

# Bridging the Language Divide:

## A Pocket Guide to Working Effectively with Interpreters in Health Care Settings



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*This publication was made possible, in part, by funding from the Wellmark Foundation PRISM Series in Culturally Competent Health Care; the National Center on Minority Health and Health Disparities, National Institutes of Health, Grant #5R24MD519-3; and the United States Department of Labor.*

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# Reducing Language Barriers to Care through Medical Interpreters

RAPID GROWTH IN IMMIGRANT AND REFUGEE POPULATIONS IN THE UNITED STATES PRESENTS CHALLENGES TO HEALTH

care providers. Perhaps the most important challenges to reducing health disparities among ethnic minority populations are associated with language and communication. The number of immigrant and refugee patients is growing rapidly in many communities. Although most of these newcomers are from Latin America and speak Spanish, the newcomer population is becoming more diverse with a growing list of home countries, ethnicities, and languages. Indeed, United States Census data (2000) indicate that 12% of the nation's population is foreign-born, and 19% of individuals over five years of age in this country speak a language other than English at home. Furthermore, there are more than 176 languages reportedly spoken in the United States, with Spanish, Russian, Vietnamese, Korean, and Arabic being among those most requested by hospitals for translation and interpretation services (CyraCom, 2006).

The introduction of new languages means that many health providers must increasingly work with interpreters to provide health services to immigrant and refugee patients. Even if providers are unfamiliar with specific



ethnic minority populations, or they are just learning how to work with these unique patients, they still must be at least minimally competent at working with interpreters in order to provide effective care. (Indeed, providers often confuse interpretation with translation. Interpretation is conversion of spoken or verbal language. Translation is conversion of written language.)

Using an interpreter is a skill. Like all skills, it must be learned and practiced. All too often, for example, a clinician may explain lengthy, complicated directions on how to take medication, only to find that the interpreter summarized the comments into just a few words. At the same time, many minority patients want to have detailed

discussions with their providers about their conditions but find that the clinicians are not using the interpreters effectively to solicit this information



from them. Increasingly, health facilities need to employ interpreters and translators, and must train their staff to work effectively with them.

Many providers feel that they must learn the language of newcomer patients in order to provide the most effective care. In a perfect world, this is true. But very few professionals have the time or resources to learn a new language and achieve fluency in a reasonable period of time. Instead, providers can learn to use interpreters to communicate with patients and when done well, the level of communication can be nearly as effective as if the provider was able to communicate directly. However, even when professional interpreters are available, it is still important to learn and use a few introductory phrases in the patient's language. Greetings like "Good Morning" and polite questions like "How are you feeling today?" go a long way to break down the barriers that often exist between newcomer patients and providers.

# Linking Medical Interpretation to Cultural Competency

multiple national policy documents, such as the landmark Institute of Medicine Report “*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*” (2002), as a critical means to reducing health disparities among diverse communities. Effective use of interpreters is cited regularly as a critical part of providing culturally

THE NEED FOR THE PROVISION OF CULTURALLY COMPETENT CARE BY MEDICAL PROVIDERS HAS BEEN CITED IN

competent health care.

In their book *Health Matters: A Pocket Guide for Working with Diverse Cultures and Underserved Populations* (2005), Drs. Yehieli and Grey state that “Providing culturally appropriate health care means that a provider or organization is sensitive to the cultural differences among patients, understands the influence of these



differences on their health status, and can modify programs from a practical standpoint to meet the specific needs of diverse clients.” Clearly, the effective use of interpreters is a critical part of creating practical programs to meet the needs of patients who do not speak English.

The effective use of interpreters is also a significant part of the Culturally and Linguistically Appropriate Services (CLAS) Standards for health care providers, which are a set of “recommendations issued by the United States Department of Health and Human Services Office of Minority Health. They are intended to inform, guide, and facilitate practices related to culturally and linguistically appropriate health services.” There are 14 CLAS standards. Increasingly, portions of these standards are being mandated by federal organizations, accreditation agencies, and other entities because of their importance. The complete list of these standards can be found at the OMH website <http://www.omhrc.gov>. Among the CLAS standards, three directly relate to hiring, training, and using interpreters, as noted below:

**CLAS Standard 4:**

*Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.*

**CLAS Standard 5:**

*Health care organizations must provide to patients/consumers in their preferred language both verbal and written notices informing them of their right to receive language assistance services.*



**CLAS Standard 6:**

*Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).*

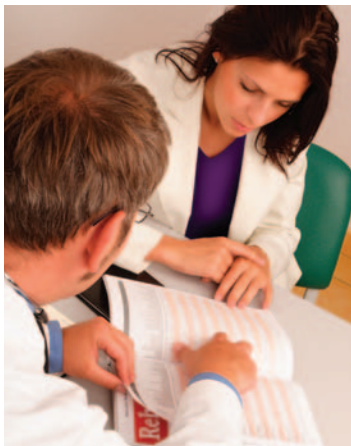
Clearly these three CLAS standards direct health care providers to provide quality interpretation services to non-English speaking patients. Recruiting bilingual staff is not always easy, particularly in small rural communities. However, it must be pointed out that fluency in two languages does not in and of itself make someone a good interpreter. Indeed, there are a growing number of training opportunities for bilingual people to become interpreters. The focus of this pocket guide, therefore, is not on how to recruit and train interpreters, but how to help personnel work more effectively with these language specialists.



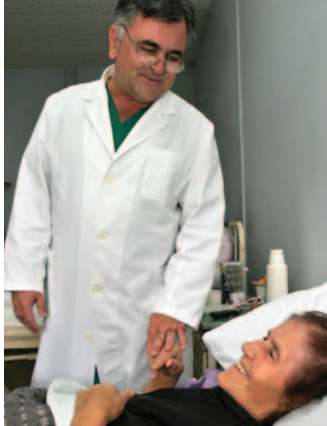
# Guidelines for Working with Interpreters

THIS SECTION DISCUSSES SOME GENERAL GUIDELINES TO USING INTERPRETERS AND PROVIDING THE BEST POSSIBLE CARE

to non-English speaking patients. Of course, hospitals, health organizations, and patients will generally benefit most when professionally trained and highly qualified interpreters are utilized. However, these individuals are not always available, particularly for some languages that are less common. Nonetheless, the use of children, family members, or friends as interpreters is strongly discouraged. (Indeed, the state of California has now banned the use of children as medical interpreters.) No matter how well-meaning or accessible they may be, bilingual family members or friends most often do not have the language skills or technical vocabulary necessary to be effective interpreters. Also, confidential health information is less likely to be shared by the patient with the provider in cases where family members, children, or friends act as interpreters. Likewise, these informal interpreters may not



protect the confidentiality of the patient among other extended family members and friends in the ethnic community. Although children may appear to speak English fairly well, they may not really understand the nuances or the medical vocabulary. And, using children as interpreters places them in a position of relative power over their parents, and can create stress



due to changes in traditional familial patterns. With this disclaimer, then, the following are general guidelines for utilizing interpreters in a culturally competent manner:

### ***Respect Patient Individuality and Heritage***

Avoid using phrases like “your people” or “you people” when talking to newcomer patients. Despite the perception that newcomers from the same cultural or ethnic group are all similar, each patient must be treated as an individual. Also be careful to avoid terms that sound like judgments about the patient’s culture, language, or conceptions of health. Don’t use terms like “backwards” or “deprived” to describe the patient’s culture. Likewise, be sure to not express body language that may indicate disdain or disapproval of an individual’s ethnic heritage or cultural beliefs and practices.

## *Accommodate Gender- and Age-Specific Needs*

Where possible, try to utilize an interpreter of the same sex as the patient. A number of cultures, particularly those that are more traditional and religiously conservative, have well-defined gender roles that sometimes inhibit patients of one sex from discussing health issues with the opposite sex. For instance, elderly Sudanese refugee women would be less likely to discuss female health concerns with a male interpreter and physician than they would if these health providers were female. Female patients in some cultures may also be unlikely to look directly into the eyes of male staff out of modesty, and patient reactions to hearing and comprehending medical information during a visit could easily be misunderstood by interpreters. Similarly, care should be taken to ensure that interpreters are age-appropriate for patients when possible, or at least “age-sensitive.” In many traditional cultures, great deference is expected to be shown by younger people to older people. When working with senior clients and adults, young interpreters should be trained to show a high level of honor to older patients, and to use respectful titles when addressing them, such as “Mr.” or “Mrs.”

## *Understand Your Own Cultural Values*

Be aware of your own cultural biases and expectations about health and how these influence your interactions with patients from different cultures. Reflect on how these biases and expectations impact the language you use when working with newcomers. For instance,

providers from a predominately white, English-speaking culture will bring very different expectations about the appropriate nature of their interaction with patients than will be brought by the immigrant or refugee patients. Reflect on how these contrasting expectations will change the way you talk to patients via an interpreter. It is acceptable to admit that you are just learning about their culture and to ask questions to learn more about how they perceive health and their health problems. Ask questions like,

*Are there any cultural considerations I should know about you to serve your health needs?*

*Can you please tell me about health care in your home country?*

*Have you noticed any differences between the type of health care you received in your home country and the care you receive here? Can you tell me about those differences?*

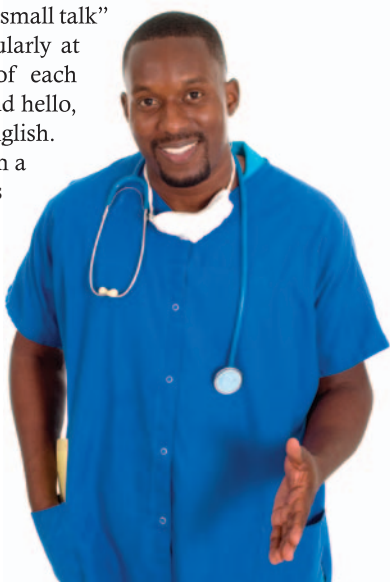


## *Avoid Generalizations*

Never make assumptions about education level or the professional background of patients. No population is homogeneous, and newcomer populations are just as diverse as established-resident populations. Although generalizations about specific populations are sometimes useful (e.g., the vast majority of Mexican immigrants speak Spanish), these become stereotypes when individual patients are expected to take on the characteristics of the generalization (i.e., not all newcomers from Mexico speak Spanish. They may speak indigenous languages).

## *Be Approachable and Open*

Regardless of the interpreter's presence, try to make at least some "small talk" with the patients, particularly at the beginning and end of each visit. Most will understand hello, thank you, and so on in English. Likewise, you should learn a few basic friendly phrases or words to share with your clients in their native languages. Smiles, respectful behavior, and a friendly attitude by providers will carry over in any language.



## *Speak in Short Phrases*

Never speak more than a sentence or two before stopping to let the interpreter interpret your statement. Avoid the very common mistake of explaining a large amount of information in English, and then waiting for the interpreter to interpret. Usually this will result in a large amount of missed information. Interpreters and providers who work together for long periods of time develop a rhythm and in many cases, the provider will speak one phrase at a time to make sure the questions or instructions are being adequately conveyed to the patient.

## *Use Open-Ended Questions*

Avoid asking questions that can be answered with a simple “yes” or “no.” The patient may say she or he understands out of fear, concerns about losing face, or not wanting to appear uneducated. Ask a lot of questions that begin with why, what, where, and how. Here are some examples:

*How do you describe your problem? What do you call it?*

*What do you think caused your problem?*

*Why do you think the problem started when it did?*

*What worries you the most?*

*How does the problem affect your daily life?*

*What do you think is the best treatment for your problem?*



### ***Pay Attention to the Patient***

Remember to speak to the patient, not the interpreter. The patient should be the focus of your attention. The interpreter merely acts as your voice in the second language. Maintain eye and body contact, if appropriate, with the patient, rather than with the interpreter.

### ***Confirm Patient Understanding***

Validate the information that your patients are receiving from the interpreter. Ask the patients to explain back to you, through the interpreter, whatever information has been shared. This is called “back interpretation.” Ask frequent questions to confirm understanding. For instance, a doctor may ask the client to repeat the prescription instructions he has just given, and a health educator may ask an elderly refugee to demonstrate the technique she



has just learned for injecting herself with insulin. Some helpful questions are:

*Can you tell me how you will take this medication?*

*Can you show me how you will use the glucometer?*

## ***Use Appropriate Language Levels***

In general, speak slowly and carefully in English when working with interpreters. Use simple, plain English, and avoid slang, idiomatic speech, fancy medical terminology, and other types of speech that can easily be confusing for clients and interpreters alike. Slang like “an arm and a leg” and “cold feet,” or idioms like “cough it up” do not interpret well, especially in health care settings!

## ***Utilize Repetition***

Repeat key words, phrases, and medical instructions frequently to ensure that the patients understand them. If patients do not understand, try to explain the information in a simpler, more practical way. Do not speak more loudly as if they are deaf or stupid; they are not. More than likely the fault will be with you, the provider, who may not be explaining things carefully.



## *Be Expressive When Needed*

In a health education talk with patients do not forget to use expression and passion, if appropriate, even if they do not understand your words. Encourage the interpreter to also use the same expression in her presentation.

## *Recognize Literacy Barriers*

When teaching patients who are not native speakers of English, rely heavily on demonstrations, visual aids, and culturally appropriate models. If using models, it is best to use real items instead of replicas. Incorporate the patients into any demonstrations you may be conducting.



## *Allow for Group Dynamics*

When working with large numbers of patients in an audience format, allow them adequate time to interpret health information for each other. Always ask simple questions to validate their know-

ledge. The same is true when speaking with families. Many immigrants and refugees will bring their families with them to medical consultations and they often prefer to make major decisions as a family. Allow them time to discuss important matters among themselves before pushing them to give an answer via the interpreter.



## *Utilize Native Speakers as Cultural Liaisons*

Sometimes interpreters can serve as “cultural liaisons” who can explain a particular term or practice that may be unfamiliar to the provider. For example, Mexican patients will often use the term “sucra” (literally “sugar”) to describe diabetes. Another common term in Spanish that may not be familiar to English speaking providers is “susto” which means “loss of soul.” In both of these cases, the interpreter must not only interpret the words, but what they mean in their cultural context.

# Ethical Considerations

PROFESSIONAL INTERPRETERS MUST ADHERE TO A CODE OF ETHICS THAT ASSURES CONFIDENTIALITY. THIS CODE OF

ethics also prohibits interpreters from practicing medicine and giving their own medical advice to patients. Here are two scenarios that illustrate these ethical issues:

## *Confidentiality*

Mrs. Alcalá has been diagnosed with an infectious disease. Through the interpreter, the physician talks to Mrs. Alcalá:

*Mrs. Alcalá, it's up to you to decide when to tell your family about your illness, but my advice is that you talk to them as soon as possible. This disease is better treated when you have your family to support you and you don't keep the information secret. Take care. I will see you next week.*

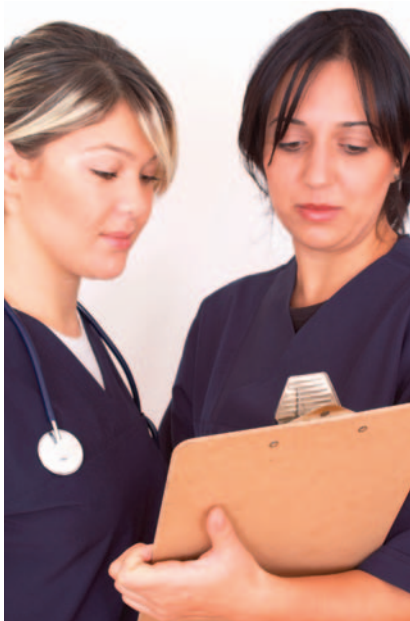
The physician leaves the examination room followed by the interpreter. As Mrs. Alcalá leaves the room, she starts crying loudly. A nurse working nearby approaches and asks the interpreter:

*So, do you know that lady? What did the doctor say to her?  
Is it that bad?*

In response, the interpreter says:

*Oh! I feel so bad. You know, she was my friend. And she was more than a friend with one of my neighbors. I wonder if her husband is also infected... Oh! And her kid goes to school with my nephew. I better call my sister and tell her.*

As noted previously in this pocket guide, one major reason to avoid using children, family members, and friends as interpreters is to prevent these kinds of breaches of confidentiality. In the scenario above, the professional interpreter knew the patient and her family and friends. Despite an ethical responsibility to keep the patient's diagnosis strictly confidential, she decides to warn numerous people about the patient's condition.





## ***Role Maintenance***

A young woman has a high-risk pregnancy and she must decide if she is going to submit to amniocentesis. At the visit with her doctor, the intake nurse talks to the patient via the interpreter:

*Hello Zaira, have you made a decision about whether or not you want to have the procedure? Do you know yet what you will tell the doctor?*

The patient responds:

*I think so. I want to go ahead with the procedure. I'm sure the doctor can perform it without risking my baby.*

The nurse ultimately leaves the room, and the patient is alone with the interpreter while waiting for the doctor. The interpreter says to the patient:

*Zaira, if I were you, I would reconsider. I don't think this doctor is very good with this type of procedure, and I've seen too many other complications. If your baby died because of your choice, it would be a sin. It's just not right. I can talk to you later about some other procedures I've seen done that would be better for you and your baby.*

The problem with this scenario is that the interpreter is no longer a neutral interpreter of language, but a provider of medical advice. The patient came to seek the advice of her physician and not the interpreter, so this advice was clearly unsolicited. Secondly, the interpreter has overstepped her boundary by imposing her own morals on the patient and using her experience with other patients to try and deter this patient from reaching her own decision.



# Promoting an Expanded Role for Interpreters

IN ANY MEDICAL INTERPRETATION SETTING, THREE FUNDAMENTAL RELATIONSHIPS EXIST: THAT BETWEEN THE

patient and provider, the interpreter and the patient, and the interpreter and the provider. The most important relationship, certainly, should exist between the patient and the provider. Therefore, health organizations that employ interpreters should ensure that their role is as minimally invasive as possible, without compromising the quality of the visit and the effectiveness of the information being exchanged between patient and provider. Interpreters should facilitate a positive, meaningful, and beneficial medical encounter for the patient. With that said, however, medical interpreters can often do far more than just change words from one language to another, and can be useful resources for health organizations and their patients. For example, medical interpreters can be encouraged to be patient advocates, cultural brokers, clarifiers, and conduits of information. Indeed, they can sometimes play all these roles during the same patient visit. These roles, which are defined below (Cross Cultural Health Care Program, 2003), range from least intrusive and labor intensive, to most intrusive and labor intensive:



**Conduit:** *This is the most basic of the roles and involves rendering in one language literally what has been said in the other: no additions, no omissions, no editing or polishing. This is the “default” role of the interpreter, which should be adopted unless a clear potential for misunderstanding exists.*

**Clarifier:** *In this role, the interpreter adjusts, explains, or makes word pictures of terms that have no linguistic equivalent (or whose linguistic equivalent will not be understood by the patient) and checks for understanding. This role should be taken when it is necessary to facilitate understanding.*

**Culture Broker:** *In this role, the interpreter provides a necessary cultural framework for understanding the message being interpreted. This role is used when cultural differences can lead to a misunderstanding on the part of either provider or patient.*

**Advocate:** *Advocacy is any action an interpreter takes on behalf of the patient outside the bounds of an interpreted interview. The advocate is concerned with quality of care in addition to quality of communication. An on-site interpreter would appropriately become an advocate when the needs of the patient are not being met due to a systemic barrier such as the complexity of the health care system or racism.*



Therefore, with the rapidly increasing ethnic diversity of the United States, health organizations and providers must recognize that the need for medical interpreters will only grow in the coming years, and that their services will require sustained commitment, budgets, training, support, and resources. An organization's investment in quality medical interpreters, with their uniquely valuable skills, can improve patient outcomes, reduce health disparities, and ultimately enhance patients' lives.

# References

<http://www.cyracom.net> Choosing a Language Services Company: Five Considerations to Help You Decide. (2006)

<http://www.diversityrx.org/HTML/MOIPR3.htm>  
Diversity Rx: Interpreter Practice; Choosing a Role. Cross Cultural Health Care Program. (2003).

<http://www.omhrc.gov> National Standards for Culturally and Linguistically Appropriate Services in Health Care (Executive Summary)

Institute of Medicine. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academies Press: Washington, D.C.

Yehieli, M. & Grey, M. (2005). *Health Matters: A Pocket Guide for Working with Diverse and Underserved Populations*. Intercultural Press: Yarmouth, ME.

# Appendix:

## Additional Resources

### Interpretation Resources

For a list of interpreter and translator associations in the United States:

*<http://www.lep.gov/statetrans.html>*

For a list of translator and interpreter organizations in the United States and other nations:

*<http://www.notisnet.org/links/orgs.html>*

For the Iowa Interpreters and Translator's Association

*<http://www.iitanet.org/>*

For the American Translation Association:

*<http://www.atanet.org/>*

### Cultural Competency and Health Literacy Resources

Office of Minority Health, U.S. Department of Health and Human Services:

*<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=11>*

Health Resources and Services Administration  
*<http://www.hrsa.gov/culturalcompetence/>*

## **Cultural Competency Self-Evaluations**

University of Michigan Health System, Program for  
Multicultural Health  
*<http://www.med.umich.edu/multicultural>*

## **Iowa Cultural Competency Resources**

Iowa Center on Health Disparities  
University of Northern Iowa  
(319) 273-7965  
*[www.iowahealthdisparities.org](http://www.iowahealthdisparities.org)*





## **Pocket Guides to Working with Diverse Patients and Newcomers**

Caring for Diverse Seniors: A Health Provider's Pocket Guide to Working with Elderly Minority, Immigrant, and Refugee Patients by Michele Yehieli, Mark A. Grey, and Annie Vander Werff. University of Northern Iowa, New Iowans Program and Project EXPORT Center of Excellence.

Health Matters: A Pocket Guide for Working with Diverse Cultures and Underserved Populations by Michele Yehieli and Mark A. Grey. Intercultural Press.

New Americans, New Iowans: Welcoming Immigrant and Refugee Newcomers by Mark A. Grey. University of Northern Iowa, Iowa Center for Immigrant Leadership and Integration. [www.newiowans.com](http://www.newiowans.com)

Orthodox Jewish Patients in Hospital Settings: A Health Provider's Pocket Guide by Norman Feinstein, Michele Yehieli, and Mark A. Grey. University of Northern Iowa, New Iowans Program and Project EXPORT Center of Excellence.

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