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Limited English proficient Hmong- and Spanish-speaking patients' perceptions of the quality of interpreter services

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Abstract

Background—Language barriers are a large and growing problem for patients in the U.S. and around the world. Interpreter services are a standard solution for addressing language barriers and most research has focused on utilization of interpreter services and their effect on health outcomes for patients who do not speak the same language as their healthcare providers including nurses. However, there is limited research on patients' perceptions of these interpreter services.

Objective—To examine Hmong- and Spanish-speaking patients' perceptions of interpreter service quality in the context of receiving cancer preventive services.

Methods—Twenty limited English proficient Hmong (n=10) and Spanish-speaking participants (N=10) ranging in age from 33 to 75 years were interviewed by two bilingual researchers in a Midwestern state. Interviews were audio taped, transcribed verbatim, and translated into English. Analysis was done using conventional content analysis.

Results—The two groups shared perceptions about the quality of interpreter services as variable along three dimensions. Specifically, both groups evaluated quality of interpreters based on the interpreters' ability to provide: (a) literal interpretation, (b) cultural interpretation, and (c) emotional interpretation during the health care encounter. The groups differed, however, on how they described the consequences of poor interpretation quality. Hmong participants described how poor quality interpretation could lead to: (a) poor interpersonal relationships among patients, providers, and interpreters, (b) inability of patients to follow through with treatment plans, and (c) emotional distress for patients.

Conclusions—Our study highlights the fact that patients are discerning consumers of interpreter services; and could be effective partners in efforts to reform and enhance interpreter services.

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Keywords

interpreter services; Healthcare; Hmong; Latino; Limited English proficient

Introduction

According to the United Nations (2013), international migrant populations living in developed countries increased from 9% in 2000 to 12% in 2013. Half of all international migrants now live in 10 countries: the United States, the Russian Federation, Germany, Saudi Arabia, United Arab Emirates, the United Kingdom, France, Canada, Australia, and Spain (United Nations Population Division, 2013). Health care providers in host countries will be challenged to become more adept at communicating with culturally and linguistically diverse patients in order to provide optimal care. Because nurses often communicate more frequently and at greater length with patients than other health care providers, they are particularly impacted by this global growth in the migrant populations.

We could only identify a few studies focusing on nurse communication with populations at risk for experiencing language barriers in health care settings. These studies were conducted in several countries including; in Australia (Blackford et al., 1997; Farley et al., 2014), Europe (Bischoff et al., 2003; Eckhardt et al., 2006; Fatahi et al., 2010) and the United States (Lehna, 2004). The studies focused on nurses' use of interpreters (Farley, Askew, & Kay, 2014; Fatahi, Mattsson, Lundgren, & Hellström, 2010; Graham, Gilchrist, & Rector, 2010; Blackford, Street, & Parsons, 1997; Gerrish, Chau, Sobowale, & Birks, 2004); barriers to using interpreters (Eckhardt, Mott, & Andrew, 2006; Stewart, 1998; Gerrish, Chau, Sobowale, & Birks, 2004), nurses' assessments of the quality of communication using different types of interpreters (Bischoff et al., 2003), and community perceptions of communication with nurses in the context of language barriers (Gerrish, Chau, Sobowale, & Birks, 2004). Only a few studies have focused on ethnic minority patients' views of using interpreters during healthcare encounters (Hadziabdic, Heikkilä, Albin, & Hjelm, 2009; Gerrish, Chau, Sobowale, & Birks, 2004).

The purpose of this study was to examine interpreter service quality as perceived by Hmong- and Spanish-speaking patients with limited English proficiency (LEP) in the United States (US). We used Migration Policy Institute's common accepted definition of LEP: the ability to speak English less than very well (Migration Policy Institute, 2011, pg. 1). Simultaneously examining two ethnic groups with limited English proficiency allowed us to explore similarities and differences in their experiences, to learn what might be inherent in patients' experiences interpreter services and what might be specific to individual groups. Understanding U.S. patients' perceptions regarding interpreter quality is the first step, future research from other countries and with other groups is necessary to learn what is common, what is unique to each group or situation because there are universal issues that arise in communication across language barriers regardless of geography or culture.

Background

Patients who experience language barriers have been shown to receive poorer quality care than patients speaking the native language, contributing to the well documented health disparities experienced by migrant groups (Kirkman-Liff & Mondragón, 1991; Woloshin, Bickell, Schwartz, Gany, & Welch, 1995). Patients who do not speak the same language as their healthcare providers have twice the risk of receiving less than optimal care (Bischoff, 2003), fewer medical visits (Marks et al., 1987) and higher costs of care (Hampers & McNulty, 2002).

Several studies from different provider types in this literature have documented the importance of having professional interpreters during a health encounter for improving health outcomes (Flores, 2005; Karliner, Jacobs, Chen, & Mutha, 2007) patient comprehension (Cheng, Chen, & Cunningham, 2007; Jacobs, Chen, Karliner, Agger-Gupta, & Mutha, 2006), health care utilization (Flores, 2005), and satisfaction with communication and clinical services (Flores, 2005; Karliner et al., 2007). However, patients' perceptions of interpreter services have not been well explored. While the presence of interpreter services is clearly a beginning point, understanding how they influence the patient/provider encounter, and the factors associated with high quality interpretation that actually promotes clear and effective communication is vital. This study provides some insights into those factors.

Methods

The study reported here used a descriptive exploratory design to identify and examine factors that influence the quality of interpreter services, and ultimately to disparities in receipt of preventive cancer screening among LEP Hmong- and Spanish-speaking patients. We used a combination of focused, semi-structured interviews to explore multiple issues including: (a) general health care experiences; (b) patient understanding of cancer; (c) patient experience with preventive cancer screening; (d); experiences with language concordant care (e.g. when the patient receives care in a language they speak) (e); and interpreter services. This paper focuses exclusively on data related to interpreter services. Manuscripts on the other topics are forthcoming. This study was approved by the Health Sciences Institutional Review Board at the University of Wisconsin-Madison.

Sample

A convenience sample of twenty-one limited English proficient (LEP) patients (11 Hmong-speaking, 10 Spanish-speaking) was recruited for the study. The final sample included 20 participants. One Hmong interview was excluded as the participant was unable to provide information relevant to the project's goals. This number is consistent with sample guidelines for qualitative studies (Morse, 2000).

Data Collection

We used a variety of methods to recruit participants for this study including; posting language-appropriate flyers in clinics and community centers, sending letters to homes of patients identified by primary care providers as Spanish and Hmong speaking (LEP), and

attending cultural events to describe the study and encourage participation. In addition, after participants were interviewed, they were asked to refer family and friends to the study (aka snowball sampling). Interested participants telephoned the study phone line and were screened for participation by bilingual staff. Eligibility criteria included: (1) self-identification as not speaking English very well (limited English proficient), (2) native Hmong or Spanish speaker, (3) eligible for preventive cancer screening (women 18 and men 50), (4) no previous cancer diagnosis, (5) visited their primary care provider in the past year, and (5) willingness to participate in one interview in a location of their choice. All participants received \$50 in appreciation for their time. The recruitment and interviews took place from July to December 2013.

Researchers conducted semi-structured interviews in: private homes, public libraries, and office meeting rooms. A semi-structured interview guide was used to ensure consistency in topics across interviews. The semi-structured interview guide was initially written in English then translated into Hmong and Spanish by bilingual study team members. Translations were based on meanings as opposed to literal translations (Larson, 1998).

Participants were asked specific questions about the experience with health care services. For example, “Are there things the clinic does to make it easier for you to get these services? What are they?” When participants did not mention interpreter services, the interviewer probed by asking global questions about participants’ experiences with interpreter services. For example, “what has been your experience with interpreter services? What are your thoughts about the quality of interpreter services?”

At least two bilingual study staff attended each interview. The first author, who is a bilingual and bi-cultural Hmong woman from the Hmong community who is also highly engaged in the American culture, conducted the interviews with Hmong participants. The third author, who is a bilingual white woman, conducted the interviews with Spanish-speaking participants. The Hmong and Spanish bilingual interviewers worked independently until all interviews were completed. Although they were both instructed to ask follow-up questions about interpreter services, the Hmong interviewer pursued the questions on interpreter services in greater depth. Interviews averaged about 70 minutes in length. All interviews were audio taped.

The audio files were initially transcribed in Hmong or Spanish and then translated into English (Larson, 1998). To maximize quality and accuracy, we used the group translation method in which a team of investigators reviewed and translated the quotes, compared them and came to a group consensus as to how to best translate the Spanish and Hmong into English, focusing on capturing meanings rather than literal translations (Lopez, Figueroa, Connor, & Maliski, 2008; Larson, 1998).

Data Analysis

Data were analyzed using conventional content analysis (Caelli, Ray, & Mill, 2003; Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). Data were entered into NVivo10 (QSR International) for management and retrieval.

Analysis included several steps. First, four members of the research team read through all transcripts several times to achieve immersion (Caelli, Ray, & Mill, 2003; Graneheim & Lundman, 2004; Hsieh & Shannon, 2005). Next, three team members read transcripts individually coding experiences that were common across participants, capturing key concepts related to patients' perceptions of interpreter quality. For example, when we read the participant's statement "...to be honest, I don't think he [the interpreter] knows English very well," we coded this as "interpreter doesn't know English well." Another example was when a Hmong-speaking participant shared "some [interpreters] come and interpret, but don't know Hmong fully," we coded this as "interpreter doesn't know patient's native language." After the transcripts were coded, we sorted the codes into categories based on the similarities and differences between codes. For example, we categorized all the codes: "interpreter doesn't know English" and "interpreter doesn't know native language (Hmong or Spanish) as final sub-categories: "literal interpretation in English and Native language." These subcategories were a composite of the final category, "literal interpretation." We engaged in an iterative process of coding and categorizing to ensure that we achieved saturation across the themes (Morse, 1995). In other words, categories were reflective of the participant's comments and all major issues identified by participants were included. We resolved disagreements or discrepancies through discussion, always referring back to the transcripts.

Results

A total of 20 participants, 10 Hmong-and 10 Spanish-speaking, participated in this study. Half of the participants were women and half were men. The average age of the two groups was similar; Hmong 55 (ranging from 34 to 70) and Spanish-speaking 53 (ranging from 33 to 75). For Hmong-speaking patients, eight were publically insured and two privately insured. For Spanish-speaking participants, four were privately insured, three were publicly insured, and three were uninsured. Most were not new arrivals to the U.S. On average, the Hmong patients in this study had been in the United States for 20 years (ranging from 8 to 33 years) while the Spanish-speaking patients had been in the United States for 16 years (ranging from 9 to 26 years).

Both groups of participants described the quality of interpreter services as variable. Probes were used to inquire into how they determined the quality of interpretation services. Because findings were similar for the two groups, we report overall findings for the total group, followed by findings specific to each group. Analysis suggested that participants evaluated the quality of interpreters based on the interpreters' ability to provide: (a) literal interpretation, (b) cultural interpretation, and (c) emotional interpretation during the health care encounter.

Literal Interpretation

Both Hmong- and Spanish-speaking participants described the quality of interpretation as influenced by the interpreter's ability to speak both their native language and English, as well as being proficient in medical terminology.

Literal Interpretation in Native Language & English—Most Hmong- and Spanish-speaking participants expected interpreters to be proficient in their native language (e.g. Hmong or Spanish) as well as in English. A Hmong woman shared her expectation that; "... the interpreters have to be the ones that know Hmong really well, so the interpreter knows what the Americans are saying and can interpret back to the Hmong person..."

Both groups of participants observed interpreters' understanding of the topics discussed as an indicator of the interpreter's level of literal proficiency. Participants determined that the interpreter understood both languages and medical terminology if; (a) the translation they were given was understandable ; (b) interpreters took an appropriate amount of time interpreting (neither longer nor shorter than the initial message), c) interpreters asked minimal follow up questions in either direction; (d) participants received a response to their question that made sense from the interpreter's interpretation; and (e) interpreters did not require long pauses before translating, in either direction. In the absence of these indicators, participants perceived that the interpreter was struggling to understand what had been said and inferred that the interpreter was not proficient in one of the languages or did not understand medical terminology. A Hmong woman shared her observation of an interpreter's insufficient Hmong language skills, and consequently poor quality interpretation.

"There are some [interpreters] that come and interpret but [they don't] know Hmong fully and the interpreter can't even interpret English words back to me. So then I don't know. When I look, I see that the interpreter doesn't understand what I said to [the doctor] and [the interpreter] can't speak back in English to them."

A Spanish-speaking participant described an interpreter who repeatedly questioned the provider, indicating that the interpreter did not understand what had been said:

"...sometimes I see that the interpreters, like umm they try, how can I tell you, like they don't understand this thing that the doctor is trying to say and they ask him again or even sometimes a- 'can you explain it to me one more time that-'"

Another common observation that both Hmong-and Spanish-speaking participants used to determine literal language proficiency was listening for whether the interpreter had picked up nuances in their native language.

Native language nuances: Language nuances were assessed differently by each group. The majority of Hmong speaking participants commented on generational language nuances, noting that younger Hmong did not always understand the nuances of language used by older Hmong. Language nuances were assessed by whether the Hmong interpreters were familiar with the terms used by Hmong patients who were often much older than the interpreters. An older Hmong female shared an experience she had with a younger Hmong interpreter, whose Hmong she did not understand, even though the interpreter was a native Hmong speaker:

"She interpreted for me and it seemed like when she interpreted, she sounded like she was still really young okay? So like [the interpreter] doesn't know anything and she said---what the doctor said was that I have a small illness in my urine, and they

needed me to take medications right? But [the interpreter] said to me, ‘Older sister, they said that you have a big illness in your urine.’”

In contrast, most of the Spanish-speaking participants spoke about nuances related to native Spanish speakers versus a non-native Spanish-speaking interpreter. As a Spanish-speaking woman shared:

“...I think that for you [referring to the interviewer], you speak Spanish and you are American. But you can’t interpret it exactly like if, are you Mexican.... Like a person that comes from Mexico and that knows exact Spanish.”

Another difference between the two groups was the Hmong participants’ only identified word number inconsistencies. In addition, only the Hmong-speaking participants described feeling sidelined when interpreter/provider conversations appeared to be an ongoing exchange from which they were excluded.

Word number inconsistency: Hmong patients described assessing the correspondence between the number of words spoken by the patient or provider and the number of words subsequently interpreted. When the numbers did not match, this was generally seen as a problem of omission, a concern that the interpreter was omitting words or only interpreting part of what had been said. A Hmong-speaking participant said:

“The doctor will say 5-6 words to the interpreter and the interpreter only says 2-3 words to me. So I don’t even know what the doctor said to the interpreter and when the interpreter explains it to me, the interpreter doesn’t discuss all the questions from the doctor. [The interpreter] only said a few word to [me].”

Discrepancies between the number of words spoken and the number interpreted, led participants to believe that important information about the condition or treatment had been omitted. Participants believed that the interpreter had edited out something that the participant had wanted the physician to know or had failed to interpret a question that the participant had asked. Significantly, the majority of Hmong-speaking participants described frequent interpreter omissions. A Hmong-speaking male participant angrily shared his perception of the interpreter omitting his passage: “Like I said, when the interpreter interprets my words [to the physician], there are some things that I want them [the interpreter] to say, point out, or ask, but they refused to.”

Sidelined by the interpreter/provider interaction: Hmong-speaking participants shared that they felt sidelined when the interpreter and provider engaged in an ongoing exchange that failed to include them. In this instance, Hmong-speaking participants perceived that the interpreter and provider were discussing the situation, exchanging opinions, and making a decision without their input. Some Hmong-speaking participants also reported being sidelined when there was disagreement between the healthcare provider and the interpreter diverting the conversation away from them. For example, a Hmong woman explained how her family had refused to let their mother have an operation, and the provider and interpreter were discussing the operation and reasons it was necessary. She described how the provider and interpreter argued about the decision without input from the patient or the patient’s family:

“Since we didn’t let the doctor do it [referring to the operation], so the doctor thought that maybe it was the Hmong interpreter that didn’t let my mom and us do it. Because the doctor doesn’t know our language ok? So the doctor was mad. The doctor’s face was super red and [s/he] yelled at that Hmong guy [interpreter].”

In contrast, most Spanish-speaking participants focused on personality traits of the interpreters including as clues to the quality of literal interpretation proficiency. Spanish-speaking interpreters who seemed to be supportive and had traits such as friendliness and trustworthiness were perceived as proficient. Examples of support from interpreters included when the interpreter protected the confidentiality of Spanish-speaking participants, advocated for the patient, spent time with the patient, and assisted in arranging appointments for them. A Spanish woman shared her perception of a high quality interpreter: “They are very patient, really good and they go and they take us through to the appointment and all of that.”

Professionalism: Being professional [*profesionalismo*] was also interpreted by Spanish speaking participants as an indicator of interpretation quality. Most of the Spanish-speaking participants described professionalism as going above and beyond the interpreter role or being caring. An example was when the interpreter stayed with her for two hours and went to the pharmacy with her. The Spanish-speaking woman inferred from this that the interpreter was proficient in the Spanish language.

“She [referring to the interpreter] helped me schedule. She didn’t leave until after we scheduled the appointment with the otolaryngologist. She was there in the clinic. So there was no need for me to call “you know that I need.” Instead she stayed with me until I left the hospital, including to the pharmacy she went with me.”

Literal Interpretation in Medical Terminology

Both groups of participants also expected the interpreter to be proficient in medical terminology, in both their native language and in English. A Spanish-speaking participant stated, “But they should be familiar. That they have a medical knowledge.”

When participants perceived that the interpreter might not be interpreting the medical terminology correctly, they concluded that the interpreter was not proficient in medical terminology. Most Hmong-speaking participants reported that many interpreters lacked proficiency in medical terminology. Hmong-speaking participants assessed this by whether interpretation made sense to them. As one Hmong male participant shared: “So then you know that maybe for urinary tract infection, sometimes some interpreters would interpret and say that you have pus in your bladder...or there is pus...So even if it’s an infection, can there be pus?”

Participants from both groups noted specific domains of medical terminology that many interpreters lacked. A few Hmong participants reported proficiency related to surgical and other procedures as often lacking. Similarly, most Spanish-speaking participants reported problems in proficiency related to body parts. One Spanish-speaking man said:

“For instance, I was once with the doctor, umm, asking him what type of medicine I needed because I had heart problems. And the doctor said that, um, I needed a medicine for my coronaries or to see if it is a study or because of the problem I had for the coronaries, and the interpreter tells me that I have a problem with the cornea.”

Cultural Interpretation

Both Hmong- and Spanish-speaking participants discussed how the quality of interpretation was also influenced by the interpreters' ability to interpret in a culturally accurate and sensitive way. A common complaint from both Hmong-and Spanish-speaking participants was receiving what they perceived as “weird” or “strange” interpretations in their native language that were culturally meaningless, hindering their ability to understand the discussion. For example, a Spanish-speaking participant said:

“...Like when we use the phrasing “la Lisa” for people, for me it’s disrespectful and in Bolivia and Colombia those places use it.”

Emotional Interpretation

Both groups strongly emphasized that the interpreter’s ability to interpret the emotional content of their messages to the providers influenced their perception of interpreter quality. For example, when a participant observed that the interpreter did not interpret his/her emotional tone, the participant inferred that the interpretation was inadequate. A female Hmong participant shared this observation of one interpreter:

“Sometimes when the doctors make me angry and I said a few words to them, the interpreter doesn’t say my words. The interpreter only says what is easy to them. So the interpreter will say, “Oh, she said she is ok with you. You do well.”

When participants observed the interpreter’s tone of voice to be similar with theirs, they inferred that the interpretation was adequate. A Spanish-speaking participant said: “...when there is a communication, not only do you capture the voice but also the emphasis or the expression, right.”

Consequences of Poor Interpretation

Although no Spanish-speaking participants spoke about the consequences of poor interpretation quality, all the Hmong participants did because the interviewer asked. Three types of consequences were mentioned: (a) poor interpersonal relationship between patient and provider, (b) patients failing to follow through on health instructions, and (c) patient emotional distress.

Poor Provider-Patient Relationship—A few Hmong participants observed that interpreters with low language proficiency negatively affected relationships between them and their providers. For example, when an interpreter misinterpreted a labor and delivery procedure (cutting the umbilical cord was confused with circumcision) and, as a direct result, the Hmong woman and her family refused the procedure, the doctor was upset with the Hmong family. The participant said:

“The interpreter, who interprets didn’t know and said that “cut to the male’s private part [referring to circumcision]...” So the interpreter interpreted to us and we said, “Oh, in our Hmong culture, we don’t like to cut it [referring to the circumcision].” When we went to see our doctor, we said that we were not going to do that.” So then the doctor was mad. So then the interpreter asked him [the doctor] again and the interpreter said: “sorry, I misunderstand... It’s cutting the cord.” So I was like “oh, if it’s the cord then they can cut it. We don’t mind.”

Poor Patient-Interpreter Relationship—Hmong participants observed that having a discussion with their interpreter regarding both how they expected the healthcare encounter to proceed, and the interpreter’s role often led to a damaged relationship between the patient and the interpreter. For example, in one instance, a Hmong participant was trying to orient the interpreter to her primary goals of the health care encounter and her expectations regarding the quality of interpretation and this led to conflict and distrust between the interpreter and patient, and ultimately the interpreter withdrew services.

“So then the interpreter will answer the phone and talk. I talked with a Hmong [interpreter], she and I spoke and did not get along... Also I am still speaking, [the interpreter] is already getting mad at me and said “I don’t know how to talk to you. You don’t understand.” So then [the interpreter] was mad at me because she didn’t understand what I said and when she spoke to me, I didn’t understand. I told her ‘I do understand what you are saying, but I want you to say and explain all my words to the doctor....So that’s then she just got mad at me...Then she hung up the phone.”

Patients failing to follow through

Most Hmong participants shared that when the quality of interpretation was inadequate, it was difficult or impossible for them to follow through with their doctors’ recommendations, often due to incorrect or missing information. For example, some of the Hmong-speaking participants shared that they did not receive the medications they needed or were unable to follow instructions on how to take their medications at home because of the poor interpretation. A Hmong female participant explained;

“Because the interpreter interprets like that so I don’t know what the message was. [The interpreter] only said one or two words to me like for the medications. [The interpreter] will say “oh, they wrote this paper for you to go buy medications. I have to go now.” So then I don’t know when I should go buy the medications....Because I don’t know the language, I want the person to tell me how to take the medications; do I take it in the morning, take it after meals, or take it before meals?”

In other instances, Hmong participants failed to pursue treatment or go in for procedures such as a pap test due to failures in interpretation. A Hmong female participant explained how her mother did not pursue a pap test because the interpreter did not interpret the importance of the procedure:

“If it’s like the elders, where they have a lot of questions and don’t understand about American rules about checking them and they refuse. They keep asking, “Why do they have to check this and this...?” Then when [the interpreter] says, [the doctor] wants to check you and [the elder] keeps asking, “why do they keep wanting to check me ?” The elders don’t understand that...Then when you listen to the interpreter talk, the interpreter is angry. Then I want the interpreter to be more patient towards the elders, like that...”

Emotional Distress

Many Hmong-speaking participants shared that when the interpretation was poor quality, they did not understand the discussion and, as a result, became emotionally distressed. A Hmong participant shared: “I think about it and say [to myself] “aww, this person makes me so stressed.” Another Hmong participant emphasized that when the interpreter did not understand her native language and when she saw the interpreter struggling with the message to the provider, she said; “So I can’t even understand anything. It makes me stressed about myself.”

Discussion

We found that Hmong- and Spanish-speaking patients’ experienced a range of interpreter quality. The participants from both groups had expectations that the interpreters would be proficient in literal, cultural, and emotional interpretation, and in both the participants’ native language and in English, as well as in medical terminology. Participants from both groups assessed quality of the interpretation by their ability to understand what the interpreter said, their careful observations of the interpreter’s behavior. These are particularly significant findings as the interpreters were all certified medical interpreters provided by the health system.

Our findings that patients expect interpreters to be proficient in both linguistic and cultural interpretation were similar to other studies examining nurses perceptions of interpreter services with nurses (Bischoff et al., 2003; Blackford et al., 1997; Eklöf, Hupli, & Leino-Kilpi, 2014) and the few studies of patients’ perceptions of interpreter services (Hadziabdic, Heikkilä, Albin, & Hjelm, 2009; Gerrish, Chau, Sobowale, & Birks, 2004). However, the emphasis on interpreters’ failure to convey the emotional content of messages to providers is new. One possible explanation could be that interpreters are editing the patients’ responses because they are afraid that providers will react negatively to a patient’s emotional response, and/or the interpreters are trying to protect themselves and/or the patients. Future research is necessary to examine interpreters’ perceptions of their roles and experiences during interpretation.

While our study demonstrated similarities between the two populations, it also highlighted differences between them, indicating that there may be important differences in interpreter quality based on population characteristics and possibly context. One implication of this finding is that research on interpreter quality and impact on patient outcomes cannot necessarily be transferred to populations and circumstances that were not included in the

studies, and that specific cultural, language and even generational differences should be carefully explored before determining the applicability of findings.

One significant difference between the Hmong and Spanish-speaking participants in this study was how the participants from each group observed the interpreter during the encounter. While Hmong watched closely to determine whether the interpreter had omitted either technical or emotional content the Spanish-speaking participants did not mention this strategy for determining quality. Omitting passages has been reported by other researchers as the most common type of medical interpretation error (Flores et al., 2003, 2012; Gany et al., 2007; Lor & Chewning, 2014). What has not been previously reported are the consequences for patient/provider and patient/interpreter relationships. This suggests that current interpreter training and certification do not sufficiently attend to these possible consequences and how to avoid them. Caution is advised with generalizing specific findings. However, the need for further research to determine the components of effective medical interpreter training is clear.

The consequences for poor quality interpretation and for different approaches to interpreting is an important topic for future research. While the link between poor quality interpretation and poor adherence to treatment has been well documented, (Catz, Kelly, Bogart, Benotsch, & McAuliffe, 2000; Harmon, Lefante, & Krousel-Wood, 2006; Jerant AF, Fenton JJ, & Franks P, 2008) other consequences have not been previously reported.

Implications for Nurses Globally

While our study included participants from only two ethnic groups, our study findings may be relevant to other ethnic minority groups and in other circumstances across the globe as interpreter services are commonly used in health care encounters. Significantly, our findings suggest important differences between the experiences of Hmong and Spanish-speaking patients. Thus, it is essential that nurses and other health care providers recognize that patients with language barriers are not a monolithic group. The Spanish-speaking participants in this study focused on differences in native versus learned Spanish interpretations. This highlights the need for nurses to consider the specific needs and expectations of each patient and the match with expectations and background of their interpreters. Even among individuals who speak the same language, but come from a different ethnic group, there may be relevant differences in language and culture. Equally important, it is essential to consider age and geographic differences of interpreters as both participant groups indicated their importance in the perceived quality of the interpretation.

Our findings also highlight that each ethnic group might need a unique set of strategies to ensure that interpreter services are acceptable. For example, while both participant groups expected interpreters to have linguistic and cultural proficiency, only the Hmong-speaking group reported that the Hmong interpreters omitted passages bi-directionally (from both the patient and provider). In addition, Hmong-speaking patients reported the consequences of omission of passages. This highlights the notion that bidirectional communication, including communicating a patient's emotional response, may be essential in a successful health care encounter

Nurses could utilize several strategies to enhance interpretation quality. They could conduct a pre-visit briefing with the interpreter and emphasize that they would like the interpreter to interpret all information, including emotional passages. They could also provide the interpreter with any information necessary to help the interpreter understand the context of the situation, including medical technical terms that will be used during the session (e.g. diagnostic terms).

It was clear from our findings that triadic interpretation between an interpreter, patient, and health care provider complicates the therapeutic relationship. Hmong participants from our study reported feeling sidelined by their providers and interpreters, which undermined their trust in the communication they did receive. This is clinically relevant as trust is a well documented determinant of following medical advice and reducing health disparities (Mechanic, 1998; O'Malley, Sheppard, Schwartz, & Mandelblatt, 2004). It is critical that nurses place the patient at the center of the health communication between healthcare providers and the interpreters and stay vigilant for some of these issues (Beach, Inui, & the Relationship-Centered Care Research Network, 2006).

Limitations

Several limitations should be noted. This study was of Hmong- and Spanish-speaking participants only; similar studies of other LEP populations are needed to examine whether patients from other cultural groups have similar experiences. Future studies could also be conducted with interpreters to examine their experiences working with LEP patients in the healthcare setting to provide a holistic review of all parties involved in the interpretation process. Because we had different interviewers conducting the interviews for both groups of participants, there may have been variations in responses from participants due to the lack of consistency of probing questions about interpreter services. For example, the identification of negative consequences of how interpretation is currently done was confined to the Hmong group. These negative consequences may also have been experienced by Spanish speaking participants. However, we tried to control this by having the two interviewers talk to each other about the probing questions they used prior to subsequent interviews for consistency. Because the participants in this study were sampled from one health care system within the Midwest, the findings from this study may not be generalizable. Future studies could assess interpreter quality across health care systems.

This study also had several strengths. Namely, we included two distinct LEP populations in our study, allowing us to examine how issues might be similar or different across very distinct cultural groups. Because in most health care settings, providers, including nurses, have to address the needs of multiple ethnic minority groups, understanding the similarities and differences across groups may increase efficiency in working with multiple LEP populations with similar needs. An additional strength is that we conducted this study in a healthcare system with high quality interpreters. Our findings highlighted that even in systems with high-quality interpreter services there could be improvement in order to provide high quality care to all LEP patients.

Conclusion

Limited research has focused on LEP patients' experiences with interpreter services. Understanding LEP patients' experiences with interpreter services will help nurses improve care for populations that experience language barriers. This is the first study to focus on the perceptions of two LEP patient populations regarding the quality of interpreter services simultaneously and we documented many similarities across these groups. Nurses working with LEP patients may not realize the challenges LEP patients encounter when communicating in this triadic relationship. This study suggests that Hmong- and Spanish-speaking patients expect their interpreters to interpret health information proficiently, specifically with literal, cultural, and emotional proficiency. It is also important to recognize that there were differences between these two groups in their observations of quality of interpreter services. LEP patients reported that poor quality interpretation had negative consequences for these patients, particularly in managing their health conditions at home. This study has important implications because it suggests that providers and the system as a whole should be more sensitive to the process of interpretation to ensure that LEP patients' needs are met.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Contribution of the**Paper What is already known about the topic?**

- Interpreters play a fundamental role in quality of interaction between nurses and limited English speaking (LEP) patients.
- Interpreters can improve or undermine health outcomes for limited English speaking (LEP) patients.
- Nurses assume interpreters are providing high quality interpretation.

What this paper adds

- LEP patients are dissatisfied with the quality of interpreter services.
- LEP patients expect interpreters to interpret accurately clinical and emotional messages in a culturally sensitive way in both directions from providers and patients.
- LEP patients perceived lower quality of care due to poor interpretation.

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