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Authors' response to letter from Bond et al. – The role of ad-hoc interpreters in teaching communication skills with ethnic minorities

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LETTERS TO THE EDITOR

The role of *ad-hoc* interpreters in teaching communication skills with ethnic minorities

Dear Sir

We congratulate Seeleman and colleagues for their recommendations in developing a curriculum that addresses communication skills with ethnic minorities (Seeleman et al. 2011). We would like to highlight the importance and frequency of family members acting as interpreters and the associated challenges. Access to professional interpreters in Europe has been reported at 11%, and almost 50% of foreign language doctor–patient consultations occur with a relative interpreting for the patient (Bischoff & Hudelson 2010). We would suggest that teaching on the use of ad-hoc interpreters be part of any curriculum that deals with communication skills in ethnic minorities.

We face difficulties using family members as interpreters, as they may fail to disclose information fully when breaking bad news, understate risks when consenting for invasive procedures or raise confidentiality issues.

Seeleman and her colleagues note the importance of practicing communication skills with professional interpreters. We propose that a topic 'family members as interpreters' should be included on any teaching programme that aims to improve communication skills with ethnic minorities. This would highlight the pitfalls that can occur in day-to-day practice as shown above.

It is possible to incorporate a communication skills standardised assessment with an interpreter as part of an undergraduate course (Lie et al. 2010). It would be feasible to develop scenarios so that the interpreter role-plays a family member and acts out the above difficult scenarios. This may prepare students for the common and difficult task of having to use an ad-hoc interpreter.

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Seeleman C, Selleger V, Essink-Bot M-L, Bonke B. 2011. Teaching communication with ethnic minority patients: Ten recommendations. Med Teach 33(10):814–819.

Authors' response to letter from Bond et al. – The role of *ad-hoc* interpreters in teaching communication skills with ethnic minorities

Dear Sir

First, we would like to thank Dr Bond and his colleagues for their valuable suggestions on working with informal interpreters in medical practice, an issue that we have not elaborated on in our paper. Indeed, it is well known that doctors often turn to family members as interpreters.

Students need to learn how to manage the tension between the 'ideal' way to overcome a language barrier (which is generally seen as working with a formal interpreter), and the everyday reality in which family members often take on the role of *ad hoc* interpreters.

All types of interpreters have their pros and cons, depending on the nature of the problem, the patient's background, or the availability of formal interpreters. Students should become aware of these and learn what is preferred and what is acceptable in each new situation (e.g., only in highly exceptional cases can children be used as interpreters).

In order for students to learn specific skills in communicating through an interpreter, we would suggest to start with a workshop using a formal interpreter. In this way students can learn the basic skills. At the same time, this may lower the barrier for working with formal interpreters that many health care professionals experience.

Working with informal, family interpreters asks for extra competencies. Students should learn about the specific pitfalls, such as the ones mentioned by Bond and colleagues, and be able to recognize and avoid them. This can be achieved, for example, by instructing family members to translate as exactly as possible, and by paying extra attention to the nonverbal communication of the patient. Students would likewise benefit of exercises in respectfully dismissing a family member who is willing to translate and to call in a formal interpreter instead, if that is what is needed in a specific situation.

All in all, education in communicating through interpreters is essential. The importance of true understanding between care provider and patient cannot be overemphasized and overcoming a language barrier is the first condition to reach this.

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PPE: A UK perspective, 'All for one, **NOT** one for all'

Dear Sir

The recently published work by Chen et al. (2001) was read with keen interest by students of the Cardiff University Surgical Society at our fortnightly journal club. Whilst all members acknowledged the benefits of Peer Physical Examination (PPE), the proposition of formally integrating PPE into our medical curriculum sparked much debate.

Whilst Chen et al. (2001) identified culture and female gender as factors reducing propensity to participate in PPE; we anticipated that in an ethnically diverse, female-dominated (approximately 2/3) cohort, such as that seen at Cardiff University School of Medicine, PPE might attract poorer involvement than those reported here. Students must be endowed the same rights to which they are dutifully bound to grant patients, namely refusal of investigation, including examination. This necessitates an educational programme designed for all, which can accommodate the inevitable disinclination to participate expressed by some students. Hence we call for a solution which satisfies 'all for one, not one for all'.

In light of this we propose three recommendations for learning clinical examinations based on a non-uniform approach. Firstly, we endorse Cardiff's utilisation of actors through high-fidelity simulation as this can incorporate simulated pathology alongside unfamiliarity between examiner and examinee. Moreover, this replicates a realistic clinical encounter that requires development of patient–doctor rapport. Secondly, we felt that PPE is more appropriate in an informal setting between self-elected individuals. This informal approach allows repetitive practice of examination routine upon friends in order to achieve flair and confidence outside of the constraints imposed by the classroom. Indeed, many students conceded PPEs effectiveness in preparation for their Objective Structured Clinical Examinations. Finally, the use of bench top models should be highlighted in order to attain proficiency in performing intimate examinations.

In conclusion, we do not feel formal PPE adequately fulfils medical students learning requirements. Instead, we propose a multifaceted approach that provides consideration to the range of different clinical examinations taught at medical school. We would once again like to thank Chen et al. (2001) for their interesting research on this topic and would recommend further research investigating validation of PPE as an effective adjunct for learning clinical skills.

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Authors' response to letter from Rizan CT et al. – PPE: A UK Perspective, "All for one, **NOT** one for all"

Dear Sir

We are most pleased that our report generated interest and discussion among Rizan and colleagues in their journal club. We agree with Rizan et al. that the learning of clinical skills can, and should be facilitated through multiple modalities including peer physical examination (PPE).

It may not have been clear that our reported findings focused only on the PPE component of a formal clinical skills programme which also uses teaching videos, audio-visual aids, demonstrations, and high- and low-fidelity models as appropriate. This programme is the introduction to our overall clinical skills curriculum which also incorporates a variety of learning approaches involving simulated patients and contextual experiential learning. As noted in our article, the vast majority of students practised PPE during class time as well as on their own time, which would suggest they perceived value in this practice, whether done as part of the formal programme or informally.

Nonetheless, we do see an important role for the setting-specific, structured use of PPE in the learning of clinical skills in medical school for practical (e.g. resource and time constraints) and educational reasons (e.g. multi-source feedback), with consideration for student informed consent (Wearn and Bhoopatkar 2006), and sensitivity to cultural and gender issues (Rees et al. 2009).

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