The interpreted diabetes consultation

Carol Rivas, Moira Kelly, Clive Seale

Article points

1. Little direct research has been carried out that considers the way language barriers can affect the consultation between healthcare provider and individual.

2. Health providers and interpreters need to communicate effectively with each other to deliver the best care to the patient.

3. One way to improve communication in interpreted consultations is to look and speak directly to the patient rather than the interpreter.

Key words

– Communication
– Individual care
– Self-management

Authors

Carol Rivas is a Senior Research Fellow, University of Southampton and Honorary Senior Research Fellow, Barts and the London School of Medicine and Dentistry, Queen Mary University of London; Moira Kelly is a Senior Lecturer, Barts and the London School of Medicine and Dentistry, Queen Mary, University of London; Clive Seale is the Head of Department and Professor of Sociology, Brunel University.

Interpreters have been used in the medical consultation room for some time now, and this article explores the relationship between healthcare provider, patient and interpreter by examining research conducted by the authors and other groups. The authors outline the benefits and potential issues associated with using an interpreter and suggest how providers can communicate clearly and concisely with patients to give the best possible care in interpreted consultations.

Language barriers are a significant cause of health disparities in minority ethnic groups (Pottie et al, 2008), which we have reviewed with regard to the treatment and management of diabetes (Seale et al, 2013a). Diabetes healthcare is holistic and individualised with a large self-management component, described by some as "hard work" (Hinder and Greenhalgh, 2012). For diabetes management to be successful, there generally needs to be support and encouragement from the healthcare provider, as well as a mutual understanding between him or her and the individual with diabetes. Good communication is, therefore, essential.

However, little direct research has been carried out that considers the way language barriers can affect the consultation between the clinician and patient. With this in mind, we carried out the only significant observational study of interpreted healthcare consultations in the UK. We analysed video recordings of diabetes review consultations filmed in inner London, with many of the people we sampled requiring an interpreter (Seale et al, 2013a). Our findings, along with what is currently established in the field, are discussed below.

Qualitative differences

When we reviewed the recorded consultations, we found that, compared with the consultations conducted in fluent English, the interpreted consultations involved: fewer questions from patients; less affective talk or humour (which can get lost in translation); less discussion of patients' "lifeworlds"; and less investigation by healthcare providers of patients' knowledge or health beliefs. This means that there can be a social distance between provider and patient and little shared empathy in consultations where there is an interpreter present.

Outside the UK, an observational study of interpreted diabetes consultations considering Turkish immigrants in Switzerland reported similar findings (Hudelson et al, 2013), and Gustafsson's (2013) study of children's diabetes consultations included two interpreted cases that also concurred with our findings.

Interpreter roles

Maria Stubbe's team in New Zealand has observed a range of health providers, interpreters and individuals with a variety of health conditions, including newly diagnosed diabetes, in various settings (MacDonald et al, 2013; Stubbe et al, 2013). Their early analyses have explored issues in the way participants in the consultation negotiate role boundaries.

The interpreter's basic role is to act as a conduit of communication, conveying the sense of what he or she hears, rather than word-for-word translating (Hsieh, 2006). However, interpreters are rarely simple conduits. As "co-diagnosticians" (Hsieh, 2007) and cultural brokers, they transform, editorialise or filter out talk they believe is not helpful for the patient or provider

(Gavioli, 2012). For this, interpreters draw on their "epistemic authority" (Heritage, 2013).

In our own observations, we sometimes found that interpreters transformed talk to a more prescriptive or paternalistic style that they thought patients might prefer, although published evidence for this is mixed (Blackhall et al, 1995; Hawthorne et al, 2003; Roberts et al, 2005).

Several past studies have found that some providers delegate general advice-giving to the interpreter, although this is without necessarily disengaging from the conversation. Information from body language, gaze and features of speech, such as pauses, minimal tokens (e.g. "okay" or "um"), prosody, pitch and so on, help the provider to determine when to rejoin the conversation or attend to the interpreter or patient (Al-Sarraj et al, 2012; see also Davitti and Pasquandrea, 2013). In this way, the provider remains in overall control even when analysis of their verbal behaviour does not show any sign of direct participation.

However, providers may remain unaware of inaccurate translations. Interpreters are not healthcare professionals, despite often having basic training in diabetes management. Also, in our study we found that editorialising by interpreters may prevent patients' issues being explored, which contrasts with English speakers' consultations (Seale et al, 2013b). On the other hand, editorialising may keep the consultation moving (Davidson, 1998) and may aid understanding. Interpreters we interviewed said they wanted to maximise efficiency and ensure the patient was satisfied in relation to the main business at hand (the control of blood glucose levels). Nonetheless, the risk remains that non-conduit roles can lead to problems. The key here is for interpreter and provider to recognise their limitations.

Two's company

Interpreted encounters are essentially triadic. But frequently, dyadic moments may be shared between patient and interpreter or interpreter and provider, and much more rarely between provider and patient (because most patients will have at least a smattering of the provider's language). Dyadic talk is often not translated, and usually consists of: small talk about mundane topics; explanations of bureaucratic procedures or service access that are deemed irrelevant for the other person; or explanation or clarifications of what one person said to aid further understanding (Seale et al, 2013b). Some interpreters in our study appeared familiar with people who had diabetes from encounters in the local community or previous appointments, and so they sometimes took it on themselves to answer for the patient, perhaps to maximise efficiency through dyadic talk. Though often helpful, dyadic talk sometimes results in loss of sharing and rapport (Seale et al, 2013b) between the patient and provider, or prevents the patient from accounting or apologising for missed appointments or medications, or lapses in self-management.

Further, dyadic talk may lead to some marginalisation of the person left out of the dyad, who has no idea what is going on, what is being kept from him or her or whether it is actually irrelevant.

Oversimplification

Our research also shows that providers may reduce the usefulness of the interpreted consultation by using oversimplified terminology when compared with English language consultations (Rivas et al, 2014). This may be to more easily facilitate translation, or because the patient might be seen as less educated. Talking through an interpreter can make it hard for the provider to understand the level of knowledge the patient has and, therefore, how to pitch the discussion appropriately.

Training for all

From our research, we have shared data with the communications skills team at Queen Mary, University of London, on how to best communicate when using interpreters, which have contributed to the training of medical students (see *Box 1* for some points raised). These skills can quite easily be trained for (Cushing, 2003) and are now well understood within the college; however, they still too often remain unimplemented in practice.

"Research such as that reported here can be used to help providers, patients and interpreters reflect on how communication in the consultation room can be improved."

Box 1. Tips for healthcare providers to enhance communication in interpreted consultations.

● Talk to the interpreter about how to work together effectively

● Look at the patient, not the interpreter

● Speak directly to the patient (e.g. do not say to the interpreter "tell her/him…")

● Speak slowly and clearly, avoiding jargon and colloquial expressions

● Break communication into small chunks with time for each chunk to be translated

● Watch the patient and the interpreter when they are talking to each other

● Check the patient's understanding

● Understand that not all monolingual exchanges with the interpreter are bad (sometimes they are needed to repair, clarify and explain – if in doubt, ask the interpreter what is being said)

Concluding remark

There is no question that without interpreters, patients would have greater problems in accessing services and would receive a worse quality of care (Karliner et al, 2007). It is important to recognise that the consultation is co-constructed by all participants (Hudelson et al, 2013). Research such as that reported here can be used to help health providers, patients and interpreters reflect on how communication in the consultation room can be improved. ■

Al-Sarraj H, Webb S, Rivas C (2012) Engaging in interaction in the interpreted diabetes consultation – analysis of audio and video data. Presented at: *BSA Medical Sociology Group 44th Annual Conference*, Leicester, 5–7 September

Blackhall J, Murphy ST, Frank G et al (1995) Ethnicity and attitudes toward patient autonomy. *JAMA* **274**: 820–5

Cushing A (2003) Interpreters in medical consultations. In: Tribe R, Raval H (eds). *Working with Interpreters in Mental Health*. Brunner-Routledge, Hove: 30–53

Davidson B (1998) *Interpreting medical discourse: A study of cross-linguistic communication in the hospital clinic*. PhD thesis, Stanford University, Stanford, CA, USA

Davitti E, Pasquandrea S (2013) Interpreters/mediators in intercultural communication: How to modulate the impact of their verbal and non-verbal practices? *Best Practice Catalogue*. Available from: http://bit.ly/1cKgySz (accessed 10.01.13)

Gavioli L (2012) Minimal responses in interpreter-mediated medical talk. In: Baraldi C, Gavioli L (eds). *Coordinating Participation in Dialogue Interpreting*. John Benjamins, Amsterdam, the Netherlands: 202–27

Gustafsson AW (2013) Empowering strategies in children's diabetes consultations with immigrant parents. Presented at: *11th Eleventh Interdisciplinary International Conference on Communication, Medicine and Ethics (COMET)*, Melbourne, Australia, 11–13 July

Hawthorne K, Rahman J, Pill R (2003) Working with Bangladeshi patients in Britain: perspectives from Primary Health Care. *Fam Pract* **20**: 185–91

Heritage J (2013) Epistemics in conversation. In: Sidnell J, Stivers T (eds). *Handbook of Conversation Analysis*. Wiley-Blackwell, Boston, MA, USA: 370–94

Hinder S, Greenhalgh T (2012) "This does my head in". Ethnographic study of self-management by people with diabetes. *BMC Health Serv Res* **12**: 83

Hsieh E (2006) Understanding medical interpreters: reconceptualizing bilingual health communication. *Health Commun* **20**: 177–86

Hsieh E (2007) Interpreters as co-diagnosticians: overlapping roles and services between providers and interpreters. *Soc Sci Med* **64**: 924–37

Hudelson P, Dominicé Dao M, Junod Perron N, Bischoff A (2013) Interpreter-mediated diabetes consultations: A qualitative analysis of physician communication practices. *BMC Fam Pract* **14**: 163

Karliner LS, Jacobs EA, Chen AH, Mutha S (2007) Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Serv Res* **42**: 727–54

MacDonald L, Stubbe M, Tester R et al (2013) Nurse-patient communication in primary care diabetes management: An exploratory study. *BMC Nurs* **12**: 20

Pottie K, Ng E, Spitzer D et al (2008) Language proficiency, gender and self-reported health: an analysis of the first two waves of the Longitudinal Survey of Immigrants to Canada. *Can J Public Health* **99**: 505–10

Rivas C, Kelly M, Seale C (2014) Differential shaping of patients' identities in the diabetes review consultation and the association with English language fluency. *Patient Educ* (submitted)

Roberts C Moss B, Wass V et al (2005) Misunderstandings: a qualitative study of primary care consultations in multilingual settings and educational implications. *Med Educ* **39**: 465–75

Seale C, Rivas C, Kelly MJ (2013a) The challenge of communication in interpreted consultations: an observational study of diabetes care. *Br J Gen Pract* **63**: 125–33

Seale C, Rivas C, Al-Sarraj H et al (2013b) Moral mediation in interpreted health care consultations. *Soc Sci Med* **98**: 141–8

Stubbe M, MacDonald L, Gray B et al (2013) Negotiating role boundaries in interpreter-mediated consultations. Presented at: *11th Eleventh Interdisciplinary International Conference on Communication, Medicine and Ethics (COMET)*, Melbourne, Australia, 11–13 July