Cross-cultural Communication

The Special Case of Interpreters in Health Care

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Cross-cultural interpretation . . . requires special training and highly developed . . . skills. Just any bilingual person, chosen at random, is not sufficient.1

COMMUNICATION in health care is a complex issue. Language and cultural barriers complicate the situation. Language is the framework in which the world view of a culture is molded, and it describes the boundaries and perspectives of a cultural system.1 A language barrier disarms a communicator'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.

Interpretation requires a great deal of skill. Interpreters find it necessary to describe and explain terms, ideas, and processes that lie outside of the linguistic systems of clients. The interpretation process must account for divergent world views. Individuals and cultures have varying perspectives regarding the cause, presentation, course, and treatment1 of sickness, as well as the risk it represents to others.

The following discussion will focus on the role of interpreters. At the same time, the complex, broader issues of cross-cultural health care and communication will be addressed.

INSTITUTIONAL ACCOMMODATIONS TO INTERPRETATION PROBLEMS

Institutions vary in their arrangements to meet the needs of monolingual patients and health care providers. Even when there is a well-described need, many facilities have not dealt with language and cultural problems in a formal operational sense. This problem has a long history. Discussing the language problem on the Navajo Reservation in 1964, Levy1 pointed out that "there are no Civil Service positions for interpreters on the reservation, no ongoing in-service training programs in interpreting techniques . . . . what attempts have been made were invariably experimental in nature, short lived, and with little influence in governmental programs in general."

In 1979 and 1980, acting as West Coast Coordinator for Indochinese Refugees for the Health Services Administration, the author visited multiple urban clinics, agencies, and medical centers serving Southeast Asian refugees. Health facilities lacked (a) organized, on-site interpreter services, (b) programs to assess and upgrade the skills of bilingual employees utilized as interpreters, and (c) programs to train monolingual providers in the complexities of cross-cultural communication. Although major programs had been initiated at institutions such as the University of California-Irvine's hospital, formally organized, on-site interpreter programs were the exception rather than the rule. Providing interpreters was not seen as an institutional responsibility. For example, Chinese-American patients have been turned away for failure to bring an interpreter to the clinic in some California medical centers.1

THE CHANGING STATUS OF LANGUAGE-RELATED HEALTH CARE PROBLEMS

During the 1970s, community-initiated legal actions through the Office of Civil Rights addressed the issues of language, including sign language. These actions were based on Title VI of the Civil Rights Act of 1964, as well as Section 504 of the Rehabilitation Act of 1973. Institutions have responded by developing interpreter programs, by supporting community-sponsored interpreter pools, and by adding bilingual staff in clinic areas serving many non-English-speaking patients.

Interpretation costs cannot be directly passed on to monolingual or hearing-impaired individuals. The Indochinese Refugee Assistance Program of the Social Security Administration formally recognized the need
to reimburse health-related interpretation services in 1979 and 1980." Medicare's 1979 language-related health policy broke new ground: "The costs incurred for bilingual services are allowable provider costs." These policies allow institutions to incorporate interpreter services into their fixed operational costs. Medicare provisions recognize (a) communication with monolinguals and hearing-impaired patients, (b) translation of documents and health education material into target languages, and (c) costs of recruitment of bilingual employees. These policies represent a remarkable development when contrasted with earlier decades.

MEDICAL INTERPRETATION

Medical interpretation is necessary for a variety of health-related activities, ranging from clinical encounters to institutional processes such as registration, appointments, pharmacy, and medical records. These activities require varying levels of skill and knowledge. Special procedures, issues such as death and dying, and patients in the intensive care unit, recovery room, or social work department all add stress and complexity to the interpreter's role. Interpreters may act as ombudsmen or counselors, and the personal care and family situations they observe may be difficult ones.

Responsibility for interpretation generally falls on the shoulders of anyone who is bilingual and convenient to the scene. Trusted bilingual family members and friends are often ill-prepared to deal with the complexity of interpreting and have variable English skills. Bilingual employees frequently serve as interpreters. Some employees interpret for the major portion of their workday. Their jobs generally have other purposes and are not formally trained or paid for interpretation. Dual work roles that include interpretation often lead to job conflicts. Employees who interpret may become uncomfortably suspended between doing "real" work for their departments and demands from the hospital at large.

The interpreter is in a position of considerable power. There are two clients to be served, and the issues are often complex. It is difficult for interpreters to be entirely neutral and nonpartisan. As the sole possessor and processor of both clients' views, questions, etc, the interpreter is in a position to manipulate not only the information exchange, but also the situation.

Health care personnel must carefully observe and assess interpreter-patient interactions. The interpreter should be thoroughly involved with patients, should maintain visual contact with the client, and should not be otherwise busy (restocking a cabinet, for example). Unfortunately, physicians and nurses often take advantage of the interpreter's presence to write notes. When this happens, little attention is paid to verbal and nonverbal interactions between the interpreter and the patient. This is a risky practice.

The emotion behind a statement may completely alter its basic meaning and intent. Estimates are that actual word meaning accounts for only a small portion of emotional expression while the majority of an emotional message is conveyed nonverbally. Dependence on an interpreter frustrates a provider's ability to accurately assess emotional responses. The conversant's ability to quickly tie meanings, vocal intonation, and nonverbal activity together is paralyzed.

When practitioners converse with patients, there is a constant shifting of emphasis between data gathering, problem solving, therapy, and education. The process is dynamic, and the interpreter must adapt to shifting roles, assuming some of the provider's role during the interview process. Extensive questioning during interviews may prove perplexing to patients or interpreters who lack experience with biomedical inquiry. To elicit cooperation or obtain a more comprehensive history, it is often necessary to clarify the purpose of such detailed inquiry.

Monolingual patients often end up with the "poor historian" label in their health record. This label may reflect lack of familiarity with Western medicine and communications rather than an inability to present or answer questions appropriately. Issues other than "interpreter error" are often operative. Focused cultural patterns may alter the patient's willingness or ability to make statements that meet the expectations of a biomedical history. How is a man who has never relied on a clock likely to respond to an inquiry regarding the duration of an episode of pain? How is time handled within his world view and language? Answering these questions is akin to translating the message "the detective dialed the number" into the language of a culture that has neither detectives nor telephones.

Finally, it is essential to recall that many interpreters live within the community in which they work. They often know things about patients even before the interview begins. They may have conflicts about the revelation of material that the patient has not volunteered, and the client's trust may be tenuous.

SELECTED ISSUES AND PROBLEMS IN MEDICAL INTERPRETATION

The illustrations that follow are drawn from both the literature and the author's experience. The episodes represent either common problems in message transfer or less-well-recognized issues that play a role in medical interpretation.

Bad Paraphrasing

Lang and Laumer used recording and retranslation to study interpretation in separate studies carried out in New Guinea and in Nigeria:

Patient (in Enga): "The cough really just lingers on."
Interpreter: "He has a cough."
Patient (in Hausa): "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."
Patient (in Hausa): "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 the pain."
Interpreter: "He has pain in the right leg. Right inside the bone."

Message changes that occur because of bad paraphrasing and frank omissions are quite variable. Studies of trained nonmedical interpreters reveal that errors most frequently involve names, omissions, additions, substitution of terms, incorrect numbers (dates, quantities, etc), and garbling of the message." A careful-
ly worded statement may be only roughly approximated. Paraphrasing may compound two separate and unrelated issues into one. Patients often allude to essential and pivotal information indirectly or briefly. A minor "omission" by the interpreter may cause a health care provider to miss a crucial comment.

**Interpreter-Patient Interactions**

Launer recorded occasional "skirmishes" with the patients:

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 the two?"

This episode points out that interpreters represent the addition of a third human to the communication process, each one subject to the same human foibles.

**Linguistic Equivalency and Training**

A Navajo woman was being interviewed prior to therapy with intravenous antibiotics. The nursing aide was frequently sought out by the physician staff because of her interpretation skills. She had been serving as an interpreter for 15 years.

Physician: "Mr., would you ask her if she is allergic to any medications?"

Aide (in Navajo): "Does the white man's medicine make you vomit?"

Patient (in Navajo): "No."

Physician: "Did you ask her if the white man's medicine makes her vomit?"

Aide: "Yes."

Physician: "That's not quite what I need to know, I have to know about allergies to medications..."

Aide: "Well, I don't know about those things... what's allergy mean anyway? If you know so much Navajo, why don't you ask her?"

The interviewing methodology failed to account for a lack of linguistic equivalency and for differing degrees of comprehension between the participants. Explaining "biomedical concepts to Native patients" has been viewed as a basic "culture broker" function of medical interpreters. "Allergy" is a biomedical abstraction and is usually used and understood by English speakers. It often requires explanation. The concept of allergy is missing in the Navajo ethnomedical system and language. Coining a new Navajo term is not a solution. Newly created terms have little practical use in day-to-day communication."

Altered interview methodologies may help overcome this kind of problem: "Did you ever have a rash from medication? Did you ever have breathing troubles from a medication? Did you ever...?" Once two or three direct inquiries are made, a word picture emerges of differing forms of sickness due to medications. At this point, the patient will frequently offer a description of sickness or symptoms induced by medication. Alternatively, the item must be explained by the use of a somewhat encyclopedic approach. Common terms such as *bacteria, depression, anxiety, or diabetes* will often require special explanation.

Training will partially neutralize the problems demonstrated by this case. The training process must include both the providers and the interpreters. Training should deal with the special nature of cross-cultural communication as well as biomedical and cultural theories, practices, and terminology.

**Interpreter Beliefs and Patient Interactions**

An elderly Navajo patient with mild senile dementia returned for an outpatient visit. His physician had recently cared for him during two prolonged hospitalizations. The patient entered, greeted the physician in Navajo, shook hands, and embraced him. He then turned and extended his hand to the nurse's aide who was acting as interpreter. She fled from the hallway to find him: "N., what are you doing? That man is one of my favorite patients..." She was visibly frightened: "My mother told me not to shake hands with gray-haired people... they might witch you. Besides, I know about that old man. My husband's family has a sheep camp out that way. He is no good."

Medical personnel bring their own unique views, emotions, and beliefs to clinical settings. The aide's views were ethnocentric. She reacted to a perceived threat with real fear and dread. She was a "true believer" in a folk system that has been well documented by Kluckhohn. Special beliefs, emotions, and prejudices exist on all levels of human activity. These issues may cause unexpected problems when health care personnel deal with a variety of issues—for example, death, suicide threats, ethnicity, or alcoholism.

**Interpretation Roles**

A monolingual woman from Mexico was being evaluated for difficulties with sleep. She had appeared worried and anxious during prior visits. The interviewer began to focus on psychosocial issues. Her marital relationship was discussed in relation to a recent event at home, and tears appeared imminent as the patient spoke: "Well, I'll tell you what's really happening..." The interpreter became uncomfortable, spoke up, and defused the situation: "You must have had some really hot chilies that night..." Both laughed and the entire direction of the interview was broken.

Interpreters must often share the provider's diagnostic or therapeutic role. In this instance, the interview was interrupted by the interpreter's comment. Later, discussing the episode, the interpreter described being overwhelmed by the need to help the woman. Remember, interpreters are co-workers and colleagues. Recognition of this fact might have led to a preinterview conference with development of a plan to deal with the special situation involved.

**The Interpreter's Self-image**

A 52-year-old Spanish-American head nurse of an ambulatory referral area in a teaching hospital frequently acted in an interpreter role. Multiple patients had confided in her regarding folk definitions and therapy relating to their illnesses. She had consistently withheld this information from the physician staff. Over time, she expressed concern about discussing traditional views and practices: "Patients shouldn't believe those things. I tell them that and I don't translate what they say to the doctors." "I don't think we should discuss things like that in a place like this—it makes it look like we approve of it." "What with my position here and all, it doesn't seem right to talk about it. This place is dedicated to modern medicine." "If I tell the doctors, they
might think that I believe in that too.

The ability to deal honestly and openly with issues that have heavy cultural overtones is highly variable. The nurse feared being labeled and wished to avoid being associated with the beliefs presented by certain patients. She overcame her reluctance to discuss special beliefs after participating in in-service education regarding cross-cultural care. The training included videotapes of cases in which patients' beliefs played a role in the course and therapy of their illnesses. She eventually provided highly educational commentary on the consistency of the beliefs and the meanings of the special terminology presented.

Ethnocentric Expectations

A mental health worker/interpreter and her supervisor were participating in a seminar about cross-cultural care. They raised the issue of physicians “who won’t listen to you.” When asked for an example, they described a psychiatrist who was interviewing a Vietnamese refugee and who was preparing to prescribe medication for recurrent anxiety.

Psychiatrist: “Ask her how long she thinks she’ll need to take these medications.”
Interpreter (in Vietnamese): “He says you should take this medicine for two weeks and then come back and see him.”

The return date and appointment were discussed in Vietnamese.
Interpreter: “He says she’ll take the medicine for two weeks and then she’ll come back to see you.”

The psychiatrist’s question was based on a Western therapeutic model. It attempts to engage the patient in decision making and it assumes she must take some responsibility for therapy. The interpreter’s response was also ethnocentric. She felt that the psychiatrist should be directive and that the patient would interpret his question as evidence of therapeutic uncertainty.

Both the interpreter and her supervisor felt that the psychiatrist was unapproachable about the manner in which he handled Vietnamese patients. The interpreter’s solution to the problem represented a basic survival technique for interpreters. She dealt with both clients and, in her view, avoided trouble. The real nature of this exchange was hidden from both monolingual participants.

Special Problems in Mental Health

Marcos describes special problems including “normalization” of patients’ thought disorders and discusses a variety of issues in interpreter-dependent interviews:

Interpreter to patient: “Is there anything that bothers you?”
Patient’s response: “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 to clinician: “He says that he is not afraid, he feels good, he doesn’t have headaches anymore.”

These distortions were thought to be due to lack of psychiatric knowledge and sophistication on the interpreter’s part. Marcos also reports distortions by family members who tended to enlarge or minimize patient symptoms and occasionally disagreed with the clinician’s suggestions in the process of translating them. Failure to perceive important shifts in language use and statements by patients may lead to inaccurate assessments of their mental health status.

CONCLUSION

Monolingualism presents a special challenge to health care. Preparation and recruitment of providers and staff with language skills will only partially resolve the problem. Responsible interactions with monolingual patients require systems to deal with issues of language and culture. Monolingual providers and staff need training to learn the implications of both language and cultural barriers.

The following guidelines are directed at communications between monolinguals in health care settings. They focus on general principles, interactions between patients, providers, and interpreters, and selected rules for language use.

General Guidelines for Monolingual Providers in a Cross-cultural Environment

1. Unless you are thoroughly effective and fluent in the target language, always use an interpreter.
2. Avoid using family members as interpreters.
3. Learn basic words and sentences in the target language. Asking interpreters about words or comments that have not been translated prompts attention to detail.
4. Utilize dictionaries of languages used by your patient population. Beware, brief “definitions” provided by translating dictionaries only serve as labels.
5. Become familiar with special terminology used by patients. Specific beliefs, practices, and traditions are often referenced by indirect language or special terms. Local beliefs and moral tenets may lead to overemphasis or underreporting of certain symptoms, issues, and events.
6. Check the quality of translated health-related materials by having them back-translated.
7. Meet with your interpreters on a regular basis. They will provide both a window and a mirror when you deal with another language and another culture.
8. Personal information is often closely guarded and difficult to obtain. Patients often request a specific interpreter or even bring one to the clinic.
9. Evaluate the interpreter’s style and approach to patients. For special situations and problem cases, try to match the interpreter to the task.
10. Be patient. Careful interpretation often requires that the interpreter use long explanatory phrases.

Guidelines for Provider-Interpreter-Patient Interactions

1. Address your patients directly. Avoid directing all of your commentary to and through the interpreter.
2. Be certain the interpreter is thoroughly involved with the patient during an interview.
3. Develop alternatives to taking histories via direct questions. Strangers to direct, Western-style inquiry may respond better to conversational modes.
4. Invite correction and induce the discussion of alternatives: “Correct me if I’m wrong, I understood it this way . . .” “Do you see it some other way?”
5. Pursue seemingly unconnected issues that the patient raises. These issues may lead to crucial information or uncover difficulties with the interpretation.
6. Come back to an issue if you
suspect a problem and get a negative response. Be certain the interpreter knows what you want. Use related questions, change the wording, and come at it indirectly.

7. Provide instructions in the format of lists. Have patients outline their understanding of the plans.

8. If alternatives exist, spell each one out.


10. Clarify your limitations. The willingness to talk about an issue may be viewed as evidence of "understanding it" or the ability to "fix it."

11. Rumors, jealousy, privacy, and reputation are crucial issues in closely knit communities. Acknowledge the problem and assure the patient of confidentiality.

12. Unless the correct circumstances are devised, it may be impossible to address certain male/female problems by way of discussion or physical examination.

Guidelines for Language Use in Interpreter-Dependent Interviews

1. Use short questions and comments. Technical terminology and professional jargon, like "workup," should be reduced to plain English.

2. When lengthy explanations are necessary, break them up and have them interpreted piece by piece in straightforward, concrete terms.

3. Use language and explanations your interpreter can handle.

4. Make allowances for terms that do not exist in the target language.

5. Try to avoid ambiguous statements and questions.

6. Avoid abstractions, idiomatic expressions, similes, and metaphors. It is useful to learn about these usages in the target language.

7. Plan what you want to say ahead of time. Avoid confusing the interpreter by backing up, inserting a proviso, rephrasing, or hesitating.

8. Avoid indefinite phrases using "would," "could," "if," and "maybe." These can be mistaken for actual agreements or firm approval of a course of action.

9. Ask the interpreter to comment on the patient's word content and emotions.

References


