enlargement of existing small shunts); we have seen this on several occasions. This was an extraordinary case, and the patient was extremely lucky not to develop serious paradoxical embolism. It is interesting to speculate that the shunt was probably very small in the past, but, as her emphysema worsened and her pulmonary arterial pressure rose, the size of the shunt increased, causing the cyanosis and dyspnoea on exertion. Normally, we prefer to embolise these patients with coils, as balloons cannot be placed so precisely in the vessel which feeds the pulmonary arteriovenous malformation; proximal placement may cause substantial loss of normal lung tissue. In this case the balloon procedure was tried while the patient received anticoagulant drugs, but the vascular anatomy was unfavourable. It may be better for her that she ended up with a more selective embolisation with fibrin coated coils.

SB: Had there been any previous pulmonary embolisation that might also have increased the size of her shunt?

JMBH: No. Her right heart pressures were normal on angiography, although the shunt itself acts as an escape valve for increased pulmonary arterial pressures.

SS: How long do you follow up patients for evidence of shunt recanalisation?

JMBH: All patients receive lung scans three months after embolisation to confirm shunt obliteration. Long term follow up is done with oximetry as this has proved to be a very reliable screening test for shunts. Patients with both hereditary haemorrhagic telangiectasia and

pulmonary arteriovenous malformations show a drop in arterial oxygen pressure when standing, as most pulmonary arteriovenous malformations are distributed basally in the lungs and are more selectively perfused in the upright position.

SB: Does thrombosis extend beyond the steel coils? How important is the fibrin coating of the coils?

JMBH: Thrombosis occurs only on the coils. Radio-labelled platelet scans performed at the time of occlusion show that this thrombosis occurs within minutes.

IR: Stainless steel by itself is poorly thrombogenic in this setting. The fibrin coated coils work by first distorting the intima of the blood vessel in which they are placed and causing the release of locally active mediators which cause platelet aggregation; this is then enhanced by the fibrin coating, which allows rapid and permanent thrombogenesis.

The *BMJ* welcomes grand rounds from other hospitals.

- 1 Sapru RP, Hutchison DCS, Hall JI. Pulmonary hypertension in patients with pulmonary arteriovenous fistulae. *Br Heart J* 1969;31:559-69.
- 2 Whyte MKB, Peters AM, Hughes JMB, Henderson BL, Bellingan GJ, Jackson JE, et al. Quantification of right-to-left shunt at rest and during exercise in patients with pulmonary arteriovenous malformations. *Thorax* 1992;47:790-6.
- 3 Ueki J, Hughes JMB, Peters AM, Bellingan GJ, Mohammed MAM, Dutton J, et al. Oxygen and ^{99m}Tc-MAA shunt estimations in patients with pulmonary arteriovenous malformations: effects of changes in posture and lung volume. *Thorax* 1994;49:327-31.
- 4 Hughes JMB. Intrapulmonary shunts: coils to transplantation. *J R Coll Physicians Lond* 1994;28:247-53.
- 5 White RJ, Lynch-Nyhan A, Terry P, Buescher PC, Farmlett EJ, Charnas L, et al. Pulmonary arteriovenous malformations: techniques and long term outcome of embolotherapy. *Radiology* 1988;169:663-9.

How To Do It

Work with an interpreter

Michael Phelan, Sue Parkman

The Audit Commission recently highlighted the need for health services to plan language services to help the problems of poor communication facing non-English speaking patients. Doctors and other health workers need to know how to work effectively when interviewing patients with an interpreter. This article describes the different options for helping non-English speaking patients; explains how interviews should be conducted with a trained interpreter, including those using sign language; and outlines the extent of interpreting services currently available in the United Kingdom, complete with a list of addresses of organisations offering interpreting services.

Patients whose first language is not English may face difficulties in being understood and in understanding diagnoses. To help such patients the health service needs to provide language services,¹ which are largely of four types.

Bilingual health workers—These workers remove the need for a third party to be involved and are the ideal option for most patients. Bilingual health workers are, however, few and will never be universally available.

Trained interpreters—The use of a professional interpreter is the next best option. These professionals maintain a strict code of confidentiality and are skilled in interpreting the sense and intent of what is said while preserving the content of the interview. Although the

provision of trained interpreters for health services appears to be increasing, their availability and use is still patchy, and doctors will often find themselves depending on informal help from friends or relatives of the patient or from untrained volunteers.

Friends or relatives—The perceived advantages of using people known to the patient are that they are readily available, that they may be knowledgeable about the patient's problems, and that their presence may be a reassurance to the patient. However, the risk is that someone close to the patient will not stop their own views of the situation colouring their translation. For the best of motives they may try to protect the patient from bad news, or decide to tell them later in private. Information about side effects may be withheld in the belief that it will improve compliance. Occasionally, more sinister reasons may be behind altering what is said. A violent husband may want to hide the true cause of his wife's bruises. Incidents of child or sexual abuse may be hidden. In addition, the patient may be inhibited from discussing embarrassing issues or disclosing past events, such as an abortion, in front of relatives.

Untrained volunteers—Informal lists of staff or volunteers who are prepared to act as interpreters are often held by hospitals. Although helpful at times, this arrangement cannot guarantee that someone will be available, especially in an emergency or outside normal working hours. Usually they will not have received any training in interpreting, and though some may have an

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instinctive understanding of what is required, others may be inept owing to a lack of empathy or a poor grasp of the language. Patients may worry about confidentiality when using an interpreter who is not known to them, especially if they are both members of a small cultural community. When available, however, volunteers should be used in preference to someone who is known to the patient.

Conducting the interview

The decision about whether an interpreter is needed is often made by the patient or by his or her relatives. However, some patients who can speak some English but are not fluent may feel that they can get by, either because they are unaware that an interpreter is available or because they do not want to put people to extra trouble. On such occasions the doctor should suggest that an interpreter is used, particularly if the results of investigations or treatment options with far reaching implications—for example, a major operation or insulin treatment—are to be discussed.

When interpreters are booked they must be given as much information as possible (box). In particular, they must know exactly which language the patient speaks—for example, stating that someone is Indian is not useful information.

Before meeting the patient, the doctor should discuss with the interpreter the purposes of the interview, the subjects that will be covered, and how long the interview will last. The doctor should also mention any potentially delicate or distressing issues that have to be covered and ask the interpreter if there are any specific cultural factors that may have a direct bearing on the interview.

If the interpreter is untrained the doctor should emphasise the importance of the interpreting role, the need for absolute confidentiality, and the requirement for him or her to translate as precisely as possible what is said. Interpreters should be told always to ask for clarification if something is not clear, rather than guessing at what has been said. The doctor should make a particular effort to speak simply and unambiguously.

At the beginning of the interview the interpreter should be introduced to the patient, the role of the interpreter explained, and confidentiality emphasised. Seating should be arranged in a triangle. This allows doctor and patient to look at each other directly and for the interpreter to be perceived as being neutral in the consultation. During the consultation the doctor should talk directly to the patient, maintain eye contact, and address the patient in the second person—"Where does it hurt you?" not, "Where does it hurt her?" This helps patient and doctor to feel that they are communicating with each other. The doctor must pause often, especially when complex or important issues are being discussed. He or she should be seen to

Key points when interviewing with an interpreter

- Address patient in the second person
- Talk directly to the patient
- Keep control of the consultation
- Pause frequently
- Appear attentive when patient responds
- Respond to non-verbal cues
- Check patient's understanding
- Make use of written material

be attentive when the patient is replying and at least try to catch the drift of what the patient is saying before the interpreter translates. If the patient laughs or gives any other non-verbal cues the doctor should respond. When the interpreter is translating, the occasional nod and look of understanding helps the patient to feel understood. Throughout the interview, the doctor should maintain control and direction and should be aware that the interpreter is not expected to intervene other than to clarify or check meaning (box).²

The doctor can help the patient to grasp important facts by summarising what has been said. It may also be appropriate to ask the patient to repeat what has been said to confirm that he or she has understood. The doctor can also write things down and ask the interpreter to translate them. Although interpreters work towards being invisible, their presence does change the dynamics of the interview and can make a patient more inhibited about interrupting or asking questions. The patient should therefore be constantly encouraged to ask questions, to comment on what has been said, and to say if something is unclear.

It is preferable to have the interpreter present during physical examinations or investigations, but the patient should be asked whether he or she has any objections. If the interpreter is unable to be present, extra care needs to be taken to explain beforehand to the patient what will happen during the examination. After the patient has left it may be appropriate for the doctor to check any queries with the interpreter and to discuss the meeting, especially if it has been emotionally taxing. However, care must be taken to ensure that the patient does not feel excluded and that confidentiality is not breached. Any discussion with the interpreter should be about issues of communication rather than about the patient. Whenever possible the same interpreter should be used for subsequent consultations.

Working with a sign language interpreter

The principles for working with a sign interpreter are very much the same as with other language interpreters, but there are some important differences in technique. A sign language interpreter will ideally sit beside and slightly behind the person conducting the interview, so that the patient can easily see both the doctor and the interpreter's hands. It is essential that there is adequate lighting, and that the interpreter is not obscured by sitting in front of a bright window. Extra time may be required for the interpreter to "finger spell" proper names. For many people who use British sign language, written English may be inaccessible, and therefore writing notes may not be helpful.³

Psychiatric interviews

Before psychiatric interviews interpreters should be warned that the interview will be longer than an

Key points when booking an interpreter

- Give as much warning as possible
- Give precise details about where (room, building) and when the interview is happening and how long it will last
- Give the name and address of the patient
- Specify the language spoken by the patient, not just the nationality (if in doubt the interpreter should be asked to contact the patient)
- Briefly explain the purpose of the interview
- Be punctual
- Try to book the same interpreter for subsequent interviews

average medical or surgical consultation and may be more emotionally harrowing. The interpreter should be told if the patient is psychotic and likely to say things that might not make immediate sense. The experience of one of us (MP) while working in an inner city area of Sydney with a large number of non-English speaking patients was that, with practice and using trained interpreters, most patients could be adequately assessed. Research on psychiatric consultations is conflicting. In an American study, patients interviewed with interpreters reported that they felt understood, that the interview had been helpful, and that they wanted to return; in contrast their therapists felt that the interviews had not been helpful.⁴ The use of interpreters has been found not to affect diagnosis in Saudi Arabia,⁵ but analysis of audiotaped interviews has led some investigators to suggest that distortions by interpreters result in the wrong evaluation of the patient's mental state.⁶

Interpreting services currently available

There are no statutory policies on or recommended minimum standards about the availability of interpreters for the health service. In some areas interpreting services have developed in response to local demand, with some coordination and training from agencies such as the London Interpreting Project, and reliance on the goodwill of community organisations. Two years ago the Association of Interpreters, Advocates, Translators and Linkworkers was set up as a national voluntary organisation with the aims of providing support and standardised policies for interpreting services. During the past decade the Nuffield Interpreter Project, in conjunction with the Institute of Linguists, has been developing criteria for the training and assessment of public service interpreters. A national register of public service interpreters is available from the Institute of Linguists, providing a directory of interpreters who have a recognised public service interpreting qualification and appropriate work experience.

The Royal National Institute for Deaf People and the British Deaf Association provide information about interpreting services. Currently there are approximately 100 qualified sign language interpreters in Britain. For someone requiring the services of a British sign language interpreter, a directory of qualified and trainee registered interpreters is held by and available directly from the Council for the Advancement of Communication with Deaf People.

The Royal College of Psychiatrists has recommended that mental health services should employ specially trained interpreters if required for the local population, and it maintains a list of psychiatrists who are able to help patients who cannot speak English.

Conclusions

Within the NHS there needs to be more awareness of the difficulties facing non-English speaking people. Whenever possible bilingual health workers or trained interpreters should be available for patients, as a formal arrangement of interpreting services is better than informal arrangements. Being able to work effectively with an interpreter is an important communication skill for any doctor.

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Appendix

USEFUL ADDRESSES

Association of Interpreters, Advocates, Translators and Linkworkers (ACITAL), 356 Holloway Road, London N7 6PA.

Council for the Advancement of Communication with Deaf People (CACDP), Pelaw House, School of Education, University of Durham, Durham DH1 1TA (tel 0191 374 3607 voice/text/Minicom).

London Interpreting Project (LIP), 20 Compton Terrace, London N1 2UN (tel 0171 359 6798).

Royal National Institute for Deaf People (RNID), 105 Gower Street, London WC1E 6AH (tel 0171 387 8033; 0171 383 3154 Minicom).

Institute of Linguists, 24a Highbury Grove, London N5 2EA (tel 0171 359 7445).

1 Audit Commission. *What seems to be the matter: communication between hospitals and patients*. London: HMSO, 1994.

2 Launer J. Taking medical histories through interpreters: practice in a Nigerian outpatients department. *BMJ* 1978;iii:934-5.

3 David A, Ebert DA, Paul S, Heckerling MD. Communication with deaf patients: knowledge, beliefs, and practices of physicians. *JAMA* 1995;273:227-9.

4 Kline F, Acosta F, Austin W, Johnson RG. The misunderstood Spanish-speaking patient. *Am J Psychiatry* 1980;137:1530-3.

5 Dodd W. Do interpreters affect consultations? *Fam Pract* 1983;1:42-7.

6 Marcos LR. Effects of interpreters on the evaluation of psychopathology in non-English-speaking patients. *Am J Psychiatry* 1979;136:171-4.

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A DOCTOR WHO CHANGED MY PRACTICE

Juniors are just as caring

The senior registrar and I were looking down on the child of 3 weeks who was dying from a rare complex metabolic acidosis. Even with the advances in DNA technology, over half of these children die without the identification of the enzyme deficiency. Therefore there was no hope of rational therapy to treat the child.

"I treated this child's elder brother a year ago," the senior registrar told me. "He also died, and it was a disaster. The child was all right for an hour or so after birth, but then he collapsed with an acidosis which was intractable, developed renal failure, and died. It was obvious from the start that the consultant at another hospital thought that I had ignored the child's condition when I sent him to the ward, but I was certain that the child was ok at that time. I told him the child was ok, but, although he agreed with me, he was still thinking

that I had been standing by while the child needed resuscitation. I just feel dreadful. This child and his brother haunt me. You don't know what it is like to be accused of something and to have no hope of exonerating yourself. I just wish he could see this child and then he would know that the death of his brother was not my fault."

"If you don't write about this to the *BMJ* I will," I said.

"But I haven't learnt anything from this," she wept.

I have. I have learnt a lot. I have learnt that what may look like inaction from a junior may have a better explanation than idleness. I have learnt how damaging condemnation can be, even if it is unspoken. Consultants do not often make a conscious decision to ignore a child, and they could valuably learn that juniors do not either.—

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