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## Missed Opportunities When Communicating With Limited English-Proficient Patients During End-of-Life Conversations: Insights From Spanish-Speaking and Chinese-Speaking Medical Interpreters

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### Abstract

**Context**—Research has shown that using medical interpreters in language-discordant patient-provider encounters improves outcomes. There is limited research evaluating the views of medical interpreters on best interpreter practices when they are used to break bad news or participate in end-of-life (EOL) conversations.

**Objectives**—To develop insights from medical interpreters about their role when interpreting discussions regarding EOL issues, identify practices interpreters perceive as helping to improve or hinder patient-provider communication, and obtain suggestions on how to improve communication during EOL conversations with Spanish-speaking and Chinese-speaking patients.

**Methods**—Semistructured interviews were conducted with Spanish or Chinese medical interpreters. Participants were recruited until thematic saturation was reached. Twelve interviews were conducted, audiotape recorded, transcribed, and analyzed using standard qualitative methods.

**Results**—Six major themes were identified: medical interpreters' perceived comfort level during EOL interpretation; perception of interpreter role; communication practices perceived as barriers to effective communication; communication practices felt to facilitate effective communication;

concrete recommendations how to best use medical interpreters; and training received/perceived training needs.

**Conclusion**—Medical interpreters provide literal interpretation of the spoken word. Because of cultural nuances in Chinese-speaking and Spanish-speaking patients/family members during EOL conversations, medical interpreters can translate the meaning of the message within a specific cultural context. Conducting premeetings and debriefings after the encounter are potentially important strategies to maximize communication during EOL conversations.

### Keywords

End of life; medical interpreter; interpreter perspective; limited English proficiency; non-English-speaking patient; palliative care

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### Introduction

Language diversity has been a key characteristic of the history of the U.S., which has become more predominant in recent decades.<sup>1–3</sup> More than 65 million (21.6%) of the nation's population aged five and older speak a language other than English at home.<sup>3</sup> Approximately 26 million (39.8%) of these individuals speak English less than very well or are considered to be limited English proficient (LEP).<sup>3</sup>

Language barriers in an English-language dominant health care system affect how LEP patients interact, communicate, and build relationships with their health care providers. When present, language barriers have been shown to decrease satisfaction with care, increase risk for inadequate assessment of pain, and lead to misunderstandings between physicians and patients.<sup>4–7</sup> Awareness of how language barriers affect LEP patients is important to minimize unnecessary physical and emotional suffering, particularly at the end of life (EOL).<sup>8</sup> This awareness is especially critical when delivering comprehensive palliative care, which requires clear communication of goals of care (GOC) especially in the face of cultural and linguistic differences.

Research has shown that using medical interpreters in language-discordant patient-provider encounters results in greater patient satisfaction, improved understanding of diagnosis, and fewer interpreter errors compared with ad hoc interpreters (e.g., family, caregiver, or untrained staff).<sup>9–11</sup> Medically licensed interpreters are certified to work in the health care field. Hospitals may employ medical interpreters or contract medical interpreter agencies to provide language services. Despite of this, most health care organizations provide inadequate interpreter services because of the financial burden of such services.<sup>12</sup> Medical interpreters have specific training to minimize errors in message delivery and improve patient comprehension.<sup>9–11,13</sup> One study of patients in an urban emergency department found that LEP patients' self-reported understanding of their diagnosis and treatment plan was more likely to be poor among those who needed but did not get an interpreter.<sup>14</sup> Most studies conducted to date have shown that LEP patients have both worse quality of EOL care and GOC discussions when medical interpreters are not used.<sup>15</sup>

Using medical interpreters during EOL or GOC discussions is important for effective communication. However, few studies have investigated the ways in which medical interpreters influence patient-provider communication during palliative care encounters. One study assessing the experiences of medical interpreters in EOL discussions found that medical interpreters felt comfortable participating in EOL discussions.<sup>16</sup> Moreover, studies suggest that in addition to strict interpretation, medical interpreters can act as cultural brokers.<sup>17–20</sup> In cultural brokering, the medical interpreter acts as an advocate for patients and caregivers during the encounter by providing the patients' and families' perspective of the social construction of illness.<sup>21</sup> In this role, the medical interpreter shares cultural information with both parties to help clarify the transmitted message and addresses terms that may be untranslatable or concepts that may not exist in the culture using the target language. Lack of understanding of how culture impacts the way illness is viewed can lead to communication problems during family meetings as the health care provider may not understand the cultural values that affect decision making at the EOL.<sup>14,16,17,22–24</sup>

There is limited research evaluating the views of medical interpreters on best interpreter practices when they are used in difficult conversations.<sup>14,15,20,25,26</sup> We conducted semistructured interviews with Spanish and Chinese medical interpreters to obtain their insights when interpreting discussions about GOC and EOL issues. Spanish and Chinese were selected as these are the languages most commonly requested at our institution and reflect the two largest populations speaking a language other than English in the U.S. The aims of our study were to develop insights from medical interpreters about their role; identify medical interpreter experiences associated with improved patient-provider communication; and obtain medical interpreter recommendations regarding provider-interpreter interactions to improve communication when interpreting discussions about GOC and EOL issues with Spanish-speaking and Chinese-speaking patients.

## Methods

### Eligibility and Recruitment

The following inclusion criteria were used: 1) medically licensed interpreter, 2) speaks Spanish or Chinese (Mandarin, Cantonese, or any Chinese dialect), 3) provide services as an in-person interpreter within a hospital-based setting, 4) 18 years and older, and 5) speaks English. The study was conducted in a large tertiary care hospital located in New York City. Participants were recruited through electronic mail, word of mouth, or flyers posted through collaboration with CP Language Institute liaison (agency that offers medical interpreter services at our institution) or the Department of Interpreter Services at our institution until thematic saturation was reached.<sup>27,28</sup> The Weill Cornell Institutional Review Board approved the study.

### Data Collection

Semistructured interviews were conducted in English by the principal investigator (M. D. S.) and/or coinvestigators (S. T. R.; M. D. S.; and B. T. A.) and audiotape recorded and subsequently transcribed for analysis. Interviews were conducted from August 2017 to

November 2017 at the convenience of the participant. All interviews were conducted either in person or over the phone.

## Data Analysis

Univariate statistics were performed on all quantitative variables (e.g., age, gender, number of languages spoken, hours of training, years of experience, time interpreting). Direct content analysis occurred in a three-step process of coding, data reduction, and identification of themes.<sup>27–29</sup> Coding of the raw data involved line-by-line extraction of key phrases, termed meaning units. Meaning units were compared both within and across interviews and grouped based on underlying similarity. This process continued until no new categories emerged. Finally, meaning units were synthesized and collapsed into central themes along with subthemes when present. The coding process used in this study was cross-validated with two team members (R. D. A. and M. C. R.) to ensure coding validity. Any discrepancies were discussed by the research team and resolved via consensus. To establish the credibility of key findings, the qualitative results were presented in the form of a preliminary report to the participants with a request for their feedback.<sup>30</sup> Participants agreed that the identified themes captured their attitudes and recommendations, suggesting that the investigators' interpretation of the recorded transcripts was credible.

## Results

Twelve semistructured interviews were conducted: five with Chinese-speaking medical interpreters and seven with Spanish-speaking medical interpreters (Table 1).

Six major themes were identified: 1) medical interpreters' perceived comfort level interpreting information conveyed in palliative care-based family meeting, 2) perception of their role as oral translators and cultural brokers, 3) communication practices that constituted perceived barriers to effective communication, 4) communication practices that were felt to facilitate effective communication, 5) concrete recommendations regarding how to use medical interpreters more effectively, and 6) training received and perceived training needs to conduct these types of conversations.

### Medical Interpreters' Perceived Comfort Level

When asked about level of comfort participating in these types of conversations, all 12 interpreters reported that they felt comfortable delivering the messages conveyed by health care providers and interpreting palliative care-related issues. However, a subset of Chinese and Spanish medical interpreters related that to perform their role, compartmentalization of their own emotions was needed.

I sympathize with the feelings of the patients and their families; however, I do not internalize the feeling because if I do, then I will not be able to do my job ... I focus on conveying the right message (Sp1)—Spanish-speaking medical interpreter

Furthermore, some medical interpreters also stated experiencing internal conflict in delivering the health care providers' message accurately and in a way that addresses the

patient and/or family members' cultural values during EOL and palliative care conversations.

Whatever, the provider said, we have to tell the patient. Professionally we really have to stick to the authenticity of what the provider said. But sometimes the provider's word is a little bit too harsh ... We have a lot of words in Chinese that are a little bit more polite than just telling them that you are going to die (Ch1)—Chinese-speaking medical interpreter

### **Medical Interpreters' Perception of Their Role as Oral Translators and Cultural Brokers**

A key role that both Chinese-speaking and Spanish-speaking participants reported is to provide literal interpretation of the spoken word. Overall both groups reported a sense of clarity and competency in their role of delivering an accurate message during family meetings regarding GOC and EOL issues. Facilitating the flow of communication in a seamless manner between the doctor and patient and/or family members was viewed by participants as a critically important outcome.

It is crucial to deliver all the information accurately. To facilitate communication back and forth, and that's how I see my job ... basically just the bridge. I'm saying everything that they're saying (Sp2)—Spanish-speaking medical interpreter

Both groups felt that a key aspect of their job was to serve as a cultural broker. Participants expressed that sharing the same culture and language with a patient naturally creates a sense of partnership. In their role as cultural brokers, participants gauged how the patient/family members are receiving the information given the cultural implications. Moreover, participants identified that death and dying conversations can be viewed as disrespectful or too blunt in Chinese and Spanish culture, and that health care providers are often not aware of these cultural aspects.

When you talk about end of life, sometimes the Western point of view doesn't really work in Chinese contexts (Ch2)—Chinese-speaking medical interpreter

I have this cultural empathy ... when there are family members with patients they just get in another state of mind, I can read that because I know the culture ... the nuances (Sp3)—Spanish-speaking medical interpreter

Providing input in the appropriate medical and cultural context and clarifying when the message needed more explanation by the health care provider were perceived as important role elements to facilitate the accuracy of all communication aspects. Techniques shared by both groups include contextualizing the meaning of various palliative care-related terminology or words that are difficult to translate, clarifying the message being delivered and using appropriate tone and body language. Participants shared that contextualizing allowed them to use words in the target language that are culturally appropriate and describe the meaning of palliative care-related words.

Hospice would roughly translate to the type of comforting care before you die ... when interpreting those two terms [hospice and palliative care] and the description by the providers I have to do 'contextualizing' ... if I don't contextualize there is discrepancy in understanding (Ch4)—Chinese-speaking medical interpreter

I can interpret the concepts instead of giving them one technical word, I have to explain the concept ... that's what we do as interpreters, but if something is too technical I just let the doctors know "what do you mean by that?" and they usually elaborate (Sp4)—Spanish-speaking medical interpreter

### **Practices Perceived as Barriers to Effective Communication**

Participants reported that medical interpreters may not know the meaning of certain medical jargon, whereas specific palliative care-related terminology such as palliative care, hospice, or do not resuscitate (DNR) does not translate well because its literal translation in Spanish or Chinese does not accurately describe the meaning of the word.

Hospice has a Chinese name ... comfort care, DNR/DNI ... all these terms have a correct translation. But when you say it, doesn't necessarily mean that your target audience understands it, you end up having to explain what they mean (Ch3)—Chinese-speaking medical interpreter

Hospice is a hard one, "hospicio" for Hispanics is mostly an orphanage ... sometimes when you tell them "hospicio" they don't understand exactly what you're saying ... you have to explain hospice, it doesn't translate well (Sp5)—Spanish-speaking medical interpreter

The use of medical jargon by health care providers (referred to by medical interpreters as high-register speech) was reported as an important barrier when delivering an accurate message to the patient and/or family member.

You have to as a doctor figure the way so that they [patient/family] can understand what you're saying. Because "high-register" are medical terms, sometimes I don't even understand them (Sp6)—Spanish-speaking medical interpreter

Using family members as ad hoc interpreters during GOC and EOL conversations was also perceived as a barrier to effective communication. Participants perceived that during these conversations family members can be in an emotional state of affairs that affect the dynamic with their health care providers.

### **Practices Perceived as Advantageous to Effective Communication**

Speaking directly to, keeping eye contact, and using empathic statements with patients and family members were all communication practices used by health care providers that medical interpreters perceived as advantageous. Several participants also reported that health care providers who knew how to effectively describe palliative care and hospice or provided effective descriptions of difficult concepts, such as DNR, intubation, resuscitation, and so on, were perceived as more effective communicators.

I have seen the team explain with more ways that enables the family to slowly see the picture. There may still be [patient] unwillingness but I definitely have seen improvements because these providers deal with this on a regular basis ... go right to the details about what hospice care means (Ch4)—Chinese-speaking medical interpreter

## Recommendations Regarding How to Use Medical Interpreters More Effectively

Conducting a premeeting with the medical interpreter to provide specifics about the case including the patient's history, information being delivered, current understanding, and key participants constituted an essential recommendation to help medical interpreters deliver messages accurately. All participants felt that being part of the team during these premeetings was important.

If you want an interpreter to do a better job, it would be very helpful before we go in to see the patient if the provider can give us a head up on what is going on ... what is the condition? What was being done? because if you don't understand, it's really hard to explain to the patient (Ch5)—Chinese-speaking medical interpreter

Several medical interpreters suggested that health care providers could benefit from undergoing specific training in how to use a medical interpreter. When participating in GOC and EOL conversations, medical interpreters felt strongly that using an in-person interpreter vs. a video or telephone interpreter was important. Finally, a few participants discussed that debriefing or meeting after the medical encounter was important to do but may not always be feasible because of time constraints.

Use an in-person interpreter whenever possible because they can read the room, they can get a better sense of family and patient dynamics ... this type of conversation needs a personal touch, so having an in-person is most likely better than phone or video. But, using the phone or video is still better than using a family member (Ch3)—Chinese-speaking medical interpreter

## Training Received and Perceived Training Needs

Although training involved formal education in medical interpretation and cultural awareness, participants acknowledged a lack of standardized and formal interpreter training in palliative care and EOL issues. Most interpreters voiced a desire for training in communication at the EOL and understanding the logistics of hospice care. Participants reported that their education in palliative and EOL care occurred through self-learning and on-the-job training. A subset of Chinese and Spanish medical interpreters reported creating their own glossary of palliative care-related terms. Participants also related that they rarely received formal debriefing or feedback after participating in breaking bad news or GOC conversations.

I think more that I have learned, it has been through experience, more than through the trainings (Sp7)—Spanish-speaking medical interpreter

## Discussion

Our study of Spanish and Chinese medical interpreters sought to obtain participant insights when interpreting discussions regarding GOC and EOL issues. When engaging in GOC conversations, medical interpreters have a code of ethics to deliver messages accurately but may not be able to provide literal interpretation of the message either because of terminology that does not translate well or because of cultural differences. Medical interpreters can experience internal conflict while facilitating communication across cultural

differences and remaining objective translators. Words like palliative care, hospice, or DNR may have a literal translation that is difficult to interpret without further explanation of its meaning by the health care provider.

All the participants viewed themselves as cultural brokers that understood the cultural implications and nonverbal cues during the medical encounter. Participants felt comfortable in their role of conveying the message during GOC and EOL conversations. However, palliative care-related and GOC conversations are emotionally charged and therefore, medical interpreters may need to compartmentalize their emotions to provide a faithful interpretation without changing the meaning or omitting information. Conducting a premeeting between the medical interpreter and health care team emerged as a key recommendation as a way of better using medical interpreters' services. Providing input in the appropriate medical and cultural context and clarifying when the message needed more explanation were important interpreter interventions to ensure patients/family members understand the information and receive a faithful interpretation.

No comparative literature exists in obtaining the insights of Spanish and Chinese medical interpreters when discussing GOC and EOL issues. However, other studies evaluating the experience of medical interpreters in EOL conversations have also recommended that health care providers conduct premeetings with interpreters as a way of improving communication.<sup>16,22,31-33</sup> These studies also found that interpreters often have a conflict between providing strict interpretation and serving as a cultural broker.<sup>22,34</sup> This conflict can affect the work of medical interpreters as some may focus on the cultural issues and give the health care provider additional information regarding the cultural implications of the message being delivered, whereas others may only do strict interpretation. Greater clarification of the interpreter role should be defined to ensure the delivery of an accurate message that is based on cultural beliefs and values. Similar recommendations have been made on how to use medical interpreters who include using simple language, allowing for questions and giving short statements.<sup>16,35-37</sup> In addition, all medical interpreters interviewed in this study related that they had received no formal training in breaking bad news or EOL conversations. A future educational focus should consider developing curricula for medical interpreters with regard to communication involving GOC and EOL conversations. According to study participants, health care providers often lacked basic training in how to use medical interpreters. This finding suggests an important need for training of health care providers to enable effective communication to occur with medical interpreters.

These findings demonstrate that GOC and EOL discussions may add an extra layer of complexity to medical interpretation as terminology commonly used in palliative care may not translate well or be unknown to the medical interpreter. Based on the study findings and related research,<sup>16,35-38</sup> we recommend that health care providers familiarize themselves with common palliative care terminology and expect to explain terminology such as hospice or palliative care to the medical interpreter, LEP patient/family member; and give permission to the medical interpreter to check in before, during, and after family meetings to provide culturally relevant information and clarify with the health care provider if the medical interpreter feels the message is not being understood by the patient or family members. Being a cultural broker constitutes an important skill that health care providers should be



aware of to improve the quality of the communication with LEP patients during GOC and EOL conversations.

Based on our findings, we recommend that health care providers conduct premeetings with medical interpreters when engaging in GOC and EOL issues. In these meetings, health care providers can share background information about the case for interpreters to understand the context of the meeting and emotionally prepare for the interpretation. It gives the health care provider an opportunity to establish expectations and give a forewarning to medical interpreters about difficult topics to be discussed such as dying and hospice. Premetings may allow the medical interpreter to ask questions, clarify terminology, share perceptions of patient and family understanding, and gain insight into the goals for the upcoming meeting. Similarly, debriefing with the medical interpreter after the medical encounter could provide an opportunity for the interpreter's input to be shared that otherwise may not be known to the medical team. Having brief premeetings and debriefing meetings could help reinforce the health care provider-medical interpreter relationship by allowing medical interpreters to process these often challenging conversations with the team and not in isolation.

This study is not without limitations. First, the insights obtained from medical interpreters are limited to a small sample of Spanish-speaking and Chinese-speaking medical interpreters. Second, we did not fully explore how medical interpreters compartmentalize their emotions, process internal conflict, or remain objective while partnering with the health care provider and patient as cultural brokers. This could be the focus of future research. Third, although the study was continued until thematic saturation was reached, it was conducted at a single site, which limits the generalizability of the findings to other settings, languages, or clinical contexts. Finally, only experienced medical interpreters were interviewed. Therefore, we were not able to determine whether differences exist in the perspectives of experienced vs. recently trained medical interpreters.

## Conclusion

Our study findings support that when discussing GOC and EOL conversations, medical interpreters often act as cultural brokers as there are cultural nuances in Chinese-speaking and Spanish-speaking patients/family members that affect their decision making when engaged in GOC and EOL conversations. Medical interpreters not only translate words but most importantly the meaning of the message within a given cultural background. Health care providers should consider, when possible, using in-person medical interpreters during GOC and EOL meetings and conduct premeetings and debriefings after the encounter to maximize communication and understanding during family meetings.

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**Key Message**

The article describes insights from Spanish-speaking and Chinese-speaking medical interpreters when facilitating end-of-life conversations for limited English-proficient patients/families. Medical interpreters can provide literal interpretation and serve as cultural brokers. Strategies to maximize communication include conducting premeetings and debriefings after the encounter.

**Table 1**Demographic Characteristics of Interpreters ( $n = 12$ )

Interpreter Characteristics	<i>N</i> (%)
Age (yrs)	
Mean (SD)	45.6 (10.1)
Gender	
Female	7 (58)
Male	5 (42)
Number of non-English languages spoken	
1	6 (50)
2	3 (25)
3 or more	3 (25)
Certificate	
Yes	12 (100)
Training	
40 hours	3 (25)
>40 hours	9 (75)
Years of experience	
Mean (SD)	5.4 (2.6)
1–5	9 (75)
6–10	3 (25)
Hours spent interpreting per week	
Mean (SD)	32.1 (11.4)
Hours spent interpreting only EOL per week	
Mean (SD)	2.7 (2.9)

EOL = end of life.

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