Chapter 7
Using a Translator in Integrated Care Settings

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Failure to address limited English proficiency (LEP) is one of the main reasons leading to health disparities among Latinos. Translators in the clinical setting facilitate communication between providers and patients with LEP. In this chapter we talk about the effect of choosing to utilize a translator or not and its relationship to the quality of communication, patient/physician satisfaction, and health-related outcomes.

We describe the different types of interpreters available and compare the advantages and disadvantages of each type, patient and physician preferences, and the quality of interpretation they provide. Our hope is to provide a framework from which the provider will be able to decide the form of interpretation most appropriate for each particular circumstance.

We also explore specific themes on using a translator for mental health encounters. We will provide some information relevant to everyday interpreter use and tips to make more effective use of interpreters in integrated care settings.

We then comment on different policies and systems approaches that have been tried in order to improve communication with Hispanic patients and improve interpreter utilization. Finally, we share some insights found in the literature from the translators themselves about improving communication with Latino LEP patients.

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Problems Latinos Face Related to Limited English Proficiency

Disparities in health care services between Latinos and non-Hispanic whites in the United States are well documented. Several of those disparities could be improved by having better access to interpreter services.

Latinos with fair and poor English proficiency reported approximately 22 % fewer physician visits than non-Latinos whose native language was English. The magnitude of the association between limited English proficiency and number of physician visits was similar to that for having poor health, no health insurance, or no regular source of care (Derose & Baker, 2000). Not being able to speak English proficiently also results in more difficulty obtaining appointments: 25 % of the Spanish-speaking patients reported regularly having problems getting an appointment in a primary care setting compared to 17 % among English-speakers (Welty et al., 2012). Disparities are even higher in the Emergency department, where 22 % of Spanish-speaking patients reported an interpreter was not used but should have been used (Baker et al., 1996).

Another problem leading to miscommunication is that patients and providers often misjudge their level of English proficiency. This could mislead them into believing an interpreter is not needed during an encounter. One study by Zun et al. administered standardized tests to clinic patients who stated they spoke English. 66 % of the self-proclaimed English speakers scored at or above a seventh grade reading level. Additionally, they found physicians and nurses overestimated their assessments of the patients' English competency (Zun, Sadoun, & Downey, 2006). Physicians may also overestimate their own ability to speak in Spanish, and assume they are communicating at an acceptable level (Lion et al., 2012), and the patient may choose to politely nod rather than express their difficulty following what the physician is trying to say (Haffner, 1992).

Two different studies involving pediatric and psychiatric residents found that there are conflicting perceptions around the usefulness of an interpreter. Patients often found the interpreter as helpful and expressed preference towards using them again in future visits, whereas the clinicians did not appreciate a significant impact in the interview (Cunningham et al., 2008; Kline et al., 1980).

Poor health literacy is also a major barrier to healthcare among Latinos. Leyva et al. evaluated how Latino parents with LEP understand written instructions accompanying a routinely prescribed medication for their young children. In their study of 100 participants, 22 % correctly demonstrated understanding of the dosing and frequency of the medication. Of subjects comfortable speaking English, 50 % correctly demonstrated the amount of medicine to give. Higher education and comfort speaking English were associated with better medication dosing (Leyva, Sharif, & Ozuah, 2005).

Communication during the clinical encounter is remarkably impaired for Latinos with LEP. Compared to English-speaking patients, Spanish-speaking patients made less attempts to describe their symptoms, feelings, expectations, and thoughts. Spanish-speaking patients also were less likely to receive responses from their

physicians that facilitate further discussion and were more likely to have their comments ignored (Rivadeneyra et al., 2000). It is not surprising then, that Latinos were less likely to report having their medical problems resolved at the end of a medical visit (Welty et al., 2012). Additionally, LEP Latinos reported significantly more dissatisfaction about feeling listened by the medical staff, receiving reassurance and support from their doctors, having their questions answered and receiving explanations about prescribed medications, medical procedures and test results (Morales et al., 1999). Clinicians reported difficulties eliciting exact symptoms, explaining treatments, and eliciting treatment preferences. Clinicians perceived that lack of knowledge of a patient's culture hindered their ability to provide quality medical care yet only 18 % felt they were unable to establish trust or rapport (Karliner, Perez-Stable, & Gildengorin, 2004).

Greater Spanish language fluency by physicians was strongly associated with optimal elicitation and responsiveness to patients' problems and concerns. Higher cultural competence also improved explanation of the patient's condition and patient empowerment (Fernandez et al., 2004). Patients randomized to language-concordant encounters reported higher comprehension and satisfaction than patients using usual and customary modes of interpretation (Gany et al., 2007a). When patients are assigned language-concordant physicians, they were more likely to be counseled on diet and physical activity compared to patients with language-discordant physicians (Eamranond et al., 2009). In summary, the majority of the literature indicates that the ability to speak Spanish with a LEP Latino patient, whether directly by the provider or through an interpreter, improves the quality of care.

Types of Interpreters

The art of interpreting involves many particular challenges above verbatim "word for word" translation. Interpretation requires an absolute command of two languages, in-depth knowledge of cultural context, and the ability to manipulate registers ranging from formal to casual, including slang. It also requires appropriate disposition to facilitate evoking from the LEP patient without feeling rushed or creating a burden. Interpreters are obligated to apply their best skills and judgment to preserve the meaning of what is said, including the style and register of the speech. That may include statements that appear nonsensical, obscene, rambling, or incoherent (Gonzalez, Vasquez, & Mikkelson, 1991; Hewitt & Lee, 1996).

The interpreter's presence makes the typical dyadic interaction of the clinical setting into a triad, adding considerable complexity to the social situation and generating operational and technical challenges. Aranguri et al. found that speech was significantly reduced and revised by the interpreter, and visits that included an interpreter had virtually no rapport-building "small talk" (Aranguri, Davidson, & Ramirez, 2006).

Every consultation with LEP patients requires clinical judgement as to the type of interpretation needed. The clinician needs to assess the complexity of the

interpreted encounters, as well as potential advantages and disadvantages that come with each type of interpreter. The clinician should always keep in mind the goal of having an interpreter is to optimize effective communication between provider and patient (Gray, Hilder, & Donaldson, 2011).

Untrained (Ad-Hoc) Interpreters

Interpreter guidelines warn against the use of untrained interpreters, yet the lack of uptake of interpreter services likely means that they are still often used. Gray et al. found that 49 % of all interpreted consultations used untrained interpreters (mostly family), with more used in the same day clinic setting (Gray et al., 2011). If the patient chooses to communicate in English or use a family member as an interpreter, it would be a good idea to confirm their understanding of the language by using open-ended questions, and asking them to repeat in their own words information you have provided (Gray, Hilder, & Stubbe, 2012).

One of the most significant disadvantages of using untrained interpreters is the decrease in technical quality of interpretation. Laws et al. evaluated the number or errors or omissions during clinic encounters (Laws et al., 2004). 66 % of segments in which translation should have occurred had substantial errors. In 30 % of segments, the interpreter engaged in speech unrelated to interpretation. Quality of interpretation was inversely associated with the word count per segment and, independently, whether the interpreter engaged in speech acts which did not consist of interpretation.

Many clinics use their bilingual support staff for translation, as they may share Hispanic ethnicity. They present the same technical limitations as untrained interpreters, but may still provide a cultural bridge between the patient and the clinician. They may be better situated to serve as interpersonal mediators, system mediators, educators, and advocates. They have also received training in patient confidentiality and may provide some degree of continuity for patients who are frequently seen at the clinic (Gray et al., 2012). However many studies confirm that the quality of trained interpretation, whether in-person or video conferencing, is higher than ad hoc interpretation (Napoles et al., 2010).

The evaluation of LEP psychiatric patients through an untrained interpreter can be inaccurate and misleading. The most common errors that untrained interpreters make include omission, addition, condensation, and substitution. Misinterpretation in mental health assessments can have significant consequences such as minimization of a patient's suicide attempt or exaggeration of a patient's passive suicidality (Vasquez & Javier, 1991).

Factors to keep in mind when assessing the appropriateness of an untrained interpreter include: complexity of the clinical presentation, the wishes of the patient, especially around trust and confidentiality, patient's need for advocacy or ongoing support and continuity of care, familiarity of the clinician with the patient and ad

hoc interpreter, patient's health literacy, and clinician's familiarity with the ethnic group. A family member/friend can be considered acceptable when the untrained interpreter has enough English proficiency to effectively interpret, is over 18 years of age, is known to the clinician to be reliable and in good relationship with the patient, and when the consultation is a fairly straightforward, nonsensitive one (Gray et al., 2012).

Family Members

Several elements that interfere with effective communication in the primary care setting include lack of trust, intense pressure with regard to time constraints, mismatch of agendas (biomedical versus lifeworld) and firm expectations of a specific outcome (e.g. referral, prescription) (Greenhalgh, Robb, & Scambler, 2006). Having a family member provide interpretation provides advantages such as general trust from the patient, sharing of the lifeworld agenda, and shift the power balance in the patient's favor (Greenhalgh et al., 2006). They may also facilitate continuity of care and bypass the resistance patients may have to an unknown interpreter (Gray et al., 2012).

At the same time, when using family members as translators, the clinician may need to work harder in eliciting patient's concerns and differentiating them from the concerns of the family member. In integrating care settings, having a family member translate may interfere with the accurate assessment of a patient's mental status and delay diagnosis and recognition of mild cognitive impairment and dementia, as relatives may attempt to cover their deficits, or answer questions for them. In particular, Latino women are often reluctant to reveal personal or private problems if their children interpret (Haffner, 1992).

Certain topics related to mental health also carry stigma for family members who are translating. Domestic violence will likely be missed if the family member serving as interpreter is the abuser, or may be normalized and ignored if it is congruent with the cultural norm. Men will likely have more difficulty expressing emotions such as fear and sadness in front of their wife or children, as children are commonly taught "men don't cry." Patients with high stigma around depression will be less likely to disclose that diagnosis to their family (Vega, Rodriguez, & Ang, 2010). The use of children is never appropriate, as they lack the emotional and maturity level to cope with difficult situations and sensitive content will likely not be offered or translated accurately (Gray et al., 2012).

Both patients and medical residents demonstrate the highest level of satisfaction for professional interpreters compared to ad-hoc and family interpreters. Patients were significantly more satisfied than providers with using family members and friends (85 % vs. 60 %) (Kuo & Fagan, 1999). Patients were also more concerned than providers about the ability of the interpreter to assist them after the physician visit (94 % vs. 45 %).

In-Person Trained Interpreters

In-person trained interpreters are regarded as the ideal method of translation, as they provide the highest degree of accuracy, confidentiality, and ethical behavior. However, even in locations where such interpreters are readily available, providers choose not to use them for every encounter (Schenker et al., 2007). Trained interpreters may not be used due to clinicians perceiving ad-hoc interpreters work well most of the time (Gray et al., 2011). Clinicians may also hold misperceptions of interpreters resulting in increased interview time (Fagan et al., 2003) or patients preferring family members to professional ones (Kuo & Fagan, 1999). Trained interpreters also result in additional cost, not currently reimbursed by insurance payors. However certified trained medical interpreters remain the gold standard to provide highest quality care.

Trained interpreters should always be used to obtain informed consent. Any consent gained without the use of a trained interpreter cannot be adequately informed and would not stand up in court if challenged (Gray et al., 2012). A trained interpreter would also be preferred when discussing sensitive issues, complex clinical presentations, or caring for vulnerable population, such as refugees and patients presenting with mental health problems.

Fagan et al. studied the impact of interpretation method on clinic visit length. They found that compared to those not requiring an interpreter, the duration of encounters for patients using certain forms of interpreter had longer mean provider times by 6.4 min and clinic times by over 10 min. This effect was present with both telephone interpreter and patient-supplied interpreters. In contrast, patients using a trained medical interpreter did not have significantly different mean provider times (26.8 min vs. 28.0 min) or mean clinic times (91.0 min vs. 82.4 min) than patients not requiring an interpreter. Even though the difference didn't reach statistical significance, the trained interpreter group had almost 10 min longer clinic time, which could be accounted for by the time it took for the interpreter to be called and arrive into the room (Fagan et al., 2003).

Telephone Interpreters

Using telephone interpreting services makes professional interpreters readily available. The preferred device is a dual-headset telephone, as it allows both parties to talk and hear the interpreter with the highest fidelity. Traditional phones may be used instead, but may provide limited help if the patient is hard of hearing, and it may be more difficult to assure confidentiality when the phone is set on speaker mode.

Cunningham et al. surveyed a cohort of almost 100 women after encounters with pediatric residents, where half were randomized to ad-hoc or no interpretation and the other half to a phone interpreter. The intervention cohort overwhelmingly rated telephonic interpretation as "very helpful" (94%), indicating the visit would have been "harder" without the service (98%). Significantly more intervention cohort

mothers were "very satisfied" with the clinic overall (85% vs. 57%). Almost all intervention cohort mothers (96%) reported a preference to use telephonic interpretation at their subsequent visit; however, only one-third of residents believed their patients would prefer to use the telephonic interpreter in the future. These findings are especially important, because most Latino patients will not be aware they have the right to an interpreter or that such service may be readily available in the form of phone interpretation. It should be the provider's duty to inform the patient about those services and encourage their use when LEP is suspected (Cunningham et al., 2008).

Locatis et al. found that the duration of interviews using phone interpreters was 7.4 min shorter than both video and in-person interpreting. Providers in the study liked telephone interpreter the least, considered it the most distracting method due to poor audio quality, lack of visual communication and restriction on the use of their hands (Locatis et al., 2010). These results differ from the earlier study by Fagan, who reported using telephone and ad hoc interpreters both increased the length of the interview by a mean of 6.4 min compared to those who did not need an interpreter (Fagan et al., 2003).

Video Conferencing Interpreters

Napoles et al. surveyed clinicians to compare quality of interpretation, visit satisfaction, degree of patient engagement, and cultural competence during visits using three different methods of interpretation. The quality of interpretation for in-person and video conferencing modes were rated similarly in all categories; both methods were superior to ad-hoc interpreting. Video conferencing only scored lower than in-person interpretation for cultural competence. The authors concluded that video conferencing increases access without compromising quality and that cultural nuances are better addressed by in-person interpreters (Napoles et al., 2010).

Locatis et al. did not find a significant difference in the duration of video interviews compared to in-person interpreting. Providers and interpreters in this study showed a distinct preference for video over phone interviews. Both rated in-person interpreting significantly higher in quality than video conferencing (Locatis et al., 2010).

Readily available handheld devices may be appropriate for remote interpreting. Wofford et al. studied the impact of audio and video technology included in handheld devices. Most patients rated overall quality of videoconferencing as good/excellent. Most patients favored using videoconferencing during future visits. The 18 clinicians that participated in the study reported similar results.

Remote Simultaneous Medical Interpreting

Remote-simultaneous medical interpretation (RSMI) is performed by interpreters trained in simultaneous interpretation. The interpreters are linked from a remote site by headsets worn by the clinician and patient. Compared to in-person consecutive

interpretation, RSMI demonstrated an increase in the number of physician and patient utterances in the visit, improved quality of interpretation, and higher preferences by physician, interpreter, and patients (Hornberger et al., 1996).

A more recent study by Gany et al. found that patients randomized to RSMI were more likely than those with usual and customary methods of interpretation to think doctors treated them with respect. RSMI resulted in fewer medical errors and was faster than all other methods of interpreting. Patients randomized to RSMI were also more likely to think the interpreting method protected their privacy (Gany et al., 2007a, 2007b).

Remote simultaneous interpreting is often employed at the United Nations and at major international conferences. However in the medical setting, superior clinical outcomes of RSMI are still to be determined (Gany et al., 2011). RSMI is not readily available in clinical practice at this time, likely due to higher technical complexity, higher implementation costs including headset equipment, and lack of reimbursement for interpreting services.

Utilization of Interpreters in Clinical Practice

Trained interpreters are underutilized despite the advantages and quality improvement with professional interpretation. A survey of pediatric residents serving a population in which 10–20 % are Spanish-speaking with LEP revealed they rarely use professional interpreters. 75 % of nonproficient residents reported use of hospital interpreters "never" or only "sometimes." Instead, they tend to rely on their own inadequate language skills, seek interpretation from their proficient colleagues, or avoid communication with Spanish-speaking families with LEP. Proficient residents estimated that they spent a mean of 2.3 h/week interpreting for other residents (Burbano O'Leary, Federico, & Hampers, 2003). Schenker et al. found that despite the availability of on-site professional interpreter services, charts of hospitalized LEP patients were less likely to contain full documentation of informed consent for common invasive procedures (53 % vs. 28 %) when compared to English-speaking patients (Schenker et al., 2007).

Interpreter utilization varies depending on the physician's level of Spanish proficiency: those with low proficiency report frequent use of ad-hoc interpreters for all information-based scenarios. For difficult conversations and procedural consent, most used professional interpreters. Medium proficiency physicians reported higher rates of using their own Spanish skills for information-based scenarios, lower rates of professional interpreter use, and little use of ad-hoc interpreters. They still relied on trained interpreters for difficult conversations. Those with high-level Spanish proficiency almost uniformly reported using their own Spanish skills (Diamond, Tuot, & Karliner, 2012).

Guidelines have emerged in order to direct the decision of whether to obtain an interpreter and which type may be most appropriate, as using trained interpreters may not always be possible due to cost and logistics involved. The judgement of

when to use trained versus untrained interpreters is a complex decision that needs careful consideration and evaluation of all the issues involved: clinical, ethical, practical, social, and financial (Gray et al., 2012).

Recommendations to improve communication with LEP start at the policy level for every practice. Practices should have an idea of the percentage of LEP patients they serve and therefore have policies that will allow them to effectively respond to those needs. Recommendations include assigning a budget for employment of interpreters, allocating longer encounter times for LEP patients, having a medical record capable of flagging which patients need to be seen with an interpreter, having patient information available in common languages of the practice, and providing staff with training on how to determine the need for an interpreter and how to work with one (Gray et al., 2012; Roat & CAFP, 2005).

When asking about language preference, clinicians should avoid leading questions, or nonverbal language hinting that using an interpreter would be burdensome to them or the practice. Rather than asking patients whether they need or want an interpreter, it is recommended to ask: "In what language would you prefer to receive your health care?" (Roat & CAFP, 2005).

Additional factors that will make a case for obtaining a trained interpreter include the complexity of the clinical presentation, the sensitivity of the content to be discussed (applies to all mental health encounters), the vulnerability of the patient (refugee or background that includes high likelihood of trauma), and urgency of the situation (which may limit available options) (Gray et al., 2012; Roat & CAFP, 2005).

Interpreter Use and Mental Health

Diagnostic Challenges During Evaluation in Patient's Non primary Language

The common errors that untrained interpreters make during primary care encounters may present severe unintended consequences in the integrated care setting. Misinterpretation has a marked impact on the quality of care, such minimization of a suicide attempt or conversely exaggeration of suicidality (Vasquez & Javier, 1991). Untrained interpreters in the patient-provider relationship can also lead suboptimal rapport building and prevents a strong therapeutic alliance required for management of behavioral health.

Interviewing patients in a language different than their native one may have greater impact on the quality of psychiatric care than in other specialties. Psychiatric evaluation hinges on observations from a detailed history and many key diagnostic symptoms that may only be obtained through the clinical interview, since laboratory and imaging data have limited added value. Additionally, patients are less likely to disclose psychological symptoms compared to physical symptoms (Bischoff et al., 2003).

A literature review by Bauer et al. elaborates on ways in which language barriers may interfere with the mental status examination. Disorders of speech and language such as aphasias, pressured speech, and neologisms may be missed. Abnormal thought processes including flight of ideas, disorganization and tangentiality, and abnormal thought contents such as delusions, grandiosity, obsessions, and magical thinking may not be identified (Bauer & Alegria, 2010).

Psychiatric assessments performed without interpreters tend to have more closed-ended questions and elicit brief responses, limiting the assessment of spontaneous thought content (Drennan & Swartz, 2002; Marcos et al., 1973a). Furthermore, when a patient with LEP tries to communicate in English, speech delays may be confused for thought blocking, word finding difficulty and delayed thought process (Marcos et al., 1973b). The quality of neuropsychological testing may also be affected for LEP patients. Interpreter use may significantly improve scores for verbally mediated tests such as Vocabulary and Similarities (Casas et al., 2012).

During psychiatric evaluations, ad hoc interpreters make more errors when translating psychotic content. When patients provided lengthy or convoluted replies, omissions are especially likely, as interpreters may have difficulty registering and remembering a patient's statement if they cannot discern its meaning (Price, 1975). Ad hoc interpreters are less likely than professional ones to report they cannot follow the patient's abnormal thought process (Drennan & Swartz, 2002). Trained interpreters may also bring to the provider's attention subtle signs of depression such as poor eye contact, decreased spontaneity, delayed responses and restricted affect.

Use of professional interpreters is associated with increased disclosure of traumatic events and psychological symptoms, as well as increase psychiatry referrals compared to ad-hoc interpreters (Eytan et al., 2002). Spanish-speaking patients seen with an interpreter for an initial therapy interview reported that they found they felt understood and helped, and subsequently wanted a return visit. In contrast, the therapists felt they provided less help to patients seen with interpreters and very few thought those patients wanted to return (Kline et al., 1980).

The Impact of Cultural Differences on Mental Health Encounters

Language barriers may also have important effects in mental health care and treatment outcomes beyond those of impaired communication and diagnostic accuracy. Language discordance may hinder the identification of important factors such as stigma, shame, patient's explanatory model of illness, patient's acceptance of the diagnosis and treatment, and fostering of a therapeutic alliance (Bauer & Alegria, 2010).

Patients reporting higher levels of perceived stigma are less likely to disclose their depression diagnosis to their family and friends and also less likely to be taking

antidepressant medication. Patients with high stigma are less likely to attend scheduled appointments and follow through with referrals to mental health providers (Vega et al., 2010). Interpreters in integrated care settings may have the unique opportunity to serve as cultural ambassadors for mental health concerns. They may help providers understand more about the common preconceptions Latinos have around psychiatric diagnoses and psychotropic medications.

Villalobos found that use of interpreters in integrated behavioral health care patients did not have a significant impact on patient's rating of the therapeutic alliance. However, patients expressed a strong preference for bilingual providers, citing greater privacy, sense of trust, and accuracy of communication as the main advantages (Villalobos et al., 2015). Among older Latino clients receiving mental health services, the degree in which the health care organization matches the cultural needs of the patient had a predictive effect in treatment outcomes (i.e., reduction of symptomatology) independent of treatment (Costantino, Malgady, & Primavera, 2009).

Treatment preferences related to Latino culture should also be taken into consideration if treatment is to be successful. Compared to non-Hispanic white responders, Spanish-speaking Hispanic but not English-speaking Hispanic respondents had a lower preference for antidepressant medications. Older age and history of depression were found to predict for antidepressant-inclusive treatments. All responders who endorsed a biomedical explanation of depression demonstrated preference for antidepressant-inclusive options (Fernandez et al., 2011).

Alternative treatments should be discussed with every patient. Sleath et al. found that 36 % of patients reported talking with a minister or other religious person about feelings of depression or sadness. 17 % of patients had used herbal remedies or nonprescription medications, and 5 % had seen a curandero for feelings of depression or sadness. Overall, Hispanic ethnicity and language were not significantly related to patient use of alternative treatments for depression (Sleath & Williams, 2004).

Clinical Pearls for Interpreter Use

The decision about whether an interpreter is needed is often made by the patient or by his or her relatives. However, some patients can speak some English but are not fluent enough to for appropriate communication during an encounter, or may not be aware that an interpreter is available. It falls to the provider to suggest an interpreter be used and subsequently how to utilize the interpreter, particularly if discussing important test results or treatment options such as surgery or other treatments (Juckett & Unger, 2014).

Before meeting with the patient, review with the interpreter the purpose of the interview. Mention any potentially delicate or distressing issues that will be covered and ask the interpreter if there are any specific cultural factors that may have direct bearing on the interview. If using an untrained interpreter, the provider should emphasize the absolute need for confidentiality and the requirement to translate as precisely as possible what is said.

Seating should be arranged as a triangle, allowing patient and doctor to look at each other directly and for the interpreter to be perceived as neutral. Talk directly to the patient, addressing him/her in second person. Appear attentive when patient responds and respond to patient's nonverbal cues. Keep control of the consultation. Feel free to stop the patient if he/she is not allowing enough time for effective translation.

During physical examinations, it's preferable to have the interpreter present, but the patient should be asked for his or her preference. If the interpreter will not be present, extra care needs to be taken to explain beforehand to the patient what will happen during the examination.

For psychiatric interviews, the interpreter should be told that the encounter will be longer than average and more emotionally challenging. If psychosis is suspected, the interpreter should be told that the patient may say things that don't make immediate sense. Abnormal mental status findings may be more accurately evaluated by using simultaneous interpretation. This method will make it easier for the interpreter to keep up with rapid speech, tangentiality, disorganization, flight of ideas, and looseness of associations. It is strongly preferred to keep using the same interpreter for future encounters whenever possible, more so if trauma narratives have been discussed.

Consider discussing a strategy in case the patient needs to get in touch with you after the encounter. Patient may experience side effects of medications, worsening of symptoms, or the need to reschedule an appointment. Reassure the patient that an interpreter can be obtained for post-visit encounters, such as by phone or at an urgent care setting if available.

Closing the Cultural and Language Gap

Improving Provider's Spanish Level Proficiency

Offering options for physicians serving LEP Hispanic populations to improve their Spanish may have significant impact in patient care. Physician self-rated language ability and cultural competence are independently associated with Hispanic patients' reports of care. Greater language fluency was strongly associated with optimal elicitation and responsiveness to patients' problems and concerns. Higher cultural competence was associated not only with higher elicitation and responsiveness, but also to improved explanation of the patient's condition and patient empowerment (Fernandez et al., 2004).

The first step towards improvement is having a reliable measurement of non-English language proficiency. Using self-report measures can result in providers overestimating their proficiency. Standardized testing can also provide immediate benefits: after being tested on their Spanish skills, nonproficient residents reported a decrease in the comfort level using Spanish in straightforward clinical scenarios from 56 to 39% (Lion et al., 2012). Such awareness may be used to increase

motivation for more frequent use of interpreters and may encourage the provider to pursue further improvement of his/her Spanish proficiency.

Proposals for improving medical care towards LEP patients with are becoming available at all levels. Escott et al. describe the development, organization, and evaluation of a workshop for medical students designed to develop their skills using trained bilingual simulated patients (Escott, Lucas, & Pearson, 2009). Surveys of fourth year medical students in a US university hospital found that 68 % had at least rudimentary Spanish skills. 85 % of them reported that they would probably or definitely participate in further individual language training, 70 % expressed at least possible willingness to have their Spanish formally evaluated, and 80 % predicted that it is at least possible that they will use their Spanish as attending physicians (Yawman et al., 2006).

Language immersion training is an option for some residency programs and faculty. After 2 weeks of language immersion, pediatric faculty demonstrated an increase from their baseline proficiency score of 28 % to a post-intervention score of 55 %, which was sustained at 6 and 12 months (Barkin et al., 2003). In one family medicine program, interns are offered a pre-residency 10-day immersion program at a nearby language institute, which includes thrice-monthly classroom instruction and personal instruction during continuity clinics by a teacher/translator for a year. All residents demonstrated significant improvement in Spanish language proficiency thru independent examiner testing (Valdini et al., 2009).

A 10-week medical Spanish course for pediatric ED physicians was associated with decreased interpreter use and increased satisfaction among Spanish-speaking-only families. The course was conducted for 2 h weekly. The class emphasized medical history taking and Hispanic cultural beliefs. Surveys found post-intervention families were significantly more likely to strongly agree that the physician was concerned about their child, made them feel comfortable, was respectful, and listened to what they said (Mazor et al., 2002).

Improving Use of Interpreters

In addition to improving cultural competency and provider's Spanish language skills, working effectively with interpreters may also require specific training. A survey of clinicians in outpatient settings found that previous training in interpreter use was associated with increased use of professional interpreters and increased satisfaction with medical care provided (Karliner et al., 2004).

In an acute psychiatry ward, a standard training package and a policy promoting interpreter use improved communication opportunities. The intervention included: (a) a survey of the multilingual skills of 80 clinical staff; (b) recording of patients' ethnic background and proficiency; (c) tracking of communications with patients in a language other than English and (d) staff training and active encouragement in interpreter use. Following the intervention, interpreter bookings and booking duration increased significantly (Stolk et al., 1998).

Interpreter Training, Standards, and Certification

Despite documented risks, the U.S. health care system lacks a required standardized certification for medical interpreters. In her recent commentary, VanderWielen makes a case for standardized certification for medical interpreters (VanderWielen et al., 2014). She illustrates lessons learned from the Federal Court system, where studies revealed interpreter's politeness could affect juror perception of witness testimony, and individuals had been found wrongfully convicted on the basis of inaccurate interpretation. As a result, the U.S. Congress passed the Federal Court Interpreters Act, which mandates that U.S. courts institute a system of qualified interpreters for judicial proceedings. Certified court interpreters must pass a written and oral examination.

For medical interpreters, the only national requirement is to demonstrate satisfactory abilities to interpret in a medical setting. Such a vague definition allows current use of family members and other ad hoc interpreters. In healthcare, two organizations have created certification processes for medical interpreters: the National Council on Interpreting in HealthCare (NCIHC) and the International Medical Interpreters Association (IMIA). These certifications include oral and written examinations to assess health care terminology, linguistic proficiency, interactions with health care professionals and cultural awareness and responsiveness (VanderWielen et al., 2014).

The NCIHC and IMIA provide the code of Ethics by which certified medical interpreters abide. Stipulations include protecting confidentiality, accurately rendering the message, taking into consideration its cultural context, striving to maintain impartiality, and refraining from projecting his/her own personal biases and beliefs. They also encourage advocacy when the patient's health, well-being, or dignity is at risk.

Insights from Interpreters

Medical interpreters offer additional insights into the complexities of translating for Latinos with LEP. Highly educated and affluent Latinos have attitudes and beliefs about healthcare reasonably comparable to those of similarly educated and wealthy Americans. Translating to Latinos who are poor, come from rural areas, have little or no schooling, and have little or marginal fluency in English pose additional challenges. Providers must recognize that the situation is bicultural and not merely bilingual (Haffner, 1992).

Latino family members often try to hide the seriousness of medical situations from ill relatives, especially if the patient may be dying. Family members feel providing encouragement is more beneficial and prefer that the doctor also convey hope, even if it is unrealistic. The head of the family is expected to make the decisions regarding any family member. These desires and cultural practices are directly

opposed to the Western notion of informed consent. Latinos feel they should agree with physicians out of politeness and respect, even when they really disagree or do not understand the issues involved (Haffner, 1992).

Hudelson identifies two additional domains where physicians and patients were likely to differ (Hudelson, 2005):

Ideas About the Patient's Health Problem

Patients may have their own ideas about what caused certain medical problems, especially for psychological diagnoses. They may experience getting a mental health diagnosis as a sign of defection and disbelief on the part of the physician. They may attribute their problems to spirits or evil eye, but feel ashamed to reveal these beliefs and their recourse of traditional healing practices to doctors, for they me be perceived as ignorant. They may feel their illness was God's will, and only God could decide to heal them. They may hide beliefs and treatment noncompliance from doctors for fear of ridicule.

Expectations of the Clinical Encounter

Appointment scheduling systems may not exist in many home countries of LEP Latinos. They are seen using a walk-in system and would normally seek the doctor only when feeling sick, rather than at previously scheduled time. This difference translates in patients often arriving for appointments too early, too late, or not at all, which often causes frustration to physicians. Patients may expect an authoritative, high-tech medical encounter, usually ending with blood or imaging studies, and not something that could be obtained over the counter. They are not familiar with the bio-psycho-social model and may be weary of answering questions about their personal life, migration, or traumatic experiences.

Interpreters are usually reluctant to offer insight or suggestions to the provider without first being asked. It is the physician's role to initiate such discussions and clarify if strict translation is expected, and the amount of cultural brokering that would be welcome (Norris et al., 2005). Clinicians may be unaware of the emotional toll that interpretation of bad news can take on the interpreter. Some interpreters feel that to use them as only a conduit, and not think of them as a member of the health care team, does them a disservice. Debriefing after a difficult or trauma-related conversation may be helpful for the interpreter (Norris et al., 2005).

Although patient and provider differences in social and cultural background and education create the potential for misunderstanding, it is the lack of awareness of these differences that is at root of the problems (Hudelson, 2005). When important communication problems occur, they are more commonly due to problems understanding the social construct of illness from the perspective of the patient, than a result of poor translation in the linguistic sense (O'Neil, Koolage, & Kaufert, 1988).

Summary

Medical interpreters facilitate communication between providers and Hispanic patients with Limited English Proficiency (LEP) who face multiple health disparities in the U.S. The art of interpreting involves many particular challenges beyond word for word translation. The clinician needs to assess the complexity of every consultation with LEP patients and make a clinical judgement as to the type of interpretation needed. A trained interpreter should always be used to obtain informed consent and would also be preferred when discussing sensitive issues, complex clinical presentations or caring for population with mental health problems. Despite their advantages in accuracy and confidentiality, professional interpreters are underutilized in clinical practice. Patient's limited English proficiency and different cultural background pose unique diagnostic challenges during a mental health assessment and treatment. Interpreters may also function as cultural brokers to help bridge these differences. Several programs are becoming available to improve use of medical interpreters, and increase Spanish fluency of clinicians serving significant Latino population. For medical interpreters, the only national requirement is to demonstrate satisfactory abilities to interpret in a medical setting, which allows for untrained interpreters and family members to be used. The National Council on Interpreting in HealthCare (NCIHC) and the International Medical Interpreters Association (IMIA) provide certification for medical interpreters, which includes oral and written examinations. Interpreters also offer insights for clinicians to improve their communication with LEP Latinos.

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