaning may require the use of metaphors as well as negotiated explanations of concepts that do not necessarily have matching referents in the other language.

In providing this linguistic conversion, the interpreter also functions to facilitate understanding and communication between people who speak different languages. The interpreter acts in the interest of the shared goal of achieving the well being of the patient.

In the health care setting, in which shared meaning is so critical to the successful achievement of the goal of the encounter, the interpreter cannot remain a passive, uninvolved party. There are times when, because of the cultural distance between the parties, the interpreter may have to serve as a cultural bridge.

Transparency in the actions of the interpreter is paramount whenever the interpreter steps out of the core function of providing a linguistic conversion. That is, the interpreter has an obligation, whenever she speaks in her own voice, to make sure that both parties understand what she has said.

Irrespective of where a role perspective draws the boundary for what is acceptable in the role, an interpreter is expected to perform only those functions for which they are qualified by training and experience.

Interpreters do not speak for either the patient or the provider during the interpreter-mediated encounter.

Disagreements among the conceptualizations of the role still arise on two points: 1) the boundaries of what are considered acceptable functions within the role, and 2) the nature of the relationship of the interpreter with the patient and the provider."

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<sup>1</sup> From Avery, MPB: The role of the health care interpreter: an evolving dialogue. National Council on Interpreting in Health Care, Working Paper Series, April, 2001, available at <http://www.ncihc.org>, p 12-13.

## Appendix C

### An annotated Transcript of a Triadic Interview

The following transcript of a videotaped physician-interpreter-patient interview is provided for discussion of provider and interpreter roles in triadic interviews: <sup>1</sup>

**Doctor:** *She's anemic and pale, which means she must be losing blood.*

**Interpreter (in Cree):** *This is what he says about you. You are pale, you have no blood.*

**Doctor:** *Has she had any bleeding from the bowel when she has a bowel movement?*

**Interpreter(in Cree):** *When you have a bowel movement, do you notice any blood?*

**Patient (in Cree):** *I'm not sure.*

**Interpreter (in Cree):** *Is your stool ever black or very light? What does it look like?*

**Patient (in Cree):** *Sometimes dark.*

*(Later...)*

**Interpreter (in Cree):** *We want to know, he says, why it is that you are lacking blood, that's why he asked you what your stool looks like. Sometimes you lose blood from "there" when your stool is black.*

The physician is talking to the interpreter instead of the patient.

There is no word in Cree for "anemia" so the phrase "you have no blood," in Cree idiom, is used.

The physician, once again is directing his inquiry (and likely attention) to the interpreter. As the interpreter's inquiry progresses, she becomes an independent interviewer using her own knowledge of gastrointestinal history taking by asking questions about stool color that are un-cued.

This interaction lacks transparency. How would transparency operate here?

In this continuing exchange, an earlier direct statement from the clinician is used, followed by an explanation about why he asked about the patient's stool color.

Why would the interpreter offer an unprompted clarification about the relationship between stool color and blood loss? What kind of interpretive role is this?

Cultural frameworks need to be conveyed in both directions in a medical interview. This applies to the cultural system of the either the patient or the provider. In her final statement, the interpreter provided an unprompted clarification of the relationship between blood loss and the appearance of the stool. This illustrates the interpreter's role regarding accuracy and cultural frameworks, that is, expanding on and explaining, meaning. However, she provided the explanation without the provider's knowledge and thereby violated the principle of maintaining transparency during the interview.

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<sup>1</sup> From Kaufert JM, Putsch RW: Communication through interpreters in healthcare: Ethical dilemmas arising from differences in class, culture, language and power. **J Clinical Ethics** 2000;8:71-87, pp.78-9.

On the following day, colonoscopic and radiological examination revealed that the patient had a polyp in her colon. The physician recommended cauterization and worked with the interpreter to negotiate consent. We pick up the exchange just after the physician has spoken about the need for the procedure. As you read this, think about the interpreter's role, about transparency, about patient/clinician interactions and about altered or embellished meanings:

**Interpreter(in Cree):** *Do you want to have this procedure done? Will you consent to have this growth removed, burned?*

As the interaction progresses, the interpreter becomes active, nearly independent participant in eliciting consent.

**Patient (in Cree):** *I don't know.*

Another unprompted, non-transparent explanation is provided to the patient.

**Interpreter (in Cree):** *You know, if it's not removed it may bleed. It may cause problems.*

At this point, the interpreter seeks clarification (a validated role) en route to undertaking her own explanation to the patient (a non-validated role). As she does so, she provides no explanation to the patient about the nature of her inquiry to the MD.

**Interpreter:** *Dr. \_\_\_, isn't it true that if it's not removed, it can bleed and she can become anemic?*

The physician switches the mode of address. This time he directly addresses the patient. This is the preferred mode of address in triadic interviews.

**Physician:** *That's correct, we feel that your anemia may result from the bleeding of the polyp.*

Consider how power operates in this exchange. What if you knew that this interpreter attended the GI Clinic patients on a regular basis and was a coworker of the gastroenterologist?

**Interpreter (in Cree):** *If it's not removed, you may end up with cancer. You know? And you will not have the operation. [that is, the proposed colonoscopy does not involve invasive surgery]. It's harder when a person has an operation. You know? The procedure [colonoscopy] that he's going to do will get it on time. Before it begins to bleed or starts to grow. You're lucky it's caught on time...this way there's no danger that this growth will bleed.*

How would role designation, relationships and trust play out in such a working arrangement?

**Patient (in Cree):** *I don't know.*

When interpreters undertake independent roles, what are the implications for setting rules, boundaries and designation of staff responsibilities?

**Interpreter (in Cree):** *Well if you want to come in for the procedure while you are here ... [the patient lived at a distance in a rural community]. It's all up to you to think about.*

How will the MD know what has transpired?

Use the Interpreter Code of Ethics to assess this interaction.

The interpreter's un-cued intervention that introduced the association with the risk of cancer is an example of the power of intermediaries to introduce information. The ability of the interpreter to introduce additional information into the decision making process is a critical aspect of the informal power of interpreters. This power is generally exercised within a "black-box," inaccessible to the other participants in the interaction. Most interpreter courses include training around the principle of transparency. Transparency was violated in both directions in the above interviews. This underscores the importance of team function and of understanding, negotiating and controlling the interpretive process.

## Appendix D

### Truth telling: An ethical dilemma across boundaries of language and culture

Mr. L. is a 52-year-old Ibo-speaking businessman who was visiting his family in the U.S. He had experienced recurrent bouts of abdominal pain and his third ER visit led to an emergent surgery for presumed acute cholecystitis. The identification of aggressive T-cell lymphoma during the surgery was unanticipated. Towards the end of the procedure the patient's oxygen saturation began to fall, he was intubated and transferred post-operatively to the Intensive Care Unit on a ventilator. As the ICU staff had difficulty weaning the patient away from the ventilator, it became apparent that he had extensive lung involvement with the lymphoma. The patient spoke only Ibo, but was responsive and cognitively competent.

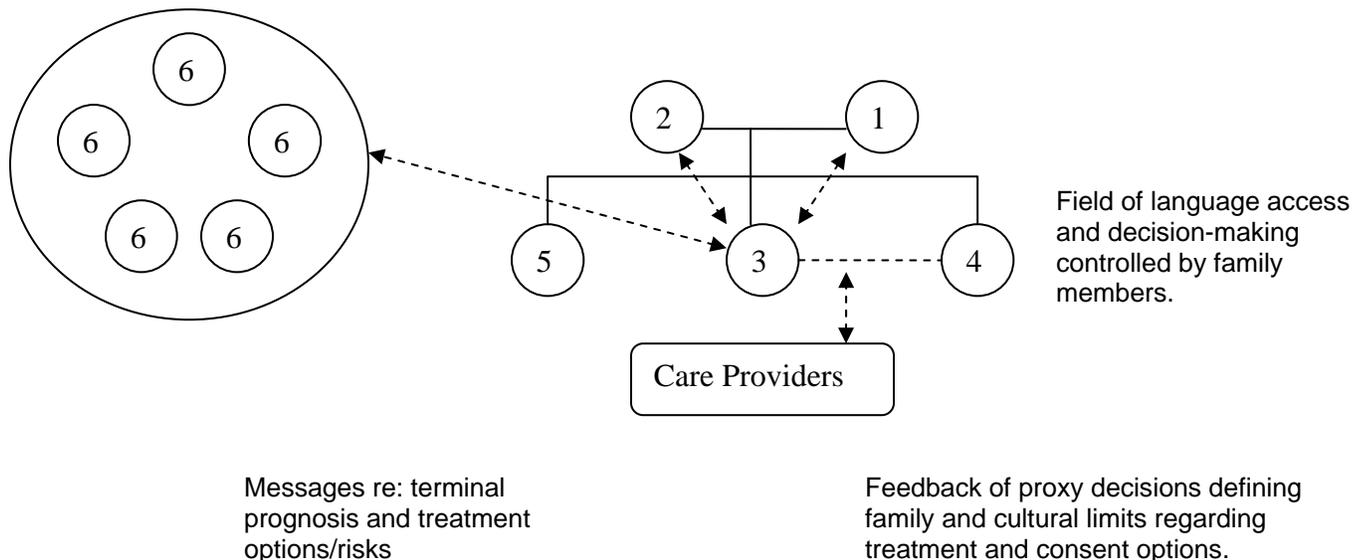
The patient's bilingual son and daughter were informed of the attending physician's request that a professional interpreter be involved in communicating with their father. They responded that they would not allow an Ibo-speaking person from outside the family to provide interpretation. They also refused the proposal that the A.T. and T. Language Line Service be used to provide objective external interpretation. Family members not only insisted that they provide all interpretation but they also asked that information on diagnosis and terminal prognosis be withheld from both the patient himself and from their monolingual sister who was accompanying their father. They explained that their sister was pregnant and needed to be protected from the trauma of knowing her father's terminal prognosis. The patient's son and daughter also stated that disclosure would abate hope and hasten the patient's death.

The figure (page 27) shows the patient and family members including the son and daughter who assumed the role of interpreters and proxy decision-makers as well as other family members who were variably informed of the terminal prognosis. The son and daughter contacted elders from their father's kin group in Nigeria, informing them of the situation and seeking their advice. They once again referenced their fear that full disclosure to their monolingual Ibo-speaking sister, who was often in the room with her father, would place her unborn child "at risk". As the patient's illness progressed the son and daughter informed their mother, who was also living in Nigeria, of their father's prognosis.

The family's complete control over communication through their involvement as interpreters created a dilemma for the caregivers. After several days the physicians informed the family members that the patient's survival and chances of getting off the ventilator might be improved by undergoing chemotherapy. Given the family members' opposition to direct communication with the patient, required for obtaining the patient's consent for therapy, the oncologist was initially unwilling to initiate the chemotherapy. The oncologist firmly stated that in order for ethical treatment to be initiated, the patient must know the diagnosis, as well as the risks and benefits of the proposed chemotherapy. The son and daughter again refused to communicate either the terminal prognosis or the risks of proposed treatment options to their father.

(Note - This case has been used extensively in internal medicine and family medicine training systems at the University of Washington using a format in which the case is read aloud by one of the participants and the moderator promotes the discussion. The fundamental questions revolve around the issues: What would you do if you were on the ward team asked to manage this case? What fundamental ethical issues are at stake here? Who are the stakeholders? How would you negotiate a solution? An annotated trainer's guide to this case is available from the author, bobp@xculture.org.)

The diagram below shows selective interpretation and communication by family members of an Ibo-speaking man with T-cell lymphoma. The son and daughter, who acted as language intermediaries, blocked the message of dangerous illness and of terminal prognosis to the patient and to selected family members.



Key:

1. Monolingual Ibo-speaking Nigerian cancer patient visiting family in US.
2. Patient's wife, resides in Nigeria, communicates with proxy decision-making family in US via phone.
3. Bilingual son employed in US as an engineer, becomes co-decision maker with sister via control of language interpretation.
4. Bilingual daughter who works as a nurse in US, shares control of communication and decision making with brother.
5. Monolingual daughter from Nigeria, accompanying father, frequently presenting hospital room, but excluded from communication because family feared the bad news would harm her pregnancy and unborn fetus.
6. Members of the extended family in Nigeria who receive delayed messages, but were fully informed of the serious nature of the illness.

## Appendix E

### OCR's Bottom Line for Linguistic Accessibility<sup>1</sup>

- Recipients of federal funds have an obligation to offer translation services at not cost to LEP (Limited English Proficient) individuals.
- Federal fund recipients need to have written policies for staff and staff awareness of the existence of such policies.
- Recipients [of federal funds] should ascertain the language needs of prospective recipients [of care] at the earliest possible opportunity.
- Recipients need to have a system for tracking LEP clients and client needs.
- Recipients should identify a single individual or department that is charged with ensuring the provision of language access services.
- Recipients should publicize the availability of no cost programs and services in non-English community newspapers and on non-English radio and television stations.
- Recipients need to provide written notices to clients in their primary languages informing them of their right to receive interpretive services.
- Family and friends of LEP individuals should be asked to provide interpretive services only after alternative, no cost methods have been explained and the patient still chooses family/friend interpretation.
- Minors should not be used to translate.
- Recipients need to ensure the availability of sufficient number of qualified interpreters on a 24-hour basis. There should be ready access to qualified interpreters so that services are not denied or delayed.
- Interpreters need to be qualified and trained, with demonstrated proficiency in both English and the other language, knowledge of specialized terms and concepts in both languages and the ethics of interpreting. Staffing levels need to be maintained, and the skill and fluency of interpreters should be evaluated on an ongoing basis.
- The use of telephone translation should be limited to situations where there is no bilingual staff person or contracted interpreter available to provide translation services.
- Translated written materials should be available. Thus, recipients will need to identify essential brochures, forms, and notices used by patients and translate them into appropriate languages.
- Recipients should conduct community outreach to immigrant communities, and give notice to community agencies and referral sources about the facility's new policies.
- Recipients should have cultural sensitivity training programs for their staff.

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<sup>1</sup> From National Health Law Program: Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities, Kaiser Family Foundation, Menlo Park, Ca, 1998, pp 25-27.

## Appendix F

The stress of an illness or having to attend a doctor's surgery can interfere with a patient's ability to communicate. This is compounded for those who speak English as a second language.<sup>1</sup>

- a) Effects of stress on language ability. Stress can create anxiety and a drop in language ability which becomes a self-reinforcing cycle including:
  - i. Isolation, confusion, lack of control
  - ii. Apprehension, anxiety, frustration
  - iii. Unable to concentrate, language ability drops below normal level
  - iv. Lack of language
- b) The health worker's intervention Stress can create anxiety and a drop in language ability which becomes a self-reinforcing cycle. The health worker is in a position to control the situation and his/her intervention can produce positive or negative results.

### Ways of Reducing Stress

- Allow more time than you would for an English-speaking Patient
- Give plenty of non-verbal reassurance
- Try to communicate some information about what's going to happen next
- Get the patient's name right and try to pronounce it correctly
- Keep full case notes (to avoid repeated unnecessary/complicated questioning) Try to ensure that the patient always sees the same staff
- Try and find out whether the patient has any specific fears or worries
- Provide the patient with clear and simple important points to take home

### Simplifying your English

To avoid confusing, patronizing or offending patients it is important to individualize the following advice according to the patient's needs (Mares et al 1985)

- Speak clearly but do not raise your voice
- Speak slowly throughout
- Repeat when you have not been understood
- Use the words the patient is likely to know
- Avoid idiomomatic speech and avoid 'pidgin' English
- Simplify the form of each sentence

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<sup>1</sup> 1- Adapted from McAvoy B: Enhancing communication with patients, in Kai J (Ed): Valuing Diversity: A Resource Guide for Effective Health Care of Ethnically Diverse communities. London, The Royal College of General Practitioners, 1999, Section 7.3.

- Give instructions in a clear, logical sequence
- Before you begin, simplify the total structure of what you want to say
- Stick to one topic at a time
- Be careful when you use examples
- Use pictures or drawings to help get your meaning across
- Be aware of your language (verbal and non-verbal) all the time

### **Checking**

Checking back properly should be done regularly throughout the consultation, using the following simple techniques (Mares, et al, 1985):

- Avoid asking "Do you understand?" or "Is that all right?" (You are almost bound to get a 'yes' for an answer)
- Try to avoid questions to which the correct answer is 'yes'
- Ask the patient to explain back to you what s/he is going to do
- Do not take nods and other gestures or expressions at face value

### **Learning the Patient's Language**

This is the most difficult of all options, and is not practical for health professionals with small number of ethnic minority patients or with several diverse language groups in their locality. It can be helpful, however, to learn a few basic phrases and key words in the commonest language(s) of your patients. Increasing your own language skills allows you to attend to the content of interpreter-dependent patient interactions.

## Appendix G

### Selected Terminology of Healthcare Interpreting<sup>1</sup>

**Ad hoc interpreter:** An untrained person who is called upon to interpret, such as a child interpreting for his/her parents, a bilingual staff member pulled away from other duties to interpret, or a self-declared bilingual who volunteers to interpret. Also called a lay or chance interpreter.

**Back translation:** The translation of a translated document, for example a medical glossary or a public health flier, back into the original language. This may be used to check the accuracy or register (level of language complexity, for example, “fifth grade English”) of the work, to examine for ‘common usage’ or in medical anthropology to analyze detailed characteristics of either spoken or written language.

**Bilingual worker/provider:** An employee who is a proficient speaker of two languages, who may provide direct services to Limited English Proficient (LEP) patients and who is often called upon to interpret for LEP patients, but who is not trained or certified as an interpreter. (Caution – most hospital and health systems lack any standards about assessing the language skills of self-declared bilingual workers or self-declared bilingual providers.)

**Certified interpreter:** A professional interpreter who is certified as competent by a professional organization or government entity through rigorous testing based on appropriate criteria. Interpreters who have had limited training or have taken a screening test administered by an employer, health facility or interpreter agency are not considered certified.

**Consecutive interpreting:** The conversion of a speaker or signer’s message into another language after the speaker or signer pauses, in a specific social context.

**First-person interpreting:** The use of first person speech, as though the interpreter were the voice of the person speaking. For example, if the patient says: “my stomach hurts,” the interpreter says (in the second language): “my stomach hurts,” and not “she says her stomach hurts.” The interpreter’s use of first person speech promotes direct communication between the principle speakers.

**Interpretation, interpreting:** The act of rendering a message spoken in one language into a second language.

**Limited English Proficiency (LEP):** A legal concept referring to a level of English proficiency that is insufficient to ensure equal access to public services without an interpreter. In clinical studies, LEP is used to describe patients adjudged by clinical personal as having limited English capability or patients who are self-described as needing an interpreter. LEP status is often intermingled with NES (non-English speaking) and studies of the role of language as an operant in health care disparities may be confounded by failures to distinguish between these two groups.

**On-site interpreting:** Interpreting done by an interpreting who is directly in the presence of the speakers. This is also referred to as face-to-face interpreting. (See remote and telephone interpreting)

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<sup>1</sup> Adapted from National Council on Interpreting in Health Care: The terminology of Health Care Interpreting: A glossary of terms, October 2001, the full text is available at <http://www.ncihc.org>

**Register:** The complexity or level of language used in spoken (interpreted) or written (translated) discourse. Register is often described by grade levels. One may read, for example, that “fifth grade English,” has been used to prepare a public health document, or a health research instrument. Interpreters are trained to alter the register used to fit their perception of the language capabilities of either conversant. They are not required to inform the health care provider of these changes.

**Sight interpretation:** Translation of a written document into spoken/signed language.

**Sing(ed) language:** Language of hand gestures and symbols used for communication with deaf and hearing-impaired people.

**Simultaneous interpreting:** Converting the speaker or signer’s message into another language while the speaker or signer continues to speak. (see consecutive interpreting)

**Telephone interpreting:** Interpreting carried out remotely, with the interpreter connected by telephone to the principle parties, typically through a speakerphone or headsets.

**Translation:** The conversion of written text into a corresponding written text in a different language. Within the language professions, **translation** is distinguished from **interpreting** according to whether the message is produced orally or in writing.

**Transparency/transparent:** The principle that everything that is said by any party in an interpreted conversation should be rendered in the other language so that every-thing said can be heard and understood by all parties. Whenever the interpreter had reason to enter into a conversation by speaking directly to either party in either language, the interpreter must subsequently interpret his/her own speech and that of the party spoken to, for the benefit of those present who do not understand the language used.

**Transparency:** is maintained when everything said by any party present, including the interpreter speaking for his/her own self, is interpreted into a language that others present can understand.