MEDICAL PRACTICE

Outside Europe

Taking medical histories through interpreters: practice in a Nigerian outpatient department

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Summary and conclusions

Consultations through interpreters in the medical outpatient department of a Nigerian hospital were tape-recorded. These recordings were translated completely into English and transcribed, and the performance of the interpreters was analysed. The interpreters often did not provide word-for-word translations of what the doctor or patient had said. Some of these deviations were helpful, but others were confusing or incorrect. In particular, interpreters were inclined to conduct much of the consultations themselves.

Hospitals using interpreters should ensure that they have no conflicting duties during consultations and that they have some training in language and interpretation. The quality of interpretation should be checked by native-speaking doctors and by using recordings. Doctors using interpreters should try to make sure that everything said is translated and check the patient's answers by asking questions in several ways.

Introduction

Almost every doctor sometimes finds himself having to take a history using an interpreter. In some hospitals interpreters are used for most consultations. I set out to find what happens in

such consultations, with a view to giving advice to doctors faced with foreign patients or hospitals needing to maintain an interpreting service.

Method

The study was carried out in the medical outpatient department of a teaching hospital in northern Nigeria. I recorded consultations between 30 Hausa patients who spoke no English and four English-speaking expatriate doctors who were using seven medical orderlies as interpreters. A Hausa doctor and medical students (all of whom spoke fluent English) then recorded spoken translations of everything said in Hausa during the consultations. I made complete English transcripts of the consultations and analysed them, noting each occasion on which the interpreter had deviated from providing a simple word-for-word translation of what the doctor or patient had said.

Results

It was generally easy to decide what constituted a simple word-for-word translation. An example of such an exchange was the following (Hausa statements are in italics).

DOCTOR: How many times a day does he pass water?

INTERPRETER: *How many times a day do you pass water?*

PATIENT: *About ten times a day.*

INTERPRETER: About ten times a day.

I classified deviations from this model as legitimate, illegitimate, or due to the interpreter acting as an independent questioner in the consultation.

Legitimate deviations—The smooth flow of question and answer between doctor and patient might be interrupted when one party did not understand something or was surprised by it, so that it had to be repeated. Also good paraphrase was often used instead of direct

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translation. This paraphrase might be either a condensed or an expanded version of the original utterance:

DOCTOR: Are the legs normal? (in a patient complaining of generalised pain)

INTERPRETER: How about the legs? Is there no pain in the legs?

PATIENT: No.

INTERPRETER: Legs normal.

Illegitimate deviations—It was uncommon, but not unknown, for the interpretation to be ruined by mistranslation:

PATIENT: When I go to the toilet I pass stools with difficulty.

INTERPRETER: He has severe pain when he's passing stools.

Similarly, bad paraphrase might condense the statement so as to exclude vital information. This was very common:

PATIENT: It's my ear that's hurting me. It's blocked and I can't hear with it. The head and the neck are hurting and I've got fever.

INTERPRETER: She says she's suffering from ear pain and headache.

OR:

PATIENT: This leg. There's pain inside it in the night. In the afternoon I can't walk around freely. If I bend it, I can't straighten it due to the pain.

INTERPRETER: He has pain in the right leg. Right inside the bone.

Such condensation almost always excluded background information about the patient's daily life and concentrated only on his symptoms.

The interpreter as independent questioner—In every consultation the interpreter initiated questions and then summarised the patient's answers. Sometimes the questions were appropriate and the summary accurate. An interpreter might, for example, take an obstetric history and then give a correct account of the patient's parity. Even when the questions were appropriate, however, a summary of the answers would not always reveal exactly what had been established:

INTERPRETER: Do you pass water normally?

PATIENT: Yes, I pass water normally.

INTERPRETER: Is there any pain?

PATIENT: No, there is no pain.

INTERPRETER: Is there blood in the urine?

PATIENT: No, there is no blood.

INTERPRETER: His urine's normal.

This apparently harmless process in fact often resulted in the patient being asked the same questions again by the doctor, and the interpreter would occasionally irritate the doctor later in the consultation by revealing that he knew the answers to a dozen questions which he had asked but not translated. This licence in the interpreter's role also led to irrelevant questions, skirmishes with patients about documentation, or arguments about the veracity of the history:

INTERPRETER: You say you were admitted here before. Why did you bring a new card this time?

INTERPRETER: You're telling us that the stools are watery and that they're hard! Do you think we're playing with you? We ask you if they're watery and you say yes. We ask you if they're hard and you say yes. Which should we take out of the two?

Discussion

My findings are similar to those of a study in Papua New Guinea.¹ This suggests that the problems depend not on local factors but on the nature of history-taking and the demands of interpretation. Histories which were dismissed as contradictory and incomprehensible by expatriate doctors or which were thought to be tinged with local beliefs about body image and diseases seemed so only because of the sketchiness of interpretation.

As guidelines for an interpreting service, I would recommend that interpreters should have no conflicting duties during consultations, such as checking documents. They should have formal training in language and the rudiments of interpretation. Doctors should be taught how to use them. The service should be checked continuously with the help of native-speaking doctors, language tests, and recorded tapes.

I would also suggest some rules for any doctor who has to use an interpreter. Greet the patient to establish direct contact. Be seen to be in charge of the interpreter. Assess the interpreter's English and try to find out how well he speaks the patient's language. Assess his interests: he may be an anxious relative or an indifferent auxiliary. Give only short sentences for translation, and get the interpreter to explain that the patient must do the same. Make sure everything is translated. Check every answer by asking questions in two or three ways. Finally, use the interpreter to tell the patient everything you would tell him if he could speak your language.

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Reference

- 1 Lang, R, *Papua New Guinea Medical Journal*, 1975, 18, 3.

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How effective is the addition of water treatment tablets containing chlorine when travelling in places such as India?

To be effective chlorination requires a minimum exposure of 30 minutes to a free chlorine concentration sufficient to deal with the prevalent pathogens. This may not be easy within the bounds of acceptable taste. Simple test materials based on orthotolidine are available which indicate how much chlorine must be added. Tablets and testing equipment are available from Boots Co Ltd, Nottingham, and Wilkinson and Simpson Ltd, Gateshead. Most bacteria are dealt with by a residual free chlorine of 0.3 mg/l. Enteric viruses are more resistant to chlorination than are the coliforms used to measure water safety. As much as 2 mg/l is required to kill cysts of *Entamoeba histolytica*,¹ however, and 1 mg/l is necessary for schistosome cercariae.² If the visitor to India remains in one place chlorination, using high test hypochlorite solution, bleaching powder, liquid laundry bleach, or commercial tablets based on chlorine or iodine, might be feasible. For the itinerant it is less practicable. Hazards are greatest in rural areas and are exacerbated by the custom, in many Indian villages, of welcoming the visitor with a cup of the local well water. In his hotel room, if he cannot be assured of the safety of

the supply, the traveller can certainly protect himself by boiling the water he intends to drink or clean his teeth with. A metal pot would be needed in places with no reliable mains electricity supply. The water must be thoroughly boiled and may be bottled for use while travelling next day, as some Indians do.³ Storage bottles and drinking vessels must be as sterile as the boiled water.

- 1 Pickford, J, in *Water, Wastes and Health in Hot Climates*, ed R Feachem, M M McGarry, and D Mara, p 185. London, Wiley, 1977.
- 2 World Health Organisation, Monograph Series No 50, p 102. Geneva, WHO, 1965.
- 3 Marwah, S M, from *Proceedings of an International Seminar: the Applicability of European Postgraduate Health Care Training Programmes and Technical Services for the Developing Countries*, ed D Robinson. Liverpool, Liverpool School of Tropical Medicine, 1978.

Is there any significance in an umbilical cord with only two blood vessels in it?

Yes; the absence of one artery is a congenital abnormality, and other abnormalities are more common when this occurs. This association should lead to especially careful investigations to exclude other anomalies. The absence of an artery does not seem to be the cause of other abnormalities, nor is another abnormality always present.