Optimizing the Involvement of Language Interpreters During the Clinical Encounter

Rebecca A. Johnson, MA¹, Lisa F. Block, MA², and Marion Danis, MD¹

¹Department of Bioethics, National Institutes of Health, Bethesda, MD, USA; ²Spanish Language Medical Interpreter, Washington, DC, USA.

KEY WORDS: language barriers; patient activation; cultural competence.

J Gen Intern Med 29(2):276–8

DOI: 10.1007/s11606-013-2610-2

© Society of General Internal Medicine 2013

Many clinicians attend to the needs of patients who do not speak the same language as they do. In the U.S., such patients are most likely to have limited English proficiency (LEP). Clinicians at medical centers with interpreters available either on staff or over-the-phone may wonder how to structure interpreter participation in the clinical conversation. There has been an explosion of literature on the provision of culturally competent medical care, and most everyone would agree that there is an association between race/ethnicity and health disparities, that language barriers contribute to these disparities, and that medical providers who encounter language barriers should request a professional interpreter. However, the nuances in how the involvement of an interpreter can be calibrated to a particular patient's degree of proficiency, needs, and preferences remain under-explored.

In particular, when deciding how to involve an interpreter, how should clinicians weigh the balance between under-reliance on the interpreter, failing to sufficiently involve an interpreter for patients whom the service could benefit, and over-reliance on the interpreter? The literature on language barriers overwhelmingly focuses on the drawbacks of interpreter under-reliance.¹

In this Comment, we focus on the other side of the equation: possible harms of interpreter over-reliance. Our primary aim is to stimulate research exploring the benefits of more flexible interpreter involvement. In the meantime, we also provide guidance for clinicians on new approaches to conversations with LEP patients.

THE HARMS OF INTERPRETER UNDER-RELIANCE AND OVER-RELIANCE

Existing literature clearly documents the harms of failing to involve a professional interpreter when a patient needs language help, or of relying on ad-hoc interpretation by

family members or untrained staff. These harms include inadequate disclosure of medication side effects, low satisfaction with the interpersonal aspects of care, and poor utilization of primary and preventive services.¹ Taking account of these harms, the literature on interpretation has focused on how to increase utilization of professional interpreters. With a focus on increasing utilization, some empirical literature documents how clinicians decide which situations warrant an interpreter, finding that clinicians weigh interpreter participation against time constraints. They rely on interpreters for “high stakes” interactions and “get by” with mimicking and gestures for “lower-stakes” encounters.²

This research has two shortcomings. First, it makes it appear that the only trade-off at stake in interpreter participation is the benefits of an interpreter versus the limits of time constraints. Second, it implicitly characterizes patients with limited English proficiency as similar in skill level, rather than appreciating varied levels of proficiency and varied interpreter needs. For patients with burgeoning English proficiency—that is, patients who are able to convey some information, concerns, and ideas in English—we argue that there are potential harms of over-reliance on an interpreter, to which the research literature should devote more attention. In particular, three potential drawbacks seem salient: the impact of interpreter involvement on a patient's self-efficacy with regards to language and health; the impact on a patient's willingness to divulge sensitive information; and the impact on the clinician–patient relationship.

The first drawback relates to a patient's sense of self-efficacy: a patient's perception of his competence in a task and the belief that he can control a desired outcome, a perception that then contributes to actual competence at a given task.³ For a patient on the borderline of full English proficiency, relying on an interpreter for every aspect of the clinical conversation may reduce that individual's sense of self-efficacy with regards to her growing English abilities. It also takes away an opportunity to practice English when discussing very practical day-to-day matters. Furthermore, there could be spillover effects on a patient's self-efficacy about health improvement: some evidence shows that while clinicians are satisfied that interpreter-mediated communication imparts adequate knowledge to patients about their

diagnosis, clinicians are much less satisfied that interpreter-mediated communication leaves patients empowered to understand their diagnosis and the need for lifestyle modification.⁴ More research on the link between interpreter involvement and different forms of self-efficacy—such as self-efficacy concerning language and self-efficacy concerning lifestyle modification or disease management—is needed.

The second potential drawback is the impact on a patient's willingness to divulge sensitive information, such as aspects of her sexual history or relationship difficulties. Patients may have different preferences for how to divulge this information, but some may feel more comfortable divulging sensitive information directly to a clinician. This may be a more pronounced concern for patients from smaller immigrant communities, despite interpreters' extensive training in privacy and confidentiality. To date, one interview-based study with primary care clinicians suggests that patients from smaller immigrant communities may feel uncomfortable divulging certain sensitive information to an interpreter who may have ties to that community.⁵ Future research should more closely investigate LEP patient preferences about divulging sensitive information either through an interpreter or directly to a clinician.

The third potential drawback of over-reliance is the impact on the clinician–patient relationship. Skilled interpreters facilitate eye contact and assist conversation between clinicians and patients, but clinicians and patients may still target communication towards the interpreter rather than towards each other. This may weaken the rapport that eye contact and person-to-person communication help build. Patients may feel a closer therapeutic connection with the clinician when they can communicate some of their thoughts directly to that clinician in English. Again, more research is needed on how patients with varying degrees of English proficiency view the effect of interpreter-mediated communication on their relationship with clinicians.

CONTINUUM OF PROFICIENCY AND CONTINUUM OF INTERPRETER PARTICIPATION

We have noted that although there is extensive research documenting the harms of under-reliance on an interpreter, little research investigates potential drawbacks of interpreter over-reliance for patients with different levels of proficiency and different preferences about which language to use to convey certain information. While the agenda for researchers is clear, what should practicing clinicians do in the face of this uneven empirical landscape?

Our suggestion is that clinicians should reject the idea that interpreter participation or nonparticipation is a binary

choice. Just as English proficiency lies on a continuum, with degrees of greater and lesser proficiency, clinicians should also think of reliance on an interpreter as a continuum. Clinicians should always include a professional interpreter in a clinic visit when there is doubt about proficiency. However, clinicians should be prepared to involve the interpreter in flexible ways, allowing the interpreter to facilitate communication as needed for information and questions that stretch the boundaries of a patient's English proficiency, and to remain silent when it is clear that the patient is able to understand and speak English on their own. Clinicians can explain that they plan to proceed with such flexible interpreter involvement at the beginning of the clinical conversation, encouraging the patient to switch between languages as needed, and encouraging the interpreter to be open to this variable participation. In implementing a continuum-based approach to interpreter involvement, clinicians could look to other areas of medicine that have embraced a continuum approach to patient support. For instance, care-giving strategies outline a "continuum of care" adapted to a patient's specific strengths and needs; decision-making strategies for early-stage dementia emphasize a person's continuous range of capacities, where he may retain the capacity to make some decisions, but need to delegate others to a surrogate. Despite this shift to continuum-based approaches in other areas of medicine, advice about interpreter services rarely addresses the possibility that the interpreter may play a more or less active role in the conversation.^{1,2,4,5}

Given our suggestion that clinicians should default to involving an interpreter, but should then involve the interpreter more flexibly, our proposal is consistent with existing U.S. language access policy. Since the 1964 Civil Rights Act, the U.S. has classified inadequate provision of language assistance as a form of national origin discrimination. The Patient Protection and Affordable Care Act (ACA) attempts to increase compliance with this civil rights approach to language interpretation: it places increased data collection requirements on federally supported healthcare facilities in order to monitor meaningful interpreter provision. Facilities could construe meaningful interpreter provision as not only ensuring that interpreters participate in clinical conversations, but also encouraging flexible interpreter involvement tailored to a patient's strengths and preferences.

Our Comment suggests that while there is a strong need for more research to systematically explore strategies for optimal involvement of interpreters, clinicians may have more satisfying clinical encounters if they involve interpreters flexibly according to the linguistic abilities, needs, and preferences of each individual patient.

Acknowledgments: This research was supported by the Intramural Research Program of the National Institutes of Health.

Conflict of Interest: The authors declare that they do not have a conflict of interest.

Disclaimer: The views represented herein are those of the authors and do not necessarily represent the positions or policies of the National Institutes of Health or the US Department of Health and Human Services.

Corresponding Author: Rebecca A. Johnson, MA; Department of Bioethics, National Institutes of Health, 10 Center Drive, Bethesda, MD 20892, USA (e-mail: Johnsonra4@mail.nih.gov).

REFERENCES

1. **Jacobs E, Chen AHM, Karliner LS, Agger-Gupta N, Mutha S.** The need for more research on language barriers in health care: a proposed research agenda. *Milbank Q.* 2006;84:111–33.
2. **Diamond LC, Curry L.** Getting by: underuse of interpreters by resident physicians. *J Gen Intern Med.* 2009;24:256–62.
3. **Bandura A.** *Social Foundations of Thought and Action: a Social Cognitive Theory.* Englewood Cliffs: Prentice-Hall; 1986.
4. **Karliner LS, Pérez-Stable EJ, Gildengorin G.** The language divide: the importance of training in the use of interpreters for outpatient practice. *J Gen Intern Med.* 2004;19:175–83.
5. **Rosenberg E, Leanza Y, Sellar R.** Doctor–patient communication in primary care with an interpreter: physician perceptions of professional and family interpreters. *Patient Educ Couns.* 2007;67:286–92.