Cross-cultural Medicine
A Decade Later

Translation Is Not Enough
Interpreting in a Medical Setting

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Unique obstacles must be overcome when providing medical care to patients who have an incomplete command of the English language. Serious barriers to effective communication may arise at the exact point where our health care system must succeed or fail. Miscommunication, differences in attitudes about health care, and various other misunderstandings interfere with or frustrate good health care for these patients and their families. Such difficulties are best overcome by the use of a professional interpreter who can ensure good communication between patients and health care professionals. My daily experiences as a professional medical interpreter and translator in Spanish provide insights into the complexities of bilingual and bicultural communication in the hospital setting. Although the examples given relate to Hispanic patients, the lessons learned can be extended to other foreign language patients as well.

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Health care professionals often experience communication difficulties with Spanish-speaking patients; some also have various misconceptions about these patients. As a professional Spanish-language interpreter and translator* at Stanford (California) University Medical Center and being from Nicaragua, I know the problems these patients have in the clinics and the hospital wards. In this article I invite readers to accompany me on a typical day and to share some of these experiences. Some of them are sad, some are amusing, and all are interesting. If they counter a misconception or provide some small insight, I will have been successful.

Before I describe a typical day in my profession, I must point out that not all Spanish-speaking patients are the same. They come from different cultural backgrounds, cultural influences, and educational levels.1 Highly educated and affluent Latinos† have attitudes and beliefs about health care reasonably comparable to those of similarly educated and wealthy Americans. The challenge, and the subject of this article, are the Hispanic patients who are poor, come from rural areas, have little or no schooling, and have little or marginal fluency in English. These patients frequently but not necessarily are migrants or recent immigrants.

Cultural Issues

My day begins at 8:30 AM. When I arrive at the hospital, three messages are already waiting for me on my beeper. The first is from an anesthesiologist in the Delivery Room who needs me to translate his explanation of the epidural procedure. An 18-year-old Mexican patient is having regular contractions, but she is only 4 cm dilated. The patient is becoming tense and exhausted from the pain, which is interfering with the childbirth process. The nurse has suggested some pain relief medication or an epidural block, but the patient refuses.

As I clarify the nurse’s offer to the patient, I learn the patient’s real concern. She thought that she was being offered a raquea. Raquea or raquidea, a term frequently encountered in patients from rural Mexico, refers to the anesthesia procedure commonly known in the United States as a spinal block. Mexican patients associate raquea with a high incidence of serious complications. This patient is afraid that she would have chronic back problems or be paralyzed for life if given the raquea, problems she believes are caused by that procedure. To make it worse, at this moment her husband reminds her that if she does not have pain, she will not be a real mother, a common belief among Mexican patients. We explain to the patient that the epidural block is not like the raquea, that she would be awake and able to push and actively participate in her baby’s birth. Finally, the husband and the patient agree to the epidural, and the baby is born without complications. The problem here is the patient’s expectation that medical practices in the United States are the same as in Mexico and her fear (justified or not) about those medical practices, all complicated by basic cultural differences and beliefs. By creating in the patient a better understanding of

*Although these terms are often used interchangeably, technically interpretation involves oral communication and translation involves written communication.
†In this article the terms “Hispanic” and “Latino” are used interchangeably to refer to persons who are Spanish speakers and whose principal cultural identity is Latin American.

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the epidural procedure, we are able to bridge the language, cultural, and knowledge gaps.

By around 9 AM the Obstetrical Diabetic Clinic is active. Each patient is seen by a physician, the hospital’s dietitian, a social worker, and the nurse in charge of drawing blood. An interpreter is needed for almost every interaction. One patient, Ramona, is being seen for the first time in this clinic. She is 34 years old, Central American, and poor. She is a first-generation immigrant and, as is typical, believes herself to be a transient by choice. She has the idea that she will return to her country someday and has not committed herself to becoming part of the Anglo culture. “I would learn English if I planned to stay,” is a common comment. Her command of English is exhausted after a few simple words and smiles.

As I go into the room, I recognize her from another clinic in the hospital, and we greet each other by name. As part of her medical history, she is asked how many pregnancies she has had. She responds, “two.” I continue to interpret for the physician as he asks all the different questions connected with her history. Ramona and I talk a little in Spanish while the physician makes some notes. Latino women, once they get to know you, tend to be talkative. She tells me how worried she is about her diabetes, which she believes she probably caused herself by “doing something wrong.”

She tells me about a third pregnancy that miscarried due, in her mind, to susto. Susto means “a terrible fright,” and she holds the common belief that a terrible fright during pregnancy is bad for both mother and baby and can even kill an unborn child. She explains that, while pregnant, she was taking care of a 15-year-old niece. Suddenly the young girl felt sick to her stomach, went to bed, and died on the spot. Our patient had been terrified and had felt responsible. To make matters worse, the girl’s family blamed our patient for the girl’s death. The patient was about four months’ pregnant at the time and miscarried four days after the incident.

On hearing her story, I realize that she actually has had three pregnancies, not the two she had stated in response to the physician’s question. For many Hispanic women, having a miscarriage or a stillborn child does not equate with a pregnancy; only the successful pregnancies count. In this example, the patient answered the physician correctly in the context of her cultural views, but, through no fault of his own, the medical history he obtained from this patient was incomplete. Her different cultural attitudes and beliefs are discovered and better understood through our conversation, and a more accurate and complete history results after those beliefs and attitudes are taken into account.

At 9:25 AM there is a knock at the door as I finish up with Ramona, this time from the dietitian. The dietitian explains that a patient needs to be put on a special diet for diabetic pregnant mothers, to see if her diabetes could be controlled without insulin. This is a major task of persuasion. There is a saying in Spanish, “Dame gordura y te daré hermosura” (“Give me plumpness and I’ll give you beauty”). This idea applies to babies, too. The belief is that a pregnant mother has to eat for two, that a thin baby is undesirable because a thin baby is unhealthy.

In addition, many of these patients come from poor rural areas where most of their food is scarce and expensive, where meat is a luxury, and where anything American-made is beyond reach. When these patients come to this country, where food is abundant and comparatively cheap, they naturally tend to indulge. They have difficulty understanding that they should voluntarily go on a diet of restricted foods in the land of plenty. This patient believes in having a big baby, and she enjoys being able to eat anything she wants. We finally convince her that she cannot do this any longer and that, for the sake of her health, she has to diet to have a smaller baby.

Often there is another complication if the family has little money to buy food. The diet we recommend, lots of vegetables and less tortillas and beans, typically is more expensive than what these patients otherwise would eat. It is also less popular because it omits the foods they like the best. The surprising result is that there are fewer compliance problems than would be expected, even with all these frustrations. Having a baby is important to Hispanic women, so most of them overcome their reluctance and comply with the recommended diet or at least try their best with their limited resources. In the Latino culture, women are supposed to sacrifice for the family, even to the point of eating a lot of vegetables.1,2

My next summons is from the Internal Medicine Clinic. The patient, a 50-year-old female peasant from Mexico, is accompanied by her 35-year-old son. Although the patient has been coming to the clinic for some time, she is new to me. Her son usually interprets, as he is reasonably fluent in both languages. This time I am called because the son has to leave to go to work.

Before going into the room, the physician expresses to me his concern about whether the health problems claimed by this woman are real or imagined. She has been in the clinic three times before, each time with different vague and diffuse complaints, none of which make medical sense. As we learn, the poor woman has a fistula in her rectum. In her previous visits, she could not bring herself to reveal her symptoms in the presence of, and therefore to, her son as he interprets for her. She tells me that she has been so embarrassed about her condition that she has invented other symptoms to justify her visits to the physician. She confesses that she has been eager to have a hospital staff interpreter from the first visit, but her hope had not materialized until now.

This story illustrates two things: first, the modesty of many Latino women can be a serious problem; second, Latino women are often reluctant to reveal personal or private problems if their children are used to interpret. I have seen many Hispanic women who are reluctant to tell their physicians about vaginal problems or to have a Papanicolaou smear done because they are afraid of a pelvic examination. Their fear is partly caused by their expectation of discomfort, but to a large degree it is the result of a higher cultural standard of modesty. In addition, traditional Hispanic women often have an amazingly limited knowledge of female sexual anatomy. These attitudes may puzzle Anglo professionals but must be dealt with for medical care to be effective.

Using Children as Interpreters

My day is becoming hectic, and I am needed in several places at once. A common and unfortunate practice when an interpreter is temporarily unavailable is to use family members to interpret. It is easy to forget that the person in the middle is affected by what is happening and must assume a normal family role when the interpreting duties are over. The next page I answer involves this difficult and disturbing problem.
The call is to help with a pregnant woman who may have a stillbirth. As I enter the patient's room, the first thing I see is a beautiful little girl with haunting big brown eyes—the patient's 7-year-old daughter. I introduce myself with the proper Spanish salutation. The mother seems upset, but the daughter looks very distressed and frightened. The child is shaking and with a quiet voice says to me, "No podia explicarle a mi mamá todo lo que los doctores me decían" ("I couldn't explain to my mom everything the doctors were telling me"). I quickly discover that this little girl was used as the interpreter during the ultrasound examination and was told to tell her mother that the baby (her little brother-to-be) is dead. This revelation stuns me. I sit and hold the little girl on my lap, trying to comfort her as she hugs me tightly. I softly talk to her about what has happened, and she starts to weep with big, slow tears. To me, one of the saddest moments is when she says to me, in a pleading voice, "Maybe my little brother's heart will work when he comes out of my mother's stomach."

I am reminded of the time when I was required for a family conference for a patient about to be discharged. When I arrive at the conference, present are a physician, a nurse, a physical therapist, a social worker, and several family members. The patient, the father, is absent. Everyone is sitting around a table except one. Standing by the physician is the patient's 9-year-old son, who is acting as the interpreter. The child looks frightened. The physician rather abruptly says to me, "We don't need you, the boy is doing fine." The boy, however, pleads with me to stay and take over, saying, "Please, Señora, can you help me? I don't know if I am doing it right."

Having to rely on interpreters certainly can be frustrating at times. The communication is inevitably slower, more awkward, and less precise, even if the interpreter is excellent. Another source of frustration is that the health care professional has less control when having to use an interpreter (professional or otherwise), and some, understandably, have a hard time with this fact. There is a simple explanation: The physician and the patient cannot speak to each other directly. Also, there may be a wait before the interpreter arrives. Because of budgetary constraints, there never are enough interpreters on staff for there to be on-call interpretation available for every need. Medical interpretation often involves unexpected matters of life and death. Being an interpreter is a heavy burden for a child, whose English is frequently marginal and certainly is not sophisticated. Disregard for these factors is hurtful to both the child and the family and threatens the effectiveness of the communication. The trauma to the unfortunate little girl (whose mother has a stillborn) is easily seen. I doubt anyone would consider using a child in this way if there were no language barrier. The situation in which the boy was used as an interpreter is similarly difficult, but the difficulty is perhaps a little more subtle.

In rural Hispanic culture, the hierarchy is strict, with authority running from older to younger and from male to female. These relationships are for life, with parents in control of adult children and older adults in control of their younger adult siblings. Traditionally in Latino culture, the head of the family is expected to make the decisions regarding any family member. The whole family looks to this person for support and advice. By using a young family member as an interpreter, the physician puts the child in control, with a much higher status than the child would otherwise have. This disrupts the family's social order.

In both of these cases, there was no emergency and no reason not to wait a few minutes for a professional interpreter to arrive. When foreign language gets in the way, however, otherwise sensitive and caring people occasionally become oblivious, and unintended harm can result.

**Informed Consent**

I am getting tired; it is nearly lunchtime, and the pages are relentless. This time I am called to the Well-Baby Nursery, where a woman needs to be asked about some routine matters: the family constellation, safety in the home, safety in the car, breast or bottle feeding, and follow-up care for her baby. Interpreting for the physician, I ask her whether she wants her baby boy circumcised. She nods, but then pauses and very seriously adds, "But my friend had a baby circumcised here, and they did it too much. I don't like how he looks. Can they just cut off a little bit?" To me, the woman clearly wants to decline the procedure but is having difficulty refusing what she considers an instruction from the physician. In general, Latinos feel they should agree with physicians out of politeness and respect, even when they really disagree or do not understand the issues involved. They expect physicians to make the decisions for them and do not understand why they are asked to make choices. They are used to, and seem to prefer, deferring to experts. These patients do not understand the American medical system and its notion of informed consent. Only when more acculturated do they start taking the level of responsibility for their own health that Americans routinely assume. Language and cultural issues once again are intermixed.

The next interpreting request, which comes from the Gynecology Ward, involves a different issue of informed consent. The patient, a seriously ill 71-year-old Nicaraguan woman, has been in this country only a few years. Her children have been with her day and night, never leaving her side. When I arrive, the patient's family is distraught. They request a conference with the physician out of the patient's presence. The physician tells the family that the mother is dying and needs radical surgery, but he emphasizes that the surgery would prolong her life only a little. The physician wants to tell the patient and to ask for her consent to the operation. The daughters are very upset and against saying anything to their mother. They beg me to explain that their mother has the right to have hopes, that she should not be told that she is going to die, and that a painful and difficult operation that may buy her only a little more time is cruel. The result is an impasse that looks to go on for several days. The daughters vigilantly watch their mother, guarding her from physicians, and hiding the truth from her. Eventually a compromise is reached, with the patient receiving an accurate but moderated version of the bad news. Here the problem is partly language barriers, but mostly it is conflicting cultural attitudes about how (or whether) bad news should be conveyed to patients.

I am convinced that the daughters would have lied to their mother about her condition (and tell the physician they did the opposite) if they were relied on to interpret. Hispanic families often try to hide the seriousness of the situation from ill relatives, especially if the patient may be dying. Instead, the patient is always given encouragement by the family with words like, "It is going to be OK," 'You'll be out of here...
I had tubal ligation. Then would have sterilization operation her. The tubes have been described to her as having her tubes "tied." She has consented, but with the idea that she can later change her mind—thinking the procedure is easily reversible. If her tubes can be "untied," she reasons, they can be "untied." She began to worry after asking a few questions to confirm her belief. She does not fully understand the answers in English but was having doubts. After I interpret the answers to her questions, she declines the procedure.

Many Latinos believe that the main purpose in life is to reproduce, to people the land. This idea is strong and deeply rooted in their religious beliefs, which must be acknowledged, respected, and understood if we want to comprehend their attitudes toward family planning. Another family planning complication in Latinos is that men can feel threatened by the sterilization of the women. They often believe that a woman who is sterilized or uses birth control is going to be unfaithful. Besides, in their eyes, maleness is proved by paternity, and their attitude is that a wife is no longer a complete woman if she cannot bear children.

Language Barriers

A patient in another room, a 30-year-old spunky but illiterate poor woman from Mexico, is hard working and proud. She is seven months pregnant and has diabetes. Her diabetes is under control, and she is generally in good health, but she has complained of swelling and pain in her hands on previous visits. Sitz baths were prescribed so that the patient could have immobilization therapy for her hands and arms. Because the physician knew some Spanish and the patient knew a little English, no interpreters were used on previous visits.

On this visit, the physician and the dietitian are concerned about the patient’s unexpected weight loss during the previous week, and they decide to call for an interpreter to help find the cause. As we try to figure out what is going on, the patient asks me to tell the physician that her hands are still hurting, but she proudly adds that she has been very good about doing her sitz baths. She says, "They are very tiring, but I have been doing them for 20 minutes twice a day," I ask her to tell me what she was doing because I wonder how a bath could be so tiring. Very seriously, she explains she would fill the bathtub with water and get in and sit down. Then she would stand up, sit down, stand up, sit down, stand up, sit down—for 20 minutes at a time. No wonder she was tired!

I want to both laugh and cry. The image of this very pregnant woman intently doing deep-knee bends in the bathtub is comical, but her pride and sincerity are touching. If she had fallen, she could have suffered serious injury. Once again I realize how important good communication is and how risks can be increased by faulty communication.

Next I am called to the Emergency Department. When I arrive, the room is full of physicians and nurses. Among them is an x-ray technician busily taking an x-ray film of a man’s leg. The patient, a 38-year-old Mexican gardener, had fallen out of a 10-ft high tree. After I introduce myself, the physicians and I ask the patient routine questions. The man keeps repeating, "Mi canilla, mi canilla." Somebody else in the room knew a little Spanish, which explains to me why the technician is taking x-ray films of the man’s leg. I tell them that he means his wrist, which turns out to be broken. In most Spanish-speaking countries, canilla means shinbone and the use of canilla for the wrist is a little unusual—except in certain parts of Mexico where the word means wrist. Spanish technically is not divided into dialects, but the meaning of a word can vary by context or the region of the speaker.

I sometimes observe physicians and nurses who know a little of the language trying to converse in Spanish with their Hispanic patients. I always encourage this practice. Among other benefits, it helps make a patient feel more comfortable and builds rapport. It is important when making this effort not to overestimate language abilities and to remember that a much lower skill level of communication is required for "chatting." It is also important to remember that even if a question appears to be more or less understood by the patient, the answer may not be understood by the health care professional well enough to be the basis for a medical decision.

Learning a foreign language to the point of the true bilingualism of a professional interpreter takes a lot of time and practice, and the subtleties involved—and the potentially disastrous consequences of an error in interpretation—are even more telling in the medical context. Proper medical interpretation requires a firm grasp of two different and complex languages to achieve immediate, highly functional, and accurate translation, often at times of high stress and in critical circumstances, plus an ability to communicate effectively in each language at many different educational levels. A modest course of study in Spanish is not enough to interpret reliably in a medical situation. An inexperienced Spanish speaker usually does not know the right Spanish word or may know the right word but not how to pronounce it properly. The results can be confusing, insulting, or comic. One physician who was trying to be friendly with a female patient, asked her, "¿Cuántos años tiene usted?" He intended, "¿Cuántos años tiene usted?" ("How old are you?") but, by mispronouncing the word años as anos, what he really asked was, "How many amuses do you have?"

In another case, a 70-year-old Cuban woman was being discharged from the hospital into the care of her daughter, also a non–English-speaking resident of Cuba. The woman’s granddaughter was doing the interpreting, as she had throughout the hospital stay with reasonable success. The young girl thought she did a good job of clearly explaining the discharge instructions, but her aunt, the person for whom she was interpreting, didn’t understand that the grandmother’s medication was to be tapered off. Instead, after release from the hospital, the aunt cut back the dosage suddenly. This error was discovered only when the patient returned to the hospital very ill with other complications.

The granddaughter, although fully bilingual, was not trained to make certain her aunt fully understood the instructions. In these instances, "back-interpretation" should be used—ask that the interpreted instructions be repeated back so that any miscommunication can be detected and corrected and questions can be cleared up. I am asked many times,
"How do you say this or that in Spanish?" In most cases several words or expressions need to be tried until the interpreter is certain that the patient truly understands what the interpreter is trying to say. Few Spanish-speaking patients or families ask a lot of questions. Most of the time they just nod and go home, wondering what they were told in the hospital or the clinic. Using a professional interpreter who is aware of this tendency helps to avoid misunderstandings.

So goes a typical day in a large university medical center. This account of my daily experiences shows why it is important to always use professional interpreters in medical settings. This may not always be possible, of course, because of limited staffing or in emergencies. It is tempting, when rushed for time, to forge ahead and "make do," relying on dimly remembered high school Spanish plus the patient’s or a family member’s broken English. However tempting it may be, this choice should be avoided. A little Spanish and broken English typically are inadequate for the level of communication required for good medical care. Using family members, friends of the patient, or Latino cleaning staff rarely is sufficient and can have bizarre consequences.5,6 Cleaning staff are untrained and inexperienced in medical interpretation, among other problems. Family members—and patients, for that matter—similarly are untrained and inexperienced and may suffer a dramatic decline in English proficiency when confronted with the stresses inherent in the context of illness. It has been observed that the "language of our childhood remains the language used during times of intimacy and stress."1

Professional interpreters are the conduit for effective, efficient, and reliable communication between a health care professional and a patient or family member not fluent in English. Health care professionals must recognize that the situation always is bicultural and not merely bilingual. Successful communication between a health care professional and a patient, if a non-English speaker is involved, requires more than mechanical translation between English and the foreign language. The use of a professional interpreter can help achieve this objective.

REFERENCES