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An Adaptable Approach to Expanding our Knowledge of Medical Interpreter Experiences

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ABSTRACT Medical interpreters are vital constituents in positively affecting the health of populations with limited English proficiency. Global Wordsmiths, a social enterprise based in Pittsburgh, Pennsylvania, explored the experiences and needs of their medical interpreters using a survey adapted from a variety of qualified sources in health care quality improvement, health literacy, and needs assessments of populations with limited English proficiency. Participant dialogue suggests that medical interpreters serve multiple roles beyond word-for-word translation; however, what also becomes apparent is a lack of adequate training and psychosocial support among the profession. The burden of extraneous roles outside their defined job responsibilities and the need for more psychosocial support hinders medical interpreters' ability to positively affect healthcare access, quality, and outcomes among populations with limited English proficiency. As such, we identify a vital need for health literacy research and practice to further investigate medical interpreters' experiences.

KEY WORDS limited English proficiency, health literacy, health services accessibility, communication barriers

INTRODUCTION

In the United States, 65.9 million people aged five and older speak a language other than English at home[1]. Further, one in every 13 people speaks English less than "very well"[1]. Language barriers between patients with limited English proficiency (LEP) and healthcare providers adversely affect healthcare access, quality, and outcomes for this population. Disparities among this demographic are so pervasive that Executive Order 13166[2], published in 2000, requires federal agencies, including federal healthcare programs, to develop systems to improve access to their services for persons with LEP. Guidance on meeting these requirements, which often necessitates enlisting medical interpreters[3], was published by the Department of Health and Human Services in 2003 and continues to be used today[4].

There are several studies exploring medical interpreter experiences in difficult medical situations such as oncologic, end-of-life, and intensive care settings[5-10]. Despite the profession's essential contribution to

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reducing healthcare disparities among the nation's growing number of individuals with LEP, there is little research exploring medical interpreter experiences outside these high-stress situations. As such, the invaluable perspectives of medical interpreters endure as untapped insight with the potential for advancing health literacy research and practice aimed at improving health care access, quality, and outcomes among the population of individuals with LEP. This report describes one approach to exploring these aspects of the profession among a group of medical interpreters based in Pittsburgh, Pennsylvania.

METHODS

Study Setting

Global Wordsmiths, a social enterprise based in Pittsburgh, Pennsylvania with the mission to create and advance a culture of language accessibility, provides translation in 40+ languages, interpretation services in-person and virtually on demand in 100+ languages, and language access consulting and training for organizations such as health care systems, school districts, corporate commerce operations, and municipal governments. Profits from these services subsidize initiatives such as free translation and interpretation to nonprofits, quality jobs and growth opportunities for their linguists, and improved language access policies and procedures among service providers. These initiatives directly enable equitable access to services for individuals with LEP while helping clients expand their service capacity, comply with legal regulations, and build sustainable accessibility policies.

Partaking in a quality improvement project, Global Wordsmiths partnered with the Health Care Improvement Foundation (HCIF) to qualitatively assess the needs and experiences of their medical interpreters. HCIF is an independent nonprofit founded to support a responsive, coordinated healthcare delivery system that fulfills the needs of patients and consumers to achieve improved health through large-scale collaboration with health systems, community-based organizations, payors, and various other stakeholders. This work was supported through the Pennsylvania Health Literacy Coalition's Immigrant Health Literacy Initiative, funded by the Centers for Disease Control's Preventive Health and Health Services Block Grant through the Pennsylvania Department of Health.

Participant Recruitment

Convenience and purposive sampling methods recruited eligible participants which included current Global Wordsmiths medical interpreters as of June 2020. This population is involved in a plethora of healthcare settings, the top three during 2019-2020 being optometry/ophthalmology, obstetrics/gynecology, and otolaryngology. The opportunity to participate in the study was communicated via email on June 10, 2020 to all 46 eligible participants. They were given 10 days to participate, with two reminder emails sent over this time. On June 21, 2020, responses were analyzed, and an additional email was sent to interpreters of underrepresented languages, offering an extra three days to participate. Compensation was provided for survey completion.

Survey Creation

A survey exploring medical interpreters' experiences with medical providers, patients, and their employers was created by HCIF and piloted by a reference group comprising a former Global Wordsmiths medical interpreter and administrative staff from Global Wordsmiths. Questions were adapted from experienced sources (Supplementary Materials 1) in healthcare quality improvement, health literacy, and needs assessments of populations with LEP. The first page of the survey included confirmation of informed consent. Questions thereafter moved from specific demographic information to more general, open-ended responses about their experiences first with medical providers, then patients, and finally their employers. The final survey questions can be found in Supplementary Materials 2.

Data Collection

The survey was administered via Qualtrics, and most participants completed the questionnaire on personal electronic devices. Seven eligible participants were asked to participate virtually due to prior written communications indicating relative ease of oral interactions. Surveys completed virtually were administered by HCIF and responses were transcribed directly into Qualtrics.

Data Analysis

The final sample size was 26, with a 56.5% response rate. Responses were cleaned, ensuring no identifying information was present, and HCIF utilized Qualtrics Stats iQ and qualitative methods to code all responses. We used the phenomenology paradigm to explore the nature of the medical interpreters' experience working at Global Wordsmiths. Phenomenology allows for rich accounts of a small number of individuals' lived experiences,

in this case, those of Global Wordsmiths medical interpreters. Responses were analyzed using a content analysis approach. The following codes were used to code all responses: medical interpreter roles, expectations of medical interpreters, needs of medical interpreters.

RESULTS

Interpreter Voices: The Medical Interpreter's Role

Participants were asked what they believe medical providers expect from them. There were mixed results, with some reporting that medical providers expect them to "just interpret" and "don't add any personal opinions" while others felt providers expect more than simple word-for-word translation and relied on them for explaining medical terms and conditions. This difference in beliefs among participants was further highlighted when subsequently asked what they believe patients expect from them. One response read, "I feel like patients trust medical interpreters more when they see me conveying the message in a similar kind of body language, not adding/subtracting from what was said."

Respondents identified additional patient expectations, such as providing medical advice and patient advocacy. One respondent noted, "Sometimes I think they want us to answer their questions. They forget that we are not the doctor." Participants mentioned that patients often want them to "be on their side" even though interpreters work for both the patient and provider. Finally, participants noted that patients often seek help navigating healthcare systems and asking questions or performing tasks the patients do not feel comfortable doing (i.e., making appointments, phone calls, etc.). This equates to many participants providing significant expectation management before and after the medical appointment – and their timed pay – ends. Expectation management includes setting boundaries for the patient-medical interpreter relationship. Boundaries may comprise, for example, reviewing questions which are better asked during an appointment with a doctor present versus while still in the waiting room with only the medical interpreter. Medical interpreters were compensated based on the time booked for an appointment. Any communication with a patient outside of an appointment time is often not captured in the books and therefore not compensated.

Interpreter Voices: Medical Interpreter Needs and Support Resources

Participants were asked how their employer could more effectively support them in their work, in which two major themes emerged: opportunities for continuing medical education and psychosocial support. Many participants desired further training in medical terminology and anatomy via webinars, workshops, articles, etc. Participants also reported often being unaware of the medical scenarios they are walking into – noting that they receive an address for the assignment and nothing more. Being unaware of the patient's condition and the type of medical service being rendered prevents the medical interpreters from supplementing their knowledge and vocabulary to feel adequately prepared. It also requires creativity and compromise on the part of the medical interpreter and patient, as encountered by one participant and a patient with explicit gender preferences. In this instance, a male medical interpreter was assigned to a patient who, for religious reasons, required only female individuals in the room. This occurred because the reason for the visit was unknown before arriving. As such, it was not known that a situation in which a male individual could not be in the room would arise. While this medical interpreter was able to face a wall during the encounter, they noted this would not have been a solution for languages that require sight, such as American Sign Language.

Regarding psychosocial support, participants relayed that they lack the necessary skills to navigate difficult medical situations and subsequently cope in healthy ways. Many participants endorsed the potential benefit of opportunities to share their experience with other interpreters and professional mental health providers.

DISCUSSION

This quality improvement project aimed to explore the experiences and needs of Global Wordsmiths medical interpreters using a phenomenology paradigm. Regarding the medical interpreter experience, there was a difference in beliefs among many participants regarding their job expectations. Some participants felt that providers and patients expected word-for-word translations conveyed with similar body language as the original speaker. This feeling is similar to the roles of both verbatim interpretation and health literacy guardians, meaning facilitators of patients' ability to understand information conferred by physicians, previously identified by medical interpreters involved in intensive care unit communications[6]. On the other hand, other participants felt they were often called on to provide medical advice and advocate on behalf of the patient, requiring significant expectation management outside of their paid time. The use of strategies outside of strict translation is similarly reported among pediatric oncology medical interpreters, who sometimes feel obligated to deviate from their role

as a neutral party to interpret in a broader cultural context rather than carry out word-for-word translation[7]. Overall, this mixed understanding of the role of medical interpreters is consistent with their multitude of understood roles reported in the literature[5, 6]. This misunderstanding of responsibilities among providers, patients, and medical interpreters themselves may prevent medical interpreters from effectively contributing to the LEP patient-provider relationship to the best of their abilities.

Regarding the theme of supporting medical interpreters employed by Global Wordsmiths, participants acknowledged a need for more preparation prior to and psychosocial support following medical interpretation visits. All participants are nationally board certified or, if they interpret a language other than the 13 for which there is national board certification, have proprietary certifications from reputable bodies with proven coursework or experience in medical terminology and settings. Still, we identified a need for continuing education beyond this initial training, with suggested preparatory resources including anatomy and physiology training pertinent to the type of appointment for which the patient is being seen. This lack of adequate preparation prior to a service is echoed in a systematic review of several studies looking at medical interpreters involved in the delivery of palliative care services to cancer patients[9]. This review suggested that pre-meetings between clinicians and interpreters are important for discussing topics and terminology[9]. Knowing more specifics about an appointment beforehand gives the interpreter a sense of autonomy in their interactions, and they are more effectively able to prepare by becoming comfortable with necessary vocabulary needed to meet the expectations of both the provider and patient.

Psychosocial support needs took the form of the opportunity for experience sharing with other interpreters and mental health professionals. As integral parts of the caregiving team, medical interpreters are at increased risk for significant work-related stress, and the accuracy of their interpretations can suffer[10]. Similar distress and lack of coping resources have been endorsed among medical interpreters in oncology, and one study piloted a resiliency program targeted at the needs of these interpreters[10]. This pilot found that interactive exercises employing relaxation response elicitation techniques (i.e., breath awareness), restructuring negative thoughts, stress awareness, and empathy improved interpreters' ability to cope[10]. Applying this pilot's findings to our results suggests further implementation should include medical interpreters in other areas of care as well.

The findings from our sample reflect that medical interpreters overwhelmingly want to do what is right by the patient. This includes word-for-word translation, but also attending to the less often thought-of needs of the patient, such as patient advocacy, and the medical interpreter themselves, such as ongoing medical education and psychosocial support. While many may leave the experience of attending to these additional needs out of the medical interpreter job description, we argue that these aspects of the medical interpreter role are important because they can ultimately impact the quality of communication during patient encounters. This is supported by Rhodes et al.'s Alterations Theory Model, which was originally formulated in the setting of end-of-life discussions and builds off the idea that medical interpreters face the challenge of finding a balance between their "human" and "professional" roles[11]. In this model, Rhodes et al. list complex influences on medical interpreters' decision of whether to alter communication with a patient[11]. Some influences listed include the medical interpreter's self-care skills, preparation for the discussion topic, and relationship with the patient and provider[11]. While the default is not to alter communication, there are unintentional and, though rare, intentional alterations which stem from the emotional and professional challenges faced by medical interpreters[11]. As such, protecting the quality of the communication between doctors, patients, and interpreters relies on medical interpreters being employed at institutions that are responsive to and supportive of the additional elements of the medical interpreter role.

Limitations

This study is not without limitations. Our survey, developed as part of a quality improvement project, has not yet been reproduced. However, the questions were adapted from experienced sources and piloted by a former medical interpreter, leaving us confident in its potential to be adapted and applied elsewhere. Furthermore, responses were self-reported and subject to recall bias as many questions asked for reflection on specific examples. Lastly, our convenience and purposive sampling methods are vulnerable to sampling bias. Those at the emotional extremes in regards to their employment may have been more inclined to participate over others. Additionally, this study was conducted entirely during the COVID-19 pandemic, and eligible participants could have experienced poor internet connection among other barriers to participation.

Implications

Considering medical interpreters' vital role in ensuring adequate health care access, quality, and outcomes for patients with LEP, it is in the best interest of health literacy and public health researchers and practitioners to explore and address the factors which hinder medical interpreters from effectively performing their jobs. In publishing this report, it is our hope to inspire researchers and practitioners to further delve into the experiences and address the needs of their medical interpreter populations outside of those that work in high-stress settings. We encourage readers to adapt our survey and methods to best fit their population and continue exploring this invaluable profession.

CONCLUSION

Many themes elicited in our survey are shared among published work looking at the experiences of medical interpreters in high-stress situations[5-10]. While our population of interpreters encounter difficult situations during their work, the medical scenarios they most frequently attend are much less stressful. This suggests that the literature on medical interpreters in high-stress situations may be applicable to the profession as a whole. The presence of multiple roles outside of their defined responsibility to "just interpret" and the need for more psychosocial support significantly hinder medical interpreters' ability to positively affect health care access, quality, and outcomes among populations with LEP. As such, we have identified a vital need for health literacy research and practice to further investigate medical interpreters' experiences through projects similar to that reported herein as well as other endeavors.

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