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The Patient-Provider-Translator Triad: A Note for Providers

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The patient-provider-translator triad constitutes a frequent configuration in the provision of health care in cross-cultural settings. Specific recommendations are offered in order to maximize the provider-translator collaboration, while insuring a sound patient-provider relationship.

In recent years, as a result of military and political upheaval in the Indo-Chinese peninsula, hundreds of thousands of refugees have immigrated into the United States from Vietnam, Kampuchea, and Laos. In addition, the painful reality of war in the Middle East has resulted in a dramatic increase in immigrations by Lebanese and Palestinians. The same can be said in reference to the effects of the political instability of Africa. In turn, the equally painful escalation of repression and political violence in Central America has resulted in countless Salvadorians and Guatemalans adding to the waves of immigrants from neighboring Latin American countries such as Mexico and Puerto Rico. The list is endless, not surprisingly. As a result, physicians, nurses and other health providers find themselves, with increased frequency, in the situation of providing health care to patients with whom they do not share a language. In some cases the provider may know rudiments of the patient's language or vice versa. In other cases, neither participant is familiar with the other's language. Due to this expanding cultural and Idiomatic diversity in the patient population, a new role has been added with increasing frequency to the patient-provider dyad: the translator. [2]

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[2] *This Triangle may be composed of many members, when the patient is a couple or a family. The text refers to *patient* in singular, but the reader may replace that word by *family* without inconvenience. Also, the considerations discussed in this paper apply equally to the scenarios of *health* and of *mental health.* Thus, the reader may choose one or the other when reading "health" in the text.

The translator has become, in fact, not an uncommon presence, especially in health care facilities in the public sector. He is usually a most welcome and sometimes an essential collaborator. However, on occasion it has been noted that the addition of this potential collaborator has the effect of interfering in the process of the patient provider exchange, disrupting the development of a sound interpersonal basis for the therapeutic contact. On these occasions, the translator, instead of retaining his position as aid to the provider, engages with the provider in a tug-of-war for the patient, insisting on becoming the interface with the patient and therefore placing himself between the patient and the provider. This may occur either when translator defines himself -or is defined - as the patient's representative and from that role *explains* the patient to the provider instead of translating the patient's statements (adding, at the most, his/her own opinions to specific remarks of the patient); or when he defines himself- or is defined as a provider's representative and from that position explains the statements of the provider to the patient (even contributing his own recommendation) rather than translating the provider's statements. Needless to say, this interference leads to an exchange that undermines the centrality of the patient-provider relationship; reducing compliance, continuity, efficiency, and, ultimately, both the patient's and the provider's gratification.

It should be added that it is not implied here that the translator "does" those maneuvers, but rather that these processes result from interaction in which patients, providers and translators are all active participants. The patient may be in the very weak position of alien, and may welcome and encourage the translator in a role of spokesperson. The provider may be, in turn, inhibited by his/her own ignorance of the culture and language of the patient (or may be overworked and tired, as is too frequently the case of a medical resident), and choose to oblige and fade away behind the apparent or real expertise displayed by the translator. Finally, the translator may be an overqualified but under trained low rank hospital employee in search of validation and self-esteem. Whatever the specifics of the interactional dynamics, the resulting power struggle in the patient-provider-translator triangle leads to an ineffective patient-provider link.[3]*

[3] *From this viewpoint of systems dynamics, it should be noted that, while dyads (and, in fact, tetrads) are comparatively stable systems, triads are, in and by themselves, rather unstable, and show a tendency to reorganize into dyadic systems with an excluded third. For a discussion of triadic relationships in experimental psychology and in clinical practice, the reader may consult, respectively, Caplow (1965) and Sluzki (1972).

In order to insure a good working relationship with the translator and a sound patient-provider relationship, there are simple strategies that the provider may consider utilizing when engaging in interactions with patients with the aid of a translator:

1) The translator should be *greeted* cordially *and personally,* even if this is the first and perhaps last contact with him (not infrequent in a major city hospital with a large pool of translators). This begins to define the translator as a member of the provider's health team, rather than as an anonymous, ill-defined character in search of a place in the plot.

2) Considering that seating arrangements frequently "map" interpersonal distances and boundaries, the provider should try to organize the seating arrangements in a way that will allow him to *engage in face-to-face contact with the patient.* An arrangement in which patient and translator both face the provider will push the translator to become a patient representative; and one in which translator and provider face the patient will lead to a "para-doctor" translator. The equidistant position of patient, translator, and provider defines the translator as a go-between, but not central to the core therapeutic relationship.

3) The provider is well-advised to always *talk to the patient;* even if the patient sends obvious signals that he doesn't understand the provider's language. Questions should be asked, and clarifications requested, to the patient. Even if the patient does not understand one word of what the provider said, he will acknowledge the eye contact, hear the tone, see the nonverbal behavior, and build on that basis the bridges that will consolidate the therapeutic link. At the same time, it defines the patient-provider axis as central, and the role of the translator as auxiliary.

4) Chase those statements, questions, or inquiries are addressed to the patient, the provider may signal or ask the translator to translate. In that way, the provider gently takes charge of regulating the flow and establishing the roles throughout the consultation.

5) When the patient talks, the provider should look at the patient, and signal to him to address his remarks to the provider (rather than to the translator) even if it is clear that they do not sham a language. That will force the patient to make an extra attempt at

direct contact, using perhaps expressive behaviors such as gestures to expand his basis of communication, and, at the least, will define through eye contact that is the center of attention for the provider.

6) Correspondingly, when the translator speaks, the provider should look at the translator (or, at least, alternate between translator and patient). Communication through a third person is confusing to all participants and, up to a point, alienating. Looking at whoever is speaking at the time, thus acknowledging the fact that each person is speaking for himself, can dramatically reduce this negative effect.

7) If the translator, in the course of his work, omits something the patient has obviously said- translating, for instance, a long statement with a short sentence, or skipping a dialogue between himself and the patient - the provider should ask gently but persistently that the translator make a complete translation to get a full view of the patient's own words or descriptions. The central flow of the exchange should be between patient and provider, and that should be preserved even at the risk of redundancy.

8) At the end of the consultation, after exchanges with the patient are over, the translator should be praised for a job well done and greeted cordially. His position as collaborator is invaluable and his own professionalism should be acknowledged. Even if some of the above-mentioned interactions took place, a tug-of-war should be seen as a learning experience in which both provider and translator participated, and it should be so acknowledged and appreciated.

Utilizing the above design as an overall guideline, then are two additional circumstances that merit discussion: The use of a family member as translator, and the use of the translator as interpreter or culture broker.

The first of these situations refers to the circumstances in which the translator at hand is one provided by the family itself, most frequently an offspring of the identified patient, occasionally a distant relative or neighbor. Those translators feel reasonably entitled, as "insiders" of the family, to speak for the patient and thus bypass or at least disrupt the direct exchanges between patient and provider. If this eagerness is detected, the provider may invite the translator to provide an overview not only to obtain it for its

potential usefulness but also to allow him to display his own mastery of the language and to voice his opinions. However, this should not replace active contact with the patient subsequently in the interview, in which the procedures noted in the first pan of this article may be enacted gently but firmly.

In regard to the second situation, i.e., the use of the translator as culture broker, it should be noted that sometimes the translator is a valuable reservoir of cultural information, sometimes not. It depends on factors such as whether the translator and the patient belong to the same regional culture. For instance, there are some common cultural traits among Latin Americans, but a Mexican translator may be totally unaware of the cultural mores; of someone raised in a Guatemalan rural native enclave.
The same can be said of the need to be aware of the *class culture* of the patient and the translator. For instance, a Phillipino translator of middle-class origin may not share values nor empathize with a Phillipino patient culturally removed from him because of a peasant origin. On occasion, clan, cultural and even regional biases, may diminish the efficacy of the translation. For instance, the Laotian-Vietnamese traditional rivalry that frequently results in a reciprocal attribution of negative traits may make of them a less-than-ideal patient-translator combination, unless the translator has transcended his own prejudices.

Keeping all of these factors in mind, a translator may be a sound source of information when the provider needs to understand a given statement against the tapestry of the patient's culture. This cultural background information will reduce the chances of attributing to the individual traits that belong to the culture, or attributing to the culture traits that are idiosyncratic to the individual. However, these specific exchanges between translator and provider must be clearly framed as such and differentiated from the regular patient-provider flow. Confusing the distinct roles of translator, cultural broker, and patient and switching freely among them may introduce considerable chaos into the interview. Also, in spite of how important the cultural information that the translator may provide may be, it would be advisable to use this source sparsely, in order to prevent a coup d'etat by which the translator becomes the central figure of the triad (which, in turn, would lead to an escalation on the part of the provider, which in turn may alienate the translator or the patient, and so on).

In the present-day reality of a world rippled with mass migrations, the translator can be considered a most valuable collaborator in the provision of health and mental health services in multi-lingual settings. The practical recommendations offered in this article will increase the quality of such a collaboration and result in better health care for patients and a more satisfactory experience for patients, providers, and translators alike.

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