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Research

'It depends on the consultation': revisiting use of family members as interpreters for general practice consultations – when and why?

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Abstract. Family members continue to be used as interpreters in medical consultations despite the well-known risks. This paper examines participant perceptions of this practice in three New Zealand clinics chosen for their frequent use of interpreters and their skill in using them. It is based on a detailed study of 17 video-recorded interpreted consultations and 48 post-consultation interviews with participants (5 doctors, 16 patients and 12 interpreters, including 6 family members). All participants expressed satisfaction with the communication. Analysis of the interviews explored what participants liked or valued about family member interpreters (FMIs). Key themes were the FMIs' personal relationship and knowledge, patient comfort, trust, cultural norms, time efficiency and continued help outside the consultation. General practitioners (GPs) expressed awareness of potential risks and how to manage them, in contrast to patients and FMIs. Although the use of professional interpreters needs to be strongly promoted, a well-informed decision to use a family member is appropriate in some situations. GPs need to be well trained in how to assess and manage the risks. Rather than striving for 'best practice' (i.e. universal use of professional interpreters), it is better to aim for 'good practice' where a considered judgement is made about each situation on an individual basis.

Additional keywords: care of Limited English Proficiency Patients, communication barriers, interpreter services, translating.

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Introduction

> Jeanine . . . took the sensible step of using May, the Lees' most Americanized daughter, as her interpreter. Not only was May's English excellent . . . but after Jeanine left, Foua and Nao Kao were able to ask May, as often as was necessary, 'Explain what Jenny said again.' [Fadiman 1997, p. 113].

This quotation from Fadiman's seminal book 'The Spirit Catches You and You Fall Down' captures the appeal of a practice that is often seen as controversial, sloppy practice or downright wrong: the use of a family member to interpret in medical situations. It flies in the face of most 'best practice' recommendations for how to manage a consultation with a patient with limited English (Aranguri *et al*. 2006; Jacobs *et al*. 2010; Phillips 2010). This article draws on the results of a study into the use of interpreters in New Zealand general practice to explore what lies behind this alternative viewpoint, and considers the circumstances in which the use of family members as interpreters might be justified.

The suggestion that there may be a place for limited use of family member interpreters (FMIs) is not to deny the benefits of using professional interpreters – these are well established and described extensively in the literature. Indeed, the use of professional interpreters in health care still needs to be strongly promoted, as they remain underutilised in New Zealand and other countries (Seers *et al*. 2013). Nevertheless, to inform clinician training, there is also a need to understand the limited conditions in which a different solution might be preferable.

There are clearly many situations (e.g. acute hospital care, mental or sexual health and so on) where use of a family member is quite inappropriate and might cause great stress (e.g. Seidelman and Bachner 2010). The risks of using untrained interpreters more generally are also well documented (see our previous article; Gray *et al*. 2011) and should not be minimised. However, some authors have argued that there is a place in some circumstances for the use of appropriate adult family members as interpreters (Butow *et al*. 2011; Fryer *et al*. 2013), and that the benefits of this practice will be maximised by training of clinicians (Meeuwesen *et al*. 2010; Ramsey *et al*. 2012).

What is known about the topic?

- Family members are often used as interpreters in general practice consultations despite guidelines advising against this. There are risks to this practice.

What does this paper add?

- Family members are sometimes preferred as interpreters for valid reasons. Health professionals need training to assess the best interpreting option for each consultation and to manage the risks and benefits.

The potential advantages of using a family member documented in previous research include high levels of trust (Edwards *et al*. 2005), the additional useful information they can provide (Leanza *et al*. 2013) and time savings afforded by the dual role the family member takes as interpreter as well as caregiver or concerned family (Meyer *et al*. 2010). The costs of employing a professional interpreter are also saved. Although it is still generally considered 'best practice' to use a professional interpreter, some authors are thus arguing for a more nuanced position, emphasising the need to consider what is best for each patient individually (Hadziabdic *et al*. 2014), with due regard for cultural norms and the need to ensure confidentiality, accuracy and safety.

Research into this issue is methodologically challenging due to the language barriers and the number of participants involved in each consultation. Previous research has studied the views of participants through interviews (Zendedel *et al*. 2016) or focus groups (O'Reilly-de Brún *et al*. 2015) or by examining recorded consultations (Meyer *et al*. 2010). This paper is based on a study that combined these methodologies, using video recordings of consultations and post-consultation interviews with all participants (patients, doctors and interpreters).

The focus on perspectives from all participants addresses limitations of our previous study (Gray *et al*. 2011) in which only the doctors' views were elicited through a written survey. The focus in this study was on analysing authentic interaction as captured in video recordings of actual consultations, and on interviewing triads of participants who had all shared a common experience; this accords with recommendations of a similar study (Zendedel *et al*. 2016).

Methods

Data collection

The study used a purposive sample of three suburban GP practices in New Zealand with patient populations from lower socioeconomic groups and with a significant proportion (estimated up to 50%) of refugees and recent migrants who are both linguistically and ethnically diverse.

GPs in the three practices (all NZ Europeans with experience but no formal training in the use of interpreters) were recruited and asked to identify future routine consultation appointments where an 'interpreter' would be used, whether professional or not. The GPs asked the patients and their interpreters before the consultation if they were willing to take part. A researcher obtained formal written consent immediately before the consultation, with the assistance of the interpreter.

Each consultation was video- and audio-recorded. Three researchers interviewed one participant each (GP, patient and interpreter) as soon after the consultation as possible, using non-participating telephone interpreters with the patients. Interviews (15–30 min long) covered a range of topics including the quality of communication and of the interpreting in the consultation, and interpreter preferences. Researchers also wrote field notes and obtained clinical notes.

Audio recordings of the consultations were closely transcribed by a professional transcriber. Translators or interpreters (in most cases from outside the local community) translated those parts of the interaction that were not in English. Only the English content of the interviews was directly transcribed. Table 1 provides an overview of the data collected for the full study. This paper draws on a subset of the full dataset (mainly the interview data), with the aim of exploring the use of family members as interpreters, where the most relevant interviews involved consultations featuring FMIs.

Analysis

The transcripts of the consultations were analysed by a researcher and several themes identified. The analysis was then further developed via several data sessions involving the full research team, which included clinicians (two GPs and a primary care nurse).

The interviews were analysed using inductive thematic–framework analysis. Views from each participant were compared with the others in the same interaction and resulting themes were cross-checked against what had occurred in the recorded consultation. Field notes provided additional ethnographic information to inform the analysis.

Pseudonyms have been used for all names of participants mentioned in quotations in this paper.

The study was approved by the New Zealand Central Regional Ethics Committee (CEN/11/12/073).

Results

Family members were used as interpreters (FMIs) in 6 of the 17 consultations in the study. This is a lower proportion than in our previous week-long audit study of one of the practices[A] (Gray *et al*. 2011), but shows the ongoing nature of FMI use.

Table 2 shows demographic information on the patients and their FMIs for these six consultations.

Participant views

Satisfaction with interpreting

All participants expressed overall satisfaction with the interpreting in all the recorded consultations, with occasional caveats such as 'very good for a family member' or 'not as good as face-to-face would have been' for a telephone interpreter.

Where FMIs were used, all participants expressed satisfaction with both the communication overall and with the interpreting.

[A]The rate in our previous study was inflated by the inclusion of drop-in clinics, which used family members at a much higher rate (83%).

Importantly, examination of the recorded consultations also found no overt signs of dissatisfaction or significant problems with communication.

Preferred type of interpreter

Patients' views

The patients' limited experience of different types of interpreters often made it difficult for them to express a preference. One who had used a FMI stated that she would like to try a professional interpreter.

Of those whose views on this issue were obtained (10 out of 16 patients), there was no clear consensus on preference; four preferred family members, two were ambivalent and four stated a preference for professional interpreters, on the basis that family members 'sometimes don't interpret everything' or don't know medical terms. Generally, patients stated a preference for the type of interpreter they had just used.

GPs' views

The five GPs' preferences also varied. Two expressed clear preferences: one for face-to-face professionals and one for FMIs. The remaining three expressed an inclination towards professionals or bilingual clinic staff, with one ambivalent between professionals and family. There was awareness of the need to judge the appropriate choice on a case-by-case basis, with the three more ambivalent GPs noting in very similar words that it depends on the situation. The following extract illustrates one GP's view of the strengths of the different options:

> I do most appreciate having a professional interpreter in person . . . second to that I guess would I would probably say I found Language Line to be surprisingly helpful especially in conveying explanations. And as far as expediting actually getting stuff done there's nothing beats family members for just being able . . . to be there spending [time] with the family member . . . got that vested interest and I think there's a lot of value in that. So depends on the situation. . . [GP36].

A different view was held by the GP who unequivocally preferred professionals, noting that confidentiality concerns in her view over-rode patient preference for FMIs.

Table 1. Overview of the whole study

	Number	Male	Female
Participants			
Patients	16	4	12
General practitioners	5	3	2
Interpreters	12	2	10
Languages ($n = 8$)			
Assyrian	5		
Gujarati	1		
Khmer	2		
Mandarin	1		
Samoan	3		
Somali	2		
Tigrinya and Arabic	1		
Tongan	1		
Consultations	17		
Professional interpreter	10		
Face-to-face (in-house = 4)	8		
Phone	2		
Family members	6		
Bilingual nurse	1		
Interviews	48		

Views on FMIs

Patients

Three main reasons for preferring FMIs were given by patients who had used one:

Personal relationship and knowledge. The most commonly mentioned reason was the close relationship patients had with the FMI. Because they knew them well, they had to explain less and could rely on them to understand and fill in any gaps.

> I want my daughter to translate what we're talking about because she knows, she knows everything about me . . . and she understanding about me [Samoan woman – own words].

> . . .the advantage there would be that they would understand me and my problems and where I'm coming from. . . Cos they, I live with them and they know my – if I had a condition they would know my health problems and they could tell that to the doctor because we – we've got that relationship – mother and daughter relationship [Somali woman – interpreted words].

Trust. Patients also mentioned the importance of the trust they had in their family member.

Table 2. Demographics of patients and their family member interpreters (FMIs)
F, female; M, male

Language	Patient gender	Patient age (years)	FMI relationship to patient	FMI age (years)	FMI education
Assyrian	F	59	Sister-in-law	36	University
Gujarati	M	51	Daughter	27	Post-graduate diploma
Samoan	F	88	Daughter	44	Secondary school
Samoan	F	49	Daughter	28	Secondary school
Somali	F	65	Son	36	Post-graduate
Tongan	M	66	Daughter	38	Secondary school

> . . .the only real reason I have to bring my daughter was I still trust my children especially this daughter [Tongan man – interpreted words].

> I believe in my family [Samoan woman – own words].

Cultural norms. In some communities, notably Pacific communities in the New Zealand context, it is a cultural norm for family members to take care of their parents and this often extends to interpreting. In fact, none of the four recorded consultations with Pacific patients used a professional interpreter (although one used a bilingual nurse who is a trusted member of the community).

> . . .because my family always around with me when I going somewhere . . . always . . . my children are take care of me very important [Samoan woman – own words].

Only 3 of the 16 patients in our study mentioned disadvantages of using FMIs. Two mentioned lack of availability, one of whom also mentioned possible lack of medical terminology, and another mentioned omissions. One patient noted the unsuitability of using children. One patient, who had just used a professional for the first time instead of his son, expressed the following view:

> Compared to my son the professional interpreter is better at interpreting. He is very (fast) and very detailed and I understood everything . . . I prefer to use this interpreter rather than my son cos sometimes my son doesn't interpret everything and he is not professional interpreter . . . the main problem is that he don't really have much time. He need to go to work [Chinese man – interpreted words].

Family member interpreters

Responses of FMIs were similar to those of patients. Although personal knowledge of their family member was prominent, they also thought patients were more comfortable with them than with a professional.

Personal relationship and knowledge. A prominent theme was their personal knowledge of their family member based on their relationship.

> I think it's advantages for me um as being a family member and interpreting for my parents . . . I know in their daily life what are the problems they are facing and the rest [Gujarati daughter].

> I think personal relationship . . . would help, you know, especially when you . . . know them by heart, you know? [Tongan daughter].

Patient comfort. FMIs also thought patients were more comfortable with them than with a professional.

> Sometime she say I feel um more comfortable with you rather than interpreter because you know with the interpreter it's a different person so you can't say . . . everything to the . . . interpreter just the main thing? . . . like when you have something . . . like feeling sad and you're like something . . . from your family you know? . . . between your family. You can't say it . . . sometimes to the interpreter. . . You have to be like very close family [Assyrian sister-in-law].

It was noted, however, that the advantage of patient comfort depends on patients having the right family member with them – one they really do feel comfortable with:

> . . .one time she took . . . one of her cousin . . . and she say oh it's not like you, you know . . . she knows everything about me . . . she can do . . . whatever . . . she can translate . . . whatever she told her but, I don't know – she doesn't feel comfortable you know [Assyrian sister-in-law].

The FMIs appeared unaware of potential risks or disadvantages of them taking on the role of interpreter when questioned on this:

> . . . no I don't think that there's any risk there at all [Tongan daughter].
>
> Researcher: Do you think that there's any disadvantages? With being family?
>
> FMI: No I don't think so. No because I believe in family. [Gujarati daughter].

However, two mentioned that professional interpreters may be more accurate and better for more complicated issues.

One noted the limitations of her own language ability, due to having grown up in a mostly English speaking environment:

> English is okay for me, you know, but . . . sometimes when trying to translate it into Tongan, you know? It's sort of like I find myself sometimes . . . stuck with the Tongan language [laughs] especially when you've been in New Zealand for a while and then . . . you don't speak much Tongan [Tongan daughter].

GPs

The GPs were more likely than other participants to mention the well-known risks of FMIs, including omissions, gate-keeping, agenda-setting, inaccuracies and confidentiality issues, as well as difficulty with eye contact and its effect on rapport building with the patient. They tended to emphasise that the best interpreter for a consultation was highly dependent on circumstances (including the quality of the relationship between the patient and FMI) and were more aware of the dual role that family members performed (i.e. as interpreter as well as on the continuum from concerned family member to caregiver), which GPs valued. They cited two main benefits to using FMIs.

Patient comfort. Like the FMIs, the GPS perceived greater patient comfort when using family members.

> . . .so I think when there's . . . quite a bit of English they feel more relaxed with family members? . . . than an outside interpreter? [GP35].

Positive aspects of the dual role. GPs valued the efficiency of one person playing two roles in the consultation.

> I think the strength . . . is she's not just interpreting but she's her caregiver, so I'm asking her the questions about caregiving at the same time as she's interpreting for her mother [GP35].

> I think many people with complex medical problems, it's also good for them to have a concerned family member who understands what's going on so I feel that this was a double value situation here [GP33].

Two specific benefits of the dual role of a FMI (when managed well) were time efficiency and the fact that the FMI could continue to help the patient outside the consultation:

> . . .in that instance I felt that it was pragmatic to talk to Amishi as though she was a supportive family member who would be able to help him to quit smoking rather than as purely as a translator . . . I knew it was going to be more time efficient just to tell her how to use the smoking, the nicotine replacement patch . . . rather than to get her to translate every sentence to him in the knowledge that she would be able to talk about that with him after the consultation [GP36].

> . . .for instance . . . exactly with this sort of situation when you've got to deal with hospital appointments or [government organisations] and so on . . . the telephone interpreter or the professional interpreter can do the consultation but the patient is left with lots of things that are going to need interpreting outside the consultation which aren't included in the interpreting service that we've engaged with [GP33].

Several GPs mentioned that the success of a FMI depended on the nature of the consultation.

> I also think family members can be really good too for some types of consultations, you know. It depends on the consultation [GP24].

The focus of these GPs on judging the best interpreter for each situation is exemplified in one GP's comment that it is not always necessary to use the same interpreter strategy with every appointment with a given patient:

> . . .if there's any doubt about the interpreting, especially when we're dealing with chronic health issues, it might be good at one point to have at least one or two consultations with a professional interpreter, just to make sure that some medical stuff's got across, and then if it can be followed up more easily [by a family member]. . . [GP24].

The need for flexibility to the point of preparedness to change interpreting strategy even in the middle of a consultation was also mentioned in one of the feedback sessions with one practice.

Discussion

This study confirms suggestions in previous research that using family members to interpret in medical consultations can be a well-considered choice in some circumstances. The selection of the FMIs recruited for the study by the GPs signalled their judgement that the FMI interpreting was likely to be successful. This was validated by the patients and their family members in interviews, and by independent examination of the recorded consultations by the research team.

It is important to note that this is a small study of practices that are not typical, in that the staff have higher awareness of interpreting issues than most. The sample is potentially skewed towards more successful interactions, especially where FMIs were used. This is because all the GPs were relatively experienced in the management of interpreted consultations, and the consultations to be recorded were all planned and selected by GPs.

Patient interview responses were limited by several factors. The methodological decision to seek maximal diversity of ethnicity and language meant that there was a need to use telephone interpreters for patient interviews (rather than the more direct method of focusing on a single language group and using a bilingual researcher). Other factors were patient medical conditions or old age in some cases, time constraints, and the likely 'halo effect' (Nisbett and Wilson 1977) that can lead to patient responses that are overly positive because of pre-existing concepts of doctors (and potentially also of interpreters) as being 'good'.

Despite these limitations, this small qualitative study gives an insight into why some GPs and patients prefer FMIs in some circumstances. The reasons given accorded with those cited in the literature (as mentioned in the introduction). Although the extra information that a FMI can provide has been previously recognised, the fact that they have to balance dual roles is often cited as a risk that should be avoided. In contrast, the GPs in our study viewed the dual role as an advantage, a point that has not been widely discussed before, with only one paper presenting it in a positive light (Meyer *et al*. 2010).

It is important to emphasise that the GPs in this study also regularly used professional interpreters and were only using FMIs under carefully considered conditions: the consultations where FMIs were used were low-stakes, routine consultations within a primary care setting; and the FMIs were all adults with reasonably good English language ability and general education. The GPs all seemed to be conscious of the possible risks involved in their choice, as well as the benefits, and appeared ready to vary their strategy according to circumstances. For example, one GP commented that for one patient who had a reasonable level of English, he could have 'communicated very well' without an interpreter if it had been 'an emergency situation', but for 'more complicated things', a professional interpreter was preferable. They also used a range of communicative strategies to increase the effectiveness of using a FMI (this is the subject of another article, but included strategies such as briefing or prompting FMIs, etc.), and remained aware of the dual role of the family member. Making the judgement of when it might be appropriate to use a family member requires either significant experience with the use of interpreters (as with these practitioners) or training on how to make these judgements. We acknowledge the risk of clinicians making the decision to use a FMI without awareness of the risks involved.

Much of this discussion has necessarily been from the perspective of health providers. The difficulties we experienced with patient interviews draws attention to the fact that patients are often not in a position to make a truly considered choice about type of interpreter for the very reason that they need one. This lack of awareness and experience of professional interpreters can be a

barrier to patients themselves determining the best interpreting strategy from their own perspective, a point highlighted by one patient who used a professional interpreter (rather than his son) for the first time in a consultation in our study and was able to see benefits he had never considered before.

Conclusion

The GPs in this study were not using FMIs just as a way of 'getting by'; rather, this represented a conscious and considered choice as an adjunct to professional interpreter use. The benefits of the dual role of the FMI in terms of continuity of care, patient comfort (though this needs to be checked and not assumed), and in cost-saving and time-efficiency need to be acknowledged and balanced against the risks. Using family members as interpreters is far from an 'easy way out', and it needs to be acknowledged that this practice requires a higher level of experience and skill on the part of the health professional. Less experienced clinicians are advised to use professional interpreters as a default option. Accordingly, there is a need to train clinicians when and how to go about using FMIs, rather than simply warning them about the potential risks of this practice. Patients also need to be made more aware of their options and should be encouraged to try professional interpreters if they have not used them before.

Each consultation with a patient with limited English needs to be assessed individually according to a range of factors, including clinician experience to determine the best option(s) to support communication in that particular instance. Experienced clinicians may consider the use of a FMI. In this case, it is also necessary to assess the appropriateness of the particular family member according to patient preferences, attributes of the family member and nature of the consultation, with awareness that this may change even during a consultation. Managing the needs of patients with limited English is complicated and we argue there can be no singular 'best practice'. Rather, 'good practice' needs to be the aim, where the best solution for each situation is established on a case-by-case basis.

Conflicts of interest

None to declare.

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