

An Elderly Woman With Severe Anxiety Associated with Anticipated Use of an Interpreter

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The use of interpreters to overcome language barriers in medical care has become commonplace. A number of issues and positive benefits have been addressed regarding the use of interpreters in clinical encounters.¹ The following case describes an unintended adverse consequence of the required use of a formal interpreter for a clinical encounter.

Case Report

A frail 91-year-old woman of Greek descent was cared for in a geriatrics clinic for falls, depression, and hypertension. Her cognitive function was intact. She lived independently in an urban apartment. Her primary language was Greek, and she had limited English language skills. In past visits, the patient's daughter served as the Greek interpreter. The patient's daughter was adept at interpreting and worked as a professional interpreter in local legal settings.

Because of her frailty, falls, and a recent bout of pneumonia, the patient was at the crossroads of maintaining her independent living status. In the past year, during several transient periods of functional decline, she had moved in with her daughter for short periods. After recovery, however, she always insisted on going back to her apartment because of her strong desire to remain independent. The patient and her daughter had a close and supportive relationship.

The hospital policy, originally implemented in 1993, required that an interpreter be present for visits in which there is a language barrier. The policy said to "use family members or friends as interpreters only after the patient has been apprised of the availability of professional interpreters and has nonetheless elected to use family and friends." The intent of the policy is to protect the patient's

confidentiality. In the case of a patient with little or no English language skills who desires to use a family member as an interpreter, a professional (not family) interpreter is required to confirm that the patient accepts the family member as an interpreter. This confirmation cannot be done with family members present. In this case, when the patient was checking out from a clinic visit, the front desk staff, in concordance with the hospital policy, informed the patient (with her daughter translating) that an interpreter would be arranged for her next clinic visit in 6 weeks.

At the follow-up visit, a professional Greek interpreter was in the examination room with the patient and her daughter. Both the patient and her daughter were quite distressed. The patient reported that during the 6 weeks leading up to the appointment, she had become quite anxious and often tearful in anticipation of the use of an interpreter other than her daughter. She believed that her daughter would no longer be able to translate for her or be in the examination room with her, and she wondered whether there was reason that she could not trust her daughter to translate. She thought that perhaps part of the reason for the third party interpreter was to facilitate an (unwanted) change in her living situation or because there was a medical concern or diagnosis that her daughter was not translating to her. She also was concerned that her daughter would not be able to help her with medical decision making. Finally, she began to distrust the clinic providers and staff. To a large extent, she did not share her concerns with her daughter. Physical manifestations of her anxiety included a decline in the quality of her sleep and home blood pressure readings elevated well above her baseline.

After the physician assessed the situation, the professional interpreter was excused. During the remainder of the visit (about 45 minutes), the situation was reviewed, including the rationale for the hospital interpreter policy. The patient's anxiety was addressed with the goal of alleviating her fears

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about her daughter and the clinic. When she left the office, although she felt better, she was still considerably distressed and upset. Her blood pressure remained elevated at the end of the visit, although it had decreased markedly from the initial measurement on her arrival. When she was seen at a follow-up visit several weeks later, she reported that her anxiety symptoms had completely resolved. Her blood pressure was at her baseline.

Discussion

There is substantial medical literature documenting the issues associated with the use of interpreters in the medical setting. The problems have been categorized into errors of omission, addition, condensation, substitution, and role exchange, often with clinical consequences.^{1,2} It is believed that, compared with family members, trained interpreters are more likely to provide accurate translation. Other reported difficulties relate to patient confidentiality, the use of nonadult family members as translators,³ and the use of interpreters in mental health clinical encounters.⁴ Finally, the issue of the high cost of interpreters has been raised.⁵

Despite the extensive medical literature on the use of interpreters, to the best of our knowledge, there has been no previous report of harm associated with the anticipated use of an interpreter. In this case, psychiatric distress occurred as an unintended consequence of a hospital policy designed to ensure patient confidentiality. It is likely that this case is not isolated and might be more common among vulnerable patients who require an inter-

preter, especially in geriatric patients. Xuo and Fagan⁶ found that 85% of patients were satisfied using family members for interpretation. Patients reported the importance of the interpreter in providing ongoing assistance after the appointment, which is possible only if a family member is the interpreter. Hospital and clinic policies that mandate that the use of interpreters in specific situations should be flexible, and care providers and staff should be alert to situations where implementation of the policy might be inappropriate and potentially harmful.

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References

1. Woloshin S, Bickell NA, Schwartz LM, Gany F, Welch HG. Language barriers in medicine in the United States. *JAMA* 1995;273:724–8.
2. Vasquez C, Javier RA. The problem with interpreters: communicating with Spanish-speaking patients. *Hosp Community Psychiatry* 1991;42:163–5.
3. Kaufert JM, Putsch RW. Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language, and power. *J Clin Ethics* 1997;8:71–87.
4. Phelan M, Parkman S. How to work with an interpreter. *BMJ* 1995;311:555–7.
5. Romano M. Speaking a different language. *Modern Healthcare* 2001:86.
6. Xuo D, Fagan MJ. Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. *J Gen Intern Med* 1999;14:547–50.