ORIGINAL ARTICLE

Interpreters’ experiences of general practitioner–patient encounters

NABI FATAHI¹, BENGT MATTSSON¹, JASAF HASANPOOR² & CAROLA SKOTT³

¹Department of Primary Health Care, Göteborg University, ²Department of Social Science, Karlstad University, and ³Faculty of Health and Caring Science, Göteborg University, Sweden

Abstract
Objective. To study interpreters’ experiences of problems in cross-cultural communication with special regard to the general practitioner (GP)–patient encounter. Design. A focus-group interview with authorized interpreters was carried out. A phenomenographic method was used in the analysis. Setting. Primary health care. Results. The interpreters displayed a number of problems mainly related to the difficulty in balancing the triad relation (GP–patient–interpreter), the role of the interpreter in relation to other healthcare staff, the time aspects of the translation procedure, and the problems of diverse health beliefs and cultural inequalities. Conclusion. The interpreters notice a set of difficulties that need to be highlighted in order to improve consultations with cross-cultural GP–patient encounters.

Key Words: Cross-cultural communication, culture, interpreter, doctor–patient consultation

In many countries healthcare providers require the assistance of interpreters to communicate with patients who have foreign cultural and linguistic backgrounds [1,2]. In Sweden in primary healthcare interpreters are essential in many consultations. Despite the extensive medical literature on the use of interpreters [3] few studies have focused on the interpreters’ experiences in the translation process [4,5].

The interpreter acts as a communication channel through which relevant matters in the general practitioner (GP)–patient interaction are translated into linguistically appropriate terms [6]. The biological nature of disease is fairly constant between cultures, but the understanding and meaning of health and illness varies between societies [7]. Pain behaviour, for example, is considered to be a kind of language and knowledge about the patient’s cultural background is advantageous in order to correctly interpret symptoms of aching [8,9].

Sweden has, over the last three decades, turned into a multicultural society. In 1998 about 950,000 of the 8.5 million inhabitants were foreign born [10]. The use of an interpreter is widespread and immigrants are legally entitled, without charge, to be assisted by an interpreter in their contacts with the Swedish authorities [11,12]. The Swedish interpreter service started in the late 1960s and training courses for interpreters have been organized since 1968 on both the academic level and as vocational courses. Every year more than 3000 participants attend some 200 different interpreter training courses. There are about 60 interpreter services agencies in Sweden and the number of immigrant languages in Sweden is at least 150 [13].

Most communities have an authorized interpreter service, employing part-time interpreters in the most
frequently occurring languages. The authorized interpreter is usually asked in advance by a nurse to come to the health centre at the same time as the patient. He or she is usually unknown to both the GP and the patient. Use of a family member as the interpreter is avoided. Göteborg, where the study has been performed, is a rather segregated city and in some outskirts the number of immigrants exceeds the number of Swedish-born citizens.

One of authors (NF) has personal experience of cross-cultural communication. For four years in the 1980s he was an interpreter and healthcare giver in Kurdish refugee Red Cross camps in Iraq, and has since been both a refugee and been helped by interpreters in Sweden.

The purpose of this study is to describe the difficulties and possibilities in the interpreting process in the Swedish primary healthcare system, mainly in the GP–patient encounter, as seen by the interpreter.

Material and methods

Eight authorized experienced interpreters, six women and two men, were contacted through the official interpreter’s office in Göteborg and were asked to participate in a focus-group interview. We were interested in persons translating from Arabic, Persian, Kurdish, and Turkish languages as these are the languages most frequently met in primary care in Göteborg. Brief information about the project was sent to the interpreters in advance. All were interested in participating and five interpreters could participate on the interview day.

Three interpreters were Arabic-speaking (from Iraq; two women and one man) and two Turkish-speaking (from Turkey; one man and one woman). They were working part time (about 60%), had altogether approximately 75 years of experience as interpreters, and their mean age was 49.5 years. They had all participated in interpreter training courses – three at the academic level and two on vocational courses. The group interview took place at the official interpreter’s office in Göteborg in 2003 and lasted for 90 minutes. It was chaired by one of the authors (BM). He is an experienced academic GP used to chairing group discussions and at the time of the study working part time in an immigrant area. The discussion started with an open question: “Please tell us about the problems you meet in your daily interpreting activity”. In the course of the interview, deepening of the content, clarifications, and condensing were achieved by means of more targeted questions. All participants were encouraged to contribute. The interview was audiotaped, and then transcribed verbatim.

The analysis was undertaken according to a phenomenographic method [14,15]. The object of study in phenomenography is mainly the ways in which people experience, understand, conceptualize, and make sense of differing phenomena in the world around them. It can be used in a study were there are variations between different ways of seeing, experiencing, and understanding a certain phenomenon, in this context the interpreting process.

The transcripts were primarily read in order to find out the participants’ different conceptions of the subject. Later conceptions of a similar kind were grouped into categories based on their relationship. This was done in order to derive a meaningful structural model of the conceptions [15]. Nine aspects or subcategories were identified, which were grouped into three main categories (Table I). In a later phase the transcripts were re-read more carefully and citations were transferred to each of the nine aspects according to the association with the subcategory.

Results

The interpreters were highly motivated to share their experiences and they often experienced pleasure in their voices being heard. There was a high level of agreement in the group. Three different categories were identified in the analysis – two were related to problems and difficulties and one revealed future possibilities.

The interpreter’s role

Attitudes among staff. The interpreters saw themselves basically as part of the health service staff. They have their own unique and separate relationship to the patient and their main aim is to pass information as correctly as possible between the patient and the GP. This overall task in favour of optimal care of the patient is contrasted with a frequently demonstrated staff attitude. Staff often displayed a more restrictive approach to the interpreter’s work and sometimes, patronizingly,

Table I. Categories and subcategories that emerged from the analysis.

<table>
<thead>
<tr>
<th>Categories</th>
<th>Subcategories</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. The interpreter’s role</td>
<td>Attitudes among staff</td>
</tr>
<tr>
<td></td>
<td>The triad problem</td>
</tr>
<tr>
<td></td>
<td>Patients’ demands of the interpreter</td>
</tr>
<tr>
<td>II. Lack of time</td>
<td>Time-related stress</td>
</tr>
<tr>
<td></td>
<td>Information shortage</td>
</tr>
<tr>
<td></td>
<td>The time and quality problem</td>
</tr>
<tr>
<td>III. Cultural aspects</td>
<td>The role of the GP</td>
</tr>
<tr>
<td></td>
<td>Health beliefs and patient satisfaction</td>
</tr>
<tr>
<td></td>
<td>Further education</td>
</tr>
</tbody>
</table>
excluded them from membership of the primary care team. Interpreters were associated with long and expensive consultations. This contrast between self-image and reality sometimes creates conflicts and anxiety for the interpreters: “In health centres, it feels now and then that we are something of a necessary evil, and we are sometimes not welcomed by the staff. They meet us with doubt, and they don’t always believe us.”

The triad problem. In the interpreting situation three persons are involved and it is difficult to correctly balance the triad relationship. Often the patient turns more to the interpreter than to the GP in the consultation room. The interpreter contributes to the intricacy of establishing and maintaining the fundamental link between GP and patient. The question is on whom the GP will focus attention: the patient or the interpreter. According to the interpreters’ experiences, the GPs’ ability to focus on the patient varies noticeably. Most doctors try to put the patient at the centre of attention but many do not, and a desired patient-centredness is lacking. The common language and the cultural context imply that the attention of the patient turns to the interpreter instead of the doctor. The interpreter may feel like a patient ombudsman instead of a facilitator of linguistic communication: “I want to be heard rather than seen; patient and GP must talk to each other directly. There is a little group of doctors who have learnt to talk to patients directly. It feels like an affirmation for patients and it is good.”

Patients’ demands of the interpreter. The interpreter’s role is influenced by the setting in the health centre. The interpreter often takes a seat in the waiting room together with other patients and a relationship between the interpreter and the patient might be established before the consultation begins. Sometimes, the interpreters experience this waiting room relationship as an attempt to privatize the link. They are asked to carry out other language tasks such as translating a letter or filling in a form. This contrast between self-image and reality sometimes creates conflicts and anxiety for the interpreters: “In health centres, it feels now and then that we are something of a necessary evil, and we are sometimes not welcomed by the staff. They meet us with doubt, and they don’t always believe us.”

Lack of time

Time-related stress. Lack of time is mentioned as an important obstacle to an effective contact. As the consultation encompasses three persons instead of the normal two persons, the talk is prolonged. The translation itself implies a prolongation of time. The communication tends to have a tentative character, which leads to a decrease in the pace of conversation. The translation cannot be accomplished word by word. To omit irrelevant words and to find the appropriate words and phrases, both in Swedish and in the target language, needs additional time: “The time is stressful both for the doctor and the patient. There isn’t enough time to talk . . . one needs more time to explain the cultural expressions; otherwise the interpreting would be parrot-like.”

Information shortage. Adequate medical treatment requires mutual understanding in the doctor–patient communication and a reduction in the information provided influences the treatment process negatively. The interpreters often experience a feeling of excluding relevant pieces of information in the decoding process and an unpleasant atmosphere is experienced: “I do not think we have enough time to give patients the opportunity to say what they think about . . . it is often an unsatisfactory moment for patients when I leave them.”

Time and quality problem. In Sweden a reduction of personnel as a result of economic strains has influenced the interpreters’ conditions negatively. As a consequence of the financial situation the use of unqualified interpreters and relatives as cheaper alternatives has increased. Fewer GPs work for longer periods at health centres and temporary locums are employed. Continuity of care is not emphasized, leading to interpreting problems: “more time and more resources are necessary in order to create patient confidence in doctors. Continuity of care is important and locums make patients confused . . . they do not have time to adapt themselves to the interpreter.”

Cultural aspects

Role of the doctor. Many patients have their origin in countries where doctors have an authoritarian role and a submissive attitude to the GP in the translation process is frequent. The patient looks upon the doctor as the person who knows best. As the interpreters often aim at a more equal footing with the doctor, tricky situations may arise. It is difficult for the interpreter to convey a more equal relationship approach if the patient believes that the GP has an answer for every question and that he/she understands how the patients feel.
The interpreter has to deal with the patients' disappointment: “When a doctor looks in the guide book for what to prescribe it is regarded as a lack of knowledge by the immigrant patient. A doctor must have it all in his/her head.”

**Health beliefs and patient satisfaction.** Attitudes to health, illness, and recovery vary a great deal between different ethnic groups. Between social groups within one nation there are also great discrepancies. Many GPs today lack knowledge of the health beliefs of different ethnic groups and are not familiar with what is needed for patients to regain their health. Many patients who need interpreters believe, for example, that injections can do miracles and make recovery faster. Some ethnic groups believe that “the evil eye” exists and describe it as a power that can harm people by looking at them. This inequality between health beliefs of doctors and patients is also reflected in the process of interpreting. In the consultation these culture-related expressions must often be explained rather than translated, a process that also needs more time: “Many patients ask the doctor to prescribe antibiotics. They believe strongly in antibiotics, even if they just catch a cold.” “The culture-related expressions are the most difficult issues in translating … I can never learn from a dictionary how cultural expressions should be translated.”

**Further education.** GPs need more knowledge about health beliefs in other parts of the world. An interest in patients' various attitudes to health and illness is a good starting point. If a GP works in an area with a mixture of different cultures it is necessary to be prepared for the task and interpreters ought to be involved at different levels of teaching and training: “We suggest further education for doctors … courses together with interpreters.”

**Discussion**

The interpreters experienced a number of problems in their daily work. These were mainly related to the following areas: the difficulty in balancing the triad relationship (GP–patient–interpreter); the role of the interpreter in relation to other healthcare staff; the time aspects of the translation procedure; and the problems of diverse health beliefs and cultural inequalities. The number of participating interpreters was small but the consensus among the interpreters in the key issues was evident. The interpreters had much experience of translation work and they represented the foreign cultural and language groups most commonly seen in primary healthcare in the area. However, the conditions vary between different areas and our study relates to a Göteborg experience. The focus-group interview was carried out without difficulties. Interpretation of the transcripts was undertaken by all the researchers. Minor differences in the analysis of the text were discussed among ourselves and one of the authors (NF) had a coordinating role.

The observation that staff have an unconstructive attitude towards the interpreters has been demonstrated earlier. In a Norwegian study interpreters complained that they were distrusted by personnel both in hospitals and in primary care [16]. The interpreters were mixed with the immigrants or refugees, and a distance between the native-born personnel and the interpreters was clear.

The interpreters themselves were often initially refugees or immigrants but had settled well and become valued residents. Yet, they were sometimes regarded with distrust. This attitude to the interpreters reflects mainly the feelings concerning cultural differences within a society. The level of segregation within a country varies, but during the last decade a more open attitude towards differences in cultural habits and health beliefs has been accepted.

We consider that personnel must be more aware of the importance of the interpreters’ role and invite them more openly to participate in the caring process. This could be in the form of joint training and education.

Time shortage in GP–patient encounters was mentioned as problematic. With consultation through an interpreter more time is needed [17], because three people are involved in the activity. Previous studies have indicated that insufficient time has an impact on the quality of service to immigrant patients. In one study, the primary care patients who used an interpreter had given fewer comments on their illness than those who consulted without language support. As the consultation time was equal in the two groups it indicates a loss of important knowledge when translation is part of the encounter [18].

**Clinical implications**

The cultural distance between the GP and the patient also enhances the need for more time. The interpreter’s link role in this situation presents its own difficulty. Some of the interpreters regarded themselves as closer to the GPs’ and Swedish cultural values than to those of the patients, often originally fellow-countrymen. The patient, on the other hand, usually looked upon the interpreter as some sort of counsellor in the meeting with the Swedish healthcare system. Strict confinement to the
language situation and avoiding the cultural aspects could sometimes help the interpreter in this balancing act between the two main actors.

The GP must also be aware of the possibility of simplifying the interpretation process by a strict focus on the patient. The link between the interpreter and the patient must not be too strong and the GP sometimes has to actively force his/her way into the strong links between the other two. By arranging the chairs and desk in a suitable way a more optimal balance in the consultation could be established. To strike the right balance during the GP–patient interaction it is quite important that neither the doctor nor the patient should have a dominant role in the consultation [19].

According to Swedish healthcare laws all residents should be given equal and high-quality care [20]. To reach this goal, adequate cross-cultural health communication is needed and the interpreter’s role is crucial. Interpreters should ideally be recognized as part of a healthcare team [21]. So far comparatively few research projects in clinical transcultural care have been carried out in Scandinavia [22]. Our study has focused on some of the problems experienced by interpreters in achieving an optimal role. Further studies concerning the interpreter’s role in clinical encounters are required in order to give patients with language limitations optimal care in consultations.

Acknowledgements

This study was financially supported by Research and Development Council (FoU-rådet) for Göteborg and Södra Bohuslän Primary Health Care in Sweden.

References

[17] Löfvander M. Få studier finns om transkulturell primärvård i Skandinavien (There are few studies about transcultural primary healthcare in Scandinavia). Läkartidningen 2003; 100:4068.