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doi:10.1093/fampra/cmi015 Family Practice Advance Access originally published online on 1 April 2005

Improving patient–provider communication: insights from interpreters

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Hudelson P. Improving patient–provider communication: insights from interpreters. *Family Practice* 2005; **22:** 311–316.

Background. It is important for physicians to recognize and address potential cross-cultural communication barriers with their patients. Several studies have demonstrated the importance of trained medical interpreters for ensuring effective patient–provider communication. Medical interpreters also represent an untapped source of insight into common communication problems. Such insights can contribute to strengthening physicians' cross cultural communication skills.

Objective. The purpose of this study was to explore professional medical interpreters' experiences and perspectives regarding patient–provider communication difficulties.

Methods. Key informant interviews were conducted with a purposive sample of nine professional interpreters working at the Geneva University Hospitals general medicine outpatient clinic.

Results. Interpreters described three domains where physicians and patients were likely to differ, and where mutual lack of awareness of those differences could lead to misunderstandings. These were: (1) ideas about the patient's health problem; (2) expectations of the clinical encounter; and (3) verbal and non-verbal communication styles. Interpreters recommended that cultural competence training for physicians focus on raising awareness about potential sources of misunderstanding and about the difficulties inherent in medical translation; providing basic background knowledge of patients' countries of origin; and adapting to patients' communication styles. While physicians' own perceptions of communication difficulties are important for developing learner-centered training activities, interpreters' bilingual and bicultural position allows for the identification of communication barriers that may be difficult for physicians to recognize.

Keywords. Cross cultural communication, cultural competence, interpreters, primary care.

Introduction

Effective patient–provider communication is central to the delivery of high quality medical care. Global migration trends have meant that physicians increasingly encounter patients who vary significantly in terms of language, illness-related beliefs and practices and health care expectations.[1–4] Such differences can lead to communication problems and can have important consequences for care.[5–7] It is important for physicians to be aware of potential cross-cultural communication barriers, and learn the skills necessary to overcome them.

Several studies have demonstrated the importance of trained medical interpreters for ensuring effective patient–provider communication.[8–13] In addition, medical interpreters can provide insight into general categories and common sources of communication problems. Their bilingual and often bicultural position and depth of experience mean that interpreters can often contribute to a broader understanding of patient–provider communication problems. However, despite their potentially important contribution to our understanding of cross-cultural patient–provider communication, the voice of medical interpreters is surprisingly absent from the literature.[14,15]

This paper reports on key informant interviews conducted with professional medical interpreters working at the Geneva University Hospitals general medicine outpatient clinic. The aim of these interviews was to gain insight into common sources of patient–provider communication difficulties observed by interpreters in their work. These were part of a larger study aimed at exploring the difficulties encountered by junior

Received 8 June 2004; Accepted 30 December 2004.
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hospital doctors working with socially and culturally diverse, and situating these difficulties within the doctors' practice context.[16]

Methods

Study site

Geneva, Switzerland (Population 424 000) has a linguistically and culturally diverse population. About 40% of Geneva's legal residents are of non-Swiss nationality, representing 180 different countries.[17] In 1990 some 30% of Geneva residents listed a language other than French as their mother tongue.[18]

The study was conducted at the Geneva University Hospitals general medicine outpatient clinic (referred to as the Policlinique).[19] Scheduled general medicine outpatient consultations are provided by 14 junior doctors who spend one year at the Policlinique as part of their post-graduate training. Physicians are mainly French-speaking (although there are occasionally bilingual/bicultural doctors), and the majority have done all their medical training in Geneva.

A study conducted at the Policlinique in 1997[20] found that during a one-month period 58% of all patients were foreign-born, and 15% of all patients had difficulty communicating in French. To facilitate access to their health services, the Policlinique dedicates a significant budget to ensuring translation for all patients who request it. The Policlinique uses a pool of professional interpreters that are trained and supervised by the Geneva Red Cross Society.[21] In Switzerland, the term 'cultural mediator' is sometimes used to emphasize the more active role that interpreters may play in medical consultations. However, at the Policlinique the term 'interpreter' is generally used, and therefore this term will be used here.

Study participants

The purpose of our study was to identify the range of cross-cultural communication difficulties observed by interpreters, and explore their perceptions of the underlying causes of these difficulties. We felt that interpreters' bridge position between patients and health care providers would offer important insights into the most common types and sources of communication difficulties encountered. We did not aim to determine the frequency with which specific communication problems were encountered, nor did we attempt to make generalizations about particular patient groups. Our main goal was to explore the range of difficulties encountered, and identify specific issues that should be addressed in cultural competence training.

In order to achieve these aims, we interviewed a small sample of interpreter-key informants. Key informants are "individuals who possess special knowledge, status or communication skills, who are willing to share their knowledge and skills with the researcher, and who have access to perspectives or observations denied the researcher through other means".[22] Key informants are purposefully selected—based on both theoretical and personal considerations—for the insights and interpretations they bring to the research topic.

For this study, we selected male and female interpreters who translated for the most common languages represented at the Policlinique, worked frequently at the Policlinique, and had at least 2 years experience as a professional medical interpreter.

To identify the most appropriate individuals, we first examined medical records at the Policlinique to identify those languages for which interpreters were required most often. We then asked key clinical staff at the Policlinique to identify those interpreters who were called most often to translate and who had several years of interpreting experience. Because Albanian is the language for which translation is requested most often, and because our physicians seem to have particular difficulty in communicating with Albanian-speaking Kosovar patients, we selected several interpreters working with Kosovar patients.

Interpreters were contacted by telephone and asked if they would be willing to be interviewed for 1–2 hours about cross-cultural communication difficulties. A total of nine interpreters were contacted and all agreed to be interviewed (Table 1).

Data collection and analysis

Depth interviews[23] were conducted by the author, with the aim of gaining a detailed understanding of interpreters' experiences and perceptions regarding patient–provider communication difficulties. An interview guide was developed, consisting of open-ended questions followed by prompts (Box 1). Respondents were encouraged to narrate their personal experiences and to talk about issues or topics most salient for them. All interviews were conducted in French between April and June 2002 and generally lasted for about 60–90 minutes. Interviews were tape-recorded, transcribed

TABLE 1 *Interpreter characteristics*

Sex	Languages translated	Years experience
Male	Persian	6
Female	Armenian, Farsi	3
Female	Somali	3
Female	Bosnian	10
Female	Albanian, Bosnian	8
Female	Albanian	2.5
Male	Albanian	4
Male	Albanian	4
Female	Spanish, Portuguese	3

Box 1 *Interview guide*

What types of patients do you translate for? (Nationality, socioeconomic and educational levels, migration status, etc.)

What types of communication difficulties have you observed between patients and physicians?

Can you describe some recent consultations where you observed communication difficulties?

To what do you attribute these difficulties?

Are there specific things that you think physicians should know or understand in order to communicate effectively with the patients for whom you translate?

In your opinion, how might physicians improve their communication with non-francophone patients?

and analyzed using Winmax© software for qualitative data analysis.[24] All translations of the interpreters' utterances are the author's.

Analysis of transcripts involved first identifying and coding all passages that described types and sources of difficulties observed, and any suggestions for improving patient–provider communication with non-francophone patients.[25] A coding system for types of difficulty was then developed and used to re-code the texts. The aim of the analysis was to describe the range of types and sources of difficulties observed by interpreters and identify key issues that could be addressed in cultural competence training of physicians.

Results

Interpreters described many situations in which they observed communication difficulties between patients and physicians, and these spanned a wide range of patients 'types' (age, sex, nationality, education level, socioeconomic status, etc.) and health problems. Their descriptions reflected 3 areas where physicians and patients were likely to differ, and where mutual lack of awareness of those differences could lead to misunderstandings. These were: (1) ideas about the patient's health problem; (2) expectations of the clinical encounter; and (3) verbal and non-verbal communication styles.

Illness perspectives

Interpreters provided many examples of the causes and consequences of physician–patient differences in ideas about the illness, its cause, treatment and meaning.

> "I've seen women who said 'I know why I have this problem. [Back home] they told me I have such-and-such a problem . . . I have that, but I can't say that here . . . the doctor will think I'm crazy'." (T3)

Differences in illness perspectives were especially common where psychological diagnoses were involved. Interpreters explained that some patients experienced a psychological diagnosis as rejection and disbelief on the part of the physician.

> "In our country, we don't accept that. We accept illnesses that come just like that, but everything that's tied to the psyche, that has to do with pains . . . or the idea that sleep problems are linked to worry . . . this goes over very very badly with women. They're going to feel that they're at fault, that it's their fault . . . in our country this is shameful . . . you are supposed to be strong. In our country you don't say 'I'm sad'." (T2)
>
> "In our country we don't know anything about psychology . . . it's after the war that physicians started training in psychiatry. There used to be neuropsychiatrists that dealt with epilepsy, with more serious diseases . . . If you talk about [going to a] psychiatrist or a psychologist it's immediately understood as craziness or some serious illness. Anxiety attacks, panic attacks, depression, all that, we aren't familiar with these problems. There are many people who suffer from these, I agree, but we don't know anything about these problems." (T6)

Some diagnoses, such as tuberculosis or psychiatric diseases, were highly stigmatizing within patients' communities, and as a result patients might reject the diagnosis or try to hide their disease. Sometimes patients attributed their health problems to spirits or evil eye, but were ashamed to reveal these beliefs and their recourse to traditional healing practices to doctors they perceived as either ignorant or disdainful of such practices. One interpreter described how patients who thought their illness was God's will might be less inclined to adhere to treatment recommendations, believing that only God could decide to heal them. They hid these beliefs—and their non-compliance—from doctors for fear of ridicule.

Expectations of the clinical encounter

Patients' health care experiences in their home countries influence their expectations of health care in Switzerland. For example, before the war in Kosovo many physicians were Serb. Many stories circulated about abuses by Serb doctors, including children stolen from the hospital, unexplained deaths, and medical experiments on Kosovar patients. A general distrust of foreign doctors developed which continues to influence some patients' attitude towards Swiss physicians. When not provided with the care they expected, some patients interpreted this as discrimination against foreigners.

Another source of misunderstanding was the scheduled appointment. In our clinic, patients are expected to make and keep scheduled appointments. However, many patients come from countries where scheduled appointment systems did not exist and where patients

were expected to wait in line for their turn to the see the doctor.

"In our country we had to wait in line and you could spend the whole day waiting. There wasn't a specific [appointment] time, even if the doctor told you 'Come at 9am'." (T4)

Interpreters said that physicians were often frustrated by patients who arrived too early, too late or not at all, and that some interpreted this as patients' lack of seriousness or respect. One interpreter told of a physician who refused to see a woman who arrived 10 minutes late for her appointment. The patient didn't understand why the doctor was angry, and later told the interpreter that the doctor must be racist.

Interpreters also observed that many patients expected be provided with authoritative, high-tech medicine, and were dissatisfied when they perceived this not to be the case.

"Sometimes they absolutely want to have a blood or urine test, or even a scan (MRI). For the doctor it's clear, he's not going to go directly to the scan before doing a whole lot of other analyses first, and so the patients are disappointed. They say to themselves 'But what is he doing? He's not doing his job'." (T8)

"They believe that if the doctor only gives a tablet, for example aspirin or Panadol or I don't know what, then he's not a real doctor yet." (T7)

The Policlinique emphasizes a biopsychosocial approach to care, and physicians are encouraged to provide psychosocial support to patients. But some patients are uncomfortable when doctors asked them questions about their personal life, migration history or war-related experiences. These sorts of questions were perceived to be invasive and inappropriate in the context of a medical consultation, and a negative reminder of their interviews with migration officials.

"There are some patients who hate it when you ask them questions. They say 'Why does he ask me those questions? I feel like I'm being interviewed for asylum status'." (T3)

Differences in communication styles

Interpreters also gave examples of how differences in gestures, eye-contact and vocabulary can have different meanings for patients and physicians. One interpreter described how a physician, in attempting to encourage his female patient to adhere to his treatment recommendations, used a gesture which instead insulted the patient.

"Some gestures that here mean you need to hurry up or get moving—in our country it's a gesture with sexual connotations, it's a sexual insult." (T1)

Patient/physician differences in conversational styles were another commonly mentioned source of difficulty. Medical questioning styles are also often experienced as foreign and incomprehensible by patients, while patients' response styles are interpreted by physicians as incoherent and illogical.

"There are some phrases used by doctors that are inaccessible, incomprehensible for patients . . . This may be in terms of the words used or even the structure of the phrases . . ." (T8)

"Here, the names of organs are pronounced easily. But in my country you have to hide them with metaphors . . . I have to look for a metaphor that would be a little less shocking than the word itself . . ." (T1)

"When you ask [patients] a question, they're going to respond to another, unrelated question. And the doctors, well they have to keep to a schedule, they're not there to repeat the same question 5 times in a row. They get angry. But in our country, this is very common. The questions are never direct . . . But the doctor thinks that the interpreter isn't doing his job." (T3)

Discussion

The examples provided by our interpreter-informants are neither representative nor exhaustive of the communication difficulties encountered in cross-cultural clinical encounters. However, such insights from medical interpreters do help us to identify and categorize commonly encountered communication pitfalls, and target our training efforts. While physicians' own perceptions of communication difficulties are important for developing learner-centered training activities, interpreters' bilingual and bicultural position allows for the identification of communication barriers that may be difficult for physicians to identify.

In our study, we asked interpreters what sorts of recommendations they would make to future physicians working at this clinic to ensure effective cross cultural communication. However, most of the interpreters were reluctant to give advice. They recognized the difficulties that physicians faced in caring for patients with complex medical, psychological and social problems, and praised them for the work they did. While it was not a specific topic of the interviews, it appears that the inherent power relations between physicians and interpreters may act as a deterrent to more open discussion about ways to improve patient–provider communication. Several interpreters recommended that physicians try to take time either before or after the consultation to talk about communication issues, but emphasized that it was the physician's place (and not theirs) to initiate such discussions and that they would not offer insight or suggestions without first being asked.

Although interpreters' were reluctant to provide specific recommendations for improving cross-cultural communication, their descriptions suggest that the following are important and should be emphasized in physicians' training.

Awareness of potential sources of misunderstanding
Interpreters' descriptions generally indicated a lack of awareness of differences in patient/provider perspectives. It is both unfeasible and unnecessary for physicians to be familiar with the specific cultural beliefs and communication styles of their patients, but a heightened awareness of potential communication pitfalls would help physicians to identify or avoid them.

Basic knowledge about patients' countries of origin (geography, politics, religion)
Interpreters said that some patients were reluctant to communicate openly with physicians who appeared to know little or nothing about their country, and felt that it was important to show interest and ask questions about a patient's country in order to establish rapport.

Recognition of the difficulties of translation
Interpreters felt that physicians needed to be more aware of how difficult it can be to meaningfully translate medical concepts and terms. Some physicians demanded word-by-word translation, which was often impossible and itself a potential source of miscommunication. Others used medical concepts that were unknown to patients. Interpreters said that communication would be facilitated by the use of simpler, less technical language.

Adaptation to patients' communication styles
Interpreters were most vocal about the need to use more conversational styles with patients. They felt that the direct, closed questioning style used by many physicians was difficult for patients. They suggested that a more narrative approach to information gathering would not only contribute to the therapeutic alliance, but also improve the quality of information provided by patients.

Conclusion
The interpreters interviewed for this study witnessed a range of communication difficulties. Although patient/provider differences in terms of social and cultural background, education and experience create the potential for misunderstanding, it is the *lack of awareness* of these differences and their potential effect on clinical communication that is at the root of the problems described.

Interpreters are uniquely placed to facilitate increased awareness of such differences and their importance for clinical communication. A number of authors have encouraged an expanded 'cultural mediation' role for medical interpreters in the consultation.[26,27] In addition, we would encourage a more general contribution to understanding and addressing cross-cultural communication difficulties. Physicians should take advantage of interpreters' knowledge and experience and discuss general cross-cultural communication problems and strategies with them. The best way to do this will have to be worked out in each specific context, but it is generally suggested that physicians schedule time immediately after a consultation to discuss communication issues with the interpreter. Although time constraints may make this seem impractical, even a brief exchange can raise awareness of potential problems. In our context, junior doctors meet with interpreters at the beginning of the year to facilitate rapport and trust, and also attend a series of three training sessions aimed at learning to work effectively with interpreters.

Recognizing and exploring potential sources of difference in perspective is the first step towards establishing a therapeutic alliance and providing patient-centered care. Interpreters can contribute unique insights to this process.

Declaration

Funding: the study was funded by the Geneva University Hospitals Fund for Research and Development.
Ethical approval: approved by the Geneva University Hospitals Research Ethics Commission.
Conflicts of interest: none.

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