Enhancing consultations with interpreters:

learning more about how

Achieving good communication, by use of interpreting, between patients and health professionals who do not share the same language is crucial for significant and growing proportions of our populations. In the current issue, a team of medical sociologists offer a fascinating snapshot into interpreted consultations.¹ They provide a content analysis from audiovisual recordings of diabetes review consultations, mainly involving practice nurses working with professional interpreters and patients of Bangladeshi origin in East London.

Consultations were found to be of similar length to same language consultations. However, patients in interpreted consultations said less, asked fewer questions, and talked less about clinical indicators such as HbA1c. Moreover, interpreted consultations had less discussion of patients' own feelings, ideas about health or social contexts, and less humour. Nurses commonly addressed patients through interpreters in the third person rather than directly; while interpreters were sometimes observed to mistranslate or change meanings.

INSIDE INTERPRETED CONSULTATIONS

These findings point to how care becomes compromised and inequitable. While perhaps familiar from clinical experience, the data are helpful because we currently have little empirical evidence about what really goes on during interpreted consultations. Understanding about the nature, efficacy, and consequences of interpreter-mediated communication in health encounters remains relatively modest.²⁻⁴

Many health professionals recognise this as difficult territory. They highlight the frustrations of mediated communication, such as establishing patients' concerns and checking understanding or how people are feeling, but also the benefits that trained interpreters or bilingual link workers can bring.⁴ Nevertheless, practitioners may

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experience further problems with accurate exchange of information and handling changes in their power and control during interpreted interactions.^{3,4}

Health practitioners commonly report little or no formal training in working with interpreters; and may be unsure of what the appropriate expectations of interpreters may be, including of interpreters' own training and skills.⁴ Correspondingly, interpreters and link workers emphasise that health professionals can be unclear about their role, or about how to work with them to the best advantage. Interpreters and link workers also face their own challenges, such as being asked to break bad news without preparation prior to the consultation.⁴

While powerful insights are available from direct observation of 'triadic' consultations, greater exploration of patient perspectives in this context would help us understand more about what patients are feeling and thinking; and how they may feel more empowered in such encounters. In my own experience, patients are sometimes very conscious that their interpreted consultations can 'put pressure on the system' and take more time. They may be reluctant, as may their practitioner, to go beyond talk of core business rather than attend to narrowing social distance or introducing humour, all of which could enhance a more human connection to facilitate communication.

CHALLENGES OF TIME AND DIVERSITY

Seale and colleagues' study¹ observed

routine diabetes reviews that lasted around 30 minutes, and where much of the agenda would be relatively well defined and expected by all parties. One may expect the challenges they observed to be amplified in 10-minute GP consultations. Many now regard those 10 minutes as unrealistically over-burdened, if assessment of undifferentiated problems, multimorbidity, and shared decision making is to be realised.⁵

This may be further compounded by practitioners' uncertainty in responding to patient diversity. Distracted by cultural difference, they may not employ the skills they habitually use with other patients to achieve effective communication.^{6,7} The less than ideal but common reality of relatives or friends interpreting for patients can add further ethical and other challenges.^{4,8} Making adequate allowance for interpreting in all these circumstances strengthens the case to increase consultation time appropriately.

EMPOWERING ALL INVOLVED

We may best consider how all players in three-way interactions could be more empowered to enhance communication: not only health practitioners and interpreters, but also patients. Relevant training for providers remains inadequately commissioned and implemented in health systems, and patchy in pre-registration training. Arguably, one reason may be little published data to expose the need. Evidence that using trained interpreters improves quality of care, while poor interpreting results in adverse outcomes, is growing.³ More research that lifts the lid on what happens, and increases our understanding of interpreted consultations^{1,4} can usefully inform what guidance and training interventions may comprise, while underlining the case for greater implementation. However, robust evidence on effectiveness of training interventions is still urgently required.

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Enabling patients during mediated consultations has been still further neglected. Patients may benefit from being more able to present themselves as knowledgeable individuals, with ability and volition in relation to their condition and care. Greater adoption by professionals of core principles in most current guidance for working with interpreters will help.⁸ However more direct approaches may develop patient interventions that have shown promise, such as brief multilingual audiovisual instruction in the waiting room; for example, to freely express any misunderstandings in the consultation.⁹

The health and economic costs of not working with trained interpreters may appear obvious but deserve greater emphasis in research. Perhaps issues such as the failure to 'bottom out' patient agendas, repeated consultations, unnecessary investigations, or patient safety may come more to the fore in our economically-straitened times. This, and further evidence of the type reported in this

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issue,¹ should help to push development and implementation of interventions to enhance the quality of interpreted consultations in the required direction.

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REFERENCES

1. Seale C, Rivas C, Kelly M. The challenge of communication in interpreted consultations in diabetes care: a mixed methods study. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X663082.
2. Kaufert JM, Putsch RW. Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language and power. *J Clin Ethics* 1997; **8(1)**: 71–87.
3. Flores G. The impact of medical interpreter services on quality of health care: a systematic review. *Med Care Res Rev* 2005; **62(3)**: 255–299.
4. Kai J, Beavan J, Faull C. Challenges of mediated communication, disclosure and patient autonomy in cross-cultural cancer care. *Br J Cancer* 2011; **105(7)**: 918–924.
5. Silverman J, Kinnersley P. Calling time on the 10-minute consultation. *Br J Gen Pract* 2012; DOI:10.3399/bjgp12X625102.
6. Daniels K, Swartz L. Understanding health care workers' anxieties in a diversifying world. *PLoS Med* 2007; **4(11)**: e319.
7. Kai J, Beavan J, Faull C, *et al*. Professional uncertainty and disempowerment responding to ethnic diversity in health care: qualitative study. *PLoS Med* 2007; **4(11)**: e323.
8. Kai J, Briddon D, Bevan J. Working with interpreters and advocates. In: Kai J (ed.). *Valuing diversity: a resource for health professional training to respond to cultural diversity*. 2nd edn. London: Royal College of General Practitioners, 2006: 201–224.
9. Harmsen H, Bernsen R, Meeuwesen L, *et al*. The effect of educational intervention on intercultural communication: results of a randomised controlled trial. *Br J Gen Pract* 2005; **55(514)**: 343–350.

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