Interviewing patients using interpreters in an oncology setting: initial evaluation of a communication skills module

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Received 4 March 2009; revised 8 April 2009; accepted 21 April 2009

Objectives: To develop a communication skills training (CST) module for health care professionals, particularly in the area of oncology, on how to conduct interviews using interpreters and to evaluate the module in terms of participant’s self-efficacy and satisfaction.

Methods: Forty-seven multi-specialty health care providers from the New York Metropolitan Area attended a communication skills module at a Comprehensive Cancer Care Center about how to conduct clinical interviews utilizing interpreters. The development of this module was on the basis of current literature and followed the Comskil model previously utilized for other doctor–patient CSTs. Participants were given pre- and post-surveys to evaluate their own confidence as well as the helpfulness of the module.

Results: On the basis of a retrospective pre–post measure, participants reported an increase in their confidence about interviewing patients via translators. In addition, at least 80% of participants reported their satisfaction with the various components of the module by either agreeing or strongly agreeing with the different statements.

Conclusions: We have developed a module that trains clinicians in effective collaboration with professional medical interpreters and shown its ability to increase the confidence of clinician’s to work with limited English proficiency patients. Our approach intends to minimize not only the language barrier but also the cultural barriers that could potentially interfere with patients’ care.

Practice implications: This work has important practice implications in the oncology setting, where cultural sensitivity is paramount and empathic exchange with the patient optimizes their sense of being well supported by their health care team. We believe that this model is generalizable to many other medical settings where use needs to be made of a professional interpreter.

Key words: communication skills training, interpreters, LEP, oncology

introduction

Being a patient in an era where complex medical and institutional processes are part of everyday clinical and nonclinical encounters makes effective patient-centered communication of paramount importance for a successful medical experience. This is never truer than in cancer care where the diagnosis can be life threatening and the treatment arduous. Therefore, effective medical interpretation is necessary not only for the clinical encounters but also for other health-related activities such as registration, appointments and pharmacy [1]. Comprehension of the information received is not only linked to the ability to speak a language but also directly linked to the culture relative to the spoken language. In essence, words will acquire a particular significance on the basis of the meaning that they have been assigned. 'Speaking a language other than English in the U.S. obviously means that one’s lived experiences are likely to be different than those of English speakers. The greater the difference between our lived experiences and those of others, the more likely our frames of reference will be different. Therein lies the potential for misunderstanding.'[2]. In an effort to reduce miscommunication due to language discordance, clinics, hospitals and physicians make use of interpreters.

In this paper, we outline our method of developing a communication skills training (CST) module designed to assist health care professionals to function collaboratively with an interpreter. Our primary aim is to describe the development and contents of this module. We then present pilot self-report data from 47 clinicians regarding changes in their confidence in working with an interpreter and their intention to use new skills learned as a result of training.

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cultural challenges in limited English proficiency patients

In a systematic review of the literature, Flores [3] found that limited English proficiency (LEP) patients’ quality of care was poor or fair when they needed, but did not receive, interpreter services. Patients were less likely to have a clear understanding of their diagnosis and discharge orders and less likely to have been told of medication side-effects when using ad hoc interpreters. Moreover, an increased risk of medical errors and misinterpretations has been linked to the use of ad hoc interpreters [3–5].

Another important aspect of communication between patient and physicians is the need to successfully address life-core values and health beliefs. In the case of Latinos, for instance, concepts like familialism (the significance of family over the individual), collectivism (the importance of friends and extended family in helping the patient solve problems), simpatia (the need for smooth interpersonal relationships in which criticism and confrontation are discouraged), religion and respeto (the need to maintain one’s personal integrity) are essential in improving communication and establishing a trustworthy relationship [6]. In the case of cancer, intrinsic concepts shared by many Latinos include the beliefs that ‘medications for pain are ineffective’, ‘a positive attitude is all you need’, ‘surgery spreads cancer’ and that ‘cancer cannot be treated’ [7]. These are obvious obstacles that if overlooked or minimized can have a negative impact on the overall health outcome of the patient. Significant lack of knowledge regarding cancer risks and symptoms is also likely to contribute to nonadherence in ethnic minority groups [8]. Communication about terminal or life-limiting illness adds complexities beyond language discordance to incorporate cultural discordance [9]. Patients not fluent in English receive less optimal palliative care, on the basis of findings that LEP patients are less likely to die at home, more likely to have emotional symptoms and less likely to receive adequate symptom control [10, 11].

Different types of people provide interpretation in the medical setting. Phelan and Parkman [12] identified four types who vary in their availability and reliability to serve as interpreters. Effective communication may depend on which types of interpreters are used. The four types are (i) bilingual health workers who are acquainted with the patient and remove the need for third parties to be involved, (ii) friends and relatives who are readily available and knowledgeable about the patient’s problems and concerns, (iii) untrained volunteers who are often available but have not received any formal training and (iv) professional interpreters who are formally trained and have a good understanding of cultural sensitivity and awareness, knowledge of medical and colloquial terminology and the respect of all parties involved [13]. Trained interpreters might, however, be limited by availability and facilities’ budgets.

need for interpretation services and cultural assessment

The number of people living in the United States with LEP is constantly growing, making the need for interpreter services a priority. The 2005 American Community Survey indicated that 19.4% of people living in the United States speak a language other than English. Of these, 44.6% speak English ‘less than well’. Latinos are considered to be the second fastest growing ethnic group in the United States (after Caucasians) and represent ~12.5% of the USA population [14]. By 2050, it is estimated that the Latino population will exceed 100 million and will account for approximately one-quarter of the USA population [15]. As an illustration of the need within cancer care, at Memorial Sloan–Kettering Cancer Center (MSKCC), ~4.5% of patients on 2006 rising to ~6% of patients seen in 2007 were classified as LEP and required the services of an interpreter.

Despite the evident centrality of interpreters to the health care system, clinicians are rarely trained in how to work with these interpreters. As this can be a complex communication challenge, clinicians at MSKCC are now offered CST in how to conduct a collaborative consultation involving an interpreter. The clinical CST approach is modular in that we select key challenges that confront oncologists and build a ‘module’ to address a teachable and coherent component, which may form either the whole or only part of any clinical encounter. Module themes are selected on the basis of previously identified communication challenges.

module development

The development of each new module includes a series of seven consecutive steps: (1) systematic literature review, (2) consensus review meetings, (3) modular blueprint development, (4) training materials development, (5) scenario development, (6) making revisions and adaptations iteratively and (7) assessment. All of our current modules are on the basis of a model we have developed, the Comskil conceptual model [16]. One critique of the literature on CST is that it is not always clear which skills are being taught and if those skills are matched with those being assessed [17]. The Comskil conceptual model seeks to answer this critique by explicitly defining the important components of a consultation. While others use sequenced guidelines as a mechanism for teaching about particular communication challenges, we propose that communication within any consultation can be guided by an overarching goal, which is achieved through the use of a set of strategies that usually fall into a logical sequence. Strategies are achieved through the use of communication skills, defined as a discrete mode by which a physician can further the clinical dialog. Process tasks, sets of dialogs or nonverbal behaviors that create an environment for effective communication are also critical to achieving strategies.

modular content for communicating with patients via interpreters

Using this process, we developed a module that makes use of six steps or strategies that can be applied with flexibility but in a way that is reproducible across virtually every occasion in which an interpreter is required. The communication goal is to collaborate with the interpreter to achieve an optimal interaction with the patient. Each of the steps involved in communicating via interpreters encompasses a series of skills and process tasks intended to achieve a communication with the patient that (i) privileges the doctor–patient dialog, (ii) promotes shared understanding and (iii) is sensitive to cultural differences.
Strategies 1 and 2 involve introducing the content and expectations of the consultation with the interpreter and eliciting interpreter’s knowledge about the patient that is relevant for a successful visit. Interpreters should notify patients that the information shared even before the actual visit takes place, i.e. while waiting in the waiting area, is considered part of the interpreter services and can be shared with the clinician. A brief meeting with the interpreter before the consultation will provide an opportunity to inform him/her about the clinician’s preferred method of interpretation and seating arrangements, as well as inquiring about the interpreter’s awareness of any cultural factors that might interfere with the doctor–patient dialog, e.g. family avoidance of use of the word ‘cancer’. This brief strategy, although potentially viewed as time consuming and unrealistic, may bring to the forefront important information that can later on save time and misunderstanding between all the parties involved [1, 12, 18].

Strategy 3 involves establishing the doctor–patient–interpreter team. During this step, clinicians should introduce the interpreter to the patient (if not done previously) and explain the process to the patient [19, 20]. Patients should be addressed directly and thus helped to avoid looking at the interpreter. Seating the interpreter just beside and behind the patient, with the interpreter’s eyes slightly downcast, can avoid the common triangular arrangement in which the patient and interpreter converse for extended periods to the exclusion of the clinician. These seating arrangements are depicted in Figure 1. The rationale for this seating which seeks to privilege the clinician–patient relationship should be explained to the patient who might not otherwise understand its purpose [21].

Strategy 4 explores the culturally held health beliefs that can potentially limit effective understanding and communication between the clinician and the patient. Strategy 5 is intended to promote effective interpretation throughout the consultation. It is crucial that the clinician plans ahead what he/she wants to say, avoiding confusing the interpreter by backing up or rephrasing. When use is made of consecutive rather than simultaneous translation, the use of short sentences, the avoidance of idiomatic phrases that can be difficult if not impossible to interpret and the use of frequent pauses are process tasks that make this strategy a successful one. Finally, strategy 6 reviews the consultation with the interpreter and provides an opportunity to discuss possible culturally sensitive issues identified by the interpreter and that might not have surfaced during the actual interpretation [1, 9, 12, 14]. These steps and their interrelationships have been organized as a modular blueprint (see Table 1).

**methods**

**participants**

Forty-seven multi-specialty health care professionals working in the oncology setting, including primarily attending physicians from MSKCC, volunteered to participate in a CST module on the topic of ‘Communicating with Patients via Interpreters’ during the 2007–2008 academic year. Participants included clinicians from the disciplines of medicine, surgery, pediatrics and palliative care. They had previously attended other core modules offered as a part of the Comskil curriculum; these modules included Breaking Bad News, Shared Decision Making about Treatment Options including Clinical Trials, Responding to Patient Anger, Conducting a Family Meeting, Discussing Prognosis, Discussing the Transition from Curative to Palliative Care and Shared Decision Making about Daunorubicin Orders.

**training in communicating with patients via interpreters**

Before the workshops, participants were given relevant literature including a workbook designed specifically for this training program titled ‘Communicating with Patients via Interpreters’. The workbook included...
**Table 1.** Modular blueprint—communicating with patients via an interpreter

<table>
<thead>
<tr>
<th>Strategies</th>
<th>Skills</th>
<th>Process tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduce the content and expectations</td>
<td>Declare agenda items; invite patient</td>
<td>Greet interpreter before consultation; inform the interpreter about your</td>
</tr>
<tr>
<td>of the consultation with the interpreter</td>
<td>questions</td>
<td>preferred method of interpretation, e.g., simultaneous or consecutive;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>ask about cultural factors that might interfere with the functioning of the</td>
</tr>
<tr>
<td></td>
<td></td>
<td>interpreter</td>
</tr>
<tr>
<td>2. Elicit interpreter’s knowledge about the</td>
<td>Ask open questions; clarify; restate</td>
<td>Ask about cultural factors that may interfere with the doctor–patient dialog</td>
</tr>
<tr>
<td>patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Establish the doctor–patient–interpreter</td>
<td>Make partnership statement; invite patient's</td>
<td>Arrange the seating before consultation; introduce interpreter to the patient;</td>
</tr>
<tr>
<td>team</td>
<td>questions</td>
<td>explain the interpretation process to the patient; address the patient directly;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>avoid looking at the interpreter</td>
</tr>
<tr>
<td>4. Explore culturally held health beliefs</td>
<td>Ask open questions; clarify; invite patient</td>
<td>Avoid statements that may be interpreted as judgmental</td>
</tr>
<tr>
<td></td>
<td>questions; acknowledge</td>
<td></td>
</tr>
<tr>
<td>5. Promote effective interpretation</td>
<td>Clarify; restate</td>
<td>Plan ahead what you want to say; avoid confusing the interpreter by backing up</td>
</tr>
<tr>
<td>throughout the consultation</td>
<td></td>
<td>or rephrasing; speak clearly; make frequent pauses; use short questions;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>avoid idiomatic expressions, abstractions or metaphors; avoid using jokes or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>humor that might be considered culturally offensive; ask about culturally</td>
</tr>
<tr>
<td></td>
<td></td>
<td>held beliefs</td>
</tr>
<tr>
<td>6. Review the consultation with the interpreter</td>
<td>Ask open question; invite interpreter</td>
<td>Consider location for discussion; provide opportunity to discuss possible</td>
</tr>
<tr>
<td></td>
<td>questions</td>
<td>culturally sensitive issues identified by the interpreter</td>
</tr>
</tbody>
</table>

The authors facilitated a group role-play exercise in which participants were able to practice the skills and process tasks reviewed during the didactic presentation. In order to facilitate a realistic encounter, a trained medical interpreter and a standardized bilingual patient were utilized during the group role-play. The medical interpreter was encouraged to sit slightly behind and next to the patient. Frequent pauses are made to discuss what has transpired from the interaction and what the learner experienced that went well as well as possible challenges faced during the role-play. Learners received feedback from the facilitator, their peers and when appropriate or requested by the interpreter and the simulated patient (in character).

Group reflection typically occurs on the length of sentences, the pacing or rhythm of the encounter, the use of physician–patient eye contact and other nonverbal communication and whether the physician–patient relationship has been privileged over the interpreter–patient relationship.

**results**

Using a paired t-test, the pre–post questions methodology demonstrates that the participants’ confidence in conducting an interview via interpreters significantly increased ($t_{46} = -7.924, P < 0.05$) after attending the module.

In order to interpret the results of the module evaluation data and for consistency with the evaluation of all other Comskil modules, we determined a rating of ‘agree’ or higher to be an indicator of satisfaction with the workshop and its effectiveness. Table 2 displays the percentages of workshop participants who agreed or strongly agreed with the six post-training items (see Table 1). Only one of the 47 participants answered to opened ended questions with the suggestion that the module could be improved, indicating more time for role-play.

**discussion**

The primary aim of this research was to describe the development and contents of a CST module targeting specific clinician behaviors during discussions with their patients that involve an interpreter. As the number of people living in the United States with LEP continues to exponentially grow, the importance of training our clinicians in how to interview patients via interpreters becomes evident. However, to date, only 23% of USA teaching hospitals provide any training, and most of them make it optional [22]. In our module, a set of six
strategies was developed that highlight the need to establish rapport with the interpreter before entering the consultation and to establish a framework for the consultation. In addition to the specific communication skills used during the clinician, patient and interpreter triad, we also indicate a concluding conversation where the clinician and the interpreter review the consultation and address any final concerns.

This module is an example of how health care professionals of different levels and specialty can be taught how to communicate with patients via interpreters. The didactic lecture and its exemplary videos introduce the participants to the relevant current literature and indicate the necessary strategies, skills and process tasks. The group role-play exercise and the use of simulated patients and medical interpreters provide them with an opportunity to practice the skills in a safe and friendly environment. Participants were able to test new strategies and rehearse ways of communication with interpreters in this way. Experimentation with seating positions enabled a comparison to be made between triangulated conversations that promote the interpreter–patient relationship to the neglect of the physician–patient relationship with seating arrangements that privilege the clinician–patient relationship.

Practice at the length of conversational segments when consecutive translation is used promotes insight into the need for relatively short ‘sound bites’ by the clinician. This in turn helps establish a rhythm for the conversation and aids the maintenance of eye contact between clinician and patient, a condition that improves the clinician’s monitoring of emotional and informational cues by the patient. Unlike other modules where role-play practice can occur in small groups with trained actors, the short supply of trained interpreters for this module necessitates use of a larger group interaction, often colloquially termed a ‘fishbowl role-play’. Facilitators do well to rotate clinicians fairly regularly into the physician’s seat so that all present have the opportunity to practice the skills used in this encounter.

Trained facilitators moderate discussions and provide constructive feedback to the participants. This is invaluable as a means of providing participants with an opportunity to observe how their peers utilize and personalize the skills. In addition, participants can not only reflect on their own communication strengths but also consider their limitations and make adjustments and experiment with alternate approaches on the basis of feedback from the expert facilitator and their peers.

We build cultural sensitivity into our role-play through the use of a clinical scenario that generates relevant themes. For example, a male from a machista culture places great store on his physique and appearance. The development of an osteosarcoma of his lower leg raises treatment possibilities that include amputation or neoadjuvant chemotherapy and limb-preserving surgery. While the rehabilitation associated with amputation may in many ways be simpler and quicker, the latter treatment approach preserves his self-image in a culturally sensitive manner. The burying of such examples within each clinical scenario ensures that a variety of cultural themes can be considered as the role-play unfolds. See Box 1 for a sample scenario.

Our second aim was to present preliminary data describing changes in participants’ sense of confidence to collaborate with an interpreter in a consultation and also the participants’ intention to utilize the skills in upcoming consultations.

Participants reported a statistically significant pre–post increase in their confidence about communicating with patients via interpreters indicating that participants found utility in the workshop. This coupled with participants’ intention to utilize the skills indicates that this is a useful module.

We recognize that this preliminary modular evaluation has some limitations. Among those, we acknowledge the fact that our trainees are from a pool of self-selected participants, with different level of preexisting communication skills. The methodology used to evaluate the effectiveness of the module is limited to a onetime assessment done at the end of the practice. While this can evaluate the experience and its perceived effectiveness, it does not measure if the confidence gained is preserved longitudinally. Another limitation of our assessment has been the lack of objective data to support the self-report evaluation method. Due to these limitations, we have begun developing standardized patient assessments (SPAs) as an evaluation tool for CST. SPAs are useful in evaluating interpersonal communication skills in a specific domain. Using inter-item and split-half reliability methods, the SPA has proved to be a reliable assessment tool and has demonstrated discriminant validity [23–25]. Utilizing SPAs will enable us to observe each participant demonstrate communication skills in a specific situation of a predetermined and standardized duration.

Future research could follow participants over a period of time and measure their self-efficacy and confidence in the skills learned. Another interesting study will be to record LEP patients’ satisfaction with the medical encounter pre- and post-participants’ training.

conclusions

We have developed a module that trains clinicians in effective collaboration with professional medical interpreters and shown its ability to increase the confidence of clinician’s to work with LEP patients. Our approach intends to minimize not only the language barrier but also the cultural barriers that could potentially interfere with patients’ care.

practice implications

This work has important practice implications in the oncology setting, where cultural sensitivity is paramount and empathic

Table 2. Participant ratings of the interpreter module

<table>
<thead>
<tr>
<th>Item from module evaluation</th>
<th>Agree or strongly agree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel confident that I will use the skills I learned in this module.</td>
<td>96</td>
</tr>
<tr>
<td>The skills I learned in this module will allow me to provide better patient care.</td>
<td>94</td>
</tr>
<tr>
<td>The module prompted me to critically evaluate my own communication skills.</td>
<td>98</td>
</tr>
<tr>
<td>The experience of observing the large-group role-play was helpful to the development of my skills.</td>
<td>96</td>
</tr>
<tr>
<td>The skills I learned were reinforced through the feedback I received as a participant in the large-group role-play.</td>
<td>90</td>
</tr>
<tr>
<td>The large-group facilitator was effective.</td>
<td>100</td>
</tr>
</tbody>
</table>
Box 1: Sample case scenario

A 42-year-old Latino man presents to his oncologist to discuss the treatment options for his newly diagnosed left lower extremity osteosarcoma. Through the medical interpreter the oncologist proceeds to explain the first option, which involves amputation. As soon as the interpreter translates this to the patient, the patient immediately gets up from his chair and proceeds to leave the office while speaking to the interpreter in what appears to be an agitated tone. The oncologist is puzzled by this reaction and attempts to seek clarification from the interpreter while the interpreter is attempting to convince the patient to sit down and have a further discussion with his oncologist. A few minutes go by and finally the patient agrees to sit back down on his chair. The visit proceeds with the interpreter clarifying for the oncologist what just took place. He explains that the patient became immediately very angry after hearing that his treatment involved amputation and refused to have any further discussion with his doctor stating: ‘have him have his leg cut off and see if he or his wife would like it!’ Through some gentle probing and reassurance that the oncologist is not recommending amputation as the only treatment option, the true concerns regarding sexual performance and body image surface. With the help of the medically trained interpreter, the oncologist further learns that the patient is concerned that if amputation is his only viable option, he will lose the respect of his peers and that of his employees (the patient owns a Bodega store). His final concern is that eventually his wife will see him as ‘less than a man’ and will end up leaving him. In a nonjudgmental way, although the oncologist recognizes that amputation will be the easiest option for this particular patient, he proceeds to acknowledge and validate his patient’s concerns explaining that amputation is only an option but that chemotherapy and limb-preserving surgery is another. The oncologist then proceeds to ask permission to continue to present to him all the risks and benefits associated with each treatment. The patient is now calmer and willing to listen to both alternatives after commenting with his interpreter: ‘I’m glad to see he understands what it will cost me to lose my leg,’ exchange with the patient optimizes their sense of being well supported by their health care team. We believe that this model is generalizable to many other medical settings where use needs to be made of a professional interpreter.

funding

Memorial Sloan–Kettering Cancer Center; Arthur Vining Davis Foundation; Josiah Macy Foundation; Kenneth B Schwartz Center.

acknowledgements

All study design, data collection, analysis, data interpretation and decisions about publication were made by the authors. There are no further acknowledgments.

disclosures

The authors have no conflicts of interest to report.

references


original article

Annals of Oncology