

## Interpreters in Medical Consultations — A Literature Review — Dr Brian Wood



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### Curriculum vitae

Brian was born in Cape Town, and obtained the MBChB at UCT in 1982. He completed his internship at Victoria Hospital, Wynberg. From 1985 to 1990 he worked in rural KwaZulu, mainly at Charles Johnson Memorial Hospital in Nqutu, then at Hlabisa Hospital. In mid 1990 he joined the Family Medicine department at Medunsa. He completed the MPraxMed in 1991, and at present is appointed as a Family Practitioner and Lecturer at Medunsa. He is responsible for the department's programme for final year medical students. He is married to Judy and they have two children.

### Summary

*Interpreted medical consultations are common in South Africa, particularly in the public sector. A common perception exists that interpreted consultations are inherently unsatisfactory, but the research literature provides little evidence for this view. Conceptual models of the interpreted consultation are discussed, the evidence concerning who should interpret is reviewed, research findings are discussed, and potential areas for further research are highlighted.*

*S Afr Fam Pract 1993; 14: 347-53*

### KEYWORDS:

Physicians, Family; Interviews; Interpreters; Physician-patient Relations; Language.

"Nurse, please will you ask the patient how he understands the cause of his disease?" A prolonged, incomprehensible interchange then follows. Eventually the nurse turns to the doctor. "The patient says 'Yes, he is willing', doctor!"

Many interactions between doctors and patients in South Africa are conducted through an interpreter. I have worked daily with interpreters for 9 years, and had numerous experiences similar to that recorded above. I felt unprepared for such consultations. The whole area of interpersonal communication received little attention in the curriculum when I was an undergraduate, let alone a sub-component like cross-cultural interviews. The doctor-patient relationship has become a core

concern for Family Practitioners. For generalists working in a cross-cultural setting, language and interpretation is of central importance to the development of this relationship, and is receiving increasing attention. The literature reviewed was sourced predominantly through the use of the Medline database.

The literature dealing with the use of interpreters is largely of recent origin. Much research originates in those developed and affluent countries which are experiencing an influx of people from less affluent countries, and are encountering new difficulties with communication related to language and culture.

Much of this literature arises out of a psychiatric setting, indicating recognition of the importance of communication in the evaluation and management of such illness forms. Some early work was conducted by western trained doctors working in non-western settings. From North America there is research dealing with communication problems experienced by the indigenous populations. Research initially focussed on the quality of the information provided to the doctor. The quality of the interaction, particularly the perceptions of the patient, have only recently been given attention.

### Conceptual Models of Medical Translation

Theoretical models have been developed to describe the interaction which occurs. It has been accepted as a starting point that, in contrast to the dyadic clinician-patient model with its single relationship, the triangular doctor-interpreter-patient model involves 3 relationships.

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Within this structure there are a variety of possible ways for the interaction to be handled.<sup>1</sup>

#### 1. *Interpreter as interviewer*

In this model, the interpreter conducts the interview along general guidelines provided by the doctor, who has no direct interaction with the patient.

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Interpreted interviews are certain to be with us for the foreseeable future

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#### 2. *Interpreter as instrument of the provider (Black box model)*

Here the doctor wishes to retain control of the interaction, and requires as direct a translation as possible of his or her questions and the responses of the patient. This model may well be appropriate in certain settings like international meetings, but it is limiting in a medical context. Many basic concepts in medical thought are not directly translatable into another language, and the same applies to the patient's conceptualization of the disease process. However, it is clear from the research articles discussed below, that many of the authors consider this to be the appropriate way for an interpreter to function.

#### 3. *Interpreter as patient advocate*

Here interpreters see themselves as protecting the patient from excesses of the doctor or the medical context to which the doctor belongs. It is unusual for

doctors to ask their interpreter to assume such a role.

#### 4. *Interpreter as culture broker*

Often there is a substantial cultural gap between doctor and patient of which the interpreter will often be aware, although the doctor and patient may both be less conscious of their own cultural determinants. Over-identification with either the doctor or the patient may put pressure on the interpreter.

#### 5. *Model of partnership*

This model is considered to be the ideal. Here it is recognized that both the doctor and the interpreter have specialized knowledge to offer the patient, and that for the patient to receive optimal care, they need to function as a team.

### Who Interprets?

Interpreters vary substantially. The literature describes the use of personnel dedicated specifically to the task of translating.<sup>2,3,4,5</sup> This

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### Language and interpretation is of central importance in the doctor-patient relationship

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arrangement is highly rated. It is probably uncommon in South Africa in a medical context, although it has been the practice in our courts for years.

The use on a casual basis of a wide variety of other medical, nursing,

paramedical or even non-medical ancillary staff as interpreters, is also described.<sup>6,7,8</sup> Such personnel are not paid to interpret, and receive no formal training or recognition for their services. This is probably the common situation in South Africa.

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### Very few articles on original research available

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This arrangement has been criticized on two counts. Firstly, because interpretation is not formally part of their job description, such interpreters receive no training and no recognition, and often experience tension between interpreting, and the requirements of their formal duties. Secondly, issues of confidentiality may arise, if for instance, the doctor is unaware that the patient and the interpreter already know each other.<sup>9,10</sup>

All authors who have considered the subject agree that the most unsatisfactory interpreters are relatives or family members of the patient. Their relationship with the ill person introduces interactions into the interview which are complex, and greatly influence the information obtained. This is particularly so when the interpreter is the child of the ill person.<sup>11,12,13</sup>

### Research Findings

Price compared the proficiency of three interpreters, one of whom was a psychiatric patient described as being in full remission.<sup>6</sup> It was found that the completely inexperienced patient was by far the most accurate interpreter, with fewest omissions and

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mistranslations. When the language proficiency of the three was compared, it was found that the patient had substantially better command of English than the other two, both of whom were medical orderlies.

Lang audiotaped consultations where medical orderlies were also used as interpreters, in Papua New Guinea.<sup>7</sup> With the emphasis on identifying mistranslations, he noted that most errors could be described as either additions or omissions. The interpreters were prone to initiate their own questions, either to clarify an answer given by a patient, or to demonstrate their own medical acumen. Interpreters were perceived as displaying little sensitivity, interrupting the flow of patients' responses indiscriminately, when the amount to be translated became substantial. No indication is contained in this study of the frequency of mistranslations. In a

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#### The experience and perceptions of the patient are seldom given

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similar study in Nigeria, Launer found that interpreters often did not provide a word-for-word translation of what the doctor or patient said.<sup>8</sup> Some deviations were thought to have been helpful, some confusing or incorrect.

In a psychiatric context in New York, Marcos looked at aspects of the use of interpreters for patients whose first language was Spanish.<sup>13</sup> Starting from the assumption that "faithfulness is the fundamental object of

interpretation", he identified three major sources of interpretive distortions: (1) Omissions, substitutions, additions and condensations arising from deficient language or translational skills of the interpreter. (2) Interpreters' lack of

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#### No longer only doctor-patient relationship. It becomes the doctor-interpreter-patient relationship

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psychiatric sophistication, resulting for instance, in the normalization of thought disorders. (Price made a similar observation.)<sup>6</sup> (3) Interpreters' attitudes towards either the patient or the clinician, sometimes leading to deliberate distortions.

Sabin reported the unanticipated suicide of two Spanish speaking patients after interpreted consultations.<sup>2</sup> He found that the severity of the illness was accurately identified, but that psychotic features were given precedence over recognition of the depth of the patients' despair. This was despite the use of a translator fluent in both languages, and with training in school counselling. Sabin concluded that *affective* components of mental illness are prone to being mistranslated.

Marcos has provided evidence that schizophrenic patients whose native language was Spanish, when interviewed in English without an interpreter, were scored as showing more evidence of psychopathy than when they were interviewed in Spanish. The patients generally

appeared to be more proficient in Spanish than in English.<sup>15</sup>

A study conducted by Kline et al had a different focus and produced somewhat surprising results.<sup>16</sup> This study was also conducted in the context of a psychiatric outpatient clinic. Questionnaires were administered to both patients and psychiatric registrars after interpreted consultations. The registrars only occasionally made use of an interpreter. A wide discordance was found between the psychiatric registrars who had little faith in the potential for a therapeutic relationship to develop when an interpreter was used, and their patients, who felt very positive about the interaction, and were keen to return under the same circumstances. Kline concluded that mental health professionals working with an interpreter in a cross-cultural context, may not understand what patients want or feel and may instead project their discomfort onto patients.

Bucci and Baxter looked at linguistic insecurity in a multicultural speech context.<sup>17</sup> Their patients were speaking a second language or a non-

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#### Family members or friends are the most unsatisfactory interpreters

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standard form of English to Standard American speaking therapists. No interpreter was readily available. They point out that even speakers who are apparently competent in the language of the consultation may be feeling insecure, and describe a method for detecting such insecurity.

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Dodd observed in the introduction to his study in Saudi Arabia, that the literature has assumed that patients are "disadvantaged" when they do not share a common language with their physician.<sup>18</sup> Dodd compared the diagnoses reached by English speaking doctors using interpreters,

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The depth of the patient's despair not interpreted

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with those reached by Arabic doctors, and found that differences were related to the experience of the doctor and not to the use of interpretation. Dodd decided the instrument for measurement was too crude to find differences which must exist. Despite the lack of evidence which he provided, he concluded that "there is no doubt that, with regard to mental diseases and ill-defined conditions, the patient is disadvantaged when the doctor and patient do not share a common language".

Kaufert and Koolage have published initial observations concerning role conflict experienced by native Canadian medical interpreters.<sup>19</sup> It was noted that: "Interpreters are often faced with conflicts between their role as health system employees and their role as culture-brokers and patient advocates". A number of examples are provided of the interpreter being pressurised by either the clinician, with a biomedical agenda, or the patient, who looks to the interpreter for cultural support.

A postal survey of GPs seeing Asian patients in Newcastle was conducted by Wright.<sup>11</sup> All interpreters used

were family members of patients. The doctors felt that members of this community were prone to complain of trivial ailments, while infrequently presenting with psychosocial problems. One GP experienced a drop in trivial complaints on learning some Hindi, and Wright postulated a connection between inadequate communication and unnecessary complaining.

Also in an Asian context, in Leicester, Ebden et al, audiotaped and transcribed consultations translated into Gujarati.<sup>12</sup> Again the interpreters were provided by the patient, and were family members. 23-52% of questions asked by the doctor were mistranslated or not translated at all! It is difficult to believe that these interactions appeared to be fairly normal to the doctors involved. Anatomical and technical terms were particularly prone to mistranslation. Children were found to be

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If patient and interpreter already know each other, sensitive issues of confidentiality may arise

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embarrassed to translate questions about menstruation or bowel movements for their parents, and there was a general tendency for questions about bodily functions to be ignored. In a similar context in Bradford, Ahmad et al, found a strong preference for doctors who could speak the patient's language, where the patient's proficiency in English was poor.<sup>20</sup>

A common recommendation made by authors is that doctors should

learn the language of their patients, but the results of attempts to do so have not received much attention. Erzinger has provided evidence that language acquisition does not by itself solve communication difficulties.<sup>21</sup> If the system for scoring patient centredness developed by Henbest is applied to the four consultations recorded by Erzinger,

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Faithfulness is the fundamental object of interpretation

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poor scores are obtained (1 = closed responses only, in 2 consultations), unless the doctor's language proficiency is of a very high standard (2 = open responses to patient offers, also in 2 consultations).<sup>22</sup> No interpreter was present during these consultations.

There is a vast literature dealing with issues relevant to the translation of a research questionnaire into another language. The relevance of this research to the use of interpreters is debatable, but it does give insight into the linguistic and social complexities involved in translation. Drennan et al have provided an interesting local account of the interactions which occurred in the preparation of a Xhosa version of the Beck Depression Inventory.<sup>23</sup> They highlight the power relationships which occur in what is essentially an interpersonal process, leading to the potential for a struggle for control.

A component of a study undertaken by Henbest to evaluate the patient centered approach in a non-western context, suggested that the use of an interpreter does not inevitably lead to

poor patient-centredness scores.<sup>24</sup> Interpreted consultations were found to be more patient centered overall than consultations where no interpreter was used. The instrument used had previously been validated in a monolingual context.

### Summary of Research Findings

1. The most common types of errors identified were omissions, additions, condensations and substitutions.<sup>14</sup>
2. Errors are reduced when the interpreter is proficient in both the languages used.<sup>6</sup>
3. Interpreters are inclined to take control of consultations (role exchange).<sup>7,8</sup>
4. If the interpreter has limited insight into the possible disease process, certain types of problems are likely to be normalized (eg thought disorders).<sup>6,14</sup>
5. Interpreters are a third party in a consultation, and influence the course of the consultation. Their attitudes towards the people concerned, ethical position and cultural background influence the interpretation provided.<sup>19</sup>
6. Patients may appreciate the presence of an interpreter, while the doctor may feel uncomfortable about conducting an interview with an interpreter. Both are likely to be unaware of this divergence.<sup>16</sup>
7. No clear disadvantage has been demonstrated in a large group of patients when an interpreter was used.<sup>18</sup>

8. Anatomical and technical terms are prone to be mistranslated.<sup>12</sup>
9. Language acquisition by the doctor, who then stops using an interpreter, does not rapidly solve communication difficulties, unless the doctor is highly proficient.<sup>21</sup>
10. The use of an interpreter is not inevitably associated with poor patient-centredness scores.<sup>24</sup>
11. Emotional content may be the component of the interaction most easily lost when an interpreter is used.<sup>2</sup> It may also be easily lost when a second language is spoken poorly by the patient.<sup>17</sup>

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### The emotional content is the one most likely to get lost

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12. The use of family members as interpreters is associated with a large number of mistranslations, and is not the ideal.<sup>11,12,18</sup>
13. Even the use of a trained, highly proficient interpreter can be associated with misunderstandings (which can certainly occur when both the doctor and patient speak the same language and no interpreter is present!)<sup>7</sup>
14. Patient proficiency in their second language if it is being used in the consultation, leads to a perception of a reduced need for a doctor who speaks the patient's first language.<sup>20</sup>

### Commonly Repeated Recommendations Lacking Supporting Evidence

The evidence available suggests that the use of casual interpreters is associated with frequent problems, particularly when they are family members. High levels of satisfaction have been reported when professional interpreters are used, for instance by Richter et al.<sup>4</sup> However, no studies have been done comparing trained interpreters with, for instance, nurses who regularly interpret but have no formal training.

In the light of identified limitations to the use of the interpreters, various recommendations have been made concerning appropriate behaviour for doctors utilizing interpreters. These include asking short, simple questions, and rephrasing and repeating questions, to check the quality of translations.<sup>7,8,25</sup> These seem to make sense, but the resulting consultations have not been reported. Such questions are likely to be closed, and not conducive to a patient centred interview.<sup>18,24</sup>

Reference is made in the literature to the importance of building an understanding with the interpreter before beginning the consultation with the patient.<sup>5</sup> This is usually said in the context of a brief interaction, and no attention has been given to the effects of a long-term relationship between a doctor and an interpreter.

The effects of exclusively or predominantly interacting with patients through an interpreter have not been studied. Many doctors in the South African public service are in this position, and the literature does not provide information concerning the adjustments likely to occur.

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Emotive statements have been made, like that of Andreyev, who asked, "Is it too radical a position to suggest that every individual deserves a doctor who can speak to him or her in his or her own language?"<sup>26</sup>

However, language acquisition as an adult is not easy. Sustained, high levels of motivation are required, often for years, to reach adequate proficiency, unless there is no available alternative to learning the language concerned. Usually, as in western countries experiencing immigration, there are much simpler alternatives for the doctor, like expecting the patient to learn the

doctor's language.<sup>13</sup> Furthermore, the research literature does not provide convincing evidence that interpreted interactions are always unsatisfactory.<sup>18</sup> Also, Erzinger's

## A plea for trained interpreters

study suggests that high levels of language and cultural knowledge are required by the doctor for the interaction to be satisfactory.<sup>21</sup> No studies have been found of the effects of the doctor understanding some of the patient's language, while

retaining an interpreter, although this is frequently recommended.<sup>26</sup>

## Local Relevance

It presently seems to be rare to have personnel dedicated to interpreting in South Africa. Usually nurses fulfill this role, and have been made to feel that it is their responsibility.

Experience suggests that the quality of the interpretation varies substantially. The importance of the interpreter role is rarely emphasized, no formal recognition is given to nurses providing interpretation, and it is generally not remunerated.

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At least some doctors make an effort to learn the language of their patients.<sup>11</sup> Despite the recommendations made in the literature to continue using an interpreter, interpreters who have other duties (usually nursing related), are keen to let the doctor "manage".<sup>26</sup> Doctors in this position lack adequate information to enable them to insist that they still require the presence of an interpreter.

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In RSA nurses have been made to feel it is their responsibility

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It is recognized in the literature that it is difficult to provide an interpretation service to doctors in private practice.<sup>4,26</sup> It could be argued that those doctors who are frequently dealing with patients who speak a different language to their own, have a responsibility to provide interpretation or learn the language. This issue is bound to become more complex and pressing if in future we have a national health scheme, with registered patients, for whom doctors have a statutory responsibility.

In conclusion, it is suggested that among others, the following issues are worth exploring further:

1. The effects of the use of an interpreter on the patient-centredness of the consultation.
2. The effects of the development of an ongoing relationship between the doctor and interpreter.
3. The impact on the interaction of the doctor's efforts to learn the patient's language, when an interpreter is used and when no interpreter is present.

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