Can patients use family members as non-professional interpreters?

When someone doesn’t speak your language, it can be tempting to ask a relative or a colleague to translate. This, however, comes with its own risks, as three experts tell Abi Rimmer.

Interpreters should be neutral
Sofia Sarfraz, senior clinical fellow in paediatrics and medical education

“For patients who don’t share your language, the gold standard is to use a professional interpreter. We’ve all, however, used patients’ family members or other health professionals as interpreters in consultations. But non-professional interpreters should be used with caution and you should consider the risks. Medical interpreters have training and experience, which family members and other health professionals may lack. Interpreters should be neutral and passive, which may prove difficult for family. A family member may also give you their own version of events, and their emphasis may skew the whole consultation. It can also be difficult to check the veracity of the interpretation. This could lead to a misdiagnosis.

“Similarly, a family member may find it hard to share difficult or bad news and they may have emotional or cultural reasons to distort your message. Or they may simply be bashful. A final point to consider is that using interpreters can alter the dynamic of the consultation and failing to recognise this can degrade the quality of care. With extra people in the consultation we need to ensure that the patient feels heard and that we pick up on their non-verbal cues. Taking all this into consideration, my advice would be to use someone who is impartial—ideally a professional interpreter—where possible in your consultations, excluding emergencies.”

NHS England, in reference to primary care, states that, ‘The use of an inappropriately trained (or no) interpreter poses risks for both the patient and healthcare provider.’ And further, ‘The error rate of untrained interpreters (including family and friends) may make their use more high risk than not having an interpreter at all.’

“Doctors have a responsibility to communicate effectively with their patients while considering timeliness of effective treatment, their disabilities, cultural needs, and human rights. At the same time, they also have a responsibility to ensure confidentiality, information governance, reliability, and safeguarding.

“Ideally, for all planned consultations, every effort should be made to engage the services of a qualified interpreter using local guidelines with allowances being made for the increased time such consultations take. Family members can, of course, stay for the consultation, if appropriate and with consent. Not all situations, however, are ideal; in emergencies where immediate patient care is a priority, an available family member may well be the only means of communication and it may well be appropriate to request them to translate. This, however, must be done with consideration given to confidentiality and safeguarding. The patients’ best interests must always take centre stage and if in doubt you can take advice from your defence organisation.”

It may be appropriate in an emergency
Joydeep Grover, specialist medicolegal adviser for Medical Defence Shield

“Our guidance is clear that doctors should make arrangements to meet patients’ communication needs wherever possible. A professional interpreter is always preferable as they provide a degree of assurance around quality, accuracy, and confidentiality.

“If a professional interpreter isn’t immediately available, and it’s not possible to delay the conversation, a health professional who is fluent in the patient’s language may be able to help. If that’s not an option, you can ask a family member but there are a few things to consider. The first is confidentiality. Before involving family in discussions about a patient’s care, you should usually check that the patient wants that to happen. This is clearly difficult if the translator is a relative. It’s also possible that patients won’t disclose all relevant information through a family member because they don’t feel comfortable sharing personal details.

“Family members can also be selective with translations based on their own views of the patient’s condition or treatment options. And there is the possibility that they don’t understand English well enough to communicate complex medical information.

“There are also some circumstances in which it would be inappropriate to involve family members—for example, where there are safeguarding concerns about the patient.”

Find out what the patient wants
Emma Saint, GMC policy standards team

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LETTERS
Selected from rapid responses on bmj.com

Letter of the Week

Silence is complicity

Like other female doctors, I have long been accustomed to the assumption that I am a nurse. But I am frequently disappointed by the silence of male witnesses to these everyday acts of sexism (Partha Kar, 7 December). On a ward round recently, I and another senior (male) registrar flanked the male consultant, stethoscopes around our necks. We gave our opinions while three male juniors stood behind us making notes. The patient, itching to leave, was demanding his cannula out. Donning gloves, I swiftly obliged. Afterwards the patient thanked “all you doctors,” adding as he gestured towards me, “and your technician.”

I waited for someone to correct him. Instead, the consultant looked embarrassed and shuffled away. I was left to explain to colleagues the harmful effect of everyday sexism and that in such instances I expected their vocal solidarity.

I contrast this with the time a patient told me that they did not want to be treated by the black senior trainee on our team. I was shocked into silence, but my consultant led by example, firmly announcing their solidarity.

The NHS is the fifth largest employer in the world, and thus reflects societal attitudes. That sexism continues to be a problem in medicine is no surprise: look no further than the recent report describing an “old boys’ culture” in the BMA, allowed to go unchallenged. Racism too remains institutionalised. In a country emboldened by racist rhetoric from the top, ethnic minority colleagues and patients are continually and systematically discriminated against with little challenge.

We are all responsible for calling out perpetrators of any form of discriminatory behaviour, but I expect most from those in positions of power—their silence is complicity, and that complicity silences us all.

Jessica Potter, honorary clinical lecturer, London

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Offensive Behaviour

The world is messy

With the advent of social media, an instantaneous call-out culture, without due consideration of all facts, has become standard (Partha Kar, 7 December). Good people with good intentions are now calling things out without considering all aspects of an issue (for example, an illustration in The BMJ being called sexist).

There is now a culture of demanding perfection from everyone except oneself. As Barack Obama said, “The world is messy. There are ambiguities. People who do really good stuff have flaws.” Even if someone is plain wrong, what about forgiveness and redemption without public shaming?

“The one who is without sin is the one who should cast the first stone”—one doesn’t need to be an adherent of any of the Abrahamic religions to consider this quote an ethical antidote to current call-out culture.

Santhanam Sundar, consultant oncologist, Nottingham

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Unhappiness of Doctors

Changing the status woe

Mathew is right to speak against the narrative of despondence that affects our profession (Rammya Mathew, 18 January). For too long inquiries have focused on what makes doctors unhappy instead of looking at how to improve wellbeing. High stakes, unsociable working hours, and an increasingly exhausted NHS are the norm.

Survival in the system demands a short sighted, task driven outlook, which comes at the expense of the fulfilment that drew us to medicine in the first place. This is exacerbated by the growing chasm between the public’s perception of doctors and our daily working lives.

But we are not blameless. The profession attracts high achieving and competitive people, which can contribute to distrust and alienation in the workplace.

The solution is clear—we must start promoting wellness at medical school or we risk failing another generation of doctors. Only then can we rebuild a sense of community in our profession.

Henry M J White, foundation year 1 doctor, London

Matthew Kane, fourth year medical student, Norwich

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Under Investigation

NHS Resolution can help

There has been increasing emphasis on valuing NHS staff through the promotion of a “just culture” (Careers Clinic, 16 November)—in 2019 Dido Harding wrote a letter to all NHS bodies about “learning lessons to improve our people practices,” and the GMC published Fair to Refer?

These communications underline the importance of tackling staff performance concerns early to understand contributing factors and to support the development of a just, learning culture for NHS staff and patients. Employers can then consider whether the concerns can be dealt with collaboratively through “informal” documented action.

NHS Resolution’s Practitioner Performance Advice service is committed to supporting healthcare organisations in achieving this. We have been providing practical and impartial advice on the effective management and resolution of concerns about doctors, dentists, and pharmacists since 2001 and now respond to around 1000 calls a year from NHS medical managers and GPs. We also offer assisted mediation and team reviews.

Helen Vernon, chief executive, NHS Resolution

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OBITUARIES

Yeshi Dhonden
Personal physician to the 14th Dalai Lama

Yeshi Dhonden (b 1927; studied Tibetan medicine at the Chakpori Institute of Tibetan Medicine, Tibet, from 1938 to 1947 and graduated with distinction), died from respiratory failure on 26 November 2019.

Born into a farming family in Namrao village, in Tibet, Yeshi Dhonden entered monastic life when he was 6 years old and took novice vows as a Buddhist monk two years later.

When he was 11, he joined the Chakpori Institute of Tibetan Medicine, where he studied for nine years and displayed impressive skills during the study of The Four Tantras.

At 20, Dhonden was recognised as the best in his class. He passed his exams with distinction and was made an honorary doctor of the 14th Dalai Lama. From 1951 onwards, he practised medicine in his native region, where he became renowned for his skill after he managed an influenza epidemic.

He became the foremost expert in Sowa-Rigpa, the Tibetan herbal medicinal system that combines the ancient healing systems of India and China, practised for thousands of years in Tibet.

In 1959 he chose to accompany the Dalai Lama into exile in India, when he fled the Chinese invasion of Tibet.

Dhonden entered monastic life when he was 6 years old and took novice vows as a Buddhist monk two years later.

Dhonden also acted as director of this institute until 1966, making traditional Tibetan medicine popular among Tibetans in exile and Indians.

From 1960 to 1980, Dhonden served as the Dalai Lama’s trusted personal physician. He also gave medical consultations to Indira Gandhi, the former prime minister of India, and other prominent Indian officials, as well as poorer people.

In 1969 Dhonden founded a private clinic in McLeod Ganj, India, near the Dalai Lama’s residence. He saw up to 50 patients a day, six days a week, relying primarily on his own senses to diagnose patients. He ran his practice for 50 years, until his retirement earlier in 2019.

Over the years, he became acclaimed as a physician, particularly as a cancer specialist, and patients travelled from around the world to consult him, often having to book an appointment two or three months in advance.

Dhonden relied primarily on his instinct and senses to diagnose and treat his patients. Sowa-Rigpa has, for thousands of years, employed a complex system of techniques—such as urine and pulse analysis and observation of tongue, skin, eyes, ears, and gait—and questioning to diagnose patients, who are then treated with a combination of dietary, physical, and spiritual methods.

These include medicines made from natural herbs and minerals, and therapies such as acupuncture, blood letting, cupping, massage, meditation, prayer, and yoga. Treatment aims to readjust the balance of the energies.

Traditional Tibetan medicine

As a physician, Dhonden relied primarily on his instinct and senses to diagnose and treat his patients. Sowa-Rigpa has, for thousands of years, employed a complex system of techniques—such as urine and pulse analysis and observation of tongue, skin, eyes, ears, and gait—and questioning to diagnose patients, who are then treated with a combination of dietary, physical, and spiritual methods.

Introducing Sowa-Rigpa to the West

Dhonden was the first to introduce the treatment techniques and principles of traditional Tibetan medicine to the West. In 1967 he travelled to Spain to participate in an international seminar on Tibetan medicine and gave an impressive presentation, which was so well received he was awarded a gold medal. In the 1980s he travelled extensively in the West, particularly the US where he later founded the Medicine Buddha Association.

In 1981 Dhonden gave a leading presentation at the International Conference on Tibetan Medicine in Washington and carried out medical consultations. He began teaching Tibetan medicine at Virginia University, where he participated in a laboratory study using Sowa-Rigpa to treat mice with sarcoma. The study showed the traditional medicine would have some potential to treat cancer.

In 2000 Dhonden travelled to San Francisco and became involved in other clinical research on the efficacy of Sowa-Rigpa to treat breast cancer; the findings, suggesting some useful potential, attracted interest from other researchers and American national television and media.

Jacqueline Young, trustee of the Tibet Foundation in London, says, “Yeshi Dhonden made an immeasurable contribution to the spread and establishment of Tibetan medicine in the West. His dialogues with Western medical practitioners were legendary, and they never failed to be astounded by the accuracy of his diagnoses, simply made through silently and respectfully taking the patient’s pulse and just listening.”

Last year, the president of India, Ram Nath Kovind, awarded the elderly monk Padma Shri, the fourth highest civilian award, for his contribution to medicine.

Because of his poor health and old age, Dhonden officially retired from medical practice in April 2019. Named “Sangye Menlha”—Medicine Buddha—by his patients, he was full of compassion, always helping others.

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