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Interpreters in Health Care

Not all are desired: Providers' views on interpreters' emotional support for patients

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ABSTRACT

Objective: This study examines (a) providers' expectations and concerns for interpreters' emotional support, and (b) the complexity and dilemma for interpreters to offer emotional support in health care settings.
Methods: We recruited 39 providers from 5 specialties to participate in in-depth interviews or focus groups. Grounded theory was used for data analysis to identify providers' expectations and concerns for interpreters' emotional support.
Results: From the providers' perspective, interpreters' emotional support: (a) is embodied through their physical presence, (b) is to be both a human being but also a professional, (c) represents the extension of the providers' care, and (d) imposes potential risks to quality of care.
Conclusion: Emotional support in bilingual health care is accomplished through the alliance of providers and interpreters, complementing each other to support patients' emotional needs.
Practice implication: Interpreters should be vigilant about how their emotional support may impact the provider–patient relationship and the providers' therapeutic objectives. Interpreters should be aware that providers also rely on them to provide emotional support, which highlights the importance of giving medical talk and rapport-building talk equal attention in medical encounters.

Recent reviews have highlighted professional interpreters' positive impacts to bilingual health care [1,2]. Professional interpreters are trained with a default role, namely the conduit model, in which they adopt a passive and neutral presence, faithfully transferring information from one language to another [3]. Interpreters often believe that a conduit role requires them to be detached, to be emotionless and to avoid interactions with others (e.g., chitchatting) [4]. However, researchers have argued that the conduit model is neither a sufficient explanation nor a practical guide for medical interpreters' practices [4,5]. In addition, providers and patients may prefer to and often do work with other types of interpreters (e.g., family members and bilingual staff) [6–9], who are not familiar with the conduit model and bring different dynamics to provider–patient interactions [10].

In interpreter-mediated medical encounters, the typical dyadic interaction between the provider and the patient becomes a triadic one [11,12]. Interpreters manage the information exchanged as well as the providers' and patients' identities and relationships [5,13,14]. For example, when interpreters focus on medical information and ignore providers' rapport-building talk, providers may appear emotionally detached [15]. Interpreters' performance has significant implications for the clinical and emotional aspects of care.

Researchers have highlighted the importance of providing emotional support (i.e., expressions of care, concern, love, and interest) in health care services [13,16–18]. The appropriate emotional support is situated in cultural contexts and enhances the recipients' overall well being [18]. Interpreters' emotional support was found to help patients to be more receptive to providers' treatment suggestion [19] and reduce patients' negative moods caused by a despondent therapist [16]. Interpreters often actively provide emotional support by noting the needs to bridge cultural differences and to ensure quality care [4,5,20].

Interpreters' emotional support, however, is a complicated issue that requires a closer examination. First, providing emotional support contradicts the conduit model and may create tensions against the providers' expectation [11,20,21]. Second, providing emotional support may blur the differences between the roles of interpreters versus patient advocates, causing dilemma in their role performances [5]. Third, interpreters' emotional support may overstep providers' responsibilities or service (e.g., meeting with patients outside of a medical encounter), which may be

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Table 1
Providers' demographic data.

Category	Range	Number	%
Gender	Male	14	35.9
	Female	25	64.1
	Total	39	100.0
Age	18–30	8	20.5
	31–40	13	33.3
	41–50	4	10.3
	51–60	8	20.5
	61–70	6	15.4
	Total	39	100.0
Specialty	OB/GYN	8	20.5
	Emergency medicine	7	17.9
	Oncology	11	28.2
	Mental health	7	17.9
	Nursing	6	15.4
	Total	39	100.0
Experience with interpreters			
	Never	3	7.7
	1–5 times	2	5.1
	6–10 times	3	7.7
	>10 times	31	79.5
	Total	32	100.0

inappropriate and have clinical consequences [20,22]. Finally, it is possible that providers' differences in their specialty (e.g., oncology and emergency medicine) may lead to different expectations of interpreters' emotional support.

Our objective is to identify providers' expectations of and concerns about interpreters' emotional support, which are essential to the provider–interpreter collaboration in bilingual health care. In this study, we problematize interpreters' emotional support, a type of non-conduit behavior often found in interpreters' practices. Although several studies have documented interpreters' desire to offer emotional support [5,23], we aim to (a) highlight the interpreter's role as a human agent in facilitating the emotional side of care and (b) critically examine the clinical and interpersonal impacts of such behavior.

1. Methods

1.1. Participants and procedures

This study is a part of a larger study that examines providers' expectations of medical interpreters. The same data were a part of the data set used to explore providers' and interpreters' competitions for control over interpreter-mediated interactions [24]. The first author recruited 39 providers from a major health care facility, which also serves as a university teaching facility, in the southern United States. The providers are from five specialty areas: OB/GYN ($n = 8$), emergency medicine ($n = 7$), oncology ($n = 11$), mental health ($n = 7$), and nursing ($n = 6$). The first author recruited providers through specialty-specific meetings held by clinics, sections, and departments. Participants in the nursing area were recruited through women and newborn services; all others are physicians of the corresponding specialties. The providers' demographics are listed in Table 1.

Because providers often have busy and variable schedules, the first author offered individual interviews to providers who were unable to attend the focus groups. The same semi-structured interview guide was used for both the focus groups and individual interviews. The interview guide explores providers' (a) expectations for medical interpreters' emotional support, (b) communicative needs in interpreter-mediated interactions, (c) criteria used to assess the success of bilingual health care, and (d) contextual factors that may influence their expectations. A sample of the interview guide is listed in Table 2.

Although professional interpreters are available in the health care facility, participants reported working with a variety of interpreters (e.g., telephone interpreters and/or family members). We encouraged providers to compare their experiences with and expectations for different types of interpreters whenever possible. In total, the research team conducted 8 specialty-specific focus groups (each lasting 1–1.5 h) and 14 individual interviews (each lasting 1–1.5 h). The first author was present in all focus groups and individual interviews.

Table 2
Interview guides (selected questions).

Areas of inquiry	Interview questions
Overview	1. In your line of work, how often do you meet a patient who may have limited-English-proficiency? How do you usually manage to communicate with the patient? 2. How often do you work with a professional interpreter, such as the interpreters provided by the hospital or telephone interpreters provided by interpreting agencies? 3. Do you have a preference in terms of the kinds of interpreters you work with (e.g., family members, professional interpreters, telephone interpreters)? Why?
Role expectations	4. If you need to describe the role of a medical interpreter, how would you describe it? 5. When treating a patient who is from a different culture or speaks a different language, do you pay more attention to certain issues? What are they? Do you think an interpreter can help you with these concerns? 6. When working with an interpreter, what are the things that you appreciate most from an interpreter? What are the things that bother you the most?
Communicative needs	7. Do interpreters facilitate your work? In what way? 8. Do interpreters present challenges to your work? In what way? 9. Do you have problems coordinating the multi-party conversations when working with an interpreter? What are the problems? How do you usually resolve these issues?
Evaluating medical encounters	10. Were you ever in situations that you feel that the interpreter was not neutral? What happened? Did you do anything to manage the situation? 11. When you have miscommunication or conflicts with a patient, how should an interpreter manage the situation? Do you think that they should still translate all the emotions and possibly foul language? Why or why not? 12. What are criteria you use to evaluate the quality and success of a provider–patient interaction? Do you use different criteria if it's a cross-cultural, bilingual interaction?
Contextual factors	13. Are there any situations that you will not talk to a patient without an interpreter? 14. Do you think your clinical specialty influence your expectations and needs for a medical interpreter? In what way?