A Bridge between cultures: Interpreters’ perspectives of consultations with migrant oncology patients

Abstract:

Background: Migration is increasing world-wide. In previous research into people with cancer from culturally and linguistically diverse (CALD) backgrounds, interpreter accuracy, professionalism, and continuity have emerged as key concerns for patients. Little is known about interpreters’ perceptions of their role and the challenges they face. This study aimed to obtain their perspective. Methods: 30 interpreters (Greek n=7, Chinese n=11, and Arabic n=12) participated in four focus groups which were audio-taped, transcribed, and analysed for themes using N-Vivo software. Results: Skills as an interpreter were broadly perceived as conveying information accurately, being confidential and impartial. Three broad dilemmas faced by interpreters emerged: accuracy versus understanding; translating only versus cultural advocacy and sensitivity; and professionalism versus providing support. Some saw themselves as merely an accurate conduit of information, while others saw their role in broader terms, encompassing patient advocacy, cultural brokerage and provision of emotional support. Perceived challenges in their role included lack of continuity, managing their own emotions especially after bad news consultations, and managing diverse patient and family expectations. Training and support needs included medical terminology, communication and counseling skills and debriefing. Interpreters suggested that oncologists check on interpreter/patient’s language or dialect compatibility; use lay language and short sentences, and speak in the first person. Conclusions: Resolving potential conflicts between information provision and advocacy is an important area of cross-cultural communication research. Further training and support is required to enhance interpreters’ competence in managing delicate situations from a professional, cultural and psychological perspective; and
to assist doctors to collaborate with interpreters to ensure culturally competent communication. Ultimately, this will improve interpreters’ well-being and patient care.
**Background**

Migration is increasing world-wide. The literature on health behaviours and outcomes in minority groups is almost entirely from the USA and UK but generally suggests poorer patient outcomes including lower survival, higher rates of reported side effects and poorer quality of life (Du, Meyer and Franzini, 2007; Chu, Miller and Springfield, 2007; Krupski, Sonn, Kwan, Maliski, Fink and Litwin, 2005; Gotay, Holup and Pagano 2002).

The reasons for poorer outcomes are complex and may include socioeconomic disadvantage (Williams, 1999; Smedley, Stith and Nelson 2002) and low screening rates, late diagnosis, lack of health insurance and not being offered all treatment options (Du et al. 2007; Williams, 1999; Smedley et al. 2002). Minority populations are also more likely to report higher levels of dissatisfaction with and distrust of treatment and care (Moore and Butow, 2005), which may restrict access to health care. Finally, research has indicated that both language difficulties (Ngo-Metzger, Massagli and Clarridge, 2003) and cultural isolation (Ponce, Hays and Cunningham, 2006) contribute to migrants’ distress.

Whilst the provision of interpreters when patients attend medical consultations may potentially address some of these difficulties, a number of studies have revealed problems with medical interpretation, including inaccuracy, inconsistency (Dysard-Gale, 2007; Flores, Laws, Mayo, Zuckerman, Abreu and Medina, 2007) and confusion regarding the interpreter’s role (Kaufert and Koolage, 1984). Medical interpreting standards of practice developed by the International Medical Interpreters Association and Education Development Center (2007) state that interpreters must maintain accuracy, confidentiality, impartiality and professional distance at all times. Similarly, in Australia, the professional Code of Ethics of the Australian Institute of Interpreters and Translators Inc. (AUSIT) states that interpreters must “relay
accurately and completely all that is said by all parties in a meeting”, and does not include other activities within the role definition. However, while in both the US and Australia accreditation bodies oversee standards of interpreter training, the content of such training is diverse and it is impossible to determine how clearly they communicate standards of conduct. A number of studies have revealed the difficulty which interpreters experience in trying to keep to these standards. Hseih (2006) interviewed medical interpreters in the USA, who reported that they struggled to work within the definition of their role and saw themselves as an advocate for patients.

These challenges may be further heightened in oncological settings, because of the complexity of information and treatment options, cultural stigma related to the illness, and the frequency with which bad news is discussed. Only a few studies have explored interpreters’ experiences in this context. Abbe, Simon, Angiolillo, Ruccione and Kodish (2006) surveyed pediatric oncologists, interpreters and patients in California. Interpreters reported that complexity of information, information overload, and lack of clinician sensitivity toward the cultural and socioeconomic backgrounds of families with limited English were their primary challenges. Within the palliative care setting, Norris, Wenrich, Nielsen, Treece, Jackson and Curtis (2005) conducted a large qualitative study of 68 professional medical interpreters in the US about communication about end of life care. These interpreters emphasized the importance of both doctor and interpreter conveying compassion when delivering bad news. They reported experiencing a tension between providing strict interpretation and being a cultural broker, finding breaking bad news difficult, feeling sometimes abandoned or abused by clinicians and finding it hard to balance the focus on patients and family.
However, there has been no research to date obtaining interpreters’ perspectives on their role in the adult oncology setting. While this setting clearly overlaps with that of pediatric and palliative care, the increasingly complex treatment decisions facing adults with cancer makes this a particularly challenging communication environment.

Aims

The aims of this study were to understand: a) interpreters’ perceptions of their role; b) challenges faced working in the adult oncology setting, and c) training and support needs.

Method

Interpreters were recruited from health care interpreter services in Victoria and New South Wales, Australia. This study is part of a larger study exploring the needs of Chinese (Mandarin and Cantonese), Greek and Arabic speaking migrants with cancer in Australia so only interpreters of these languages were included. Eligibility criteria included: a) age 18 years and over; b) formal training in interpretation and c) currently interpreting with Arabic, Chinese (Mandarin and Cantonese) or Greek speaking people with cancer. Recruitment continued until saturation of themes was evident, which occurred after four groups.

Interpreters were invited to attend a focus group of 1.5 to 2 hours duration with 5-7 other participants, facilitated by researchers with expertise in qualitative methodology and migrant issues. Prompt questions exploring the three aims listed above, guided the interview (see Appendix A). Participants also completed a short demographic questionnaire eliciting details of age, gender, country of birth, years in Australia, education level, interpretation accreditation level, years interpreting and perceived understanding of medical terminology; and the Rissell Acculturation Scale, a theoretically grounded measure with proven
psychometric properties used previously with Australian immigrant cancer patients (Rissel, 1997). A higher score on the acculturation scale indicates greater acculturation to the host country.

The focus groups were audio-taped, transcribed, then analysed using an interpretative phenomenological analysis (IPA) framework (Smith et al, 2009). Briefly, the IPA is a qualitative research approach for understanding how people experience and ascribe meaning to an aspect of their lives. IPA is concerned with eliciting in-depth personal accounts of a “phenomenon” (that is, a particular event or process) from the participants who take part in the study. In order to understand their perspectives, IPA researchers inevitably apply their own conceptions trying to understand their participants’ world through a process of “interpretative” activity.

Two researchers (EL, PS) independently read and content analysed each interview and developed a set of themes and subthemes. The coding systems were compared, disparities discussed and a final coding scheme was agreed upon. The transcripts were then coded thematically line by line by the same two researchers and characteristic quotes identified. The software package N-Vivo (QSR International Pty Ltd, Victoria, Australia) was used to assist this process.

**Results**

All interpreters invited, participated in the study, a response rate of 100%. Thirty interpreters were recruited (Chinese n = 11, Arabic, n = 12 and Greek, n = 7), 18 being female (see Table 1); their mean age was 48 years (range 27-72). Interpreters’ mean Acculturation Score was 19
(range 13-25), indicating a moderate level of acculturation. They had spent on average eight years interpreting (range 1-30) with eight having reached a National Accreditation Authority for Translators and Interpreters (NAATI) II level of accreditation (paraprofessional) and 12 NAATI III (professional). All interpreters provided interpretation services across the hospital; therefore Oncology was only one setting in which they worked. As no clear differences were evident between language groups their data were combined.

**Skills as an interpreter**

Participants were on the whole very clear about the role they were supposed to take in the consultation, which they saw principally as conveying information, ensuring understanding, and being accurate, confidential and impartial.

> “According to our training we are meant to be, I guess, invisible, we are just that language bridge. So I guess whatever information comes out of the professional’s, ... mouth, needs to be transferred into the other language and vice versa”.

However, despite their role clarity, the interpreters described three broad dilemmas which faced them daily:

a) **being accurate but also ensuring understanding**;

b) **translating only versus cultural advocacy and sensitivity**;

c) **maintaining a professional distance versus providing support**.

1. **Being accurate but also ensuring understanding.**
Many interpreters felt their role was to ensure understanding, as well as to convey information accurately.

“…to make sure both sides understand each other... for the patient to understand everything and of course for the healthcare provider to understand what the patient is suffering and to make the right decision to help this patient”.

Interpreters felt that different dialects, low levels of education and literacy and unfamiliarity with the Australian health system led to many migrants struggling to understand what was said, even when it was interpreted accurately. Interpreters saw their role as including asking the oncologist to clarify terminology, paraphrase, or use simpler language if necessary. If the doctor did not assist in this process, they were often in a bind, perceiving that the patient had not understood the message. In some instances they felt bound to re-word what the doctor said to simplify the message. Interpreters seemed to make their own judgment about whether patients would understand what the doctor was saying.

“If the patient looks or says ‘what are you talking about’, I will ……tell the doctor this is what they have asked can you explain it again”.

“If you say blood transfusion . . . I guess the simple way to say it is to give someone blood. So you are paraphrasing but you are still passing on the message.”

2. Translating only versus cultural advocacy and sensitivity
The interpreters noted that some cultures have a tradition of passivity in medical encounters and/or a deep respect for the doctor which stops patients from asking the questions they need to ask in order to fully understand their situation.

“Now back home, a doctor is someone who has high social status. You wouldn’t dare to argue with [the doctor]- whatever doctor say, you got to listen. So…they don’t like talk, and whatever doctor says they will agree…whatever doctor think best”.

Interpreters sometimes felt the need to act as a cultural advocate, by intervening to encourage patients to ask questions, or to ask questions on their behalf. They also felt that migrant patients sometimes became confused when asked to make treatment decisions, as they expected to be told by the doctor what to do; and may be disadvantaged by having the “Western approach” to decision-making imposed upon them. Sometimes they were put into a difficult position when patients turned to them for advice, which they felt unable to give.

“[Here] the doctors ... tell them the choices and let the patient decide what to do . . and it seems like especially older patients, they don’t know what to do..... And then the patient sometimes.. in such a situation will turn to the interpreter what do you think? What do all the other patients in similar cases as mine... I feel sorry for them as they don’t really know what to do in the Western eyes... it’s a different approach.”

Many interpreters felt a responsibility to protect the patient from culturally inappropriate words or messages. The word “cancer” was challenging; interpreters noted it is associated with unavoidable death in many cultures. Some interpreters preferred to use a euphemism,
such as “tumour” in its stead, or to at least add a few words to acknowledge the seriousness of the term. Most emphasised the importance of negotiating with the doctor about this.

“If there are, like certain sentence or certain words (that) are culturally very sensitive I will tell the healthcare provider that I can’t say that and I’ll explain why and I’ll ask the doctor to choose something which is less sensitive. I can’t actually add a word in you know.”

“I mean to the patients (it) is... critical because in our culture it is really cruel to tell the patient that he is or she is diagnosed with cancer...maybe it can cause him to be depressed or maybe diminish his ability or willingness to survive. So we ... can find some code word, like instead of saying you have cancer, we can use the word tumour... and we’re going to ... treat you for that tumour, but knowing that a tumour will be treated the same way as cancer would be treated. So we can get around that and use code words just to, you know, just to make it easier...just to alleviate the situation and make it acceptable, more acceptable.”

“They call it the killer, ... the malignant one, always. ... So you have to say a few words for example ‘God forbidden’... Although the doctor ... would not say it unless it’s from the same background, from Arabic background, they would say it. ... we have to say it, as I said because it’s a cultural thing for it.”

Many of the Arabic speaking interpreters noted the cultural belief that no one can predict a patient’s prognosis as “only God can decide who lives or dies” and highlighted the need for doctors to be sensitive around this issue.
Some interpreters noted that they highly valued the opportunity to discuss culturally challenging issues without the patient present.

“*Other times they give you the opportunity to talk to them before ... a lot of times they will pull you aside and they will inform you or brief you about the situation and [ask ... what is in your culture? ... How you approach this person? ... Should I tell him he’s dying in six months or not, that sort of thing."

3. **Maintaining a professional distance versus providing support.**

There was disagreement around what level of involvement an interpreter should have with the patient outside of the consultation. Interpreters noted a tension between the comfort they could offer people from their own culture, and the need to keep a professional distance. Some felt it was impossible not to engage with the human emotions and stories to which they were witness.

“We’re supposed to be just a voice there like a box who’s got no senses or no feeling but you can’t take the human factor out of it it’s no matter what you do you know what I mean. Yes we are there, we have to be impartial, we have to be independent but er, you can’t take the heart out of a person, you know what I mean?”

Some enjoyed their capacity to provide support, others felt they would be emotionally overwhelmed if they became involved, or felt bound by their professional ethics to maintain distance and impartiality.
The interpreters discussed a range of support they offered, ranging from implicit support when they provided a bridge between the patient’s culture and that of the doctor, to more active intervention. Implicit support is demonstrated by the following quote.

“…..most of those people in their late eighties didn’t get a chance to educate themselves because of the war in Greece and in Europe, and in that way they feel a little bit intimidated by the non speaking English (sic) professional. And when they find out there is an interpreter present they feel relaxed number one, comfortable …..and yes so ...we break the ice between the professional and the patient.”

A few interpreters felt their role in providing support required active intervention, because of the unmet needs they observed in these patients. These interpreters reported that patients often identified with them as someone from their own culture who represented a familiar link within an unfamiliar health system and someone who could advocate for them.

“Yeah, sometimes (I have ) multiple roles…. sometimes I ... do a little bit extra... in English-speaking community if someone gets cancer they usually can be easily referred to a … cancer patient support group. For the Chinese we have a sort of organisation ... so sometimes we will just give them a leaflet with the contact number. ... And some patients may have difficulties accessing information on the internet because they don’t read that much English ... So if they have a question that they are not sure, (not specific question, but more general question), then I sometimes do a bit of research for them after I go home and then just call them back just let them know ... what I have found. But I will tell them that for this specific information they have to ask their treating doctor.”
Other interpreters were much more circumspect in their involvement with patients. They said that they avoid having long conversations and talks with the patients as it blurs the distinction between a personal and professional relationship. They felt they would quickly become burned out if they engaged emotionally with patients. Further they felt such interaction could interfere with their primary role of interpretation.

“…if the patient needs support, refer them to a social worker .., but to ask (me) to stay in the waiting time, support that patient it’s – it’s heartbreaking for us. I try to keep distance between me and the patient.”

Other challenges of interpretation in the cancer context

Apart from the dilemmas outlined above, and inevitable time constraints, the interpreters noted a number of challenges in their role which were exacerbated in the emotionally charged atmosphere of a cancer consultation. These included lack of continuity with patients, managing their own feelings, dealing with families, and telephone interpretation.

Continuity

Some interpreters stressed the importance of patient-interpreter continuity so there was an opportunity to build a trusting relationship.

“It would be a good idea if one interpreter stick to one patient in the end.. because I don’t feel comfortable having many different interpreters...I think for confidentiality...having to tell your story again.”
However, some interpreters did not like continuity, as it increased the likelihood they would become emotionally involved.

“I think for the sake of the interpreter...it’s better not to book the same interpreter for the same patients for the following appointments....because [this] is very stressful for us – it’s better to give a bit of a break between appointments...because you’re ...emotional.”

**Emotional burden**

Many interpreters talked about the emotional impact of sitting in on cancer consultations, particularly those in which bad news was delivered, for which they were ill prepared. Interpreters noted that some consultations were so distressing that they found it difficult to “switch off” and that it intruded on their home life. They felt this is an under-recognised issue for interpreters for which they get little or no support.

“Many times I go outside and I cry. Many times especially .... I sit on the bus stop you know...and I cry there because you know it affects us. We get emotional ..I have a family. Yeah it’s very bad. It’s very sad.”

“You know when you’ve got five cancer patients a day there’s too much on you and there’s no body to talk to. I had to keep on ringing ... I rang different colleagues I couldn’t cope because I was suffering from something myself, I found it so overwhelming. There’s no sensitivity about us.”
Interpreting in the “bad news consultation” also highlighted the tension between upholding the code of practice for interpreters that required impartiality yet responding in a compassionate manner.

“I told her in the few words as the doctor said it and she burst into tears and uncontrollable sobbing . . . That was sad in a way but of course my time, my composure, you are there ... to do break that unfortunate news but it’s part of the job.”

Some interpreters noted the lack of debriefing they received after emotional encounters.

“Unfortunately that is a problem that we all have that there is no debriefing for interpreters. So I can walk out of an appointment feeling very, very bad and there is no one that you can talk to. In all the years that I have been working as an interpreter only once have I been offered debriefing and that was at the Coroner’s Court. Never in any other situation.”

**Family members**

Interpreters described several challenges in dealing with family members. The first was when family members asked the interpreter not to disclose a cancer diagnosis.

“And now the other dilemma concerning the family when they know that an interpreter is coming for a family meeting.....the patient is in the ward and the others are waiting outside.... You ...greet them in their language, they greet you back and they say please, please don’t tell the patient that they have got cancer or are dying”.
The second was when family members undertook to interpret for the patient themselves but provided inaccurate information. Interpreters felt it could be difficult for them to intervene in both of these circumstances, and that it required the doctor’s authority to ensure accurate interpretation was achieved.

“Sometimes the doctor says something, some family members know English and they try to interpret in their own way and they don’t deliver the proper information and then the doctor, some doctor will stop them and say will you please let the interpreter do their job”

Family conferences presented a particular challenge to interpreters as simultaneous translating when large numbers were present in the room was difficult. Interpreters believed that the doctors should “take control of the situation and do crowd control” by limiting the number of people who were present and managing the flow of communication. “So they have to have the authority over the interview”.

**Telephone interpreting**

Telephone interpreting was also identified as a major challenge, as it was impossible to observe patients’ body language to gauge their reactions. Many considered it inappropriate to deliver sensitive news or bad news over the telephone. They deplored the increased use of telephone interpreting as a response to budgetary pressures.

“It’s harder because you can’t see the person face to face. Sometimes you get a different accent you might have an Egyptian or an Iraqi to Lebanese and they don’t really understand. . . . . You’re telling somebody something really bad on the phone and they can’t even handle
face to face, how can you, and let alone the phone ..... I mean it disserves (sic) me, as an interpreter I don't like doing it.”

Training and support needs of interpreters; advice for oncologists

Participants expressed a need for ongoing training in medical terminology to ensure they were up-to-date and could translate these terms accurately. Some also desired training in basic counseling skills, so they could interact supportively with patients where appropriate. Interpreters suggested that an opportunity to be “mentored” or to accompany a qualified interpreter into the field would be valuable for those in training, and that all interpreters be provided with opportunities to debrief after emotive consultations and to learn other strategies to manage their own emotional responses. Participants provided suggestions to optimise the consultation when an interpreter was present, summarised in Table 2.
DISCUSSION

This is the first paper to explore interpreter perspectives in the adult oncology consultation. Despite expressing support for the parameters outlined in professional guidelines for the interpreter role, these interpreters identified a number of dilemmas and challenges they experienced daily in their role.

While noting that accurate translation is their fundamental goal, some interpreters felt that merely being a conduit of spoken language was inadequate. They noted additional barriers faced by some migrants, including broken education resulting in poor literacy in both their new and original languages, a lack of understanding of the health system in their adopted country and a dis-connect between migrants’ and oncologists’ conceptualization of illness and treatment. Some interpreters also noted the discomfort some cultural groups experienced in being exposed to the Western style of informed decision-making. Such patients expected to be told what to do, and were confused, lacking in confidence and fearful of making the wrong decision. Is it the interpreter’s responsibility to note misunderstanding and cultural clashes and to advocate on the patient's behalf for clarification, paraphrasing and sensitivity?

Some have argued that interpreters should assume the role of ‘culture brokers’ (e.g., Dysard-Gale, 2007; Kaufert et al., 1984). This may include explaining biomedical terminology, diseases and processes of disease and treatment to patients in a manner likely to be understood by patients, initiating information-seeking behaviours, participating in diagnostic tasks, and explaining to the clinician the possible cultural origins of the patient’s illness perspective and illness behavior, and broader cultural factors that may be influencing the patient and the patient’s communication with the clinician (Dysard-Gale, 2007; Kaufert et al., 1984; Hsieh, 2007).
It should be noted that there was considerable diversity of opinion concerning whether it is appropriate to assume this cultural brokerage role and strong preference for negotiating such a role before the consultation to ensure they could work together, rather than against each other. Indeed, others (e.g., Kaufert et al., 1984) have noted that an excessive alliance between patients and interpreters may lead clinicians to feel left out and unable to forge the clinical relationship required to ensure optimal treatment negotiation and consequent therapeutic outcomes (Mechanic and Meyer, 2000). The interpreters’ awareness of such dynamics shows a sophisticated approach to communication in this setting. If an advocacy role is adopted, it would certainly be important for interpreters to explicitly signal to both doctor and patient that they were temporarily departing from strict translation to take on this different role.

The words of participants in this study echoed the work of Hsieh (2006, 2007). He notes that although certain behaviors, such as developing rapport with patients, may seem natural for providers, interpreters are trained to avoid any verbal, physical, or emotional interactions with the patient without the presence of providers. Indeed, transgression of this rule was regarded as justification for dismissal in 1984 (Kaufert et al., 1984), yet our findings indicate that not only does this occur but it is perceived to be a rewarding part of the role.

Interpreters in this study reported distress because they had to refrain from comforting patients and in reality spoke to patients outside of the medical consultation. They felt that it is unfeeling to expect interpreters not to comfort a patient when they may be the only persons that the patient can relate to or communicate with in health care settings. Schapiro, Vargas, Hidalgo, Brier, Sanchez, Hobrecker et al. (2008) also note that the “standard” model of
impartiality championed by interpreter societies and the medical profession may, in certain emotional or controversial situations, place the interpreter in an ethically difficult position. Some (Putsch, 1985) have argued that real neutrality is a myth, and certainly this was reinforced by our findings, with many interpreters openly disclosing their inability to remain neutral. The California Standards for Healthcare Interpreters (http://chiaonline.org/standards/) acknowledges multiple interpreter roles, including cultural clarifier and patient advocate. This suggests that at least in some countries, the standards applied to medical interpretation are slowly changing.

We agree with Hsieh (2006) that we need to better understand the parameters of extending the interpreters role and where it can be helpful or unhelpful. By developing realistic expectations and policy guidelines for interpreters providing patient advocacy and support, interpreters are less likely to depart from an appropriate role and are more likely to be held accountable for any inappropriate behaviors, such as acting in the role of a social worker. Further, recognition of interpreter engagement with patient distress is likely to increase interpreters’ sense of control over their work environment and the provision of support and debriefing, needs well articulated by the participants in the current study.

Dean & Pollard (2001) note that the capacity and autonomy to manage work demands (by making decisions, bringing skills or resources or altering the environment) are essential to preventing stress and burn-out, according to the demand-control theory of Karasek & Theorell (1990). These authors note that the lack of autonomy experienced by many interpreters places this profession at a high risk of stress and burnout, as evidenced by the distress expressed by many of the participants in the current study. With better role definition and training, we
believe that interpreters can be equipped to bring skills and resources to the cancer consultation that will allow them to make a more positive contribution and reduce their own burnout. For example, skills training in delivering bad news; training in ways to provide support to patients/families; training in self care and managing emotions; and training in oncology and cancer terminology. Thus educational opportunities may need to be developed both within generic training programs and within specialist environments, such as the Oncology setting.

However, interpreters providing care in parallel to but without much communication with the medical team does not appear to work well, at least in the setting of cancer care. Many oncologists would be concerned if information they intended to convey (such as diagnosis or prognosis) was being filtered by the interpreter. A model where interpreters were integrated into the multi-disciplinary team might be optimal, although hard to achieve in the current health system. Ways in which oncologists can work more effectively with interpreters were identified in this study, as previously documented (e.g. Abbe et al., 2006; Schapiro et al., 2008; Norris et al, 2005) but in addition emphasise the importance of the doctor taking control of the consultation in terms of family involvement. The interpreters in this study noted that they could not control family members who blocked or mis-translated what the oncologist said, and that the doctor’s authority was required to negotiate this effectively. Further they felt the oncologist should limit the number of family members invited into the consultation to make it possible for the interpreter to follow all the conversational threads and interpret correctly. Other useful suggestions for the oncologist are summarised in Table 2. Di Ciccone, Brown, Gueguen et al (2010) recently reported an evaluation of a training program for oncologists working with interpreters. This represents an important step forward; training for
oncologists will likely produce as many benefits as specialised training for interpreters. Without all stakeholders participating in changed processes, they are unlikely to succeed.

In summary, challenges reported by interpreters in other medical settings are highlighted and emphasised in the emotional context of the cancer consultation. While the findings are not unique to Oncology, it does appear that interpreter challenges are heightened when bad news is given, and when the word “cancer” is used. It is unrealistic to expect interpreters to be silent conduits of information in this setting. Further research is needed to identify how to most effectively integrate interpreters into the multi-disciplinary team, articulate their role and provide them with appropriate guidance, training and support.
References


### Table 1. Demographic and training characteristics of participating interpreters

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<thead>
<tr>
<th>Demographic</th>
<th>Mean (range)</th>
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<tbody>
<tr>
<td>Age</td>
<td>48 (27-72)</td>
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<tr>
<td>Years in Australia</td>
<td>20 (4-52)</td>
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<tr>
<td>Acculturation</td>
<td>19*(13-26) (maximum score=35)</td>
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<td>Years interpreting</td>
<td>8 (1-30)</td>
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<td>Ethnicity</td>
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<td>Chinese</td>
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<td>Arabic</td>
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<td>Greek</td>
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<td>Gender</td>
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<td>Lebanon</td>
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<td>Sudan</td>
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Greece 3
Cyprus 1
Eritrea 1

Highest Education

School 1
Technical Education 8
University graduate 13
Post-graduate 8
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<th>Before the Consultation</th>
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<tbody>
<tr>
<td>Book an interpreter who speaks the same dialect as the patient</td>
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<td>Plan for a long consultation</td>
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<td>Minimise administrative tasks for the interpreter</td>
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<td>Keep to schedule so that the interpreter’s time is spent in the consultation</td>
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<td>Brief the interpreter on the case beforehand and discuss potential challenges</td>
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<td>Limit the number of family members who can attend</td>
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<th>During the Consultation</th>
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<tr>
<td>Be directive, take control of the consultation</td>
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<td>Use the interpreter, not a family member, and advocate for the interpreter if necessary</td>
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<td>Check understanding and paraphrase</td>
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<td>Invite and endorse questions</td>
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<tr>
<td>Speak slowly and in small chunks</td>
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<tr>
<td>Speak directly to the patient, rather than through the interpreter</td>
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<td>Check first if and what kind of prognostic information is required;</td>
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Many cultures would prefer an in-exact prognosis

Provide information on support services

Provide access to translated information

Summarise the main take-home messages

**After the Consultation**

Check how the interpreter is feeling after a difficult consultation.

De-brief with the interpreter

Undertake training in cross-cultural sensitivity

Train junior doctors on the role of interpreter
FOCUS GROUPS INTERVIEW SCHEDULE

Interpreter Role in the Oncology setting - General

1. How do you view your role as an interpreter in the cancer setting?
   a. In your experience what comprises good interpreting?
   b. What are you told in training, and is this different from actual practice?

2. What (if any) aspects of interpreting in Oncology consultations do you find difficult?
   a. Describe a particular situation that you found challenging.
   b. Do patients ever ask your opinion or seek your help in decision making? How do you manage these situations?

3. What is your experience of having a member of the cancer patient’s family present during the consultation and how has this impacted on your interpreting?

4. What situations do you find emotionally challenging?
   a. How does this affect you? How does it affect the patient?
   b. How do you cope with such situations
   c. Have you ever sought or received some support with these issues.

5. What system or structural problems have you come across?
   a. How these issues impact on you and on the patient.

   a. What are the consequences of mis-communication
   b. In your experience, how can an interpreter ensure effective communication?

Cultural Differences

7. How is cancer perceived in your culture, and how is this different from Western culture?
   a. Does this cause any problems when interpreting? (elaborate)
   b. How do you overcome these issues?
c. What do you suggest is an appropriate way to talk about this issue with people from your cultural background

8. What do patients expect from a consultation with an oncologist?

9. How do you manage cultural differences?

10. Are there specific issues which you find difficult to interpret due to cultural differences on these issues?

**Overall:**

11. How can clinicians make your job easier?

12. What advice would you give to oncologists dealing with CALD patients?

13. Do you think interpreters should be trained differently? How?

14. Anything else you would like to add that we have not covered?