

## Practitioner's blog

# Are we misinterpreting our patients' needs?

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I recently stumbled upon a blog on which a healthcare worker had posted the following: 'I see so many frightened women, trotting along with their children, unable to speak English. If they could, they would be able to communicate with me, their doctors and their children's teachers. They would get so much more out of life ...'

This is such a common sentiment, and yet this situation was played out recently in our emergency department. A woman who did not appear to speak English attended the department accompanied by her two children. In our department, telephone interpreters are readily available, 24 hours a day. Use of the service is actively encouraged, despite the cost, in a concerted effort to eliminate or at the very least reduce the tendency to muddle through with patients whose English is poor. However, an initial brief consultation is required to establish whether an interpreter is actually needed.

After the initial introductions had been made, there was no verbal response from the woman herself. Her daughter, an articulate, chatty, multilingual 10-year-old, explained that her mum did not speak English, and that she would translate for her. A few baseline facts were ascertained, with the intention of moving to telephone interpretation. However, it became evident that the woman had a good level of understanding of the English language, as she was answering my questions before her daughter translated them.

The art of good communication between patient and practitioner relies on gathering both verbal and non-verbal clues. Words account for only a small part of communication, with the remainder made up of non-verbal clues. This woman was listening intently to what was being asked, and was responding through her daughter in her native language. Eventually, the woman was asked directly if she understood English. With initial hesitancy she said that she did, but that she could not speak it. With encouragement and reassurance she gradually relaxed and a 15-minute conversation ensued, mostly in English, in which she was able to explain not only her current injury, but also how her

children were both the result of IVF, how proud she was of them, how many languages the children could speak, and how she had arrived in the UK around 14 years previously, as a result of civil unrest in her native country. Her English proficiency was perfectly adequate for the situation, and she emerged as someone with an entertaining and warm personality who was extremely grateful to have her injury examined and treated. She was also able to explain, with humour and pride, that her children delighted in tricking her into repeating phrases that were either wrong (in context) or a little risqué. As funny as she found this, she admitted that it did deter her from communicating, for fear of 'getting it wrong.'

What I saw initially, like the blogger, was a woman who could not speak English, 'trotting along with her children'. However, when I looked beyond her clothing and my own pre-conditioned expectations, what I saw was a woman who understood perfectly what I was asking. All that was required was a little empathy and encouragement, time and support to enable her to speak for herself, to explain what had happened, and to express her pride in what she had achieved since arriving in the UK.

The importance of providing culturally and linguistically appropriate healthcare has been highlighted as essential for reducing racial and ethnic disparities in health (Smedley *et al*, 2003). It is difficult to obtain accurate data about the number of people in the UK who do not speak English, but in 1996 the Basic Skills Agency estimated that approximately 23% of immigrants born in China, Bangladesh, India and Pakistan have no functional skill in English, and 70% cannot function fully in an English-speaking social environment (Carr-Hill *et al*, 1996). The current figure is likely to be much higher, especially in the major cities. This has serious implications for communication in healthcare, especially in emergency situations where time is of the essence, and the inability to communicate accurately could delay appropriate care. Obtaining an accurate history of the presenting complaint is an important part of formulating a management plan

and ultimately reaching a diagnosis. Without an adequate history, the practitioner is left somewhat in the dark. History taking is recognised as being most effective if taken from the patient him- or herself, and non-English-speaking patients should not be denied this opportunity. In their study of cultural racism, Johnstone and Kanitsaki (2008) found that language prejudice was a potent but overlooked form of cultural racism related to discrimination against people who do not speak a country's official language. Best practice guidelines advocate the use of interpreters who should preferably not be family members (Donini-Lenhoff and Hedrick, 2000). Issues of confidentiality, other people's agendas and the possibility of misinterpretation inform this thinking. A family member may feel uncomfortable asking questions, may not understand the questions, and may be too embarrassed to admit to this. For their part, patients may have information that they do not want to share with the family member, for example, about domestic violence or very personal matters. It is important to recognise and remember that many asylum seekers and refugees have experienced extremely traumatic events before arriving in the UK, which they may be unable or unwilling to talk about because they believe that what has happened to them is a source of great shame.

The use of children as interpreters for their parents is particularly discouraged. Altering the balance of power in an established relationship is difficult and unfair on children, who may end up feeling responsible for their parent's healthcare (British Psychological Society, 2008). This is especially important when the children are very young but, irrespective of age, it is an unsafe and unacceptable practice. Children do not have the medical vocabulary or health literacy necessary to understand and communicate at the level that is needed. Moreover, they may feel overwhelmed by having to ask sensitive questions or relay bad news (Levine, 2006).

It was rewarding to look after this woman, and it was very evident that she derived a great sense of pride and a new level of confidence as a result of successfully speaking for herself without having to use an interpreter. I would like to think this achievement marked the opening of a new chapter in her life. However, the irony and certain paradox of this encounter were not

lost on me. Health promotion is about empowering the person and, in following best practice guidelines, I was about to use an interpreter when in fact all that was needed was a little more time, encouragement and respect, all of which cost less but in this situation had far greater benefit than an interpreter. Interpreting services are invaluable and essential in many situations, but I wonder how often we disempower our patients in our genuine efforts to deliver culturally competent healthcare. Balancing the need for an interpreter with the need to empower and encourage our patients is a challenge, but it is one that we must embrace if we are serious about integrating our communities and promoting their health in the long term. It is essential that in ensuring culturally competent care we recognise that calling for an interpreter is not always in the patient's best interest.

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