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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?

1.2. Data analysis

After all the interviews and focus groups were transcribed, the authors analyzed the data through constant comparative analysis and its corresponding coding procedures [25,26]. Interpreters' emotional support first emerged as a major theme in the open coding process. We then adopted focused coding and independently reviewed all transcripts to identify the providers' narratives about interpreters' emotional support. We coded emotional support through the providers' perspectives, which allowed us to explore providers' complex and diverse understanding of interpreters' emotional support. Finally, we adopted axial coding and explored (a) how interpreters' emotional support was conceptualized by providers, and (b) what are the consequences of interpreters' (lack of) emotional support.

In all phases of the coding, each theme proposed by one investigator was then probed by the other in a second pass through the data. We then combined similar findings; however, claims proposed by one investigator but not corroborated by the other were discussed in detail with further consultation of the data for evidence to support or contradict the claim. Our final analysis resulted in a list of recurring themes of emotional support.

Focus groups and in-depth interviews may lead to variations in participant dynamics and discussions [27]. The combination of data collection methods, however, allows us to obtain richer data by including more perspectives from participants with diverse expertise and communicative needs. We did not find any thematic differences concerning emotional support between these two types of data.

Finally, although we do find some expectations to be emphasized by one specialty more than others, we have avoided explicitly making this correlation. The claim of correlation between the providers' various specialties and their expectations is best explained through large-scale quantitative analysis. We plan to examine such correlations in our future studies.

1.3. Transcription

The texts are CAPITALIZED to reflect the speakers' emphasis. We denote the providers' expertise with abbreviated superscripts after their pseudonyms. Obstetrics-gynecology is abbreviated as $^{OB/GYN}$, emergency medicine as ^{EM}, oncology as ^{ONC}, nursing as ^{NUR}, and mental health as ^{MH}.

2. Results

We identified four recurring themes of providers' understanding of interpreters' emotional support, which highlight the complexity of interpreters' roles and functions in health care settings.

2.1. Embodied through physical presence

Many providers emphasized that interpreters' emotional support is implied by their simple presence. A patient can be comforted by having an interpreter there. Ginger$^{OB/GYN}$ noted, "It's much easier to relate to someone who speaks your own language and maybe make you feel more comfortable. And anytime you can have a patient feel more comfortable and more relaxed, I think it's a good thing." Interpreters are not necessarily viewed by providers as active agents in providing support to the patient. This understanding of interpreters' emotional support allows interpreters to remain as conduits. Gemma$^{OB/GYN}$ explained, "[An interpreter is] a relayer of information. I think it's also a source of comfort." Interpreters' emotional support is offered as they help the patient understand the situation and to communicate with the providers.

From this perspective, it would seem that both telephone and on-site interpreters can provide emotional support. However, several providers used telephone interpreters to contrast on-site (professional and ad hoc) interpreters, illustrating why telephone interpreters could not offer emotional support the way on-site interpreters can. Cara^{NUR} commented, "It's a matter of eye contact, it's a matter of body habitus, [...] sometimes, the family NEEDS to be able to make eye contact, and feel like they are having some human CONNECTION." Cecil^{ONC} explained that when disclosing poor prognosis, "I want somebody stands in there WITH me. To look me in the face. [...] I just couldn't use a telephone [interpreter]." Providers also noted that information became succinct and focused on medical issues when working with telephone interpreters. In fact, many providers emphasized that they would not use telephone interpreters if they believed emotional support is needed.

Some providers, however, talked about the physical presence of an on-site interpreter as a form of the providers' emotional support to patients. Nacia^{NUR} explained,

> The translators are providing a service that a [telephone interpreter] can't give. And that's that personal: 'Your nurse is interested in you. [...] She's there FOR YOU. She'll contact [the interpreter] if you all are not communicating well.' So [the on-site interpreter] gives a personal touch to that.

Nancy^{NUR} echoed, "It shows that you're caring and you brought somebody else in, for them to understand." On-site interpreters' physical presence is symbolic, representing a caring gesture from the providers. As a result, an on-site interpreter is better than a telephone interpreter because it implies providers care enough to go through the troubles to find an on-site interpreter.

2.2. To be human but also professional

In the conduit role, an interpreter may be perceived to be emotionless or uncaring. Carmen^{ONC} explained, "It makes everybody in the room uncomfortable when a human being is acting like a computer. [...] there's NO body language, there's NO emotions." Other providers also made similar comments, suggesting that providers were aware of interpreters' practice in showing little emotion but viewed such performance as failing to facilitate humane care.

This is an important critique to the conduit model because the providers recognize that interpreters in general, apart from their institutional roles, also are human beings. Candice^{ONC} noted, "It's okay to put their hands on the patient to show support. I don't want them to be a non-human being in the room." Some providers also noted interpreters' ability to offer emotional support both inside and outside of medical encounters. For example, Curtis^{ONC} mentioned a case where both the mother and the child were diagnosed with cancer. He explained, "The translator has become very attached and would visit the patient before I go into the room and she'd visit them afterwards. I've seen her visiting when I don't need her." Both Curtis^{ONC} and Claudia^{ONC} agreed that the interpreter's volunteer visits were helpful to the mother.

Interpreters' emotions and emotional support, however, are not without limits. Ed's^{EM} commented, "I like the interpreters that are compassionate and empathetic in the appropriate situations." Many mental health providers noted that it is important for interpreters to conceal emotions during the treatment process even though it is natural to be shocked by some of the stories or behaviors of their patients. The challenge faced by interpreters is to find a balance between these two roles (e.g., human beings vs. professionals). Carmen^{ONC} commented,

> Is there an in-between? I guess that's what we are saying. You don't want [the interpreters] to be the person's friend and you don't want [them] to hold their hands and give them hugs but you want them to still be a human and act like they care.

2.3. Extension to providers' care

2.3.1. Establishing effective provider–patient communication

Providers in our study noted that when patients feel comfortable, they may be more willing to provide important information or be receptive to providers' care. For example, Mandy[MH] commented, "When [interpreters] get on one on one terms with the patient, with just the small talk, they can sometimes tell you WAY MORE than if you've had a formal communication with everybody in the room."

Providers' sense of effective communication, however, often centers on patients' willingness to accept their care. For example, Michael[MH] noted, "If [the patients] are connecting with the interpreter and the language gives them comfort, I want to connect myself with the interpreter if that's going to give us some kind of benefit to that patient that will improve their outcome." Interpreters' emotional support allows them to enter into patients' private worlds (e.g., patients may volunteer certain information), to which the providers may not be privy, and provide additional treatment opportunities.

Other providers talk about how interpreters' emotional support allows the interpreters to become trusted agents to the patients. For example, Cecil[ONC] explained,

> Usually the interpreter has aided me in assuring the patient. "Yes. [The procedure] is going to hurt, but yes it is really necessary." [...] I don't know what they're saying. The interpreter doesn't really say what he or she saying. [.] The patient is relaxed about what I'm gonna do and says, "Okay, it ok and I'll tolerate it."

From this perspective, interpreters are active agents in utilizing their relationship with the patients to pursue providers' agendas. As a result, some non-conduit behaviors (e.g., screening information or encouraging patients to accept the providers' suggestions) are considered acceptable and appropriate.

2.3.2. Providing culturally sensitive care

If providers want to be perceived as supportive to patients, interpreters need to relay their attitudes to the patients. Grace[OB/GYN] explained, "If I walk in and I like my patient's shoes, I'd say, 'OH, I LOVE your shoes! They are so cute' [high cheery tone]. [...] some of [the interpreters] go like, 'Yeah, haha.' I'm like, 'NO! Tell her! I like her shoes!!'" Providers, thus, may view interpreters' emotional support as a reenactment of their own supportive attitudes.

Because providers' identities (e.g., an empathetic provider) are mediated by the interpreters, the interpreters inevitably blend their own empathy with that of the providers. As a result, the interpreters' and providers' emotional support are deeply intertwined. Providers were aware of the difficulties in offering emotional support in bilingual health care. For example, providers may feel inadequate in expressing empathy through the interpreter. Grace[OB/GYN] explained,

> [If] I have a patient who came in and the baby was dead. To have to share that information through a translator is BETTER than my ability to try to stumble through. But it always, I think, takes away your ability to empathize with the patient.

Alternatively, interpreters may feel that the emotional support or empathy offered by providers is not culturally appropriate in certain situations. Gregory[OB/GYN] noted, "We have the empathy. [The interpreters] find it difficult sometimes, to translate that empathy that we are talking to the patient, to translate that in their language" because several interpreters informed him that their cultures expect straight talk and facts in those situations. For example, whereas a miscarriage is a tragic event that requires emotional support in the U.S. [28], people from other cultures may experience it as a common event that does not carry the same disheartening overtone [29]. As a result, offering empathy may be inconsistent with their cultural norms.

Providers rely on interpreters to offer culturally sensitive care and empathy. Interpreters' cultural and linguistic expertise can be extremely valuable to providers to understand a patient's distress. For example, Celia[ONC] explained, "[Once I noticed] the mother was so horrified about the child losing hair. [The interpreter] explained to me, in this particular culture, hair is regarded as a wedding veil, and you don't cut your hair. That was very helpful to me to understand that reaction." Interpreters' emotional support, thus, takes an interesting turn. Interpreters' cultural knowledge serves as a source of information for providers, allowing providers to act on such knowledge and provide culturally sensitive care.

2.4. Potential risk to quality of care

2.4.1. Risk to provider–patient bonding

The triadic relationship in bilingual health communication implies an inherent tension: the growth of one relationship may threaten other relationships. Several providers appeared ambivalent about interpreters' emotional support. Cordell[ONC] noted, "I think that we in oncology provide emotional support all the time. You have to support your patient through difficult decisions. I think it's an important part. That's why I'm uncomfortable having the third party do that." Candice[ONC] explained that she likes the conduit model of interpreting because "the parents are looking at ME and reading MY nonverbal and MY emotions. And they are bonded to me, not the interpreter." In short, providers may hold negative views about interpreters' emotional support if it threatens provider–patient relationship, which they believe to be the primary relationship in bilingual health care.

2.4.2. Risk to therapeutic objectives

Providers also showed strong concerns for interpreters' emotional support if they suspect that it may hinder the therapeutic process. Mira[MH] noted,

> You don't want interpreters to interact with the patient so much that the patient begins to TRUST the interpreter more than the physician. [...] If the patient opens up so much to the interpreter that they become so emotional or have an emotional breakdown. That can interfere with the treatment process tremendously.

Several mental health providers shared similar attitudes, noting that the provider–patient relationship is not just about bonding but serves therapeutic functions. As a result, they were particularly concerned about how interpreters' relationship with patients may impact the therapeutic process.

The types of interpreters may have different impacts on providers' therapeutic objectives. For example, several providers argued that although family interpreters can be an important source of support to the patient, they often interfere with the interaction by interjecting their own opinions or making decisions for the patients. In contrast, Mira[MH] commented that a telephone interpreter is not acceptable because her patients "can be paranoid, and the presence of a voice without knowing who the person is can make them even more paranoid and unwilling to open up."

It is important to note that the risk to provider–patient bonding and the risk to therapeutic objectives are conceptually distinctive. The former centers on interpersonal relationship (i.e., provider–patient relationship should be the primary relationship) whereas the later focuses on the providers' therapeutic objectives (e.g., whether interpreters' emotional support interferes with providers' treatment plans). These two categories, however, are not mutually exclusive.

2.4.3. Risk to malpractice litigation

Curtis[ONC] commented, "With the medical malpractice climate in the US, it's probably something in the back of every physician's mind somewhere, almost all the time." It is important to note that all providers, regardless of specialty, felt strongly about interpreters not offering medical opinions in the guise of emotional support. For example, Ginger[OB/GYN] explained,

> I don't like it when we are in the middle of trying to explain how epidural works and they are like, 'Well, when I have my baby. Let me tell you about it.' [...] If they want to add any of their personal thing, make a DISTINCTION between when we are done talking and the medical translation part is finished and when it's just a conversation between the two people.

Because interpreters may speak for the providers or speak as themselves, providers emphasized the importance of separating the interpreters' emotional support and the providers' medical opinions. Ginger[OB/GYN] explained that it is okay for interpreters to chitchat with patients but "when I am not talking to the patient, I would hope the patient would know that none of it is coming from me." Providers often cited malpractice litigation as a potential risk if they believe that a patient can be uncertain about whether the specific information comes from the provider or the interpreter.

3. Discussion and conclusion

3.1. Discussion

To the providers in our study, 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. Our findings echo with several recent studies that have argued that medical interpreters are active agents [15,23]. In addition, we explore the complexity and dilemma for interpreters to offer emotional support in health care settings.

Our findings highlight several issues that have not been systematically examined in the literature. First, it is important to recognize the potential risks of offering emotional support. Although providers in our study valued interpreters' emotional support, they also showed ambivalence and/or a negative attitude toward interpreters' emotional support. For example, although family members may provide more emotional support, researchers have found that they actively influence the patients' therapeutic and decision-making processes [12,30], a concern shared by many providers in our study. The strength of interpreter–patient relationships also may threaten patient–provider bonding. Although an interpreter may feel that not having some small talk can be perceived as being rude [5], casual interactions with patients with mental illness may lead to serious clinical consequences.

Second, the current study highlights the importance recognizing that different types of interpreters are not interchangeable. Due to the convenience and cost-effectiveness of telephone interpreting services, health care organizations may believe that offering telephone interpreting services is a sufficient replacement for on-site interpreters. However, our findings highlight the non-interchangeable aspects of on-site and telephone interpreters. In addition, in certain situations (e.g., a patient with paranoia), telephone interpreters may compromise the therapeutic process. Our findings suggest that the use of telephone interpreters is an inadequate replacement to on-site interpreters in situations that emotional support is considered an essential part of care.

Third, the dilemma of viewing interpreters as passive conduits versus active agents is still salient for providers. By viewing interpreters' physical presence as emotional support and as objects that can be offered as a gift (e.g., as a caring gesture), providers in our study echoed the prevalent ideology of viewing interpreters as conduits [31]. However, they also expected interpreters to be more than conduits. Interpreters need to be human and compassionate. They need to be proactive in offering culturally sensitive care by noting issues (e.g., nonverbal cues) that providers may fail to notice. From this perspective, providers shifted their expectations of interpreters from being neutral conduits to active agents in providing culturally appropriate and sensitive care.

Fourth, providers' conceptualizations of interpreters' emotional support implies an institutional hierarchy and a functional perspective that may motivate interpreters to be biased toward providers. Past studies have noted that interpreters are fearful to contradict providers due to their lack of job security [5,32]. In this study, providers viewed interpreters' emotional support as an additional means for actualizing their therapeutic objectives: interpreters' emotional support is expected to back up providers' therapeutic objectives (rather than the patients' emotional needs or decisions). However, having interpreters seek information or consent that providers otherwise may not obtain presents ethical problems to patient privacy and consent process. Taking such a utilitarian view of interpreters' emotional support can be dangerous. When interpreters are motivated to bias toward the providers and to accomplish the providers' objectives, the patients' emotional needs and quality of care may be neglected or ignored.

3.2. Conclusion

Providers' and interpreters' emotional support are intertwined and may be difficult to separate. Although providers in our study believed interpreters should not interact with patients in such a way that the providers' and interpreters' voices blend together, they also viewed interpreters' emotional support as the reproduction of their emotional support for patients. Because providers' and interpreters' voices are presented as one through interpreters' performance [14,16], providers' expectation to draw a clear line between their own voice and that of the interpreters' may not be realistic. Instead, a more realistic and effective way of conceptualizing emotional support in bilingual health care is to consider providers and interpreters as allies, complementing each other to support the patients' emotional needs and acting as joined forces to reinforce and complement each other. They do not necessarily do the exact same thing but function interdependently to form a synergy to achieve optimal care.

3.3. Practice implications

Interpreters need to recognize that emotional support carries clinical consequences and therapeutic implications in health care settings. Their emotional support may impact the provider–patient relationship and the providers' therapeutic objectives. In addition, interpreters should be aware that providers also rely on them to provide (culturally appropriate and sensitive) emotional support to the patient, which highlights the importance of giving medical talk and rapport-building talk equal attention in interpreter-mediated medical encounters.

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