Scandinavian Journal of Primary Health Care

ISSN: 0281-3432 (Print) 1502-7724 (Online) Journal homepage: informahealthcare.com/journals/ipri20

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To cite this article: Nabi Fatahi, Mikael Hellström, Carola Skott & Bengt Mattsson (2008) General practitioners' views on consultations with interpreters: A triad situation with complex issues, Scandinavian Journal of Primary Health Care, 26:1, 40-45, DOI: 10.1080/02813430701877633

To link to this article: https://doi.org/10.1080/02813430701877633

Scandinavian Journal of Primary Health Care, 2008; 26: 40–45

informa
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ORIGINAL ARTICLE

General practitioners' views on consultations with interpreters: A triad situation with complex issues

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Abstract

Objective. To study a group of general practitioners' (GPs) views on cross-cultural consultations through interpreters in primary healthcare in Sweden. *Design*. Two group interviews and three personal interviews with experienced GPs regarding clinical consultation through interpreters were carried out. The interviews were transcribed and analysed and the text was categorized according to content analysis. *Setting*. Primary healthcare. *Subjects*. Eight GPs were interviewed. *Main outcome measures*. The response and opinions of the GPs. *Results*. In the analysis it appeared that an optimal clinical encounter demands an active role by all participants involved in the consultation. The interpreter has to strive after being a stable neutral information bridge, and has a balancing role between the GP and the patient. The GP has to be open to cultural inequalities and recognize consultation through an interpreter as a part of her/his job. The patient needs to be an active and visible participant, not hiding behind the interpreter. Common obstacles and imperfections to reach the best possible triad were discussed. Additionally, practical assets in the encounter were delineated. Accurate physical placing of the persons in the room, adequate length of consultation time, and using the same interpreter from one visit to another were mentioned as factors influencing the outcome of the consultation. *Conclusion*. Barriers in cross-cultural communications could originate from all persons involved, the interpreter, the GP, and the patient, as well as from tangible factors. Ways to reduce misunderstandings in GP–patient encounters through interpreters are suggested.

Key Words: *Consultation, cooperation, cross-cultural communication, culture, family practice, general practitioner, general practice, interpreter*

The quality of the general practitioner (GP)–patient encounter is important for an adequate diagnosis and treatment and a language barrier in the consultation is a risk factor for adverse outcome [1,2]. A thoughtful arrangement to overcome cross-cultural and language difficulties seems necessary to provide adequate healthcare to immigrants [3].

Warfare, conflicts or poverty in large parts of the world has initiated migration and the number of individuals with diverse cultural and linguistic backgrounds has thereby increased considerably in many countries. In Sweden in 2006, almost 17% of the population of 9 million had a foreign background [4]. The number of immigrant languages is at least 150 in the country and 140 languages have been represented at interpreter training courses. Every

In consultations through interpreters, general practitioners (GPs) face obstacles in establishing optimal communication.

- All persons in the triad situation, the interpreter, the GP, and the patient, need to be involved to enhance the interchange and facilitate contact.
- The interpreter has a key role as a neutral creator of a bridge to understanding and to balance support between the doctor and the patient.
- Practical planning (arrangement of chairs, remote or physically present interpreter) has an impact on the quality of the consultation.

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(Received 8 March 2007; accepted 30 November 2007)

ISSN 0281-3432 print/ISSN 1502-7724 online
DOI: 10.1080/02813430701877633

day, 3000 hours of interpreting are provided by interpreters in over 100 working languages mainly in medical care and social welfare. Most communities provide an authorized interpreter service [5].

An individual's ability to communicate may decrease during illness and the weakness is accentuated by cultural and language differences in the encounter [6]. The competence of the interpreter is thus crucial [7]. GPs, especially those working in immigrant areas, must try to obtain familiarity in working effectively with an interpreter and be aware of the interpreter–patient interaction [8,9].

GP–patient communication through an interpreter is a triad encounter and when a third party is involved in the interview situation it may become more difficult. The relationship could be even more complicated when a relative or friend is acting as interpreter [10,11]. Too close a relationship between the patient and the interpreter might jeopardize the objectivity and sincerity that is part of every good medical encounter. In spite of an extensive use of interpreters in GP–patient encounters in primary care in Sweden, few studies have been published in this field [12]. The purpose of this study was to analyse the difficulties and alternatives in the interpreting process in the GP–patient encounter as seen by the GP.

Material and methods

Thirty experienced GPs at nine healthcare centres in five areas with a high rate of immigrant patients in Göteborg were contacted through the Department of Primary Health Care at Göteborg University. GPs experienced in consultations through interpreters were especially aimed at. Brief information about the project was sent by mail to the GPs in advance and 14 of them responded and 13 were initially interested in participating. However, five of the GPs declared problems in participating (various practical obstacles) while eight, four men and four women, from five healthcare centres finally took part in the interviews. The age of the GPs varied between 36 and 65 years and they had worked as GPs for 10–28 years, including 2–8 years in areas with high rates of immigrant patients. Two of them had a non-Swedish ethnic background but they had been settled in Sweden for many years and were fluent in Swedish.

Data were collected at two group interviews and three individual interviews, which took place at healthcare centres between March 2003 and November 2005. The prime intention was to perform just group interviews but it was difficult to find time for all to participate at the same time. The GPs (n = 3) who could not take part were offered individual interviews.

The group interviews, one with two and one with three GPs, lasted for about 75 minutes and the personal interviews for about 60 minutes. The groups were chaired by one of the authors (BM), an experienced academic and part-time working GP in an immigrant area. The personal interviews were led by another researcher (NF).

The interviews started with an open question: "Could you comment on difficulties and possibilities in daily clinical encounters including an interpreter?" In the course of the discussions, deepening of the content, clarifications, and condensing were achieved by means of more targeted questions. The interviews were audiotaped, and then transcribed verbatim.

Data were analysed according to qualitative content analysis [13]. When the interviews were completed, the text was read for an overview of the material. "Units of meaning" were identified and transformed to the language of the researchers. In a number of meetings between the authors the transformed units of meaning were condensed to subcategories and later grouped into categories and a theme.

Results

All participants in the group discussions participated actively. The most frequently occurring languages in the consultations were Serbo-Croat, Persian, Kurdish, and Arabic. An overall estimation of the rates of consultations that involved an interpreter was about 20% of the total number of patients during a surgery session.

Four main categories and a number of subcategories emerged from the analysis of the interviews (Figure 1). Three categories cover the three members of the consultation: the interpreter, the GP, and the patient. The fourth category reflects the tangible prerequisites of the session.

The interpreter – ability to build bridges

According to the GPs, the task of the interpreter is like building a bridge. Impartiality and credibility (*neutrality*) of the interpreter were desirable qualities often stressed. *"Sometimes the patient talks for five minutes and it is interpreted in two seconds, or the patient says something and the interpreter keeps quite silent".*

It was also emphasized that neutrality could be a question of sex and political opinion. In some countries gender independence is less pronounced and it makes it easier if the interpreter and the patient are of the same sex. *"A female patient once presented unclear symptoms. Two weeks later she came back with a female interpreter and hemorrhoids were diagnosed."*

The GPs expressed the opinion that the interpreter is not supposed to add or take anything away

Subcategories	Categories	Theme
Neutrality Unbiased Balancing	***The interpreter – capacity of bridge constructing***	
Cultural openness Acceptance Patient orientation	***The general practitioner – capacity of embracing cultural circumstances***	
		Intertwined triadic relationship
Visible Cooperating Language knowledge	***The patient - capacity of active participation***	
Spatial orientation Continuity Time Technical support	***Tangible prerequisites***	

Figure 1. Categories and subcategories that emerged in the interviews.

from the narrative (*unbiased*). He/she should literally act as a pure "interpreting machine". *"Sometimes the patient says something but the interpreter does not react. If I ask the interpreter what the patient just said the interpreter could reply that the patient just repeated an earlier statement."*

A sought-after competence of the interpreter was also emotional constancy. The interpreter had a balancing role and provocations and/or loyalties could force him/her to choose an attitude in favour of the GP or the patient (*balancing*). *"An interpreter must be able to keep an emotional balance regarding nearness and distance in relation to patients."*

Additional views were that relatives and especially children should not ideally act as interpreters, since familial and cultural factors may influence neutrality and the outcome of the consultation.

The general practitioner – ability to embrace cultural circumstances

Desirable qualities of the GPs that were mentioned were: experience of cultural differences and interest in other cultural conditions, including ethnic and social matters (*cultural openness*). *"Of course it is easier to meet a patient from another ethnic background if I understand a little about the foreign culture. I know in some cultures pain in the head is regarded as more dangerous than pain in other parts of the body."*

Acceptance of the patient as an applicant for relief, regardless of patient background, was essential in the attitude of the GP (*acceptance*). *"When I see immigrants with an interpreter on the patient list of the day, I think it is just part of my job."*

Directness towards the patient's situation and patient orientation in the consultation style was essential in the attitude of the GP (*patient orientation*). *"To look at the patient during the consultation could help us to pick up the body language."* It was also mentioned that the ability of the GP to understand and interpret differences in body language in different cultures is of importance. *"To move the head in a certain way means nothing in one culture, but it stands for distance in another."*

The patient – ability to participate

It was stated that the key relation and the crucial exchange of views should be between the GP and the patient with, optimally, the interpreter being just a neutral translator. But in the triad the GP and the interpreter were usually in a safe and familiar setting, hence the patient was easily transferred to a weaker position (*underdog*). It was reflected by a tendency for the patient sometimes to turn directly to the interpreter. *"I have tried to speak directly to patients many times, but they often turn to the interpreter when they speak."*

Cooperation with the patient was not always present and could be difficult to establish (*cooperation*). The interpreter might be an ombudsman, and was looked upon as the person who can best inform the GP about the illness in question. *"The patient needs to take responsibility for her illness"*; *"it is in the meeting between the patient and doctor that the important issues need to be discussed"*.

Another tendency was an inclination for some patients not to use the new language, instead preferring the mother tongue (*language knowledge*). *"I have a patient who has been in Sweden for 36*

years, and she still does not speak Swedish in a consultation."

Tangible prerequisites

The position of the participating persons in the room was stressed (*spatial orientation*). The distance between the GP and the patient should be the shortest, the interpreter being an equal distance from the GP and the patient. The spatial arrangement of the chairs could facilitate the necessary informative exchange. The furnishing of the consultation room may limit the possibility of optimal location. *"It is important how you sit; bad physical organization could spoil the openness searched for."*

Continuity was stressed (*continuity*). If possible, the same interpreter ought to be used in recurrent visits, as a more personal ingredient increased the content exchange. All three persons were usually more relaxed if they knew each other in advance. *"Especially with psychological problems the use of the same interpreter in successive visits has a significant impact on the consultation outcome."*

The time factor was also emphasized (*time*). It took quite a time to involve a third person in an information exchange. The possibilities for mistakes multiply with more persons engaged and uncertainties take time to elucidate. *"When talking through an interpreter the message is going through a third person and it takes additional time."*

The alternative that was mentioned to a physically present interpreter was a remote interpreter. It implied an interpreter just listening to the conversation by telephone and translating through an external loud speaker (*technical support*). Personal attendance was usually preferred. *"The interpreter is a physical contact link to the healthcare personnel, which gives security for the patients."*

Discussion

Comments on methods

The purpose of this study was to examine the experience of the GPs and we needed a dynamic form of analysis that stays close to the data. Qualitative content analysis is a systematic text analysis of verbal data that is oriented toward summarizing the informal content of what was expressed in the interviews and discussions.

Content analysis initially dealt with a more objective, systematic, and quantitative description of the manifest content. However, over time, it has also expanded to include interpretations of latent content. This widening of the method is described by Graneheim and Lundman [13] and our analysis was made according to their suggestions.

Strengths and weaknesses

The number of participating GPs was relatively small, yet the material presented was rich. The GPs were familiar with cross-cultural patient encounters and represented more than 160 years as GPs including 40 years' experience of interpreters. Thus, the views expressed were based on relevant clinical background.

The transferability of the information is always difficult to claim in qualitative studies. It is partly in the minds of the readers that the transferability is tested. We believe that the credibility of data was acceptable and detailed information is given on how data were received, allowing the reader to follow the steps taken by the researchers.

The interviewing of colleagues could be problematic. If the interviewer and the interviewees are equals and have the same background, confidence might be promoted between group members and could augment the trustworthiness of the interviewer [14]. The interview could also be seen as a check on the professional quality of the interviewee, thus obstructing open-heartedness and confidentiality. The objectives of our questioning, however, had few aspects of a checking of knowledge and the informants were quite free and sincere in their comments.

General comments

Person-related as well as practical issues were reported as influential on the quality of the GP–patient consultation through an interpreter. The presence of a third active person in the room multiplied the interactive processes and situations that could end in communication hurdles. The importance of competent interpretations in cross-cultural encounters was clearly demonstrated by the GPs. It has previously been shown that patients who rated the interpreter as "excellent "or "very good" were more likely to rate the healthcare received as positive [15] and difficulties are best overcome with professional interpreters [16]. Interpreters' own views on cross-cultural meetings also indicate that the triad situation and the lack of relevant training for interpreters hold a number of problems [17]. Authorized interpreters are available only for less than a third of the different languages and only 40% of interpreters are authorized [Johansson DE, personal communication (http://www.tolkserviceradet.org)].

The actors in the triad

The interpreter's presence turns a traditional dyadic interaction into a triadic, adding considerable complexity to the social situation and the many challenges it generates. The choice of interpreter should be individualized, minimizing the influence of differences in factors such as sex, ethnic background, and native language between patient and interpreter. The most difficult commission for the interpreter is probably the balancing role. The interpreter is the only person who to some extent understands and embraces the other two persons and a certain sensitivity and a perceptive mind are desirable [18].

The GP's role in achieving the best possible benefit of the triad gathering seems to be related to two conditions, an open attitude towards cultural disparities and a patient-oriented approach. The latter is a basic position frequently demanded in patient–doctor relations, and is not specific to cross-cultural meetings. A patient with different cultural background may reinforce a sense of distance and feeling of alienation. This tendency to enhance the remoteness to the patient could in fact be some sort of counter-transference from the GP [19]. The inclination to notice cultural dissimilarities more than similarities seemed to be more evident among some GPs, as also experienced by Wachtler et al. They stated that cultural differences seem to be one of many individual factors that influence how well doctor and patient understand each other.

A potential problem in the triad encounter, highlighted by the GPs, was the patients' lack of trust (from earlier experiences and insecure present conditions) and power inequality. The tendency of the patient to be invisible, hiding behind the interpreter, could reflect a lack of confidence and insecurity. The personal mother tongue as compared with Swedish could for some remain preferable forever. The unwillingness to use Swedish may also be a sign of the comparatively generous Swedish policy of offering free public interpreter support.

Some of the difficulties described could be overcome by being conscious of how to organize the facilities used. A mindful placing of chairs and desk can diminish the authority imbalance. The GP and the patient are the key persons and direct communication between them must be facilitated. The interpreter should be a neutral person standing slightly apart.

A greater awareness of the time perspective is often mentioned – interpretation processes take time. Studies are needed to clarify many of the obstacles in cross-cultural communication with the interpreter, including the role of distant interpretation. Experiences of sociologists, psychologists, and anthropologists could probably add important inputs into a realm that needs more knowledge.

Ethical approval

According to the regional research ethics committee at Göteborg University the study did not need formal approval. However, the study was performed according to general ethical procedures such as voluntariness, possibility to discontinue the participation at any time, and written and oral information.

Acknowledgements

This study was financially supported by AFA sjukförsäkring in Sweden.

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