LOST IN INTERPRETATION: THE LIVED EXPERIENCE OF NURSE INTERPRETERS IN THE CLINICAL SETTING

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UNIVERSITY OF SAN DIEGO
Hahn School of Nursing and Health Sciences
DOCTOR OF PHILOSOPHY IN NURSING

LOST IN INTERPRETATION: THE LIVED EXPERIENCE OF NURSE INTERPRETERS IN THE CLINICAL SETTING

By
Byron Batz

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Abstract

The use of language interpreters in the health care setting constitutes a vital part of provider-patient communication but remains a relatively unexplored phenomenon. Registered nurses (RNs) are often called upon to serve as interpreters when linguistically diverse patients constitute a large segment of the patient population. That RNs serve simultaneously in an interpreter role—in addition to clinical and advocacy roles—is a complex facet of contemporary nursing practice in a diverse U.S. culture. The purpose of this qualitative descriptive study was to examine the lived experience of RNs serving as interpreters in health care institutions in Southern California. Specifically, this study sought to describe RNs perceptions of their role as interpreters and their attitudes and beliefs regarding their interpersonal efficacy in this role. Ten RNs with a documented level of language proficiency from health care institutions in Southern California completed a semi-structured recorded interview. Using process and line by line coding, the 10 interviews yielded four main categories: protection of patient, uncertainty, challenges, and RN interpreter effect. The following descriptive summary emerged from this qualitative descriptive study: nurse interpreters may harm the patient-provider interaction by increasing noise, but they protect the patient by reducing uncertainty, increasing comfort, and creating a connection while offering interpreting services. Implications for future study include the need for the identification and analysis of the factors shaping the RN interpretive experience in the health care setting.
Dedication

This dissertation is dedicated to my late brother, Luis Batz (1981–2022). I am glad I had you, even if only for those short 40 years. I love every memory I have of you. I miss you.
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Chapter 1

Background and Significance

Interpretation is vital. It is engrained in activities of daily living. A parent interprets the cry of a baby. Pet owners interpret the behaviors of their pets. The sailor interprets cloud formations. Health care providers interpret lab values, diagnostic imaging results, or patients’ signs and symptoms. Effective interpretation can potentially save a life, while ineffective interpretation can, in certain situations, cause detrimental outcomes and even death. Language interpreters in the medical field play an essential role in patient care, and in the management of acute or chronic health conditions. A national survey conducted by the Center for Medicare and Medicaid Services (CMS) in 2013 presents bleak findings regarding interpreting services (CMS, 2017). Over 4,700 providers from a variety of practice settings completed the survey. The findings indicate that only about one third of providers ask about language preference at intake or initial encounters. In addition, close to one quarter of providers use contracted professional interpretation services, and only eight percent hire or train multilingual staff (CMS, 2017).

The inability to read and/or speak the dominant language of a country or region may increasingly add a certain degree of difficulty when purchasing products or seeking services. Ineffective communication is a major contributor to health disparity and inequities (Augusto et al., 2019). The Spanish-only speaking population (SOSP) in the United States (US) experiences great inconvenience daily whether purchasing items at grocery or clothing stores or seeking personal or health care services due to their language barrier. Unfortunately, the US census does not collect data about the percentage of the immigrant population who only speak the predominant language of their birthplace.
(U.S. Census Bureau, 2020). Nonetheless, the Pew Research Center in 2019 reported there were 60.6 million Latinos living in the United States, and approximately two-thirds (a percentage changing very little since 1980) of Latino first generation immigrants did not speak English proficiently in 2018 (Krogstad & Noe-Bustamante, 2020). In addition, Elderkin-Thompson and colleagues (2001), found immigrants rate their biggest barriers to receiving health care to be language and cultural differences.

The United States has Spanish-speaking immigrants from every Latin American country and the Caribbean (Krogstad & Noe-Bustamante, 2020). Everyday items can be named differently by people from different countries or different regions. Similarly, one word can have one meaning for an individual from a country or region and have a completely different meaning for an individual from a different place. This presents a challenge for interpreters sometimes having to use two or more Spanish words to interpret one English word (Pope & Roberson, 2018). Frequently, interpreters interpret not only from one language to another, English to Spanish for example, but also from a providers’ level of understanding to SOSPs who may have a third or fifth grade reading/speaking level.

The language barrier potentially puts the SOSP at-risk for health disparities and inequities (Pope & Roberson, 2018). Although interpreting services are available at many health care organizations, hospitals, and clinics, seeking health care services when there is uncertainty about the availability of interpreting services can be daunting. The ways in which the inability to speak the dominant language influences health care seeking across immigrant populations is an understudied area. The inability to speak English proficiently presents a multitude of challenges for the SOSP. These challenges include making
appointments or seeking medical advice over the phone when the operators are English-speakers and then finding directions to medical centers in a city in which most streets have names in English. Additional challenges include understanding a transportation system that has mostly English instructions and then navigating the hospital or clinic building. Finally, once at a clinic or hospital, filling out forms written only in English and trying to communicate with mostly English-speaking staff are substantial challenges for the SOSP (Brown, 2014).

These challenges do not stop once the patients leave the hospital or clinic, however. Reading discharge instructions or home care directions, going to the pharmacy, diagnostic imaging center, or laboratory for additional health care attention, as well as scheduling follow-up appointments, add a great degree of difficulty for the SOSP in a country where English is the predominant language.

**Problem**

The need for competent interpreting services is rapidly increasing, since maintaining equity during access to care can be threatened by the gaps in communication occurring during interpreter-mediated sessions (Haralambous et al., 2018). In a study of patients, their family members, providers, and interpreters, Haralambous et al. (2018) found that perception of adequate interpreting services is related to improved communication and an increase in the probability of patients and their families feeling more relaxed during the interaction. The importance of the role interpreters play is often overlooked in patient-provider interactions. Po and colleagues (2018) found that patients with limited English proficiency (LEP) who received interpreting services at admission and discharge had shorter length of stay (LOS) and fewer re-admissions than LEP
patients who received no interpreting services. However, in the same study, these researchers also found LEP patients who received interpreting services at admission and discharge still had longer LOS and more re-admissions than English proficient patients (Po et al., 2018). These findings indicate that effective communication can potentially improve health care outcomes and improve metrics benefiting patients as well as health care organizations.

In a study conducted by Augusto et al. (2019), Latinos with a high risk for cancer were less likely than non-Latino whites to participate in genetic counseling or testing. The researchers found underutilization of cancer genetic services may be increased due to the language barrier and limited availability of bilingual genetic counselors (Augusto et al., 2019). Diamond et al. (2008) found that resident physicians underutilize the assistance of interpreters for various reasons, including the inconvenience of having to wait for an interpreter and the providers’ own perceived need for, and value of, interpretation services rather than the patients’ perceived need.

Even if/when interpreting services are widely and easily available, it is difficult to determine to what degree this intermediary service removes a provider from the patient, or how much discordance or mistrust is added to a patient-provider relationship because of this language barrier (Ault et al., 2019). An additional effort is necessary to acquire effective communication with the patient as the conversation becomes a three-way conversation rather than a two-way interaction. Furthermore, the presence of an interpreter may alter the dynamic interaction or communication between provider and patient (Kamara et al., 2018). Ault et al. (2019) found that communication engagement between patient and genetic counselor is decreased when interpreter-mediated sessions
are required; a decreased patient-provider interaction occurred if an interpreter was present.

Additionally, the presence of an interpreter can add another complication layer, a loss in interpretation, or potential for errors by the interpreter (Kamara et al., 2018). Kamara et al. (2018) found interpreters are susceptible to misunderstanding or misinterpreting critical information. Such misinterpretation can potentially lead to patients making decisions based upon incorrect understanding; following the wrong treatment plans; interference with patient-provider goals; decreasing patient-provider relationship and rapport; and impeding effective ongoing medical discussions.

Specifically, RNs – whose primary role is to deliver care and advocate for patients – are often tasked with the role of interpreter in health care settings. This can present a challenge for an interpreter whose ongoing functions as a nurse include complex clinical care and advocacy. Thus, this qualitative descriptive study of the lived experience of RNs serving as interpreters in health care institutions was a salient starting place in creating a knowledge base in this understudied area.

**Research Question**

The overall question, “What is the lived experience of RNs serving as interpreters in health care institutions in Southern California?” was used to direct this qualitative descriptive study.

**Purpose and Aims**

There is a paucity of research on the lived experiences of nurse interpreters, and this qualitative descriptive study was performed with the purpose of decreasing that knowledge gap. To capture the lived experience of nurse interpreters, this study sought to
explore the perceptions, attitudes and beliefs of RNs who perform the role of interpreters in the clinical setting in addition to their nursing role. This study had two specific aims:

Aim 1. Describe the perceptions of their role as interpreters in a group of RNs who perform the role of interpreters in the clinical setting in addition to their nursing role.

Aim 2. Describe the attitudes and beliefs regarding their interpersonal efficacy in a group of RNs who perform the role of interpreters in the clinical setting in addition to their nursing role.

Methodology

A constructivist qualitative descriptive approach was used to guide semi-structured interviews, explore the lived experience of a phenomenon, and gain rich data. The qualitative descriptive approach is defined by Sandelowski (2000) as having a goal of a comprehensive summary of events in the everyday terms of these events. Interviewing is a method of data collection within qualitative description which allows the researcher to gain insight and context (Doody & Noonan, 2013). In a semi-structured interview, participants were asked open-ended questions, using responsive interviewing style techniques to guide a flexible question designed to seek depth and detail (Rubin & Rubin, 2012). Because interviews provide deeper insights into the intricate actions of this population’s experiences, a constructivist descriptive investigation was best suited for exploring and identifying the issues of caring for a patient while providing interpretation services. The interview questions constructed for this study were designed to capture the lived experience of the RN interpreter as a comprehensive summary of events surrounding this experience, thus fulfilling Sandelowski’s (2000) goal described above for the qualitative descriptive approach.
Theoretical Influences

Three theoretical models provided sensitizing perspectives for this study: (a) The Transactional Model of Communication; (b) Critical Race Theory; and (c) Uncertainty Reduction Theory. The role of theories in providing sensitizing perspectives in qualitative research remains an underexplored phenomenon; however, Nibbelink et al. (2023) have asserted the value of utilizing such theories to establish predispositions around the topic and support study design. For the purposes of this study, the following three frameworks provided the philosophical underpinnings for approaching this topic and supporting the use of the qualitative descriptive design.

Transactional Model of Communication

The first theoretical framework sensitizing this study was the Transactional Model of Communication, which puts an emphasis on the shared and individual experiences of the communicators (Pierce, 2019) and views communication as a transaction between two or more individuals in which people create shared meaning in a dynamic process. This model does not view individuals as senders and receivers, but rather as co-creators, equally responsible for the outcome and effectiveness of the interaction. According to this model, to communicate effectively, the communicators must, to some degree of overlap, share a language, a culture, or an environment. Furthermore, back and forth messages between communicators are interrelated or interdependent, influencing responses and interactions between individuals (Pierce, 2019).

The noise in a transactional communication process (Figure 1) usually has a negative effect on the interaction between providers and patients. This noise can present in any form; psychological, physiological, physical, or/and semantic (Rothwell, 2016).
Rothwell defines noise as anything interfering with the reception, or with the effective transmission, of a message. According to him, psychological noise can come from preconceived notions, biases, stereotypes, and assumptions any of the communicators can have during the interaction. Physical noise usually comes from the surrounding environment, such as people talking in the background, personal interruptions, inadequate room temperature, or background music. In other words, physical noise can present as a sound, sight, or any other sensory stimuli distracting the communicators. Physiological noise presents in the form of biological influences, such as anxiety, hunger, or a persistent cough, preventing competent communication. Lastly, semantic noise comes from using confusing or hard-to-understand words during the interaction.

Having interpreters mediating a patient-provider interaction can either reduce semantic noise or increase it depending on the interpreter’s level of competence, or on whether the person interpreting is a nurse interpreter, professional interpreter, a friend/family member, or an uncertified/untrained staff interpreter. The interpreter can also potentially increase physical noise by just merely being present. Inevitably, the presence of an interpreter increases one or more types of noise. In turn, this increase in noise potentially elevates the degree of information loss during interpretation.
Critical Race Theory

Critical Race Theory (Creswell & Poth, 2018) constituted a second sensitizing theory for this study, as it is particularly relevant to studying perceptions and lived experiences of nurse interpreters. According to Creswell and Poth (2018), the relationship between race, racism, and power can be studied and transformed using this theory, as one of the goals of critical race theory is to address “other areas of difference, such as gender, class, and any inequities experienced by individuals.” The phenomenon with the potential to be explored in a qualitative descriptive study using this theory is how cultural backgrounds and ethnicities shape the interaction between patients and RN interpreters. Understanding how socially constructed differences among all participants benefit or harm interactions can, in turn, help with development of more appropriate interpreting training, creation of improved interpreting programs and credentialing, improvement of communication effectiveness, as well as raising awareness of personal differences and similarities during the interpretative process. Acquiring a deeper understanding of how
nurse interpreters experience or perceive their role in a diverse population can also help with development and/or improvement of effective interpreter training programs.

**Uncertainty Reduction Theory**

The third theoretical model used to sensitize this study of patient-interpreter-provider interaction is the Uncertainty Reduction Theory (Berger & Calabrese, 2006). This theory assumes there is a mutual desire to reduce uncertainty or increase predictability of the behaviors of both self and others when strangers meet. This theory postulates an increase in uncertainty leads to an increase in uncertainty-reducing behavior. In addition, the Uncertainty Reduction Theory suggests uncertainty may be high during initial interactions between strangers. This initial high level of uncertainty decreases as the strangers increase their verbal communication, acknowledge perceived similarities, and increase their use of nonverbal amiable expressions (Berger & Calabrese, 2006).

Interpreters, whether professionals, certified bilingual nurses, or family/friend members, create a bridge, a connection during the patient-provider interaction (Gerrish et al., 2004). This bridge or connection can have a strong foundation if uncertainty is reduced, but it can also collapse if uncertainty-reduction is not achieved. As Rothwell (2016) states, the source of meaning is language, and this meaning is responsible for how humans act toward people or things. Interpreters have the essential role of reducing uncertainty during the patient-provider interaction, as it is imperative to reduce negative responses from providers or patients to maintain a cohesive and effective interaction.

**Assumptions**

The assumptions conceived during the design of this qualitative descriptive study were sensitized by the above three theories and are as follows:
1. Having interpreters during the patient-provider interaction can either reduce or increase semantic noise.

2. Nurse interpreters can improve the quality of patient-provider interactions by removing or minimizing power relations related to language differences.

3. Nurse interpreters can reduce uncertainty in the patient-provider interaction and create a bridge for enhanced patient-provider communication.

**Implications for Nursing Research, Education, and Practice**

There is an enormous need to increase resources and services for the SOSP and LEP populations. There is also increased need to understand how current bilingual or Spanish resources and services are either benefitting or failing to benefit this underserved population, along with a need to understand which is the most effective communication approach for them during patient-provider interactions (Augusto et al., 2019). More importantly, there can be countless benefits to understanding the role of nurse interpreters, as this can potentially improve the patient-provider interaction, bridge the communication gap between providers and patients more effectively, increase access to care, improve satisfaction, decrease health inequities and disparities, and enhance the overall patient-interpreter-provider experience.

Although interpreters improve access to health care for the LEP and SOSP, interpreters alone are not enough to decrease the inequities and health disparities affecting this population (Ault et al., 2019). Nursing schools can potentially play a major role in decreasing health disparities and inequities in the SOSP by offering interpreting training for bilingual students as part of a baccalaureate nursing program. However, more research is needed to study how to best implement that training, as schools offering
anything of this sort are insubstantial or non-existent. The literature review below substantiates the increased need to create a knowledge base, beginning with a qualitative descriptive approach, regarding the lived experience of nurse interpreters in the health care system.
Chapter 2

Literature Review

Journal repositories used to search interpreter related words were CINAHL Plus with Full Text, Cochrane Database of Systematic Reviews (COCH), Medline Via Ovid, and PubMed. The words used in the search included: interpreters, interpreting, interpretation, health care interpreter, health care interpretation, health care interpreting, interpreting programs, nurse interpreters, medical interpreters, clinical interpreters, interpretation services, clinical interpreters, qualified interpreters, certified interpreters, professional interpreters, family/friend interpreters, and bilingual interpreters. During this search, four types of interpreters were identified: professional interpreters (Bohm & Paula Cupertino, 2015; Brown, 2014; Flores et al., 2012; Gerrish et al., 2004; Lai & Costello, 2021; Patriksson et al., 2019; Po, 2018; Rosenberg et al., 2008), family/friend interpreter (Cox et al., 2019; Flores et al., 2012; Rosenberg et al., 2008), certified medical/nurse interpreter (Aitken, 2019; Bischoff & Steinauer, 2007; Brandl et al., 2020; Diamond et al., 2012; Elderkin-Thompson et al., 2001; Quesada et al, 2020; Yang & Gray, 2008), and uncertified/untrained bilingual staff (CMS, 2017; Elderkin-Thompson et al., 2001) The time frame for the search was established at 2011 to 2021, but after limited literature availability, this was expanded to 2000 to 2021.

Professional Interpreters

During its survey, the CMS found about 85% of acute care hospitals, 68% of hospital-based physician practices, and only about 25% of private practices employ professional interpretation services. However, about 58% of providers use professional interpreters (CMS, 2017). Professional interpreters can be directly hired by the
organizations, contracted by agencies providing interpretation services to a multitude of organizations, be free-lancers, or community/public based. The interpretation services usually provided by professional interpreters can be in-person, over the telephone, or via videoconference.

Since most of these professional interpreters do not have a medical degree, they are more likely to suffer vicarious trauma when interpreting between providers and patients (Lai & Costello, 2021). Due to the nature of professionalism, most professional interpreters relay the back-and-forth messages in professional or collegiate terms. For effective patient communication, whether in spoken or written form, a third to fifth grade level has been widely accepted in health care. Additionally, as professional interpreters are most likely contracted, they must adhere to their role and are probably discouraged from advocating for patients during the patient-provider interaction.

In a qualitative study, Lai and Costello (2021) conducted focus group interviews to gain an understanding on how public service interpreters respond to vicarious trauma. In addition, they also investigated how public service interpreters maintain mental well-being and how their culture influences their practice. This study was conducted in Australia with a total of 47 participants. The researchers found: cultural perceptions influence whether interpreters seek emotional help for their vicarious trauma, or not. Interpreters’ use of “I” when interpreting difficult stories in first person, increased the internalization of trauma. Work stress is increased when interpreters are treated as merely a “mouthpiece” or a “shadow.” Interpreters’ misunderstanding of confidentiality prevented them from seeking emotional help. Participants developed coping strategies to decrease their emotional toll by hearing traumatic stories from other interpreters.
Although they developed their own coping mechanisms, Lai and Costello (2021) found interpreters want professional support, to be treated as part of the team, to have access to employee assistance programs, and receive ongoing training and/or courses for targeted professional development.

Since a focus group approach was used in Lai and Costello’s (2021) research study, it is difficult to assess if individual cultural or ethnic backgrounds played a factor in the level of vicarious trauma the participants experienced. Due to the qualitative nature of the study, the level of trauma could not be quantified in the participants. The participants in the study were community or public service interpreters and served in a range of professional fields, from legal to environmental health. They were not medical professionals or exclusively medical interpreters.

**Family/Friend Interpreters**

CMS found about 37% of acute care hospitals, 35% of hospital-based physician practices, and about 52% (more than twice the percentage who used professional interpreters) of private practices asked accompanying family members or friends for interpretation assistance. These numbers present a worrisome impression; private practices rely heavily on family and friends for transmission and reception of health information when SOSP members seek medical care. The percentage of providers who ask family members or companions to interpret is about 38% (CMS, 2017).

Rosenberg et al. (2008) found family members acting as interpreters can serve as valuable patient advocates. These family members often consider themselves as third participants in which they facilitate understanding, ensure diagnosis and treatment, and interact with the healthcare system during the interpretive session. This can present
negative consequences, for example, family members make healthcare decisions they themselves would make, rather than what patients would decide if they could communicate directly. Family members or friends can potentially withhold critical information to “protect” the patient, such as in terminal diagnosis discussions, which can potentially prevent patients from making informed decisions. Lastly, friends or family members acting as interpreters are also more likely to misunderstand or misinterpret medical language, such as treatments, medications, or necessary procedures (Flores et al., 2012).

Rosenberg et al. (2008) employed a two-phase exploratory focus groups and interviews approach to collect their data. They recruited six professional interpreters and nine interpreting family members to describe and compare how they perceived their roles and tasks during interpretation sessions in the primary care clinic environment. The researchers of this study concluded most professional interpreters perceive themselves as information transferers, information flow controllers, trackers and guides of the patient-provider conversation, providers of a safe environment by ensuring confidentiality and respect, cultural mediators by clarifying meanings and references, adjusting patterns of communication, explaining social norms and the medical system, and definers of roles and boundaries.

Conversely, most family interpreters perceived themselves as facilitators of understanding by ensuring the patient was included in decision making after full comprehension of diagnosis and different options for treatments, and recovery time. Lastly, family interpreters viewed themselves as being responsible for the organization of care while fulfilling their perceived family role.
The identified limitations in the study by Rosenberg et al. (2008) were: a small sampling, the setting was limited to primary care clinics located in two districts of Montreal, Canada, no interpreters who exclusively interpret for medical terminology or who are themselves medical professionals were recruited, and the effect of cultural or ethnic differences were not accounted for in the findings.

Another study by Cox et al. (2019) used a mixed method approach to review ten patient-provider-companion encounters in an emergency department (ED) in which companion interpreters (family members, friends, or acquaintances) were used to serve as ad hoc interpreters (AHIs) during the ED visit. The researchers’ aims were to explore how misunderstandings occur in a linguistically diverse population, and to explore perceived and actual quality of communication. Interpreting errors and how they affected treatment option decisions were quantified. Viewing and reviewing of video recordings using ethnography to have a richer understanding of the patient-provider-AHI interaction context was performed.

There were 704 AHI interpretation opportunities during the 10 clinical encounters. Cox et al. (2019) found accurate interpretation was achieved in only 20% of those opportunities. They also found 34% of AHI answered in lieu of the patients, and 24% of them omitted information. Additionally, the researchers concluded 20% of misinterpretations were of high clinical significance, 30% were mild to moderate, and 29% were insignificant, and 11% had a harmful effect on the patient-provider relationship.

There were two medical doctors (MDs) who were included in the coding phase of the study. This inclusion of medical professionals potentially strengthened the findings.
The limitations identified are as follows: except for gender, no AHI demographics were collected by the researchers. Cultural backgrounds and educational levels of the AHIs were not accounted for in the analysis of the data.

**Certified/Trained Medical/Nurse Interpreters**

According to CMS, about 40% of acute care hospitals, 47% of hospital-based physician practices, and about 13% of private practices have trained/certified interpreters on site. The percentage of providers who used trained/certified interpreters on site was about 33% (CMS, 2017).

Nurse interpreters can potentially experience an identity crisis during the interpretation session (Bischoff & Steinauer, 2007). The primary role of these individuals is that of a nurse, and because of this, they may be more likely to advocate for their patients than a professional interpreter would. Research on the use of certified nurse interpreters and its cost or cost-savings is limited. However, it is postulated immediate availability of certified nurse interpreters can potentially decrease inequities and disparities in the SOSP or LEP population.

Comparative studies with a focus on the lived experience of nurse interpreters were not found during literature review. Hence, this qualitative descriptive study was undertaken to fill this gap in knowledge.

**Uncertified/Untrained Staff interpreters**

According to CMS, about 41% of acute care hospitals, 39% of hospital-based physician practices, and about 44% of private practice have untrained/uncertified interpreters on site. The percentage of providers who use untrained/uncertified staff interpreters is about 41% (CMS, 2017). This group of interpreters commit errors
frequently. Untrained staff interpreters provide information incongruent with patients’ comments, slanted interpretations undermining patients’ credibility, and provide information using incompatible cultural metaphors (Elderkin-Thompson et al., 2001). The use of uncertified/untrained staff interpreters should be a last resort option.

In a study conducted by Elderkin-Thompson et al. (2001), the researchers examined the accuracy in interpretation by nurses who were not trained or certified to interpret. A qualitative approach was used in the study, and the setting was a multi-ethnic, university-affiliated primary care clinic in Southern California. The 21 cases studied involved 21 patients who spoke only Spanish and did not bring a companion to interpret for them, requiring the assistance of non-certified/untrained bilingual nurse-interpreters. The patient-interpreter-provider interactions were video recorded. These recordings were transcribed by bilingual research assistants, and then analyzed by the researchers.

Elderkin-Thompson et al. (2001) concluded half of the 21 encounters were considered complicated cases (multiple possible etiologies) and the other half uncomplicated. They found ten of the total encounters had minor non-clinically significant interpreting errors. About one third of the uncomplicated cases and about two thirds of the complicated ones had communication problems.

Except for gender, the researchers did not include demographics, nursing experience, educational level, cultural background, or other pertinent information describing the characteristics of the non-certified/untrained nurse interpreters. This study did not interview the nurse interpreters to record their perceived encounter experience. Thus, a gap in knowledge exists regarding the relationship of interpreter characteristics and the efficacy of patient-interpreter efficacy remains unknown.
Summary

From the above review of the literature, the lived experience of these RNs remains an understudied phenomenon. In particular, a qualitative descriptive approach regarding this phenomenon does not appear in the current health care literature. It can be posited that beginning with such an approach creates a basis for future investigations that can examine more closely the efficacy of RNs performing the interpreter role.
Chapter 3

Methodology

This chapter outlines the study design to explore the lived experience of nurses serving as qualified and/or certified interpreters while caring for patients. The research design and rationale, role of the researcher, participants and sampling, data collection, and the data analysis process will be discussed. In addition, ethical considerations and trustworthiness of the study will be presented.

Research Design

A qualitative descriptive study design with one-on-one semi-structured interviews via videoconference or in-person was used to capture the lived experience of interpreters. The questions were written with the goal of probing the feelings of interpreters regarding their role, their perception of the patient-provider interaction, their view of other interpreting options available to patients, and the challenges they have encountered while interpreting for patients and providers. Except for one in-person interview, the interviews were conducted via videoconference for convenience and following COVID-19 precautions. The interviews were video, and audio recorded. GMR Transcription Services, Inc. was contracted for professional transcription of the audio-only part of the interviews.

Qualitative Descriptive Methodology

A qualitative descriptive approach was used to guide semi-structured interviews and gain rich data. Interviewing is a method of data collection that allows the researcher to gain insight and context (Doody & Noonan, 2013). In a semi-structured interview, participants are asked open-ended questions, using responsive interviewing style techniques to guide a flexible question designed to seek depth and detail (Rubin & Rubin,
Because interviews provide deeper insights into the intricate actions of this population’s experiences, a qualitative descriptive investigation was best suited for exploring and identifying the issues of caring for a patient while providing interpretation services. Congruent with Sandelowski’s (2000) stance, the qualitative descriptive study is the method of choice when straight descriptions of phenomena are desired, as in this case of the lived experience of RN interpreters.

Sample

The qualified bilingual speaker (QBS) model utilized by a large health maintenance organization (HMO) in Southern California was chosen as an inclusion model for RNs participating in this study. This model includes a QBS program, which trains, tests, and certifies bilingual providers as well as bilingual staff, including medical providers, RNs, and other supportive team members. The QBS certified employees, in addition to their main medical roles, help with interpretation services between patients and providers at the clinics and in the hospital setting.

There are two levels of the QBS program in this model. Level I certification is for interpreters who can only interpret non-medical (directions and everyday language) English language to Spanish. Level II certifies interpreters who can, in addition to non-medical English language, interpret English language with medical terminology to Spanish. During QBS training, interpreters are instructed to stay as true as possible, and even to interpret verbatim when appropriate, to the back-and-forth communication between patients and providers. Interpreters are told a successful interpreter is one who is barely noticed during the patient-provider interaction.

Registered nurse interpreters were recruited from multiple health care
organizations located throughout the Counties of San Diego, Riverside, and Los Angeles. These RN interpreters were chosen if their clinical setting utilized a model of QBS II certification similar to the one described above. The recruitment of participants was done through word-of-mouth, employee posting-board, and through the use of social media such as X (formerly known as Twitter; https://twitter.com/CertifiedSan) and Facebook (https://www.facebook.com/RNCertifiedInterpretersOfSanDiego).

The inclusion criteria were as follows:

1. A registered nurse with at least one year of nursing experience,
2. Certified as a QBS (Spanish-English) level II using the QBS model its equivalent in the institution,
3. 18 years or age and older,
4. Have access to an internet connection and a computer or mobile device capable of videoconferencing (working speakers, microphone, and camera),
5. Able to use, or be familiar with, videoconference applications or programs for computer or mobile devices,
6. Have a quiet space during interviews to minimize interruptions and distractions,
7. Have at least one year of interpreting experience.

The exclusion criteria were interpreters of languages other than Spanish and English, nurse interpreters with less than one year experience in nursing, or less than one year as certified nurse interpreters.

**Data Collection**

A total of 10 participants meeting the inclusion criteria were recruited and gave informed consent. The interviews were conducted in a mutually agreed-upon location in
which privacy could be assured, either remotely or in-person. Data collection was
accomplished using initial survey questions, field notes, and individual, digitally recorded
semi-structured interviews of about 30-45 minutes. Field notes were recorded during
and/or immediately following every project related activity.

The researcher developed an interview guide for the purposes of this study, which
included questions and additional probes. These questions were used to create a narrative
about being a nurse interpreter whose primary role is providing direct patient care. These
interviews were recorded, transcribed, and then analyzed to identify essential themes
from which to derive a better understanding of the meaning of the experiences of the
participants. Personal information and demographic data were also collected. The
demographics included: age, gender identification, ethnic identification, country of origin,
years in the United States (if born in a different country), languages spoken, educational
level, years of nursing, years as a qualified/certified interpreter, employer, and nursing
role/position.

The collection of data was closed after 10 successful interviews were completed.
There was a total of 15 nurse interpreters who were initially interested in participating. Of
the 15 who received consent forms to sign, four did not sign them, while one did and
returned the signed consent form, but ultimately decided to not participate due to
“personal difficulties.”

**Interview Script**

A questionnaire with four questions was provided to each participant in advance.
This was done to allow participants some degree of preparation for the interviews. The
interviews included all four of the following questions with additional follow up
questions if/when appropriate:

1. Tell me one memorable experience you have had with interpreting.
2. What separates certified/qualified RN interpreters from other types of interpreters, such as family members, friends, or professional interpreters?
3. What do you find challenging when interpreting?
4. What effect do you think having an interpreter has on the interaction between provider and patient?

**Data Analysis**

A qualitative descriptive approach guided the data analysis. This method involved reviewing the text from the transcriptions and identifying any themes, facilitating the development of an understanding of the lived experiences of nurse interpreters. A line-by-line analysis was performed to capture meaning by identifying statements or phrases that seemed essential to the participant's experience, and each sentence was carefully analyzed. Once themes were identified, they were placed into clusters, and the clusters were given a name that represented the emergent themes. These clusters were used to develop insights into the essence of the experience the participant had described (Polit, & Beck, 2017; Smith et al., 2012).

**Protection of Human Subjects**

This researcher received approval for the conduct of this study from the Institutional Review Board of the University of San Diego (Appendix B). Written informed consent was obtained from each participant before starting the interview session. The consent form included information regarding confidentiality and a description of the study and their voluntary participation. Participants were also informed they could
withdraw from the study at any time. Data collected for this study, including initial questionnaires, audio files, transcripts, and field notes were kept in a locked file cabinet in the researcher’s office. The researcher removed all personal identifiers from the collected data. Pseudonyms in the form of alphanumeric codes were assigned to each participant to be used in reporting participant statements.
Chapter 4

Findings

Characteristics of Study Participants

The characteristics of the participants in this study are presented in Table 1. There was a total of 10 nurse interpreter participants who met the inclusion criteria and fully consented to participating. Of these, one identified as a male and the other 9 identified as females. This is congruent with the current gender distribution among American nurses recorded by the National Council of State Boards of Nursing (NCSBN), which found 9% of registered nurses in the United States identify as males (NCSBN, 2021). The average age of the nurse interpreters in this study was 43.2 years old with an average 15.3 years of licensed nursing experience, while the national median age of registered nurses in this country is 52 years old with a median licensed nursing experience of 20 years (NCSBN, 2021).

The birthplace of seven of the nurse interpreters in this study was the US, while the other three were born in Mexico. At the time of this study, The HMO employed seven of the participants, while Los Angeles Public Health (LAPH) employed the rest. Nine possessed at least a bachelor’s degree and one was a registered nurse with an associate’s degree. Their roles included: five nurse case managers, two nurse educators, two intensive care unit nurses, and one public health nurse.
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*Note. N = 10. HMO = health management organization; ICU = intensive care unit; RN = registered nurse.*

**Themes**

Using process and line by line coding, the 10 interviews produced a total of 641 first level codes. Once all repeat codes were removed, there were 160 individual first level codes left. These 160 codes were categorized into four main categories: protection of patient, uncertainty, challenges, and RN interpreter effect.

The four main categories were then analyzed and produced the following themes for this study:

1. Protecting the patient may be conceptualized differently by providers, RN
interpreters, and family/friend interpreters.

2. RN interpreters consistently face conflict and uncertainty during their interpretation sessions, compelling them to generate uncertainty reduction strategies and reconciliation.

3. The presence of RN interpreters harms the patient-provider interaction by increasing noise but enhances it by eliminating the language barrier and reducing uncertainty.

**Protecting the Patient**

The protection of patients may be conceptualized differently by different entities. These differences may have some similarity, can be intertwined, or can be at opposite ends of a spectrum. This study exposed the ways in which RN interpreters perceive their own concept of patient protection, and how they view patient-protection offered by family interpreters and providers.

**RN Interpreters**

While intention is difficult to be perceived and described in any interaction, the intention of the RN interpreters interviewed to protect the patient appears more evident during analysis of the interview transcripts (full interview transcripts are presented in Appendix A). RN interpreters protect the patients by ensuring they get fully informed before making a decision. They also protect the patients by helping them reach comfort and trust, so they feel “safe” with their providers. For example, one participant, Nancy, stated “I always wanna make sure that whatever the member chooses or that they understand. And they know – basically be educated. I feel like that’s important. […] I feel like I – well my hope is that by the end of their conversation that the patient will get
all the information and education that they may need. And I also hope that they feel more comfortable with the provider as well. You know, just feeling safe from this provider and knowing that the provider knows exactly what their wish is for whatever the – I guess appointment was for.”

Reyna, supported the claim of RN interpreters protecting the patients by providing complete information during interpretation, “But, the nurse will make sure that all the information that the provider has said is given to the patient. Versus I don’t think the family always says everything by the doctor. […] Like, me as a person versus being a nurse. How much do I respect this person to be able to give all the information that is provided to me to give to convey to the patient or to the person.”

Protecting the patients by providing complete information and a safe environment with the providers was echoed by a third participant, Suzana, “I’m just gonna speak on Spanish, we use more words to describe something than in English, so I just remember a provider wanting to rush the visit and I remember having to stop him and tell him well, she still has questions, and for you they may be yes or no, but she’s – there’s a story she’s giving me, so I have to take that story. Or I have to describe it, it’s just not easy. So, yes, the provider seemed bothered or upset or I just wanted to make sure that my patients always have the – you know that they’re getting all their questions asked, or that they have the information.”

The same RN interpreter, Suzana, also stated the importance of protecting the patient by providing the information without biases and without influencing the decision: “What I find challenging is not trying to – just trying to be very unbiased and making sure that the information is given without any emotion, or just very concrete, and having
the patient make the decision, and without influencing the patient one way or the other.” The follow up question by the interviewer, “So, as a nurse, what do you think are your biases when you are interpreting?” encouraged the following response furthering the understanding of how nurse interpreters protect the patient by having bias awareness and eliminate or minimize any biases to safeguard an informed decision by the patient: “The treatment – whatever. Depending on the treatment, I have biases toward specific treatments. Yeah. I mean, an example would be, just the last example, I’m a diabetic nurse, I’m not big on medications if I could avoid them, so I’m not just gonna push over the med without making sure that my patient understands all the side effects. The benefits and the risks. And I sometimes feel that that’s missed, so I try to just interpret what the doctors say, it’s very hard for me not to step in as a provider and give my educate – The education that I would want my family member to get. The most important thing is for me, as a nurse, for them to leave with an informed decision, so I like to present all the information.”

RN interpreters protect their patients by maintaining their nursing roles and delegations during interpretation sessions, as stated by Violeta, “I think for us [nurses], as interpreters, our roles they just intertwine; I mean, you can’t just do interpreter and not be a nurse – and forget you’re a nurse, you can’t do that, you’re still a nurse. I mean, I’m still a nurse, a registered nurse when I’m interpreting; that does not change.” Additionally, RN interpreters remain strong patient advocates, an essential component of nursing, during the patient-provider interaction and/or when professional interpreters or family members do not interpret appropriately. RN interpreter, Suzana, stated “I think that would – just what I mentioned right now that we’re also patient advocates, we’re familiar
with the medical terminology. I’ve heard interpreters, and they’re not interpreting – they’re just interpreting it, but they’re not interpreting the words correctly; family members don’t understand the medical terminology. The education level just that we have to translate something, and even if they’re saying the word, they might not know how to describe something.”

Lastly, RN interpreters protect the patients by pacing the conversation with their providers. It is well understood providers have a limited time with each patient and the pressure to keep a timely appointment flow often forces them to hasten the patient-provider interactions. This is especially important when the person requiring interpretation comes from a culture in which symptoms are usually described in a storytelling manner. Graciela presented an example of how RN interpreters protect patients by pacing the interaction when providers hasten the encounter, “I think it might be when I get somebody who’s asking me to interpret, who’s very unemotional and won’t take emotions into consideration for me, that’s challenging. I think that just comes from the provider, though; whoever I seem to interpret, it already comes with this energy of, let’s just get this done, I just want the facts, and they don’t wanna hear anything about actually what the patient is going through. For me that’s frustrating because I think you can clinically miss so much with not taking into account what somebody is going through and their experience. And it can be something that’s extraneous; it could be something else that’s happening. Does it hurt, yes or no? Well, no, but when I think about this other thing – well, that’s not what I asked, does it hurt, yes or no. And so, I will be an advocate at that point, and I’ll say, look, I’m just here to interpret, but in my experience, I feel like there’s something going on. And I might get a response well, nobody asked you – and I’ll
say this is part of interpreting; if you’re asking a nurse to interpret, you’re gonna get the full spectrum of what a nurse is, and that’s our intuition, that’s our experience, that’s our ability to assess and evaluate in the moment because we’re taught that.”

Another RN interpreter, Carla, provided support to the claim RN interpreters protect the patient by pacing the conversation, sharing: “Well, you know, I think that’s not unique just to nurses, but to any interpreter, it is just being able to set the pace between the two – the interaction, like okay, give me a chance to interpret. They [patients] wanna add; they wanna get everything in. Their story. More of a little bit of a story, tell a story when the patient – when that provider just wants that answer, and they don’t wanna go through the story of things.”

Occasionally, RN interpreters are unsuccessful at protecting the patient being unable to keep the pace of the patient-provider interaction. When this happens, the uncertainty reduction the patient experiences because of the presence of the RN interpreter is splintered by the providers’ actions. Beto presented this example, “I feel that sometimes when you’re translating for patients, they get more comfortable and then instead of answering the providers questions in yes or no, they’re now answering in – well, yeah, but also when I was a little girl – it’s often a little bit more time-consuming, even the provider is getting mad; okay, tell her yes or no. And then as the interpreter, you’re like so-and-so the provider says yes or no questions, like okay, so that changes that dynamic a little bit. If they see the provider, their non-verbal communication of like – sometimes these doctors they have no shame. They’re like – they facially like show that they’re annoyed or kind of like bothered; and the patient’s obviously they’re gonna see that, so I think that also gets used to the decrease, even if no matter what the interpreter
does, I think.”

**Family Interpreters**

During interpretation sessions, RN interpreters often observe family members withholding information, adding to the information, or misunderstanding the information being relayed from provider to patient or vice versa. The addition to withholding of information by family interpreters may be intended to protect the patient, but a research study would be appropriate to provide a better understanding of this phenomenon.

Cristina stated during the interview, “Well, because that’s our profession, we’re nurses, but we know all the medical terminology, and we know what comes with the disease process. We know what the medications are, whereas family members they’re just hearing portions. I believe that with past experience that I’ve had or what I’ve heard, family members interpret to their family members is what they want them to know, and there’s a lot of words that are omitted. Or they reword it in a way that doesn’t make sense or that it’s not correct; it’s not correct at all.”

The withholding of information, even if intended to protect the patient, by family interpreters can have a detrimental effect. For example, Beatriz shared, “I took care of a – I was helping another nurse with a Hispanic patient. And the patient had been sedated and intubated for a few days. We finally were able to wake her up and extubate her. And when we went to position her, of course, we gave her privacy, and we were going to put her on the [inaudible] [00:21:58], was going to eat, she didn’t realize they amputated her leg. […] She woke up to an amputated leg. And the family made the decision […] and then the brother comes out, and he goes, “Yes, she didn’t know. We were trying to keep it from her.””
The presence of family members and their contribution to the interaction between patients and the providers can also influence patients’ decision-making process. Again, this phenomenon needs further investigation, but it appears the intention is to protect the patient. This can be seen in the statement by Beatriz, “it’s very difficult to have – to be unbiased in your interpretation, and then there’s always that side conversation. “¿Pero de veras quieres decirle eso?” “Do you really want to say that, or do you really mean this?” And trying to navigate the conversation from – from the patient’s desires, needs, wants, you know? And what they want to really convey to the doctor. “Do you really want to say that? That’s going go to into your medical record number, you know? That’s going to be on there for life.” You know?”

Reyna provides a clearer perceived view into how family members may intend to protect patients from negative emotions by omitting parts of a message while interpreting, “Well, the family members, they don’t wanna make the family member uncomfortable. They may leave words out or something out, so they don’t upset the family member.”

**Providers**

The RN interpreters’ perception of how providers protect the patient was not captured often during the interviews or in the analysis of the transcripts. There is one example in which a provider willingly slowed the interpretation session to protect the patient, providing a glance into patient protection by providers. This example was presented by Ana, “the provider was willing to work and understood because it’s a barrier of communication that they were willing to slow things down and explain; they showed me that their patient was first, and they were okay with slowing things down, so they could understand a little bit better.”
Conflict and Reconciliation

The conflict experienced by RN interpreters were identified as internal, personal feelings and emotions, or external, other participants’ contributions to the interaction. However, the nurses who participated in this study felt well equipped to develop and utilize effective reconciliating strategies.

Internal Conflict

A common internal conflict expressed by some RN interpreters was role conflict. However, even when experiencing role conflict, RN interpreters find a way to connect to their patients through their humanity. This is expressed effectively by Graciela, “In general. Over any scenario, nurse interpreters have the ability already because of our experience as nurses. As nurses, we wear the hats of social workers; we’re teachers, we’re psychologists, we’re physicians, we’re friends; we’re human we admit our faults, we sometime connect with people because we’re able to connect with them on a level and say I’ve made that same mistake.”

Regarding role conflicts, described as “one of the hardest acting gigs,” affecting RN interpreters Graciela added, “But I think ultimately, as interpreters, the most important thing is be dutiful and be responsible because you can affect so much that it’s not intended, and it’s none of our business, really, I mean, it is, but it’s not; it’s – we’re there to – it’s almost like the – it’s like one of the hardest acting gigs someone could have. Right? Yeah, it’s like you have to put yourself in that moment. What if I’m not ready to interpret for an 11-year-old that was sexually abused? What if I’m not ready to tell someone we have to disconnect your family member because there’s no hope. Right? What if I’m there to interpret for a gang member who – I’ve had this a lot where it’s like,
oh, they don’t deserve to – I’m not gonna say that.”

RN interpreters find ways to reconcile their internal conflicts, requiring them to separate their feelings and emotions from the interpreting encounters. As expressed by Graciela, “So, after I finished the interview, I hung up, and I sat there for a second and had to just reevaluate and make sure that I said everything that I needed to say correctly. And I had to leave myself out of it; I had to leave other experiences that I’ve had with other patients. I had to leave behind the data I just had; I was there overtime because of this, I had stuff waiting for me at home, all of it has to go out the window when we’re dealing with something like that. […] I have to leave my own emotions out of this. […] So, I felt a lot of – I felt a lot of responsibility in that moment, and I really tried to set aside any part of myself that might feel anger or hopelessness or just wanting to reach out and cuddle this child.”

External Conflict

The external conflicts reported came from either the patient, the provider, or the family members accompanying the patient.

The level of education and/or understanding of the patient and accompanying family members was often reported by the RN interpreters as conflicting. Suzana mentioned, “And then with the interpreter over the phone or just the paid interpreter, sometimes it’s just an education level, they’re saying the correct word, but the patient doesn’t understand. […] family or friends are gonna be biased to how they feel, even within when the doctor is speaking, I’ve seen they’ll answer for the patient. So, there’s that bias. There’s the lack of knowledge on the both of them, because none of them have medical knowledge or they might not even have the interpreter knowledge to actually
translate something correctly. Something could get missed in the interpretation. So, I feel like information does get missed.”

Cristina, expressed a conflict regarding level of understanding of the patient, compelling this RN interpreter to “go a little bit out of the way to explain” and provide a clearer message, “if you are all about patient advocacy, you oversee that, and you try to get – assist the patient in providing them with the information that’s being given to them and also the support that they need. Because sometimes, we do go a little bit out of the way to explain it a little bit more in-depth than what the doctor’s doing. But when I have done that, I will tell the doctor could I go ahead and tell them a little bit more because they’re not understanding what you’re trying to tell them, and they’re like, okay. So, I’ll go into a little bit more in-depth of this is what the doctor’s trying to explain, so I’ll explain it to them.”

The patients’ own preconceived notions regarding providers could also present external conflicts to RN interpreters. Nancy, “Sometimes, even with their beliefs as far as even with doctors. They’ll just be like, “The doctor just wants more money you know. That’s why they keep giving me all these things.” And it’s like, “Wait, hold on, let’s have him explain to you better, like why”, you know.”

Patients’ Spanish with their diverse and regional variations of words also presents external conflict for RN interpreters. Nancy shared, “What I find challenging is the slang or the dialects or sometimes just the meanings of words can change between – it’s all Spanish, but it’s like different meanings.”

Family members’ emotions, hindering the message being relayed back and forth between patients and providers, can present a challenge for RN interpreters, as stated by
Violeta, “When it’s a family member, there’s a lot of emotion sometimes, and sometimes those emotions get in the way of even trying to – they don’t always or necessarily advocate for the patient, but they’re asking more for themselves rather than ask for the patient, they ask more questions just for themselves to know. […] if you have, say, family members are interpreting, a lot can be lost in translation, a lot. A lot can be lost. I’ve seen it happen too. So, I think we have that ability to make a better world for our patients if we’re able to interpret for them.”

Providers also contribute to external conflict, hastening the interaction, and this appears to stem from the limited time providers have with all patients regardless of interpretation needs. Beto verbalized, “one thing that I find challenging while interpreting is sometimes the provider will start talking and just talking, talking, and doesn’t give you a break to translate in pieces. […] But if the provider is going too fast, I’ll probably say hey, do you think you can slow it down a little bit I wanna make sure that the message is clearly and fully received by the patient.”

**Effect of RN Interpreter in Patient-Provider Interaction**

Besides the evident benefit of interpretation and transmission of verbal messages between patients and providers, RN interpreters have additional, mostly positive, effects during patient-provider interactions: a cultural and linguistic connection, a comforting role, a clarification and simplification contribution, and uncertainty assessment, analysis, and reduction provision. However, there is one negative effect, increase of noise, RN interpreters appear to have in the patient-provider interaction.

**Connection**

The connection provided by RN interpreters during the patient-provider
interaction can be subdivided into a linguistic connection and a cultural connection.

**Linguistic Connection**

More than a pure interpreting connection, RN interpreters provide a connection of “talking” with the patients. The connection goes beyond the sending and receiving of a message, to a talking and listening one. Cristina provided the following: “They’re not communicating hand-to-hand with that provider whereas in with the interpreters or with the nurses at the bedside if they’re speaking to them in their language and they’re not really interpreting, they’re talking to them, and they’re giving their care plan, it’s more of a connection because they understand that. […] I honestly believe they become more connected with the interpreter because they’re the ones that are talking to them, and they’re trying to get their point across, whereas in the provider’s there, but I don’t think they’re really listening to them, they’re more listening to the person that’s interpreting for them.”

**Cultural Connection**

Having cultural awareness/knowledge of the different Latino cultures, increases the plausibility of being an effective RN interpreter by better understanding the patients and by providing an improved individualized interpretation. Violeta supported this claim by stating, “I try and understand, at least throughout my years of interpreting, trying to get to know the different cultures so that when I do interpret, and I know a little bit about the patient, it helps me to better understand them so I can be a better interpreter for them, and make that connection and help them. […] So, it helps. I think we just really make a really good connection, and ultimately the goal is for our patients to have a better health outcome. […] we, as nurses – at least I, as a nurse, I try and understand cultural
competence. I try and understand the member, the background and I believe that the
member sees this as a connection that we’re truly invested and interested in their health.”

Having cultural knowledge increasing the probability of being an effective RN
interpreter was echoed by Beatriz, “they had somebody that understood their language
and their – not dialect, but we have our cultural way of speaking. And because I
understand their cultural way of speaking, I was able to convey that to the surgeon.”

Cultural awareness of RN interpreters and the cultural connection they provide
fundamentally increase the effectiveness of the transmission and reception of patient-
provider messages during interpretation. In turn, this effective communication potentially
helps the patients and providers reach optimal health goals and outcomes. Carla stated,
“We’re bridging the lack of understanding each other, the clarity for the patient, the
clarity for the doctor to understand what the patient is communicating. So, it’s able to
bridge between the two. You bring in your own cultural experience to translate, right?
Not only their words but their cultural experience. How can they – they might say a word,
or I ate Menudo, and maybe the provider doesn’t know what that is, and so you have to
bridge, well, it’s a soup, you know, and it does have carbohydrates. And it’s got, I mean,
it’s got some protein, but it has got a lot of carbohydrates and a lot of fat. So, maybe you
have to bridge, how does that effect the glucose for the patient when they have Menudo,
right? So, you bring in your cultural awareness of what they’re sharing.”

Comforting

According to Uncertainty Reduction Theory, uncertainty may be high during
initial interactions between strangers. This initial high level of uncertainty decreases as
the strangers increase their verbal communication, acknowledge perceived similarities,
and increase their use of nonverbal amiable expressions (Berger & Calabrese, 2006). Therefore, RN interpreters’ caring and comforting verbal and non-verbal communication is essential to decrease uncertainty during the patient-provider interaction.

**Verbal**

An initial introduction explaining the role of the RN interpreter during a medical visit can potentially minimize patients’ uncertainty and discomfort. This is well explained by Reyna, “Versus having the registered nurse who’s medically trained and is able to explain in different words what the provider’s trying to convey to the patient. I think the patient not only feels more comfortable, but they’re to the point where they can ask more [than] if it’s somebody that’s been on the phone and is not present or has no medical knowledge or background. […] Well, first of all, one of the things that works for me in getting them to relax is to let the patient know who I am and what is my role being there. And, I try to have a little conversation with them before actually doing the interpretation for the provider, so they feel a little more comfortable.”

Beatriz, in support of RN interpreters decreasing uncertainty and discomfort, explained the use comforting words, “As you’re interpreting, you want to make sure they understand, but at the same time, you want to give them comfort in their understanding, and in what we’re trying to help with. We’re here to help you. We’re not here to frighten you.”

**Non-Verbal**

Amiable expressions by RN interpreters not only decrease uncertainty and discomfort, but also encourage open communication, as stated by Reyna, “I think the human touch, the tone of voice, it makes the patient more comfortable. They loosen up
and they’re able to open up more and really say, “I don’t understand.” A lot of times, they just don’t say. They just shut down.”

In addition to decreasing uncertainty and discomfort, and improving openness in communication, RN interpreters’ nonverbal language also builds trust. Beatriz made the following statement: “But you’re supposed to develop that trust relationship first. Same thing, when you have a physical person there, your body language, and the way that you introduce yourself, you – you’re establishing trust with them. You’re hoping that they can trust what you’re interpreting. That you’re interpreting – that they can tell you what they really feel, what their concerns are.”

**Clarification and Simplification**

RN interpreters play a major role in clarifying and simplifying the message, assisting patients and providers in the transmission, reception, and understanding of information. An example of this was provided by Reyna, “What the provider stated, the patient didn’t comprehend. So, I had to translate more than once, twice, three, four, five times in different ways so the patient would understand it. […] Well, one of the things I gather also from the different people when I interpret is that they have a different level of education. Some people, they don’t read. They don’t write. So, you really have to lower your level of interpretation to like a kindergarten level, if you would. […] Sometimes, I have to use on paper to draw information to show because they don’t always understand the translation or the interpretation.

The use of illustrations to simplify and clarify the message was also used by Beatriz, “They don’t understand a lot of that. And they say, “Why can you just...?” Especially when the patient is intubated, “Why can you just go in and suck it out?” “It’s
not that easy.” So, I started drawing pictures on the board – on their patient board. And I say, “Well, our lungs are made of little and [inaudible] [00:12:46].” So, they can understand the why. How it works. […] This is how it presents on the X-ray, but this is how it's in the body. And this is how we get it out.” “Oh, now I understand.”

**Uncertainty Assessment, Analysis, and Reduction**

The nursing process; assessment, diagnosis, planning, implementation, and evaluation; remains employed by RNs when they are called to assume the role of interpreters. They assess and determine the level of patients’ understanding, plan the best approach to interpreting, implement the most appropriate interpretation style and use of words, and evaluate the patients’ reception and perception of the messages.

Ensuring a correct perception of the message is expressed by Beatriz, “We’re [nurse interpreters] also analyzing what their level of understanding is and how they perceive what they are hearing. It’s not just interpreting. I’m making sure I understand what their perception is of what you’re saying, what you’re translating, what you’re interpreting for the physician, for the nephrologist, for the cardiologist. They could be describing it one way, and if you describe it in the same way that they did, the family or the patient can be completely lost.”

The assessment, planning, and evaluation of the best communication approach to reach optimal outcomes, compels RN interpreters to “think outside the box,” as stated by Violeta, “I’ve found just in previous times, and I’ve interpreted is sometimes my challenges can also be that our physicians don’t understand the culture of this patient. […] I’ve come across several situations like that; obviously, we work it out because there’s always a solution to something; you just have to think about your different options
to find that solution. [...] as nurses, we advocate, we think outside the box, we have to; we are proactive, and we need to be proactive about these or should be proactive about this, at least we should be proactive, and try and find out find out what would help out the patient best so that they can have a better outcome [...] you’re observing their mannerisms, their facial expressions. Some people don’t say a lot, but you can tell your demeanor changes; the family, the wife, the child, the son, the adult son, their demeanor changes. So, I believe it's nurses, myself, I look at all of that, I mean I’m not seeing just doing, but it’s part of what we do, it’s our assessment. Right? In what we do, even when we’re interpreting, we’re still assessing the situation; we’re assessing the patient.”

Continuous observation for non-verbal expressions, in many instances conflicting patients’ verbal communication, is vital in the assessment of effective transmission and reception of messages. Nancy, “So, I feel like if I wasn’t there, maybe they would just feel like okay, okay, right. Like I don’t feel like they’d say anything or be like, “Can you explain it to me more? Can you give me more details?” Because just by looking at them I would be like, “Wait, I don’t think they understand what that means.” [...] I mean because you see what they’re saying but you can also see their facial expressions. And sometimes they say yeah, they get it, but it doesn’t look like they do. Or maybe they have more questions, but they’re maybe just culturally don’t want to ask for more information. So, yeah, definitely pick up on those other cues, yeah.”

Beto expressed how uncertainty reduction interventions can have the negative effect of role conflict in RN interpreters, “The interpreter role is so you wanna be able to communicate their concerns with the provider, and kind of – also at sometimes I feel like you have to mitigate disagreements between the provider and the patient, because, again,
that same role conflict, you’re there as the advocate but also the interpreter, but also you’re part of the care team like from a medical standpoint.”

**Noise**

Although RN interpreters effectively remove the linguistic barrier existing between SOSP and English-speaking providers, and reduce uncertainty through verbal and non-verbal comforting communication, the addition of noise presented by the Transactional Model of Communication is unavoidable due to the mere presence of a third party in the patient-provider interaction.

The presence of RN interpreters may cause the patient to experience physiological noise in the form of anxiety or preoccupation, since they may fear their message is being transmitted incorrectly. Reyna expressed, “It [the presence of an interpreter] hurts some patients that of course would prefer to have a Spanish speaking doctor. They feel they would be more comfortable themselves directly communicating with the doctor versus having a third person. Because again, even though we’re professionals and we are qualified bilingual staff, they all have a little hesitant because they feel, “This is what I’ve heard.” They feel that perhaps something might get missed. That it was important to them that they would prefer to relay the information to the provider themselves.”

Semantic noise can interfere with the message if the RN interpreter uses medical terminology or collegiate words. Beatriz stated the need to define or expand words at times to ensure semantic noise reduction, “But how is the receiving end going to – are they going to be able to understand it if I just say it straight across or are they – or do I have to – what words or phrases or in what form? Because sometimes when there isn’t a word to interpret, you can use a definition. Like the definition of that word to convey the
interpretation. Because you don’t want to change it. You want to convey what the healthcare provider is saying. But at the same time, you need to put it in a way that they’ll listen and can understand what is trying to be conveyed by the healthcare provider.”

Semantic noise doesn’t always come from employing medical terminology or the use of collegiate words, however, this type of noise is potentially increased by use of regional or ethnic words having different meanings in the diverse Latino population. Cristina presented the challenge of reducing semantic noise this way: “Because there’s different – we may be Spanish speakers, but there’s different words for each country. So, it can make it a little bit difficult where they do not understand what you’re trying to tell them. For example, when I used to interpret for head and neck surgery, we used to call them [speaking Spanish] [anginas] because that’s for tonsils, and some people would call them [speaking Spanish] [amigdalas], right? if you learn to listen to their accent and you’re like, oh, okay, this person is from, let’s say from Argentina, or this one’s from Chile or from Mexico, El Salvador, and places like that, so you get to know. And if I do not know, I’ll ask. I’ll say like what’s your background what country are you from, and then we’ll go from there. […] I don’t feel like they [providers] try to connect, they’re more relying on the interpreter to get their point across but not really connecting the actual patient. So, maybe by them having more of a looking at them the whole time, and trying to even though they may not understand what’s going on but more of a visual face-to-face. Because sometimes, I feel like they put their backs towards them, and they’re for focused on their computer typing away when there’s an interpreter involved, and they’re not really talking to the patient, but talking to the interpreter instead.”

Violeta supports how semantic noise is increased when proper Spanish is used
and how cultural awareness is important to minimize it in her statement, “I’ve actually tried it using proper Spanish with some of my patients; they’re looking at me like – they’re lost, they don’t know what I – and you can see in their face they don’t know exactly what I’m talking about. So, then they look at me – what do you mean? Are you referring to this? Oh, no, that’s not what it’s called; it’s called this. And I know certain terms are called – certain body parts are called a certain way, and it’s under certain cultures, so I know that. But I want to use my proper Spanish, and I end up just using Spanish that I know they’re going to understand. And it works. […] Are they able to receive this message that the doctor wants me to convey to the patient?

Violeta presented another example of physiological noise, not necessarily from the presence of the RN interpreter, but in the form of presence of anesthesia (this can also come from any other mind-altering medication) in a patient’s body. Violeta effectively identified the barrier, and presented an intervention employed to help with minimizing physiological noise by inviting a caregiver to the patient-provider interaction, “He just woke up from anesthesia. Is he going to remember this? Probably not. And that’s why I let the doctor know – give me a minute, I’m going to call, I believe a wife is waiting out in the waiting area; let me call her in. So, if she has any questions, this would be a good time to have that conversation since I’m going to be interpreting. So, again, we’re advocating, right, where if you call an interpreter, he’s not gonna do that; he’s not gonna say, oh, doctor, by the way, how long has he been out of anesthesia? Do you think he’s awake enough? Do you think that maybe we should have a family member here to listen and maybe ask questions? This is just an example. […] when I was working in the recovery room, and we had a patient who was overnight, and then the following day, the
doctor comes by, and he was still there, and we discharged this patient, so there were
certain instructions that the physician came over and said I’d like for you to convey this
message. It’s very important that he does this with his Foley catheter because I don’t
want him to accidentally pull it out and cause problems for him. So, when I was
explaining to the patient what the doctor had conveyed me because he was standing there
– I showed him, and I also had another family member, with his permission, of course,
the patient’s permission, be there because I wanted them both; if one didn’t remember, I
have somebody else that remembers. Right? Or they can ask questions, and maybe the
patient’s just really tired, they’re just not there, but you have another family member that
will ask these questions. So, when we finished, the doctor left, and both the wife and the
patient were very, very appreciative.

**Summary**

According to Sandelowski (2000), the expected outcome of qualitative descriptive
studies is a “straight descriptive summary” of the informational data from the study
organized in a way that best fits the data. Thus, the four main categories and subsequent
themes from this qualitative descriptive study generated the following descriptive
summary: nurse interpreters may harm the patient-provider interaction by increasing
noise, but they protect the patient by reducing uncertainty, increasing comfort, and
creating a connection while offering interpreting services (Figure 2).
Figure 2

*Uncertainty Reduction Connection Amidst Noise*

Conclusions

Nurse interpreters play an extremely important role in health care organizations and in the overall health care system, bringing immeasurable benefits to patients and providers alike. The interactions between patients and providers are essentially enhanced with RN interpreters as intermediators, since reaching optimal health outcomes would be impractical without effective communication. RN interpreters overwhelmingly perceive their interpreting roles and quality of their medical interpretation skills, superior to any other type of interpreting assistance. The findings of this study suggest that RN interpreters can play a role as key contributors to the improvement of access to care for patients from the SOSP and LEP groups.

Although RN interpreters face multiple challenges when interpreting, they are well equipped to overcome those challenges in a professional and effective manner. The internal and external conflicts reported in this study were, in most cases, overcome with a
variety of interventions and coping mechanisms. The internal conflict, in the form of role identity crisis, often expressed by the RN interpreters interviewed, appears to be dealt with by placing the nursing role as the guiding force during interpretation sessions. This nursing role was a lantern providing the guiding light when RN interpreters found themselves in situations requiring skills beyond those of pure interpretation. RN interpreters perceive their protection of and advocacy for the patient an ultimate goal.

In data from this study, the RN interpreter participants understand the importance of creating not only a linguistic connection but a cultural one as well. They also understand how verbal and non-verbal communication can be equally important in creating and allowing a comfortable environment for the patient. The nursing process remained firmly present when RN interpreters assisted during patient-provider interactions. The assessment and analysis of uncertainty throughout the patient-provider encounters were vital for developing uncertainty reduction strategies. Clarification and simplification of the message was fundamental for effective communication between all communicators. RN interpreters employ multiple skills to ensure the message is simplified and clarified enough, for patients to get complete information and make well-informed decisions regarding their care.

Lastly, the addition of noise to the patient-provider interaction is unavoidable when RN interpreters mediate the encounters. However, the added noise is greater if other forms of interpreting assistance are used, and even greater if there were no interpreting services employed by the providers. The RN interpreters have a high degree of self-awareness when called to interpret for a patient and are resourceful and successful at minimizing noise with the use of their extensive nursing skills.
Chapter 5
Discussion

This study found RN interpreters protect the patients by increasing patients’ comfort levels during the patient-provider interaction, confirming the findings by Haralambous et al. (2018). In addition, RN interpreters reduce uncertainty, advocate, and clarify and simplify the message so it can be understood as completely as possible promoting patients’ informed decisions. The connection RN interpreters described in this study, confirms the findings by Gerrish et al. (2004), which states all interpreters create a bridge or connection between patients and providers. However, RN interpreters create not only a linguistic connection, but a cultural one as well. This connection can crumble when uncertainty reduction strategies are unsuccessful.

Conversely, family interpreters seem to protect the patient by concealing or withholding information during interpretation. The withholding, addition, or misunderstanding of information by family interpreters observed by the RN interpreters in this study, was also observed in the research study by Flores et al., (2012).

Inevitably, the presence of a third party in the patient-provider interaction, whether nurse interpreter, professional interpreter, or family/friend interpreter, has the negative effect of increasing noise. This increase in noise varies in degree, depending on the interpretation skills and cultural competence of the interpreter. In other words, RN interpreters alter the patient-provider interaction dynamics. This alteration of interaction dynamics was also found in the studies by Kamara et al. (2018) and Ault et al. (2019).

RN interpreters in this study continued to use the nursing process when interpreting between patients and providers. This expertise eliminated or minimized the
loss in interpretation potentially occurring when other types of interpretation assistance are employed. This was also observed by Kamara et al. (2018). The other essential skill often shared by RN interpreters interviewed for this study, increasing the effectiveness of transmission, reception, and perception of messages, is cultural and linguistic awareness.

In both studies by Krogstad and Noe-Bustamante (2020) and Pope and Roberson (2018), the researchers present how a diverse Latino population, with their own regional words and customs, can challenge interpreters having to use two or more words or descriptions to interpret a single word from English to Spanish effectively. The immense diversity, linguistic and customarily, among Latinos and the need to use descriptions or two or more words to interpret a single word, was also reported by the RN interpreters who participated in this study.

The internal conflict experienced by RN interpreters in this study was role identity crisis. This was also observed by the researchers, Bischoff & Steinauer (2007). The participants in this study, however, perceived their nursing role as inseparable from their interpreting role, putting patients’ needs at the center of the patient-provider interaction. This helped them cope with their internal conflict and be able to provide an enhanced interpreting experience. RN interpreters, in most cases presented during the interviews for this study, continued to employ nursing skills; assessment, planning, evaluation, and advocacy to help the patient-provider interactions.

**Implications**

This study was designed to meet a critical gap in knowledge by establishing a basis for theory development and future exploration of the factors shaping the RN interpretive experience in the health care setting. By exploring the lived experiences of
RNs who additionally perform interpretation in the clinical setting, barriers and
promoters of culturally competent interpretation can be identified. These data can then
form the basis for future studies focusing on the testing and optimization of successful
RN interpretation and ultimately have the potential to decrease existing health inequities
across diverse populations. By establishing an empiric basis for culturally sensitive
communication in the clinical setting, the proposed study has the potential to contribute
to improved patient outcomes among previously marginalized groups.

Providers becoming annoyed or bothered by story-telling some patients employ to
describe their symptoms, also presents an important opportunity to educate providers in
how to best listen to their patients with these cultural customs. There is a need for
increased provider-awareness of how RN interpreters do not stop being nurses when they
assist in interpretation, and to allow RN interpreters to feel empowered to use their
critical thinking skills, advocacy, care, and compassion for a more effective patient-
provider interaction and improved uncertainty reduction.

**Further Research**

Because of the added time the SOSP requires during medical visits due to the
need for effective interpretation, finding solutions to increase equity for improved health
outcomes in this population is necessary. There is an opportunity for further research on
how equal time allotted to providers potentially harms the patient-provider interaction
when the assistance of RN interpreters is required. In many cases, there is a need for
simplification or clarification, or the patient requires more time describing symptoms. To
encourage equity, just as we would allow adequate time for those with a physical or
cognitive limitation to interact to their maximum ability, we must move towards
providing SOSP patients with similar parity. However, further research is necessary to find an appropriate and effective way of providing equity benefitting patients, providers, and health care organizations.

Additional research to explore or measure the internal and external conflicts experienced by RN interpreters can potentially provide added knowledge for developing best practice approaches to eliminate or minimize them. It appears this is the first published study utilizing the Transactional Model of Communication, Critical Race Theory, and the Uncertainty Reduction Theory as sensitizing frameworks in the area of health care interpretation. Thus, this study provided a unique approach into studying the role RN interpreters play in the patient-provider interaction. Further research is necessary to gain an improved understanding of the effect, added noise, has in RN interpreter mediated patient-provider interactions. Additionally, uncertainty reduction strategies need to be researched and best practices implemented for optimal RN interpreter-patient-provider encounters.

**Study Limitations**

Time constraints and low participation rate did not allow for this study to reach saturation. Therefore, it is postulated there may be additional factors, variables, and phenomena not attained or detected in this small sample. The research study was limited to RN interpreters and no members from other disciplines were interviewed. The lived experience of other types of interpreters may provide rich data to complement the findings of this study. The participants were employed by two health care organizations, located in two counties of Southern California, Riverside and Los Angeles. The lived experience of RN interpreters in other counties or states may provide support or contrast
the findings of this study.

COVID-19 pandemic precautions were in place during the time interviews for this study were done. Therefore, only one interview was done in person in a public place and following social distancing. The rest were videoconferences with most participants having a filtered background, preventing the researcher from analyzing the settings and interactions of the interviewees with their surroundings. Only Spanish-English interpreters from USA and Mexico participated in the study. Due to the immense diversity of Latino cultures, having RN interpreters from other countries may have produced other data not captured in this study.

**Summary**

This study represents an initial step in the process of understanding the complex role of language interpreters in the health care setting, particularly RNs who take on the role of interpreter in addition to their ongoing clinical and advocacy roles. Data from this study provide a basis for the development of future models of patient-provider interaction in which linguistic interpretation is needed. Given the growing diversity of language and ethnicities in the U.S. population, this study area represents an important focus for decreasing health inequities and enhancing nursing practice.
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Appendix A
Interview Transcripts
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Interviewer, Female Speaker, Interviewee

Interviewer: All right. And then, let me –

Female Speaker: Recording in progress.

Interviewer: All right. Well, thank you very much for joining me today. I am conducting this research study. The name of my study is Lost in Translation: the Lived Experience of Nurse Interpreters in the Clinical Setting. I do wanna thank you for participating today. I will be asking you a few questions. Do not use any identifiers. I will be using a code to identify you, and that code will be 4112023-1. So, that is going to be the way I identify you. And again, your name and other identifiers will be protected under password. And, if I ever publish, no identifiers will be published. Can we begin by telling me your age?

Interviewee: 57.

Interviewer: Gender identification?

Interviewee: Female.

Interviewer: Ethnic identification?

Interviewee: Latina.

Interviewer: Country of origin?

Interviewee: Mexico.

Interviewer: Years in the United States?

Interviewer: Okay. Languages spoken?

Interviewee: English and Spanish.

Interviewer: Educational level?

Interviewee: Bachelors. University.

Interviewer: Okay. Years of nursing?


Interviewer: Okay. Years as a qualified or certified interpreter?

Interviewee: 20.

Interviewer: Employer?

Interviewee: [Inaudible] [00:02:11].

Interviewer: Your nursing role or position?

Interviewee: I’m a care manager.

Interviewer: Okay. Now, tell me one memorable experience you had with interpreting. So, basically between you, a provider, and a patient. One memorable experience.

Interviewee: When the patient asked me to repeat what the provider told me more than five times. ‘Cause the patient didn’t understand.

Interviewer: Okay. So, that was one occasion in which the patient had to repeat the question? Or, the provider had to repeat the question?

Interviewee: The provider. What the provider stated, the patient didn’t comprehend. So, I had to translate more than once, twice, three, four, five times in different ways so the patient would understand it.
Interviewer: Got it. What made this memorable?

Interviewee: Because that reminded me that not every person that requires interpretation, not everyone is at the same level of literacy or understanding. So, that was an eye opener for me. So, I always try to interpret the same way, and it doesn’t work out that way all the time. So, that’s what made –

Interviewer: Okay. So, why do you think the patient in this case was not understanding the question? What do you think was the barrier?

Interviewee: The problem? I think it was because we have different patients. Some from Salvador. Some from Guatemala. Some from Mexico. Some from Peru. And, each and every one of them may perceive the way the interpretation goes on different.

Interviewer: So, do you think it was the words you were using that may not have been understood by the patient?

Interviewee: Right. I have to say it in different ways. Statements in different ways.

Interviewer: Got it. So, it was not the use of medical terminology?

Interviewee: No.

Interviewer: No, it was not the use of medical terminology? The patient wasn’t grasping the idea? It was more of the actual difference in words?

Interviewee: Right. The difference of the way it was stated. It wasn’t medical terms. The beginning of my learning to interpret, I was always told not to use medical terms as much as possible. Just try to explain what the meaning of the context. So, always try not to use medical terms as much as possible.
Interviewer: Got it. The way the patient was able to finally understand it. What made that effective? How were you finally effective about that? Transmitting the message.

Interviewee: Well, one of the things I gather also from the different people when I interpret is that they have a different level of education. Some people, they don’t read. They don’t write. So, you really have to lower your level of interpretation to like a kindergarten level, if you would. So, that time, I had to really, really bring it down to a low literacy level for them to understand.

Interviewer: Got it. Did you have to use descriptive words? A lot more description?

Interviewee: Yes. Sometimes, I have to use on paper to draw information to show because they don’t always understand the translation or the interpretation.

Interviewer: That’s interesting. So, you have used drawings and pictures in order for you to transmit the message?

Interviewee: Yes.

Interviewer: Wow. That is interesting. Interesting. Now, what do you think separates the qualified or certified registered nurse interpreters from other types? Let’s put it this way. What separates interpreters who are nurses from let’s say professional interpreters?

Interviewee: Because we understand the medical aspect, we’re able to really, really nail it to the core of what we’re trying to say to the patient or to the person. And, when it’s just a professional interpreter – Let’s say sometimes we use a couple for other languages. And, sometimes we’re able to
understand a little bit of the language and we can identify if that
information gets lost in the translation.

Interviewer: Do you think that professional interpreter will have been more successful
or least successful with that occasion you presented us your example?

Interviewee: I think least. Least because also, if the interpreter is not available in the
room where they can actually visualize the interpreter, there’s also
information that can be missed. Versus having the registered nurse whose
medically trained and is able to explain in different words what the
provider’s trying to convey to the patient. I think the patient not only feels
more comfortable, but they’re to the point where they can ask more if it’s
somebody that’s been on the phone and is not present or has no medical
knowledge or background. They’re very cold. Flat. Word for word, the
translation is not the same.

Interviewer: Yeah. So, when you say a little colder, when nurses interpret, do you think
they put a little more warmth into the –

Interviewee: I think so. I think the human touch, the tone of voice, it makes the patient
more comfortable. They loosen up and they’re able to open up more and
really say, “I don’t understand.” A lot of times, they just don’t say. They
just shut down.

Interviewer: Okay. If they don’t feel comfortable enough, they will just pretend they
understand.

Interviewee: Right. Exactly.

Interviewer: Now, an interpreter who is a nurse, what’s the difference between that
interpreter and a family member of a friend?

Interviewee: Well, the family members, they don’t wanna make the family member uncomfortable. They may leave words out or something out so they don’t upset the family member. But, the nurse will make sure that all the information that the provider has said is given to the patient. Versus I don’t think the family always says everything by the doctor.

Interviewer: Got it. So, you think they withhold information or they add maybe to the information?

Interviewee: They could.

Interviewer: They could? Interesting. Now, does your nursing role influence your interpreting role in any way? Being a nurse. Does it influence you when you’re interpreting?

Interviewee: Yeah. Does it influence me to interpret? No. I don’t think so.

Interviewer: Okay. Not in a positive way or a negative way?

Interviewee: A little bit on the positive way. But, for the most part, I think it’s individual. Like, me as a person versus being a nurse. How much do I respect this person to be able to give all the information that is provided to me to give to convey to the patient or to the person. I think it’s me as a person that wants to do a good job.

Interviewer: Oh, okay. Okay. So, the influence comes more from your personal values? Personal morals? Beliefs, maybe, even?

Interviewee: Right. There you go. Personal morals. How I want to always interpret or say what is being said to me to give to the other person. Sure.
Interviewer: Yeah. That’s also interesting. So, your personal, moral values, beliefs may influence your interpreting more than the nursing role.

Interviewee: Right.

Interviewer: Okay. Got it. Now, what do you find challenging when you interpret?

Interviewee: When the patient is talking over me. When sometimes they have because they wanna give all this information to the provider, and I’m here interpreting, and they start talking over me. It makes it difficult.

Interviewer: Now, why do you think that’s difficult? Is it because of the message? You’re trying to convey the message and this new message comes through? Or, is it just the fact that they’re almost just interrupting your conversation with the provider?

Interviewee: I think they’re so anxious to know more, and quicker to get the information [inaudible] [00:13:57] that they don’t even think or even acknowledge that wait, I need to let the interpreter tell the doctor that point. It’s a back and forth. But, no. They tend to keep on going and going. And, wait a minute. A minute. Let me finish what you just said, and then I can tell you what the doctor said. They get so emotionally overexcited, if you would, that they just start talking, talking, talking. So, they make it challenging.

Interviewer: Oh, got it. So, how can you remove that challenge when you are there and that’s happening? How do you remove it?

Interviewee: Well, I try to educate them that if I’m gonna interpret for them, that I need time to obtain the information, process it, and deliver it. And, not miss
anything, or not miss at least as much as possible. But, if they’re trying to
give me too much at one time, I might miss something. So, I ask them to
please pause a little bit to give me a chance to interpret what they’re
telling me.

Interviewer:  Got it. Okay. So, that’s an interesting point. So, you provide a little
education to the patient. As you are also doing the interpreting role, you’re
educating the patient as to your role in that moment to be an interpreter
and to allow time.

Interviewee:  Mm-hmm.

Interviewer:  Got it. Okay. Now, what effect do you think having an interpreter has on
the interaction between a provider and a patient? So now, we have the
provider, the patient. There is that message being sent from one to the
other. What effect do you think having you in there has on this
interaction?

Interviewee:  It hurts some patients that of course would prefer to have a Spanish
speaking doctor. They feel they would be more comfortable themselves
directly communicating with the doctor versus having a third person.
Because again, even though we’re professionals and we are qualified
bilingual staff, they all have a little hesitant because they feel, “This is
what I’ve heard.” They feel that perhaps, something might get missed.
That it was important to them that they would prefer to relay the
information to the provider themselves.

Interviewer:  Okay. So, there is a little fear that there is a little loss of a message if there
is an interpreter in the middle.

Interviewee: Right.

Interviewer: Okay. So, you’ve heard this from patients. Now, you being in there in the middle, how do you think that effects it? From your perspective.

Interviewee: Well, first of all, one of the things that works for me in getting them to relax is to let the patient know who I am and what is my role being there. And, I try to have a little conversation with them before actually doing the interpretation for the provider so they feel a little more comfortable. Yeah. I notice that if I just come in a total stranger in the room, they don’t know who I am, they don’t know what I do, and I’m here to interact with them, sometimes I can sense they’re little uncomfortable. You can feel them tense because there’s somebody strange. And, I think that happens a lot with the culture.

Interviewer: Oh, okay. So, in order for you to be more effective, that introduction of yourself to the patient prior to the actual interaction is necessary.

Interviewee: Yes.

Interviewer: And, you bring up a very good point because that’s something that we don’t necessarily think about. When it comes to interpreting in the room, the doctor calls somebody. Says, “Hey, come and interpret for me.” Here comes the interpreter. And then, now you’re conveying the message. That preliminary introduction that I think culturally speaking, it is very important to some cultures to have kind of that little rapport built before the actual interaction. That is interesting. Yeah.
Interviewee:  Right. We cannot just come in and impose. It’s like you come in. I’m here and I’m gonna do this for you. But, the person might say, “Well, why do I have to have – I have my daughter here.” But, just having the person come in and say, “Yeah. I’ll interpret for you. My name is so and so, and I’m gonna be here to assist you.” ‘Cause they just feel like okay, I’m being respected.

Interviewer:  Yeah. So, having the interpreter come before the provider may be more effective than – Yeah. That’s good. So, the effect can be a little more positive if the interpreter comes prior to the provider as opposed to usually the way it is, is the interpreter comes – I’m sorry. The provider comes in, realizes, “Oh, I need somebody to interpret for me.” Goes and grabs an interpreter, bring him into the room, and I’m assuming that’s the process, right?

Interviewee:  Right. Well, when we receive the training to be qualified bilingual staff, that is part of the training. That we respectfully come in, introduce ourselves, and let them know what I’m going to do. Versus just jumping in and doing the interpretation. But, I think that gets lost with time. Initially, perhaps the qualified bilingual interpreters do it initially because they’re freshly trained to do. But then, as time goes, it just goes down the highway.

Interviewer:  Got it. And, do you think that has to do with not allowing time for these interactions? Do they get the same amount of time with a provider? The people who do need interpreters as the people who are English speakers?
Interviewee: No. And, the other thing in my experience, what has happened is I have the same load of work as everybody else. But yet, I’m pulled away from my work to go interpret for a provider. So, my work still has to be done. Nobody steps in to do the work.

Interviewer: Yeah. Creating that challenge for you time wise. And, the providers, when they have their office visits, do people who need interpreter and people who do not need interpreter, do they get the same timeframe? The same amount of time with the providers?

Interviewee: Right. 10 minutes.

Interviewer: That’s it? Whether they need an interpreter or they don’t?

Interviewee: Right. The same time. There’s no different timing.

Interviewer: So, yeah. So then, of course, having that little introductory period where the interpreter finds them and the patient will probably benefit and value having that introductory time, it’s almost impossible if all you have is 10 minutes to do this visit. Same as an English speaker.

Interviewee: Exactly. And, I strongly believe that this is why some of the providers that speak a different language like Spanish, they don’t stay and they don’t take the exams to actually be qualified because they’re not given any extra time. Which is unfortunate, but that’s how it is. [Inaudible] [00:22:52] 10 minutes or 20 minutes. That’s it.

Interviewer: Yes. Yeah. Interesting. Well, the last one is really just open for you if you have anything to add to the interview, feel free. I’m done with my questions, and I thank you very much. Your answers were extremely
helpful. Very, very eye opening. But, do you have anything else you
would like to add to the interview before I stop recording?

Interviewee: Another thing that I’ve noticed is the use of a standing interpreter
computer. They bring it in the room. I forget what they’re called. But, they
use it. So, I don’t know if it is a qualified bilingual interpreter that they use
from an app. But, there’s no human involved. It’s just a machine. They
speak to the machine and the machine interprets for the patient. That’s
another one that I’m so opposed to because there is no one. No emotions.
No nothing. It’s just dry [inaudible] [00:24:16]. I just feel that it’s always
best to have a person interpreter to some machine. Or, even a phone call.
A lot of the times, information gets missed through the phone, as well,
when we have a third party interpreting.

Interviewer: Oh. True. Very true. Now, that you mentioned this –

Interviewee: Yeah. But –

Interviewer: Yeah. Go ahead.

Interviewee: But unfortunately, the qualified bilingual staff are supposed to be available
to everybody in the event they need us, but we’re all tied up doing our
work. Especially myself. Talking on the phone all day. ‘Cause I can’t step
away to interpret for a doctor going, “Where is the qualified – Can I get a
qualified nurse?” I can’t step out and say, “I can help you.” And, I’m sure
that happens with a lot of the qualified bilingual staff. They’re doing the
specific job and they just can’t get away to help. So, I don’t know how we
can solve that. But, that has been an issue. So, they’re having to use the
phone and this other computer. I forget what they call it. The computer. They roll it to the room. It’s just different. Yeah.

Interviewer: Got it. Yeah. That is interesting. If you were to put them in order from best to least or from best to worst when it comes to interpreting or interpreting services. You have the RNs who are interpreters, professional interpreters, family or friends, and now we add that to the mix. The actual screen, or a device, or an app. In which order would you put them? From best to worst.

Interviewee: Best would be the RN. Second would be the family. Third would be the professional interpreter. And, four would be phone and app.

Interviewer: Yeah. Got it. And, you were mentioning that as an interpreter yourself, a qualified bilingual speaker at your place of work, you get the same amount or workload as somebody who’s not qualified. So, you get the same amount of workload. And then, be expected to interpret, as well, in addition to the full workload.

Interviewee: Correct. Right.

Interviewer: Yeah. And again, this is why I’m doing this study. It’s to see if there is any way of improving the access to the qualified bilingual speakers. All right. Anything else?

Interviewee: Yeah. I just wish there was more – at least, in California, there was more doctors that spoke Spanish to provide services for the patients. That way, they wouldn’t require an interpreter to help. But, that’s asking for a lot, I guess. But, we don’t have hardly any.

Interviewer: I agree. Yeah. Okay. Well, if there is nothing else, I will be stopping the
recorder. And, do you have anything else?

Interviewee: Yeah. Okay. No. That’s all.

Interviewer: Okay. I will be stopping then. Hold on.

[End of Audio]

Duration: 29 minutes
Interviewer: Okay, alright. So, we will begin this recording today. Thank you for participating in this study. I wanted to let you know, no identifiers will be used today. I will be giving you your participant code number. And I will be using that just to – again, for my study and for me to able to identify my participants, so try to avoid using any identifiers. I will be asking you a series of questions about you. And then I will also be asking you questions for my study. But again, thank you for participating. Your participant code, number, will be today’s date. So, 5.18.2023.1. So, 5.18.2023.1. Can you please tell me your age?

Interviewee: Forty-five.

Interviewer: Gender identification?

Interviewee: Female.

Interviewer: Ethnic identification?

Interviewee: Hispanic.

Interviewer: Country of origin?

Interviewee: Mexico.

Interviewer: Years in the United States?

Interviewee: Forty-three.

Interviewer: Languages spoken?

Interviewee: English and Spanish.

Interviewer: Educational level?
Interviewee: Master’s degree in nursing.

Interviewer: Years in nursing?

Interviewee: Eight.

Interviewer: Years as a qualified or certified interpreter?

Interviewee: Two.

Interviewer: Sorry, employer?

Interviewee: [HMO].

Interviewer: Nursing role or position?

Interviewee: ICU.

Interviewer: Thank you. Alright. Let’s begin with the questions. Tell me one memorable experience you’ve had in interpreting – just with interpreting. Any event. One memorable experience between a provider and a patient where you had to interpret.

Interviewee: Patient was unresponsive due to severe sepsis. And needed urgent surgery to help get rid of the sores and help start treating the severe sepsis with antibiotics. We needed consent. Patient was completely [inaudible] [00:02:22], wasn’t able to give consent just for himself. Patient’s brother only spoke Spanish and was the only one in the country that was Mexican. Interpretation was done between surgeon, myself, and the patient’s brother. And the patient’s brother was also able to get in contact with patient’s wife and children, and their origin – their country of origin. And we were able to obtain consent from the whole wife. Primary’s wife and brother at [inaudible] was also able to sign.
And she gave permission. But all of this was interpreted with surgical precision, and risks and benefits and everything that – all of the questions were answered for the patient, and consent was obtained in order for the patient to be able to get that life-saving surgical procedure. It was a lengthy conversation, but the family was able to understand the why and the how, and the risks. And that to me was very important because it has to be an informed consent. And we were protecting the patient and the family from just saying yes to a physician, you know? In fear of not knowing the why. So, they were definitely one of my – it’s one of the reasons why I do and I enjoy doing interpretation because nobody should go into a procedure not knowing the why or the risks. It needs – that’s why it’s called informed consent. They need to be fully informed if they want to take the risk, or [inaudible] there’s a risk.

Interviewer: Yes, got it. Now, so what I am understanding is the fact that you were successful in getting this consent form so that this life-saving procedure could be done on the patient, but what do you think made it memorable over other events? So, what is memorable about this one?

Interviewee: The fact that even though the primary family, the wife, and children were outside the country –

Interviewer: Got it.

Interviewee: – they had somebody that understood their language and their – not dialect, but we have our cultural way of speaking. And because I understand their cultural way of speaking, I was able to convey that to the
surgeon. And because I understand the [inaudible] [00:05:31] and technical terms the doctor – even though he was speaking in layman’s terms, his layman’s terms aren’t necessarily other people’s layman’s terms, understandable layman’s terms. And so, because I was able to understand and interpret at their level of understanding and being able to make that connection because of my medical background, and my Latin background, I was able to – I felt it was a successful conversation between the physician at his level, and technical terms, and pathophysiology that we explained, and the family being able to understand at their level of understanding. That’s what made it memorable and being able to see that even though they were afraid for their husband and their dad, they were at peace with the understanding of what was going on. It’s not – there wasn’t any mystery behind it.

Interviewer: Got it. Yes. Yes.

Interviewee: Does that makes sense?

Interviewer: Yes, yes. The confusion side of it was removed from the experience. Them being confused. And this is actually a pretty fascinating case because something I’m gathering from what you’re saying is the surgeon, even though they speak at a more – at a lower level when they are trying to communicate with patients. Even that level when it goes through to you, you still have to even convert to another level. So, not only are you really interpreting from English to Spanish, but you’re interpreting from a medical level to even a much more [inaudible] [00:07:24] level, which is
again for individuals who may not be, you know, again medically aware or medically – what’s the word I am looking for?

Interviewee: Inclined.

Interviewer: Yes, inclined.

Interviewee: Inclined. And not just that. Not even the medical aspect of it. If you take in our Latin community that we have – there’s an erroneous expectation that as soon as you graduate high school, you’ve succeeded, right?

Interviewer: Yes.

Interviewee: And so, even in our Latin countries there’s not a lot of opportunity to continue education. I have a cousin that only went to kindergarten, and couldn’t afford it – couldn’t go to school, didn’t go to school for the rest of his life. He had to work to feed himself. And he has a kindergarten education. And he’s living like that. There are other individuals that only have a first-grade, second-grade education. And there are a lot of places in our countries where sixth grade is the equivalent of American high school. And that’s like a big – they do a big ceremony for that.

So, being able, and because we’re very much the majority of our population – our type of population is having to because of being immigrants and so forth, are having to work over having an education. I remember working full-time my senior year in high school. So, my concentration was yes, passing my classes so I can graduate high school. But I also had to work to keep the lights on at home – my parent’s house, you know? So, it’s this having to work, having to be out in the work
environment at an early age doesn’t give us a lot of opportunity to continue our education.

And so, because a lot of people get stuck in that working environment and not being able to continue, then they don’t have the understanding even in layman’s terms of a lot of verbiage, a lot of language because we also – it’s not just interpreting. We’re also analyzing what their level of understanding is and how they perceive what they are hearing. It’s not just interpreting. I’m making sure I understand what their perception is of what you’re saying, what you’re translating, what you’re interpreting for the physician, for the nephrologist, for the cardiologist. They could be describing it one way, and if you describe it in the same way that they did, the family or the patient can be completely lost.

Interviewer: A lot can be lost.

Interviewee: A lot can be lost or a lot can be misinterpreted, and they’re understanding, and they’re knowledge-based, you know?

Interviewer: Interesting.

Interviewee: So, the description. Has to be different.

Interviewer: Yes, yes. And now, your experience being with a surgeon, and you mentioned a cardiologist, nephrologist maybe even a primary care doctor, right? Where their language can even change, right? From a cardiologist's language to a nephrologist’s language. Now we are talking about surgeons who have almost their own language, right? When it comes to communicating.

Interviewee: Absolutely.
Interviewer: And the fact that you mentioned that you’re at the same time you’re interpreting you’re assessing what level of language, what level of Spanish you need to use in order for you to communicate effectively. That is again, extremely eye-opening because going back to what you were saying, it’s not necessarily just English to Spanish. It’s English, and now I have to find out what level of understanding this person has. Whether it’s education level or anything else, right? Where you need to now understand how much of a Spanish level I need to use in order for me to communicate effectively.

Interviewee: And what kind of depictions will help in their understanding perspective? Because there have been times when cardiopulmonary – a cardiopulmonologist will come and, “Oh, yes, they have pneumonia.” They have little, “You have or your family member has pneumonia, and we’re trying to keep you moving from side to side. We want you to cough. We want you to do these things to move the fluids around. So, you can bring them up. So, they can be absorbed by the body.” They don’t understand a lot of that. And they say, “Why can you just...?” Especially when the patient is intubated, “Why can you just go in and suck it out?” “It’s not that easy.” So, I started drawing pictures on the board – on their patient board. And I say, “Well, our lungs are made of little and [inaudible] [00:12:46].” So, they can understand the why. How it works. Because they’re like, “Well, if you have a – if that whole section is full of fluid just take it out.” “Well, that’s not how it works.” “Just stick a needle
in and pull it out. Suction it out with a [inaudible].” You know? “You can’t do that, you know? This is how it presents on the X-ray, but this is how it’s in the body. And this is how we get it out.” “Oh, now I understand.”

Interviewer: Great.

Interviewee: So, that kind of educational – we need to assess what is it that they understand, how are they perceiving it, what is it that I need to be more in detail in presenting.

Interviewer: Got it.

Interviewee: And how am I going to present it without scaring them?

Interviewer: Yes. Yes.

Interviewee: Because that’s a big aspect. A lot of the unknown is very scary. It can be – I mean, they’re already frightened that their family member is in the hospital might even be several thousands of miles away, completely different country, and you don’t want to add more fear. As you’re interpreting, you want to make sure they understand, but at the same time, you want to give them comfort in their understanding, and in what we’re trying to help with. We’re here to help you. We’re not here to frighten you.

Interviewer: Yes.

Interviewee: But at the same time, I don’t sugarcoat anything. I lay the cards on the table. I think that’s the best way to practice because you’re not giving anybody a false sense of hope.
Interviewer: Yes.

Interviewee: We’re being real, but at the same time, I’m not here to frighten you. I’m here to help you.

Interviewer: Yes.

Interviewee: Do you know what I mean?

Interviewer: Great. Yes. And that’s actually –

Interviewee: Does that make sense?

Interviewer: Yes, very. Very. And it’s a very good segue into that second question, right? What separates certified or qualified RN interpreters?

Interviewee: Okay.

Interviewer: Oh, can you hear me?

Interviewee: Yes, I can hear you.

Interviewer: That’s a good segue into that next question, which is what separates a certified or qualified registered nurse interpreter from professional interpreters?

Interviewee: The professional interpreters are – I believe, my knowledge of them is that they can interpret in law, at the courthouse, at the bedside with a video or in person, but they don’t have the knowledge to be able to take the nephrologist or the cardiologist, or the [inaudible] [00:15:39] or, you know, the medical professional information, they can interpret the words, but not necessarily the meaning behind them. The why behind it.

Interviewer: So, you’re talking about verbatim. So, when they interpret it’s more about verbatim.
Interviewee: Verbatim.

Interviewer: And you think a nurse doesn’t do it verbatim?

Interviewee: We do it, but there’s a lot of phrases, words, terms, that we can use, utilize within our interpretation that help specify what that doctor’s conveying to the patient or the family member, you know? For example, I had a patient, I am interpreting – it wasn’t even my patient, they just called me over.

And the doctor – the patient kept saying, “¿Pues qué se puede hacer?” You know? His grandpa, he goes, “¿Pues qué se puede hacer?” You know, “What else can be done?” And the doctor was saying, “Well, all of this stuff can be done, but it’s not lifesaving. It’s just prolonging the inevitable.” And so, he just kept saying, “Well, what else can be done?”

And the thing is that the doctor, when I started – when I noticed that the doctor was not realizing it’s just a saying, you know? I had to explain to the doctor that in the culture these are just sayings and that I had to explain to him.

Interviewer: It’s more of an expression.

Interviewee: What the patient’s meaning of it was. It’s not like he was saying, “So, what else can be done?” There’s a difference.

Interviewer: Yes, it’s more of an expression. Right.

Interviewee: Yes.

Interviewer: In reality, the expression is more of a there’s nothing else that can be done.

Interviewee: Exactly.

Interviewer: Just be here, right? Whatever happens happens, almost.
Interviewee: Yes.

Interviewer: But in reality when you interpret that as, “What else can be done?” Then the doctor is like, “Oh, okay, well, we need to respond to it.” And in reality, there isn’t – oh, that’s fascinating. Very good.

Interviewee: Yes.

Interviewer: Yes.

Interviewee: So, that was – and I had to explain it to the doctor, and he goes, “Oh, okay.” He started going through all of these things, “Well, this can be done. And this can be done. And this can be done. And this can be done. But at the end of the day, you’re just going to be in the same.” So, the patient is like, “Well, what else can be done?” I was like, “I need to stop this circle.”

Interviewer: Almost like there’s nothing else that can be done. “So, what can you do?” It’s like the expression, “Oh, what can you do?” Just move on, right?

Interviewee: Exactly. So, I explained that to the doctor. And the doctor was like, “Oh, okay. So, now let’s talk about what his wishes are. Since we’ve already crossed, and we’ve already talked about all this stuff.”

Interviewer: Yes.

Interviewee: “Let’s see what his wishes are and what would you expect. What would you like?”

Interviewer: Yes, yes.

Interviewee: You know? And so, we went down that route.

Interviewer: Got it. Got it. What about –
Interviewee: Allowing the patient to express his wishes.

Interviewer: Yes, yes. What do you think separates then the RN interpreter from a family or a friend? You know how families sometimes come to interpret.

Interviewee: They do, but it takes a special – okay, so family and friends can be very knowledgeable, but they also – it’s very difficult to have – to be unbiased in your interpretation, and then there’s always that side conversation. “¿Pero de veras quieres decirle eso?” “Do you really want to say that or do you really mean this?” And trying to navigate the conversation from – from the patient’s desires, needs, wants, you know? And what they want to really convey to the doctor. “Do you really want to say that? That’s going go to into your medical record number, you know? That’s going to be on there for life.” You know? For example, and I know this is all mental health [inaudible] [00:20:06], and you know, let’s say la comadre comes or the neighbor, you know?

La comadre comes and she’s with her friend, and they’re sitting there. And she’s translating for the doctor and the patient. And then, “Ay, pero mira dile que he estado bien triste y no me he podido salir de la cama.” “¿De veras quieres decirle eso? ¿Sabes que te van a diagnosticar con cosas? A lo mejor no quieres que tengan eso. Y luego en el trabajo, bla, bla, bla.” And they can have that side conversation that might inhibit the patient from saying something.

Or I’ve also heard family members not want to interpret or tell the medical professional, even the nurse, certain things that the patient might
be saying because they don’t agree with the patient. “You know what? I’m
tired. I don’t want to do this anymore. I don’t want any more poking. I
don’t want any more surgeries. I don’t want any more of this. I don’t want
any more of that.” And “Oh, but you can’t give up. Le tienes que echar
ganas.” You know? “Ponte fuerte. You can do this.” And I totally get
encouraging someone. But we also need to respect their wishes. I took
care of a – I was helping another nurse with a Hispanic patient. And the
patient had been sedated and intubated for a few days, we finally were
able to wake her up and extubate her. And when we went to position her,
of course, we gave her privacy, and we were going to put her on the
[inaudible] [00:21:58], was going to eat, she didn’t realize they
amputated her leg.

Interviewer: Oh, no.

Interviewee: She woke up to an amputated leg. And the family made the decision – I
don’t know what the background was. I don’t know if she was going into
septic shock because of her ulcer. I don’t know why the leg was
amputated. I just know that she woke up, as we were repositioning her, she
noticed that her leg was missing. She goes, “What happened? Mi pierna.
¿Qué le pasó a mi pierna?” It was a below-the-knee amputation. And she
was just like – and then the brother comes out, and he goes, “Yes, she
didn’t know. We were trying to keep it from her.” And it’s those kinds of
things. I’m not sure if she was completely lethargic that she couldn’t make
a decision for herself, and then she found out. Like I said I don’t know the
background, but it’s situations like that that their bias can get in the way, their belief systems can get in the way.

And not to say that there aren’t resourceful family members, because I’ve been that family member over the phone. I had an uncle. He had an aortic aneurysm just erupt. He was bleeding out. They called the ambulance. They rushed him in, obviously intubated, and all of that stuff. The repair was done, but he had already had a lot of neurological damage, and he wasn’t there anymore. So, my cousins who only had a high school education, and they thought they knew quite a bit because they were medical assistants, they didn’t understand the aspect of neurological damage, and intubation, and sedation, and the medications that he was on, so I had them actually tell me. So, “I need you to tell me.” They couldn’t even read the medication. So, I had to tell them, “Spell it out for me.” And they would spell the medication. And I would tell them, “Okay, so what does the machine say? What letters are on the ventilator?”

The machine that’s there, you know? There’s a tube from his mouth that goes to a machine. I need you to tell me the letters and all the numbers on there.” So, I had to figure it out. And I would call at 5:00 a.m. and speak with the nurse. And then from speaking with the nurse, I would speak with my cousin. And even though they were born here, they grew up here, but because they lived in their little bubble, their little Latino bubble, right? Their English was limited, and their understanding was limited. So, I had explained to her, “This is what’s going on.” And she was
the primary person to give consent, and decision-maker for my uncle. And I had to explain things to her. And that’s when they realized, “Okay, Dad’s not here anymore.” He’s not going to come back. And it’s either leave him as practically a vegetable…” Actually, they were going to do the neural test – the neurologists were going to do a test to see if he was neurologically dead. I told them, “The doctor is going to make a decision, you know? To put him in comfort.” I didn’t want to say pull the plug or anything like that. “To put him in comfort and remove the ventilator or it’s going to be your decision to do that. So, it’s up to you because this is the pathway we’re walking right now. It’s not by our choice, and this is just the medical trajectory of what’s going on.” And when I present it as a medical trajectory because of my uncle’s presentation, then that’s when they were like, “Okay, so it’s not on us, but at least we get to call the time.” And you know, they all brought the grandkids in, and – and were able to say their prayers and their goodbyes. And it was done on their time, and not just on somebody else’s time.

Interviewer: So, you think that – and I know that families or friends, they try to advocate, right? And in reality, probably that’s what they’re doing at the moment when they don’t want to convey the message. The patient says a message, and then this family member or friend, with their bias, right? They want to advocate for these patients. So, you know? And in the advocation, sometimes it is for the worst. Sometimes they’re like, “Do you really want me to say that? Maybe we shouldn’t be saying that.”
And they, of course, convey a different message to the doctor that may not be for the best of the patient, but it was advocating based on what you were just saying, maybe not having the knowledge, right? As to what it means to not convey that message. How is that going to impact the health of a patient, whereas you said before, you know? In the [inaudible] [00:27:07], right?

When we are nurses, we can understand a little bit more of those pathways. So, it is interesting the fact that family members try to advocate for their family, and for the patient, and in reality it can actually be detrimental in the end. Very interesting. Yes. Well, thank you for that. So, let’s see. What do you find challenging when you interpret?

Interviewee: Being able to – that aspect of assessing the [inaudible] patient, family members, the [inaudible] knowledge and perception of what you’re telling them, and assessing that, and being able to appropriately and adequately interpret what the primary care provider is trying to say, trying to convey. That is a difficult bridge. As your listening and you’re walking the bridge, you’re trying to figure out what is the best way to present what you just heard to this individual.

Interviewer: The most effective.

Interviewee: Exactly. The most effective way. The most – for their understanding.

Interviewer: Yes, yes.

Interviewee: Because you want them to understand. And again, we want to present it exactly what they’re saying or exactly what the healthcare provider is
saying. And a lot of times you can’t, you can just interpret straight across. But there are those moments in that process where we have to go, “How can I say this where it doesn’t change the meaning but it’s able to be accepted and understood from the receiving end?” That is the – because there are a lot of different ways of saying the same thing.

But how is the receiving end going to – are they going to be able to understand it if I just say it straight across or are they – or do I have to – what words or phrases or in what form? Because sometimes when there isn’t a word to interpret, you can use a definition. Like the definition of that word to convey the interpretation. Because you don’t want to change it.

You want to convey what the healthcare provider is saying. But at the same time, you need to put it in a way that they’ll listen and can understand what is trying to be conveyed by the healthcare provider. Does that make sense?

Interviewer: Yes, it makes sense. There are of course, as you said before, messages that can just, “Take 325 milligrams of Tylenol twice a day.” There is no – but then there are those messages that are a little more sensitive, more critical, and based on how they receive that message on the other side, right? They have to now make a decision that can really be – interesting.

Interviewee: Exactly.

Interviewer: So, you struggle a little with making sure that that message comes to those ears, and that that person is making the best decision based on that information.

Interviewee: Being able to understand the information so they can. Being able to
understand, and their perception of that information. “Oh, so they’re
dying?” “No, no, that’s not what we’re saying. We’re saying...” You
know? Because it’s all about the perception and the reception.

Interviewer: Got it. Got it.

Interviewee: So, even if the message is being delivered appropriately and effectively,
now we still have to worry about the perception. How do they receive this
message? Did they receive it the way it was meant to be? Very good. How
do you think we can remove that challenge? How can we make that
better? How can we remove it, you know, remove that, but I’m just asking
because it just came as a question in my mind. It’s a very challenging one.

Interviewee: So, for me, I don’t immerse myself – I’m actually losing some of my
Spanish because we don’t speak it in my household, as opposed to how it
was our primary language growing up. And so, I only speak it at work. It
was my primary language. I speak it with my parents, my grandmothers,
my aunts, and whenever I make calls to family members.

Interviewer: Yes.

Interviewee: But I speak for me – and I watch Spanish news and things like that. But I
think for me, I need to actually become either – read more, probably read
more. Medical books maybe studies or things like that in Spanish.

Interviewer: Yes, yes.

Interviewee: So, I can sharpen my verbiage.

Interviewer: Of course.

Interviewee: But at the same time, that will give me more tools in my interpretation,
even though I need to bring it down. I want to read more higher education
health [inaudible] [00:33:15] Spanish literature that will help me in the
conveying and interpreting to a much simpler audience, if that’s even
correct to say.

Interviewer: No, yes, it is.

Interviewee: I don’t want to be rude. Because I’ve been that simpler audience.

Interviewer: Yes, we all have. Yes.

Interviewee: So, I want to be able to take some of that verbiage and just maybe expand
my Spanish vocabulary.

Interviewer: I like your solution though because again, and this is what we may see,
even among us in the group of interpreters, that all of us can have different
levels, right? Not only different levels but different nationalities. In your
case, for example, growing up in America, most of you – the huge
majority of your life as opposed to someone who came older in life, right?

And being able to communicate with these patients. I mean, there’s
even that, kind of certain different levels as to – as to how much we can
communicate with our patients, depending on our experience, on our own
upbringing and experience with our parents, right?

Interviewee: Absolutely.

Interviewer: Interesting.

Interviewee: Because even though I grew up going to Mexico, my grandmother was a
nurse, and my great aunts were nurses. They spoke shop all the time, you
know smoking their cigarettes, and drinking their bad coffee at the table.
Interviewer: Yes.

Interviewee: And I was like [inaudible] [00:34:57] nurses, and they’re like, “Everybody smoked in our era.”

Interviewer: Yes, yes.

Interviewee: But it was black coffee with a whole bunch of sugar and a cigarette in their hand, and they would talk, you know? They were still nurses, you know? And in my time they were private nurses at that time, already retired from the hospital. They were nurses that ever since they were 14, 15 years old with the nuns, and that’s how they learned.

And we all learned how to give shots to our great uncles and our great aunts whenever they would come out of surgery, they would go to my grandma’s house, and everybody went down to visit to take turns caring for them post-surgical. So, we all learned. We all learned, you know? From bathing my great-grandfather and all that stuff. So, we all participated. All the grandkids know how to be CNAs.

Interviewer: Yes, yes.

Interviewee: And give intramuscular injections. And I heard the verbiage, but it’s different the Spanish is very different – the tools that you have in your Spanish toolbox. Yours is very different than mine because you went to school in Mexico. So, you have a greater array of words that you’re very comfortable pronouncing and using.

Interviewer: Yes.

Interviewee: As for me when I speak Spanish now, I used to speak it really fast, and
now I actually slow down and have to think about what I am going to say, how I am going to say it, even in a simple conversation.

Interviewer: Oh, interesting, yes, yes. Very good. Wonderful. So, what effect do you think having an interpreter in that interaction between a provider and a patient, what effect do you think having that interpreter in the middle – what is the effect of that person in that interaction?

Interviewee: What is the effect of the interpreter?

Interviewer: Yes, so being - having an interpreter in that room, so we have the patient and the – and the doctor having that interaction. But now we have a third person in there. What do you think the effect is of having a third person interpreting between this interaction, the patient and the provider?

Interviewee: I would –

Interviewer: It can be a positive effect. It can be a negative effect.

Interviewee: I feel that it’s a positive effect actually having a physical being there because that physical interaction between the interpreter and the patient or family member, just [inaudible] [00:37:34] nursing, you go in and you establish – we have to and we’re supposed to establish – gosh, I am forgetting my words now, we’re supposed to establish trust, and instill trust in our patients literally like two minutes before you start pulling the sheets off. You know?

Because you’re going to come into your private space. But you’re supposed to develop that trust relationship first. Same thing, when you have a physical person there, your body language, and the way that you
introduce yourself, you – you’re establishing trust with them. You’re hoping that they can trust what you’re interpreting. That you’re interpreting – that they can tell you what they really feel, what their concerns are.

That you need to instill trust in them in you for them – and you, as the interpreter to be able to convey what they need, or if they don’t understand something, to be able to tell you, instead of standing there and nodding, “Yes, yes, yes,” without knowing. You need to instill that trust, have that trust relationship so they can trust you to tell you, “You know what? I don’t understand what he’s trying to say. I don’t get it.” Or “I don’t understand why they have to do this.” Or the why.

Interviewer: Got it.

Interviewee: Or how can this have happened? You know? You need to instill that trust as a physical being there.

Interviewer: Got it.

Interviewee: They’re going to be telling you the most private things in their lives. They’re entrusting you to be able to convey what they would like to convey to the physician. And the same thing, the physician, if they know you, you’ve worked with them, they’re going to know, they know what they’re talking about and they’ll be able to interpret what I’m trying to say.

Interviewer: Yes.

Interviewee: Or I am trying to convey. And I’ve had physicians say, “No, no, no, just bring me Bertha, she – we’ve done this.” You know?
Interviewer: Yes, yes, yes.

Interviewee: Yes.

Interviewer: So, the building of that trust with that interpreter being there, in this case, you, an interpreter being there, it really builds trust between patient and providers, between patient and you, between you and the doctor. So, you think it’s building trust?

Interviewee: Yes, I do believe it.

Interviewer: And that’s the effect it has. Having an interpreter in there, it builds trust.

Interviewee: A physical interpreter.

Interviewer: Oh, yes, yes.

Interviewee: When you have an interpreter via video, it could be very helpful. I am sure it’s very helpful especially when the resources are very limited. It’s better to have something instead of nothing.

Interviewer: Yes.

Interviewee: So, having a video interpreter you don’t get to go in and start building that trust with the patient. You – video goes up, “Okay,” you know, “Medical record number, interpreter number, and it’s all about numbers.” And so, you don’t want to be another number. You know? You don’t – all I hear is numbers.

Interviewer: Yes.

Interviewee: And I’ve seen that expression like, “Okay, they’re going to help me, but they’re only...” And then the video goes blank. “Thank you,” kind of thing. Instead, when it’s a physical interpreter, time allotted, you know,
you go in, “Okay, I’m here with Dr. [inaudible] [00:41:09] or Dr. [Bxxxxx] or whatever. I’m here with Dr. [inaudible], he’s a nephrologist. Good morning or good afternoon.

My name is so-and-so, I’m one of the nurses here at [HMO] ICU. I am going to be interpreting for Dr. [inaudible]. I’m here for whatever it is that you need to say. I want to make sure that you have an understanding of what we’re trying to convey. So, we – the doctor, and that’s when you instead of just saying, “How are you?” It’s the doctor’s, “How are you feeling that morning?” “¿Cómo se ha sentido?” And having that physical body language.

Interviewer: Yes, yes.

Interviewee: There. You know? Smile and body language. Being sincere. I am not saying that the interpreters on video or over the phone are not, it’s just – it’s different when you can actually see someone there, and actually read the patient or the corresponding individual's body language as well.

Interviewer: Yes, especially for our generation. Certain generations who are not necessarily very – they don’t feel comfortable with video conferencing, right? They still want that person. So, that’s an interesting thing, yes. You brought up a great point in regards as to going back to the different side when I asked the difference between having an RN interpreter or a professional or a family, but in this case, it’s also video interpreting service.

Interviewee: And telephone.

Interviewer: Yes, telephone. Very good.
Interviewee: Those are all communicational aspects that are being inhibited by not being – not having that physical being.

Interviewer: Yes.

Interviewee: Yes.

Interviewer: Great insight. Well, that really is the end of my questions. You have provided amazing insight. So, I really appreciate your time. And before I stop recording do you have anything else you want to add to the interview?

Interviewee: I appreciate you taking the time and considering me for this interview.

Interviewer: Oh, thank you.

Interviewee: I’m very blessed to be part of this great experiment and experience.

Interviewer: So am I. Thank you very much. Thank you very much.

Interviewee: Thank you.

Interviewer: Alright. I will stop recording now.

Recording: Recording stopped.

[End of Audio]

Duration: 44 minutes
Interviewer, Interviewee

Interviewer: In audio, right. Okay. Can you please state your name, full name.

Interviewee: XXXXXX.

Interviewer: Your age.

Interviewee: Forty.

Interviewer: Gender identification?

Interviewee: Female.

Interviewer: City of residence?

Interviewee: North Hollywood.

Interviewer: Years of nursing?

Interviewee: Seventeen.

Interviewer: And years as a qualified or certified interpreter?

Interviewee: Well, ever since I started with the county system 17 years ago, I was already an interpreter; I took the exam. I broke service for a little bit, for about seven years, and I came back five years ago to the county and took the exam, so, again, I’m considered one of the interpreters for the county.

Interviewer: Just the name of the employer? You don’t have to give me location.

Interviewee: County of Los Angeles, Department of Public Health.

Interviewer: And role or position at your current job?

Interviewee: District public health nurse.

Interviewer: All right. Thank you. Now, as we begin this interview, the interview questions as I am asking you this, again if at any point you feel
uncomfortable and you do not want to answer the questions, we can move on to the next. If you want to move on to the next and then come back to this question, we can do that as well. You are free to stop the meeting or the interview at any moment, and again none of your identifiers will be in my publication if I ever publish, and this recording will only be to be transcribed into Word; it will be saved with a password so that it is not, again, just put out there into the public.

Okay? In the hands of the public. I may ask also follow-up questions, we do have these four questions, and then from that, if I have any follow-ups, I may ask those. And again, you feel free to answer them or not answer them, and then we can go on to the next one. All right.

Interviewee: Okay.

Interviewer: Thank you. Tell me one memorable experience you have had with interpreting.

Interviewee: In his opinion, this question, there’s so many that came to mind, but I figured I would start with probably the most recent one that I had. That actually happened approximately two weeks ago and it was in the office, and I was the only Spanish speaker in the office at that moment. And so, my co-worker approached me to ask if I could make a phone call to help make an appointment for an individual that hadda come into our clinic for testing. Now, this individual was approximately 11 years old and we were suspecting that she was a victim of child sexual abuse.

And so, it was a conversation between myself, the child’s mother,
[inaudible] [00:03:15], and I had to go, they couldn’t make it right away, and so that means that if we can’t get them in right away to be interviewed and be evaluated, I had to at least get some questions out of the way to make sure that the child wasn’t in any danger. And so, I found myself now having to interpret questions from the nurse that I was assisting to the child’s mother, knowing that the child was listening, asking about sexual abuse encounter. So, I – in that moment, I had to very quickly put myself in the mindset of how I was gonna affect this mom’s my incentive.

How I was gonna affect this child because children are very impressionable, especially at any age, but I’m thinking of that age, especially after what she may or may not have been through. And even if it was a false case and nothing happened, I still had to be very careful with the words that I use because now I was gonna be [inaudible] to this world of sex and topics that maybe her mom hadn’t spoken to her about. So, I hadda be very gentle with my words; I hadda convey emotion, even emotion that – my co-worker she’s also very gentle very empathetic; I wanted to convey those same emotions which I, also, felt.

But I didn’t wanna be responsible to the point of causing alarm. So, there was this delicate balance between being empathetic and being factual, and using the right words because I think the one place where I could improve on is some physiological – like physical like the terminology for physical parts of the body which can have so many ranges depending on where you’re from. And this was in Spanish obviously,
where you’re from, and what slang is used also, so it was just a matter of
being delicate, and also at the same time not scare them enough where
they didn’t wanna come into the clinic because that was the whole point of
trying to get them into us.

Because their provider wasn’t doing what they needed to do to run
the correct tests. So, after I finished the interview I hung up, and I sat there
for a second and had to just reevaluate and make sure that I said
everything that I needed to say correctly. And I hadda leave myself out of
it; I had to leave other experiences that I’ve had with other patients. I had
to leave behind the data I just had; I was there overtime because of this, I
had stuff waiting for me at home, all of it has to go out the window when
we’re dealing with something like that.

Interviewer: Yeah. If you can, tell me a little bit more about those emotions. What
emotions were you experiencing as you were interpreting for this family?

Interviewee: Well, like I said, I have to leave my own emotions out of this. I was trying
to perceive the emotions of what an 11-year-old might be feeling at that
moment, or what a mom of an 11-year-old might be feeling, especially if
something did happen and she wasn’t aware, or she wasn’t home because
she hadda work. So, I felt a lot of – I felt a lot of responsibility in that
moment, and I really tried to set aside any part of myself that might feel
anger or hopelessness or just wanting to reach out and cuddle this child. I
really do have – as interpreters, we can’t show emotion, but it can be to a
fault if it’s too much, the facts can get lost.
So, we’re there to get facts; we’re there to get information. But that doesn’t mean we can – we have to be emotionless; I think that the emotion helps us if it’s genuine. But we also have a responsibility, so it’s important not to let that emotion steer the whole conversation; there are things that we actually have to get done.

Interviewer: Yeah. Now, so you were experiencing emotion, some of them you had to kinda suppress, this is kinda what I’m understanding, suppress them and kind of eliminate them. Some emotions, you have to find that balance and present those emotions. Right? But you had multiple emotions is kind of what I’m understanding from this, and correct me if I’m wrong. So, some emotions were suppressed, you did not let them affect your interaction, then you had to also – even those emotions you did experience that where appropriate for the interaction you had to still bring them a level that’s more appropriate per se. Right?

Interviewee: Right. Because this deals with – I mean along the same lines of interpreting but even just speaking to a patient in English about a very difficult topic, let’s say it’s like – you’re telling somebody that they have syphilis and it’s a woman. And she says we’ll I’ve never cheated on my partner, and so now they’re talking about how their partner cheated on them and going on and on about – and I feel terrible because I really don’t know the story. It could be a total lie, it could be a total – but I’m listening to this emotion, and it’s very easy to get carried away in the emotion of that story where my role right there is now saying, I know you’re feeling
terrible about what could have happened, but let’s find answers first.

Once we find the answers, come to us. We’ll help you, and then we’ll help navigate through the others. So, it’s always a push and pull but also try to reel in ultimately what our job – we’re still there to do a job.

Interviewer:  Got it. Thank you. Thank you very much. Now, anything else you wanna add before we move on to the next question?

Interviewee:  No, just to say that in the end, this little girl tested negative for everything, so it was a good outcome.

Interviewer:  Yes. I’m glad. I’m glad. Sometimes it doesn’t, but I’m glad, in this case, it didn’t. Very good. All right. So, what separates certified or qualified registered nurse interpreters from other types of interpreters, such as family members, friends, even professional interpreters? What do you think separates you as a certified or qualified interpreter from the rest?

Interviewee:  I wanna divide that. So, professional interpreter [inaudible] [00:11:07], family and friends, I found that again, it’s that – I think nurse interpreters are able to separate a little bit more emotion than family and friends are from what’s really going on. I can’t say – I’m thinking emotional intelligence, but not everybody is emotional intelligent, maybe I’m not even at times either, but I think when it comes to just fulfilling our role, we know that we can’t let certain emotions or biases come in the way of telling the story of what’s going on. And it’s really not our story, it’s the patient, or it’s the person I’m interpreting for, it’s their story, so we have a duty to do that.
In terms of between nurse interpreters and other professional interpreters, I mean, if we're talking specifically in the role of interviewing a patient, we have the advantage of having the lingo and know how and what to say and have the experience. In general. Over any scenario, nurse interpreters have the ability already because of our experience as nurses. As nurses, we wear the hats of social workers; we’re teachers, we’re psychologists, we’re physicians, we’re friends; we’re human we admit our faults, we sometime connect with people because we’re able to connect with them on a level and say I’ve made that same mistake.

Professional interpreters might not let their guard down that much, and nurses have this balance of knowing when to let their guard down enough to get what they want. It sounds manipulative, but it’s actually quite the opposite because when we go home, we’re left with this sorta, okay, what do we do with everything that’s happened today? We’ve really taken everything that we’ve said and done that day, so I mean, at least for me I don’t take anything that I say lightly. I know that I’m still gonna go home with it, and knowing that it’s gonna be part; because they do say that nursing is an art, it’s art to balance between the art and the science.

And it is, it's a nuance, and we are very scientific, we’re very knowledgeable, so we use that, but then we use that other part to navigate, kind of like a boat with its sails, and we have to know when to pull the said and when to let the wind take us. That’s just how it works, and we
have to have a lot of confidence in it; where I feel like a professional interpreter have rules and things that they do and what they’re supposed to do. I think with nurses; we take a little bit more liberty to get the ultimate payout from it.

Interviewer: Very good. Thank you. Now, so that’s something that – from what I’m – especially between professional interpreters and nursing interpreters. It seems that there is a structure we both have a very structured training as to how we interpret. It seems that professional interpreters, from what I’m gathering, that they stay within that structure. They don’t necessarily deviate as much.

Interviewee: I mean, I don’t have a lot of experience with professional interpreters; I mean, I don’t wanna speculate here, but from my experience of what I’ve seen, and I have been in jury duty in the court system and being able to see how professional interpreters interpret, it seems a little bit more black and white, which it is, it should be black and white because it’s facts that you’re getting, but sometimes the emotion that’s being conveyed gets lost in translation, and I really feel that’s important. I’ve found myself in positions where, let’s say, a physician has asked me to interpret for our patient, and so the physician says ask the patient if they have pain.

And so, I’ll say do you have pain in Spanish? And then they’ll come up with a huge response, and then instead of interpreting exactly what I say, I’ll come back with a clarification or something. Because sometimes, it’s clear, but when you interpret, I wanna make sure that I
convey the right emotion. So, if I say excruciating versus stabbing versus dull pain, I wanna clarify, and so I get in a little conversation, and then I get a tap on the shoulder and say, hey, you’re supposed to be telling me exactly what they’re saying. I’m like I am; there’s nuances here that I gotta – I’m not influencing them, we’re not talking about you, don’t worry, it’s just I want to make sure that I’m getting the exact phrase and emotion.

And then I can come back and do an interpretive of like it hurts here, or it hurts there, and this is how it feels. So, I don’t know that court interpreters or formal interpreters do that.

Interviewer: Got it. Got it. Interesting. Now, do you find yourself mirroring the emotion of the patient to the provider? And do you also feel you mirror the emotion in the message? Do you mirror those emotions as well?

Interviewee: For me, personally, yes, I do.


Interviewee: Yeah, I do. But if it’s something I don’t agree with, like especially from the provider to the patient, I might mirror, and I’ll look at the patient and – but I mean, I don’t have a really good poker face, so I’ll do it, so they’re knowing that I’m mirroring it, but they’re also looking at you get me. So, it’s a certain trust. And there’s no disrespect happening at all, and I’m not [inaudible] [00:17:24] or anything, but it’s just – I mean, we have to be intermediaries between these two parties responsibly. And sometimes the two parties will start understanding each other just by body language, so
for me, it’s sorta fun to see that too.

Interviewer: Yeah. Interesting, isn’t it. That we also have that body language that is coming into the whole interaction, very interesting. Good. Good. Anything else?

Interviewee: Not as far as that topic, unless you want to elaborate or -?

Interviewer: No. No. I think you touch on this subject very well on this question. What do you find challenging when you interpret?

Interviewee: I think it might be when I get somebody who’s asking me to interpret, who’s very unemotional and won’t take emotions into consideration for me, that’s challenging. I think that just comes from the provider, though; whoever I seem to interpret, it already comes with this energy of, let’s just get this done, I just want the facts, and they don’t wanna hear anything about actually what the patient is going through. For me that’s frustrating because I think you can clinically miss so much with not taking into account what somebody is going through and their experience. And it can be something that’s extraneous; it could be something else that’s happening.

Does it hurt, yes or no? Well, no, but when I think about this other thing – well, that’s not what I asked, does it hurt, yes or no. And so, I will be an advocate at that point, and I’ll say, look, I’m just here to interpret, but in my experience, I feel like there’s something going on. And I might get a response well, nobody asked you – and I’ll say this is part of interpreting; if you’re asking a nurse to interpret, you’re gonna get the full
spectrum of what a nurse is, and that’s our intuition, that’s our experience, that’s our ability to assess and evaluate in the moment because we’re taught that. Right? But the more education we have we are taught to evaluate and assess; it’s the basics of nursing in nurse theory. It’s what we do.

So, if you ask a nurse to be an interpreter, I mean, you’re not asking us to be a professional black-and-white interpreter; you’re asking us to be a nurse interpreter. So, I don’t know if people realize that, also.

Interviewer: Oh, yeah. That is –

Interviewee: And it comes with our own assessment, it doesn’t mean we’re gonna sway when we have to responsible with that too, the way we sway one way or another, but you’ve asked a nurse to interpret you’re bringing all the education we were taught, all those – I was taught the royada patient models and the public health, all the models everything comes into play at that moment. And we can say experience can go out the window; fine, I can throw all my experience because I don’t wanna be that biased. But the facts are there.

Interviewer: Now, when you say then that these other roles, because in the room if you are interpreting and you are an interpreter at that moment, the nursing role is also having an influence in there.

Interviewee: Right.

Interviewer: But what about that advocate? We are being an advocate as a nurse. And in having those roles in that moment, kind of the main role being interpreter, how do they play? What do you think they do to you in that little moment? Or of these multiple roles being a public health nurse,
being again, maybe even your own experiences in life.

Interviewee: Okay. Well, I’ll give it to you in two slightly different scenarios. One is, yes, when you’re physically in the room with someone and they’re being aware of your body presence, your body language, everything comes into play at that moment. But again, it’s always being responsible that you’re not influencing, that you’re not undermining the provider or whoever’s asking you to interpret because that’s not why you’re there; there’s no ego there. And we haven’t – maybe this is a patient that I’ve never met, so we have to be careful not to make assumptions right off the bat. So, it’s like a checks and balances constantly when you’re in that interaction.

A lot of my interaction as interpreter, especially since COVID, are over the phone, and that presents a unique challenge. Because over the phone, I mean as a district public health nurse, a lot of our interactions are cold calls to patients, and we’re telling them life-changing diagnoses. Right? You’ve never met me, but you have break a diagnosis, and I need you to come into the clinic, or you have syphilis, or you have hepatitis, or you have COVID, and we have to get them to trust us very quickly within like 15 minutes they have to be on our side, come into the clinic, and assess it. And they’ve never really met us.

So, I think it depends on whether it’s in person or not, so I’m not sure if your focus in terms of asking these questions is always in person. My experience for the majority is actually not in person; I would say pre-
COVID I would say 50/50, now it’s a lot more over the phone.

Interviewer: Got it.

Interviewee: Especially with monkeypox, I’m doing a lot of monkeypox over the phone. We’re actually getting people to, when I interpret, I’m convincing people to send me pictures of the areas where they have monkeypox lesions to my county phone. So, my county phone is filled with a lot of very intimate pictures of body parts, and we’re having them do this within, what, 15 minutes of us talking to them on the phone and interpreting. So, we really have to be careful with this; it’s not something that’s to be taken lightly. Unless you’re in person, I think in person is probably where we can probably do our best work because we can really show the empathy.

I tell my co-workers I hope that when we hang up on the phone that they don’t hang up and going, why did I just say all that? Like have this air of regret when you say too much to someone that you’ve never met and you’re probably never gonna talk to again. I hope that we’ve made them feel comfortable enough that they don’t feel instant regret.

Interviewer: Got it. Yeah. Very, very good. Interesting. Yeah, a lot to think about, really, as we are going through this.

Interviewee: Seriously, our job, it’s so different than any other nursing job I’ve had when it comes to interpreting. It’s different, different [inaudible] [00:25:17].

Interviewer: Yeah. Yeah. And again, even that when it comes to being a nurse myself, as I hear you – did I lose you? I think I lost you.
No Dictation [00:25:34] to [00:28:36]

Interviewer: I’m so sorry. Can you hear me?

Interviewee: Yeah. It kind of panned out or something.

Interviewer: I know; I’m so sorry. I don’t know. We’re back. Okay.

Interviewee: Okay.

Interviewer: That’s, again, interesting going back to that nursing; even within our nursing careers, we talked to another nurse in a different field, and my mind is blown just by hearing those examples as well. We have no idea as to what you have experienced in your nursing career; it’s very, very interesting. All right. Anything else on challenges when interpreting? Anything else there?

Interviewee: I just – I think we need to learn a little bit more about specific body parts when it comes to how different people – where they come from in parts of the world in slang, and being comfortable. I mean, I find that – okay, so my background is – when I did my master’s thesis, my focus was on sexual health. So, that in and of itself comes with a lot of challenges, so, in public health, there is a lot of talk of STDs or any type of sexual, monkeypox and those things, and so people are asking me how do you say this in Spanish? Or how do you call this? And I’m thinking, oh, gosh, it really depends on where they’re coming from, what part of the world, and what’s comfortable.

Even in English, people aren’t comfortable saying certain words or going for certain things, so this is a real challenge now. So, interpreting,
sometimes you make fumbles, you’re trying to do your best, and you
maybe say the wrong word because that’s your experience. So, I say in
nursing, there’s a lot of asking for allowances and forgiveness because we
don’t know what someone’s experience is ultimately as we’re gonna
approach them to interpret. And so, but I think if we come at it from an
angle of just respect and understanding and trying to help, I think that we
can ultimately get to where – the end goal, which is again, I think different
from professional interpreters because there’s –

– you can’t be playing that sort of – like that field, you can’t have
those allowances, there’s comical moments even in – right? You say the
wrong thing, or you say something, you really start laughing, and you
have to just play it off. I can’t see in a professional setting how that would
work; I think I would be terrible in those settings because, again, you have
to allow for – so, I have this story where there was a co-worker she retired,
but she’s Chinese she had worked for us for I think maybe 10 plus years,
15 years in public health, but she was an ICU nurse, huge career she
retired very well. And we have a good group, she was gonna interview a
Chinese patient, very young, like 20 years old, and she had syphilis.

And so, she’s about to call her, and she says I don’t know that
we’re gonna be able to communicate. And I said why? And maybe
because it’s a different dialect? She goes no, I think she does speak
Mandarin like I do; she goes but Mandarin now there’s a modern
Mandarin, and there’s a traditional. She goes I speak more of a traditional,
she goes, and she goes I can speak Cantonese also because of my husband, but I can’t speak the modern Mandarin. I said so what are you trying to say, and she says I don’t know the word syphilis, so I took out my Google, my phone, and I went on Google Translate, and so I typed in the word, and then it said modern and traditional. Oh my gosh, what happened? Why did this happen in the Chinese culture?

And she said the characters were too complex, and people started to want to simplify, so it’s a simplified version, basically. What they call it. So, now a lot of younger people only know the simplified version, not the more complex version, but with the characters also comes with how you pronounce it. So, we looked up the word syphilis, and so, we were laughing and laughing because we were just thinking like – we’re really trying to do our best, but I hope it comes out right. And so, as she was translating, she was speaking, she was translating, everything came out fine, and then once the call ended, I said, so what’s the difference between the old way of saying syphilis and the new?

And she said well, the older is more like a disease sort of syphilis. And the new one means poison. I said oh, that’s a huge difference; I said so when you give that meaning, it comes with a little bit more of a – it’s more pointed, it’s more like danger, it’s more – you mean even offensive versus maybe in traditional that maybe was a little softer, or a little bit more like, yeah it’s a bacteria it’s a disease, like no, you have poison.

Interviewer:  Wow. Yeah. Extremely interesting. And again, going back to maybe that
in itself can be a field of study to see what that transition between the
traditional Mandarin and the modern one.

Interviewee:  Yeah, the modern and the traditional. I guess called like simplified versus
a traditional. And then I saw the same characters for syphilis on both and
it was a completely different, I said oh, my gosh, I said for the people that
are born right in the middle of this and have to learn that and that.

Interviewer:  Wow. I didn’t know that about that language or even that culture. That’s
very interesting. All right. Anything else before we move to the last one?

Interviewee:  No. No.

Interviewer:  Okay. So, what effect do you think having an interpreter has on being a
[inaudible] [00:35:24] that provider and the patient?

Interviewee:  I think we touch a lot on this, but just to narrow it down, the interpreter
needs to have the sense of duty first and foremost to know what your role
is. Why am I here? And it’s not just to portray words back and forth. It’s, I
think – I mean, as specifically being a Spanish language interpreter, I am
tasked with learning different cultures within the Spanish-speaking world,
to know how some words might come across, how some demeanors might
come across, apologies go a long way for sure. If you can show a little bit
of humility and just show a little bit of I’m sorry, and just show that – it’s
like human error; I think that goes a long way because I think it speaks to
a larger question in the world where we could be so perfect.

We just show we’re imperfect, but I’m here to try and help you.
Again, not something a professional interpreter could say or gear towards.
But in the nursing world, I think it goes a long way. It’s also conveying the emotion of the person that’s asking the question or the person that’s answering. If there’s lack of emotion, sometimes there’s a little bit of an apology that you give with a little [inaudible] because the energy is there; you can always feel the energy. And you can just say I’m asking this; I’m very sorry that I have to ask this, but I have to ask this. And I think the delicacy of certain situations like, in my field, child abuse. Things that don’t even pertain to us, infidelity – I have people that say like oh, I went to an orgy this weekend.

And then they’re like, what did they say? I’m like, ahh. Well, I’ll tell you later. But you can’t – sometimes you hear things that are outrageous, and you can’t let that affect you in the moment, you just have to be professional because that person’s not embarrassed, you’re gonna embarrass that person. Right? So, I’m having an affair with three people; I’m cheating on my wife. And it’s like, oh, they’re cheating on their wife, and I’m counting on this person that I’m interpreting for not to make a face either. We’re just presenting the facts. So, I think those are the big challenges. And also staying true to what is being said, it’s not embellishing, not adding, I think the addition can come in afterwards, where you can say maybe I got a little thing about this or that.

It can’t be proven; that’s just the nurse sort of thing going. But I think ultimately, as interpreters, the most important thing is be dutiful and be responsible because you can affect so much that it’s not intended, and
it’s none of our business, really, I mean, it is, but it’s not; it’s – we’re there to – it’s almost like the – it’s like one of the hardest acting gigs someone could have. Right? Yeah, it’s like you have to put yourself in that moment. What if I’m not ready to interpret for an 11-year-old that was sexually abused? What if I’m not ready to tell someone we have to disconnect your family member because there’s no hope. Right? What if I’m there to interpret for a gang member who – I’ve had this a lot where it’s like, oh, they don’t deserve to – I’m not gonna say that.

Everyone deserves – we need to put our biases aside, so it’s the ultimate test; I think for us nurses as what we’re taught how to be nurses, and to be dutiful but also be empathetic, again that’s another hat that you wear, keeping all the hats, all the badges in what we do, and I think it goes right in line into what we are meant to do as nurses, to find that balance between the art and the science.

Interviewer: Now, if you go back to a very sensitive situation, very sensitive whether it’s fixing nature, or just a very sensitive situation, then there is a patient, and then there’s a provider. Now, you’re in there; you are in the middle; if it is a very sensitive situation, do you think a person who is about to share a very sensitive encounter, do you think you’re affecting how they send that message to the provider in any way?

Interviewee: Definitely, by my body language, and if that provider seems like they’re closed off, I might even turn to the provider and just say I feel like something important is happening, you have to trust me at this point.
Interviewer: Got it.

Interviewee: And I’m comfortable saying that. I’m thinking like would I be comfortable now versus early in my career? No, I think for me, personally, because of that interpreter, once you say you’re an interpreter, I do feel like you wear that hat already, and you just say you have to trust me, give me a second. We can have our powwow later and we can talk about this. But I feel like something is about to happen, and it’s like if you travel to another country, and you all of a sudden find someone that speaks the same language as you, that creates a whole sense of camaraderie instantly. Right? Or someone who shares the same passion as you, or someone who reads the same books as you, or someone who – all of a sudden, it just creates an environment that’s completely different.

So, not to exclude the other person, it’s just – I mean, I’ve been caught in that where I’m in my office, and everybody is Filipino, and they’re all speaking Tagalog, and I just sit there, and whatever, I don’t even feel offended, I just keep going and I just do my stuff because ultimately I know either they clue me in or not, but I can still feel energies, I can still feel body language. It’s just sometimes what it has to be, and that’s the world we live in; we live in this really beautiful world where there’s so much you have to trust a lot of the process. You have to trust the people that are around you. Now, are there people who maybe abuse it or maybe don’t understand the nuances?

Yeah, probably; of course, that should be something as we test for
people who are interpreters, not just test to see fluency, but also ability to
pick up on nuances and know how to advocate and know how to balance.
But that would be within nursing only. All the others, I’m not sure how
that can be applied, but within our field, I feel like it shouldn’t be just
down to a test. How can you do this X, Y, Z? That should be a part of it, it
should be so much more included in that.

else you would like to add before we end the interview?

Interviewee:  No. I’m really happy that you’re doing this; I think this is a great – I like it
when there’s studies on fields that aren’t like well-studied. So, there’s a
gap in the field of study and the field of knowledge, so I think that’s super
interesting. So, I can’t wait to see what the results of your dissertation are
and then everybody else’s experience if everybody else that you’re
interviewing really has their own experience with this. But again, I just
wanna remind you being an interpreter isn’t always a [inaudible]
[00:44:28], so in my field of study, it’s usually not, so the way I teach new
public health nurses I teach them in the art of convincing people to tell you
their – spill their guts in 15 minutes, over the phone, and you meet them,
and you never see them again.

Interviewer:  Yeah.

Interviewee:  Or we convince them to, like, we have to pull you from work, and you
have to give a stool sample, so then all of a sudden they’re putting their
stool samples on their doorstep. And we never meet then, and so how do I
interpret this? You have to do—okay, and it works, and they do it, so there’s a certain trust that nurses bring into [inaudible] [00:45:18], I think. When I did my master’s thesis, it was about sexual health education, and part of it was why it’s important to have nurses sexual health educators versus other fields and what they can bring also.

Interviewer: Oh, wow. Very interesting. Oh, man, I’m gonna have to pick your brain on that. Maybe we can talk a little bit more. I’m gonna stop the recording unless there is anything else, and then I’ll talk to you off the record.

Interviewee: No, that’s it. Thank you.

[End of Audio]

Duration: 46 minutes
Interviewer, 913221

Interviewer: All right thank you for participating; I just wanted to let you know that you’re; basically, you will be known as a code, and the code you will be given is 913221. That will be the code that I’ll be using for you. Don’t use your name for your protection we will just use a few of the other identifiers without, again, being specific. So, first question I have for you is your age.

913221: Fifty-two.

Interviewer: All right. Gender identification?

913221: Female.

Interviewer: Ethnic identification?

913221: Hispanic.

Interviewer: Country of origin?


Interviewer: Years – okay languages spoken?

913221: English and Spanish.

Interviewer: Educational level?

913221: Masters in nursing.

Interviewer: Years in nursing?

913221: Years in nursing, 12 years.

Interviewer: What about years as a qualified or certified interpreter?

913221: Oh, certified interpreter, I would have to say 12 years.
Interviewer: Okay. Your employer?

913221: [HMO].

Interviewer: Your nursing role or position?

913221: Cardiac case manager.

Interviewer: Okay. Thank you. So, now we will begin the questions; there will be a series of four question that will be used for my study. And please be – you know, these are just open-ended questions; there is – you can tell me as much as you would like to, and if I have any follow-up questions, I will be asking those as well; otherwise, we can just move on. If at any moment you feel uncomfortable with any of the questions, or if you feel uncomfortable with the conversation itself, then you can always skip to the next question, or you can also say I decline to answer that one. Okay? So, always feel free to decline to answer questions. And no identifiers will be used, and we’ll begin.

913221: Okay.

Interviewer: All right. Okay, tell me one memorable experience you have had with interpreting.

913221: One memorable experience, I had many but usually, well, I’ll just say just recently I had a patient come into the clinic, and they were Spanish speakers, and they were having – they came in he recently had a non-stymie, and due to disability forms that needed to be filled out. They had come in, well they actually called me and asked me about it to fill the papers, and I told them that I could not help them fill out the paperwork,
but if they could come into the clinic, I would direct them, and show them the paperwork that needed to be filled out. So, when they came in, I was able to go ahead and highlight the areas that needed to be filled out, and I told them that if they had a family member, they said that they did, they had their son, and I told them specifically these are the things that need to be filled out.

This is what you need to ask for at the doctor’s office, request the op reporter, and that he needs to say the dates. And then gave him the office number for the disability. So, it was – Recording in Progress [Inaudible] [00:03:46]. It was an area that I had to do; however, when they went home, they were grateful, and then they called me, and they said I was their angel that I directed them in the right way by me interpreting for them and giving them the right directions. So, that was just recently.

Interviewer: Okay. And did you say they came with a family member?
913221: No, it was a husband wife, both Spanish speakers.
Interviewer: Oh, both of them were Spanish speakers?
913221: Yeah, both of them were Spanish speakers. So, I had to go ahead and look at the paperwork, go redo it with them, and just tell them what was being said and explain to them in Spanish what was being said, and then from there, directed them to the disability office.

Interviewer: Got it. Got it. Now, what do you think separates certified or qualified registered nurse interpreters from other types, such as family members, friends, professional interpreters. And you can divide it into all three of
them if you think it separates interpreters from family members, from
friends, or from professional interpreters. Or if you think we can just
group all of them. What do you think separates certified interpreters who
are RNs, who are nurses from the rest, from the other interpreters?

913221: Well, because that’s our profession, we’re nurses, but we know all the
medical terminology, and we know what comes with the disease process.
We know what the medications are, whereas family members they’re just
hearing portions. I believe that with past experience that I’ve had or what
I’ve heard, family members interpret to their family members is what they
want them to know, and there’s a lot of words that are omitted. Or they
reword it in a way that doesn’t make sense or that it’s not correct; it’s not
correct at all. Whereas in us nurses, we’re specific, and we’re letting them
know what the doctor’s being, what is the doctor or whoever it is we’re
interpreting for.

Interviewer: So, would you say that when we interpret the nursing role, do you think
that influences the interpreting in a positive way or in a negative way if we

913221: In a – yeah, go ahead.

Interviewer: Yeah, if we are using our [inaudible] [00:06:20] and knowledge, of
course, which is kinda what you mentioned, we have that nursing
knowledge. So, would you say that influences the interpreting session in a
positive way, then?

913221: Yes, it does. Yes, we do do it in a positive way because we’re – we’re
actually we’re supposed to be interpreting word-by-word what the
physician or whoever it is that we’re interpreting for.

Interviewer: Mm-hmm. Do you have any experience with professional interpreters? By experience, I mean seeing them do the interpretation for you or for somebody else.

913221: I’ve seen – I have heard on the phone interpreters, let’s say for example a Spanish interpreter trying to give the patient directions from like a, say for example, a company that’s contracted the [inaudible] [00:07:18] is not as specific, because they’re not nursing, so their wording may not be correct, so I have to let them know, wait that’s not what I said. That’s not what was said; we have to stay in the right, correct manner. So, yes.

Interviewer: Now, so do you think the wording then changes if we are doing the interpreting by nurses? Does the wording change from an interpreter who is a professional interpreter? Do you think the level of that language, the level of the words, do you think it differs significantly?

913221: Yes, I do. Because they may not – yes, they are professionals, but they don’t know the process of it, whereas us nurses do know the process of it. We know assessments, we know the overall disease process, whatever it may be, we’re able to – because we’re not – we’re evaluating everything, that’s one thing about nurses, we evaluate and assess everything that may come our way. Where an interpret isn’t, they’re not trained, or they’re not in that mindset the way we are.

Interviewer: Mm-hmm. Mm-hmm. Now, when you say in the mindset, what do you mean by that? What mindset they’re not in [crosstalk] [00:08:39].
913221: Of assessing patients. Of assessing and looking for signs and symptoms, what is it they’re trying to let us know, because sometimes they may just, for example, they say a little blue pill, or we need to go into more depth of that. What blue pill? What is it that you’re taking it for? What is the disease that you have? Let’s go ahead and review your medications and to go from there. Whereas in professional interpreter’s probably not gonna know about all that.

Interviewer: I see, I see. So, basically, a professional interpreter would be there and just interpret the word for word, whereas a nurse who is an interpreter may be able to catch maybe, how can I say this? Catch a few things, catch a few things that may be – what’s the word I’m looking for? More of the medical, right? More of that –

913221: Sorry. I’m so sorry, my dog. I [inaudible] [00:09:51]. Sorry.

Interviewer: [Crosstalk] [00:09:52].

913221: Hold on one minute; I apologize for that; let me let them out. Okay. Okay. There we go. Sorry. Sorry.

Interviewer: No worries.

913221: Right at the wrong time. So where were we at?

Interviewer: So, do you think it’s advocacy is that what you think maybe -?

913221: I think it’s – yes, we are advocating, but we’re also investigating, too. We’re investigators as well because they may be trying to let us know something, and then we could – I know we’re supposed to be interpreting, but we could go into further depth in asking them specific questions that
may be related to that disease process.

Interviewer: I see.

913221: Does that make sense?


913221: Okay.

Interviewer: I forgot when it came to the first question, the experience you shared, what do you think made that a memorable experience for you? What made it memorable?

913221: Because they were very thankful, it made it memorable because I felt like I did something for them that probably somebody else wouldn’t have done. I went out of my way and because I understand speaking a second language can be very difficult, and you may not be getting the support that you need. So, somebody that is knowledgeable in that area can – I felt that I was advocating for them at that moment. And so, they came back and shared their experience that all the information I gave them; they were able to get their point across and to get the process going just with the little bit of information that I gave them.

Interviewer: Got it. So, do you think that if you were not a nurse and you were, in this case, a professional interpreter or a family member, would you have been able to happen the same way to the same level? What do you think?

913221: Probably, I’m not too sure. Well, probably not because with nursing comes empathy. And I don’t think – I not gonna down say a person doesn’t have empathy, but we’re more empathetic we have that empathy
towards our patients.

Interviewer: Mm-hmm. Mm-hmm. I see exactly what you’re saying.

913221: Yeah. So, we’re able to – and plus the advocacy as nurses.

Interviewer: Got it.

913221: We advocate for our patients or for the general public.

Interviewer: I see. I see. Now, what do you find challenging when you interpret?

913221: Challenging when I interpret. When they’re speaking too fast.

Interviewer: Oh, mm-hmm. Okay.

913221: Yeah, when a provider is speaking too fast, that I find challenging.

Interviewer: So, do you slow them down when they do?

913221: Yes, I have to tell them. Could you repeat that once again?

Interviewer: Okay. But it is from the provider speaking too fast, or do you also find it challenging when the patients are speaking too fast?

913221: It could go both ways, and then also, the language. Because there’s different – we may be Spanish speakers, but there’s different words for each country. So, it can make it a little bit difficult where they do not understand what you’re trying to tell them. For example, when I used to interpret for head and neck surgery, we used to call them [speaking Spanish] because that’s for tonsils, and some people would call them [speaking Spanish], right?

Interviewer: Yeah. [Speaking Spanish].

913221: [Speaking Spanish]. And it’s like, oh, [speaking Spanish] and be like what is that? I do not know [speaking Spanish], I do not understand, it’s
like okay. Okay. It’s [speaking Spanish] [00:13:48], or different parts of the body, or different – the way that you would present certain clothing or body parts, or just, in general, they wouldn’t understand, so that makes it a little bit challenging, but you would still get your point across.

Interviewer: Yes. Yes, of course. You know most of our English, of course, it is understood across the nations, but we do have those different words. Right? You presented a very good example when it comes to [speaking Spanish] versus [speaking Spanish]. Right? And to be able to know, and that is only between two regions, sometimes the south part of a country calls it a certain way, and the northern part of the country calls it a different way. But now only that, but now we have different nations. Right? The Caribbean they use many, many, very different words than Central Americans, South Americans, or even Northern Americans. So, the challenge will be, in this case, trying to understand or see what culture they’re coming from so then maybe we can adapt even the language in Spanish to that region. [Crosstalk] [00:14:58]

913221: That’s correct.

Interviewer: Ah, interesting, that is an interesting point. Even do you have mostly people from Mexico who you interpret for? Or do you find yourself interpreting for people from South America, Central America, the Caribbean?

913221: Just recently the population has grown, I would have to say within the last five years it’s a big combination. There’s South America, Central
America, and Mexico that is all there, and it’s all different even with types of foods, you name them differently, the fruits, vegetables they have to [inaudible] [00:15:38] what it means to them. So, you’re not talking down if you learn to know – if you learn to listen to their accent and you’re like, oh, okay, this person is from, let’s say from Argentina, or this one’s from Chile or from Mexico, El Salvador, and places like that, so you get to know. And if I do not know, I’ll ask. I’ll say like what’s your background what country are you from, and then we’ll go from there.

Interviewer: Oh, that is an interesting point you’re presenting, so even in your own Spanish, you need to adapt your Spanish for the region, for the country, right, of origin. Very interesting. Right. But you never think about it when it comes to Spanish. Right? A lot of people are gonna say oh, it’s Spanish. But in reality, even within the Spanish, we still have to - interpreters have to adapt to that Spanish for that specific patient. Very interesting.

913221: That’s correct. That’s correct. That’s correct.

Interviewer: All right. Now, what effect do you think having an interpreter has on the interaction between a provider and a patient, what effect, what do you think – what’s the effect that happens by having that third person, that interpreter between a provider and a patient?

913221: Well, it could be a positive and a negative effect. A positive effect because they feel that whatever they’re saying, they’re getting their point across, which is important for them because they need to be heard with whatever it is that they’re trying to explain. The negative part is they don’t feel the
connection with that provider.

Interviewer: Ah, interesting.

913221: They’re not communicating hand-to-hand with that provider whereas in with the interpreters or with the nurses at the bedside if they’re speaking to them in their language and they’re not really interpreting, they’re talking to them, and they’re giving their care plan, it’s more of a connection because they understand that.

Interviewer: That is very –

913221: Does that make sense?

Interviewer: Yeah. No, it’s extremely interesting, too, because now that you bring out a very good point. Right? So, if we have an interpreter in there, will that connection between the patient and provider be the same, or does that patient become connected to the interpreter more than the provider? Right?

913221: I honestly believe they become more connected with the interpreter because they’re the ones that are talking to them, and they’re trying to get their point across, whereas in the provider’s there, but I don’t think they’re really listening to them, they’re more listening to the person that’s interpreting for them.

Interviewer: Hmm. Hey, that’s a good one. Now, do you think there is a way of improving that relationship between the patient and the provider when there is an interpreter in the middle?

913221: Well, I think that – the providers try to do their best, they don’t understand
what’s being said, but I think in my experience it’s been the providers
have not really been – I don’t feel like they try to connect, they’re more
relying on the interpreter to get their point across but not really connecting
the actual patient. So, maybe by them having more of a looking at them
the whole time, and trying to even though they may not understand what’s
going on but more of a visual face-to-face. Because sometimes, I feel like
they put their backs towards them, and they’re for focused on their
computer typing away when there’s an interpreter involved, and they’re
not really talking to the patient, but talking to the interpreter instead.

Interviewer: Ah. So, I see where that negative can come by having an interpreter in the
room. So, if I’m getting this right, then that means the doctor thinks, oh,
okay, there is someone who can connect with the patient; I don’t have to
connect with the patient because –

913221: That is correct.

Interviewer: – maybe someone who will do that for me. Now do you find in providers –
do you think the majority talks directly to the patients, or do you think the
majority talks to the interpreter? In your experience, do they talk to you so
that you can transmit the message to the patients? Or the majority talks to
the patients?

913221: I have to say it’s half and half. I would have to say half and half. In my
experience, it’s been half and half. I’ve had some providers look straight at
the patient, but I still don’t feel like the patients are being connected;
they’re relying more on what the interpreter’s saying because they feel
like they’re getting their point across like there’s a connection with that. I know that we’re supposed to be interpreting word by word, but sometimes the thing with that is there’s certain words in English they may require more wording, more explanation than what the word is. Right?


913221: Okay. Yeah.

Interviewer: Now, when it comes to the patients, and they are answering back to the providers do you think the majority of the patients direct their attention to you or to the provider? I know in the providers and the providers to the patients, you said it’s 50/50; some of these providers look at you and kind of talk to you so that you can convey the message 50/50. Now, what do you think the patients? Do they talk to you when they’re answering those questions, or do they seem to talk to the providers?

913221: They talk to me. They talk to me.

Interviewer: Mm-hmm. The majority?

913221: Yes. The majority talk to me.

Interviewer: So, it seems probably from the patient’s perspective going back to the connection you mentioned earlier, right, there is probably that – a sign that they are more connected to you than they are the provider, the fact that they answer to you when they are answering those questions.

913221: Yes.

Interviewer: Interesting. Huh. Wow. Very interesting. Now, those are really the four questions I had for you, but do you have anything to add regarding
interpreting experiences or anything you would like to – this is more of a time for you to freelance it, basically just tell me what you think about interpreting, nursing interpreters, anything, any thoughts that you have on that?

913221: I think that nursing interpreters are a valuable to our community or whatever community it is that you’re talking to, but even me – because I’m a Spanish speaker interpreter, however, I have used other interpreters for other countries, and I could tell that whatever I’m saying they’re going into further details, so that explanation is always there. So, it would be nice if we would have more of a support when it comes to interpreters because I’ve noticed that we don’t have classes that we could go to updates with certain things that would be great if we could have that, I think that support would be wonderful. And then we do do a lot of where I work; we do a lot of interpreting, but yet the pay is very, very minimal – very, very minimal, some people don’t even wanna interpret for that reason, because it’s so very, very minimal.

Interview: Mm-hmm. So, the compensation for being able to be an interpreter is not there; it’s not enough.

913221: Isn’t there. It’s not enough. No, it’s not enough, but of course, if you are all about patient advocacy, you oversee that, and you try to get – assist the patient in providing them with the information that’s being given to them and also the support that they need. Because sometimes, we do go a little bit out of the way to explain it a little bit more in-depth than what the
doctor’s doing. But when I have done that, I will tell the doctor could I go ahead and tell them a little bit more because they’re not understanding what you’re trying to tell them, and they’re like, okay. So, I’ll go into a little bit more in-depth of this is what the doctor’s trying to explain, so I’ll explain it to them.

Interviewer: Okay. Now you bring up a very good point as well regarding training, ongoing training for interpreters because it seems, I don’t know in your case, but the certification once you’re certified, there is no follow-up trainings after you become certified?

913221: That’s correct. None.

Interviewer: Mm-hmm. And it will be interesting, and one of the reasons why of the study is because of improving that experience, especially what you mentioned earlier today regarding people from different regions. Again, when we are trained, we are trained on a very, let’s say, specific Spanish. Right? Tested, maybe that certification that is happening in our world, and [inaudible] [00:24:59] is very one Spanish test for everyone, but there is not necessarily any training to, hey, these people from this region call this this way, or people from this region do not appreciate, you have to refer to them as, for example certain [inaudible] words, right? But we don’t have that, and you’re completely right about it.

913221: Well, as a matter of fact, you bring something up. I just on grinding. Was it this past Friday, one of my patients said to me, he goes, he asked me, he goes, what’s your background? I said well, my family’s from Peru. He
goes because you had mentioned, he goes, I knew you were not from Mexico because you had mentioned a – what was it I told him? I said [speaking Spanish] [00:25:59], I said [speaking Spanish] he goes in my country [speaking Spanish] means [speaking Spanish]. He goes, and they’re ballet shoes, and I wanted to tell you I don’t wear ballet shoes, and he goes and I was thinking where is she from where you say [speaking Spanish], and I was like, I am so sorry, I did not know that.

But this is wonderful, he goes yeah, in Mexico we call [speaking Spanish] ballet shoes. He goes and you call it – and he goes what do you call walking shoes, like tennis shoes? What do you call them? He goes [speaking Spanish]. I was like I did not know that; I told him we call them [speaking Spanish] [00:26:47], he goes no you don’t call them [speaking Spanish]. I go, oh, okay. I go. I did not know that, so there may be some words, and the patients are great letting you know if there’s a word that is probably seen as rude or vulgar, they’ll let you know. They’ll say oh, that’s not the way you say it, this is the way you say it. I’ll be like, oh, okay, thank you, because they know that we’re trying – well, I’m trying to work with them as much as I can.

Interviewer: Yeah. Yeah. They’re also aware that these interpreters, nurse interpreters, are also from different countries themselves, so very likely, gladly, they understand the fact that, hey, this person is interpreting for me, but it’s also not from my region, so I’m gonna have to also be patient with them. Right? As to how you –
913221: Yeah, open my head. Open my head.

Interviewer: Well, anything else you would like to add?

913221: No, that’s it. That’s it.

Interviewer: All right. I will be stopping the recording now, and then we can just touch bases off the record.

913221: Okay.

[End of Audio]

Duration: 28 minutes
Interviewer: I’m recording in; let’s see. **Recording in progress**

Interviewer: All right, so we are recording, again the device on Zoom recording our meeting today, and I have a second device just in case as a backup. Again, your name will not be used today; you will be assigned a code; your code is basically how I will identify you will be 92720221, so that will be your code. And again, thank you for participating today. The questions if at any point you feel uncomfortable with any of the questions, you can either decline to answer that question, or you can move to the next question; you can ask me that over. Even if the interview is sending you in a place where it makes you uncomfortable, please feel free, you can stop this meeting or this interview at any moment; you are free to do that.

And again, that will not change anything. It will just be – again; you can just stop the interview at any moment if it makes you uncomfortable. Your name, again, will not be used; identifiers – potential identifiers will not be used today. This recording will be used only for these purposes and also to transcribe them into Word; once we are done with this interview, they will be put in a password-protected storage on a device, and again, thank you for being here. Okay. So, I will be asking a series of questions; this very first questions are just demographics regarding you, just so that we can get to know you a little bit. And then, after that, I will be asking the actual research questions. First question I
have for you is, what is your age?

92720221: Fifty.

Interviewer: Gender identification?

92720221: Female.

Interviewer: Ethnic identification?

92720221: Mexican-American.

Interviewer: Country of origin?

92720221: U.S.A.

Interviewer: Okay. Languages spoken?

92720221: Spanish and English.

Interviewer: Educational level?

92720221: Bachelor’s degree.

Interviewer: Okay. Years in nursing?

92720221: Years in nursing 20 years.

Interviewer: Years as a qualified or certified bilingual speaker, interpreter.

92720221: Okay. So, that would be – that would be 19 years.

Interviewer: Employer?

92720221: [HMO]

Interviewer: And your nursing role or position?

92720221: That’s my case manager.

Interviewer: Okay. Thank you. All right. So, the research questions I have for you that first, we’ll begin with is tell me one memorable experience you have had with interpreting?
Okay. Let’s see if I turn off my phone here. Okay, so, my goodness, I mean, I have various, I can say they’re all pretty positive because as I’ve interpreted for our physicians in the past, I try and think about the patient and bring in the culture because it really helps them to - it helps them with their healthcare outcome as well, with their health outcome as well. Right. But their health outcome and they’re appreciative; they’re appreciative because you’ve made that connection with them and you understand. The other thing is when I talk to some of these patients, a lot of the Spanish is not proper Spanish.

So, there are certain words that say people from Mexico use that are saying different from people from Peru. Right? So, I try and understand, at least throughout my years of interpreting, trying to get to know the different cultures so that when I do interpret, and I know a little bit about the patient, it helps me to better understand them so I can be a better interpreter for them, and make that connection and help them.

Interviewer: Now, will you endure some -

And the patients appreciate it very much, they’ll say, oh you’ve been to Peru, or you went to – how do you know that? How do you understand that? So, I’ll share I went to Peru, or I have friends, and they teach me, or I learn, or I read. So, it helps. I think we just really make a really good connection, and ultimately the goal is for our patients to have a better health outcome. Whatever the physician is trying to convey to the patient to be effective, and my interpretation to that not just words that are spilled
out to them that they understand and that they can ask questions if something is not understood.

Interviewer: Okay. Now – and I’m glad you mentioned that your experiences have been mostly positive, and maybe if you can recall, maybe, one of them. And I know that if you have had – these experience way in the past, it’s sometimes hard to remember those experiences. But do you have one that stands out from -?

92720221: A specific one. Let me see. Okay. So, when I was working in the recovery room, and we had a patient who was overnight, and then the following day, the doctor comes by, and he was still there, and we discharged this patient, so there were certain instructions that the physician came over and said I’d like for you to convey this message. It’s very important that he does this with his Foley catheter because I don’t want him to accidentally pull it out and cause problems for him. So, when I was explaining to the patient what the doctor had conveyed me because he was standing there – I showed him, and I also had another family member, with his permission, of course, the patient’s permission, be there –

– because I wanted them both; if one didn’t remember, I have somebody else that remembers. Right? Or they can ask questions, and maybe the patient’s just really tired, they’re just not there, but you have another family member that will ask these questions. So, when we finished, the doctor left, and both the wife and the patient were very, very appreciative. They said thank you so much; no one has explained anything
in so much detail as you did; he said you really explained everything very
detailed, what to do if I see this to do this or to call here. Yeah, the wife
was writing notes galore, so she was writing all the notes; that’s why I’m
very thorough, and I want to make sure that when these patients go home,
I can cover as much ground.

And especially what that physician has said, it was very, very, very
important that that patient was careful with that Foley catheter that he
didn’t pull a certain way and basically where to put it, even in the bed and
what to do, and when to come back specifically. So, that was –

Interviewer:  Now, what do you think made it memorable? Why do you think this is a
memorable experience from all your -?

92720221:  For me?

Interviewer:  Mm-hmm.

92720221:  Oh, because the patient was really happy, and so was the family member, I
mean – and you know, and actually, I’m gonna say as nurses typically, at
least for me, it’s gratifying when your patients tell you, or they praise you,
oh, my goodness, thank you so much I didn’t know that. Or thank you for
explaining this to me, I’ve been coming here for so many years or so many
times, and no one’s really taken the time to explain it as well as you have.
And now I understand – I understand why it was not working and why
now, what I’m going to do now it’s going to work, or it’s supposed to
work.

So, it’s memorable. I mean, that is really memorable for me
because it was a positive outcome for the patient.

Interviewer: Wonderful. Wonderful. All right. Anything else before we move on to the next question?

92720221: No, I think that’s it.

Interviewer: Okay. Now, what separates certified or qualified registered nurse interpreters from other types of interpreters? Like just family members, friends, or professional interpreters?

92720221: There’s a lot of differences. One of them is our clinical judgment; we’re clinicians. We know the ins and outs of – what we’re trying to even accomplish; even if it’s something very general, we can explain it in a better manner than someone who doesn’t have that experience. The other one is we’re working directly with the physician, so we know what the physician’s really asking for, where it happens to be on the phone. A lot of things, in my opinion, can get lost in translation, and before I did become a certified bilingual interpreter, although I could speak the language and I can interpret, I did call the interpreter line at the time because I wasn’t certified my first year.

And I listened to them, and I had to intervene myself because I knew that what they were saying was not precise and it wasn’t correct; they did not understand because they’re not clinicians. The other one is we understand the healthcare system, right? Where I don’t know if these interpreters, again, do they have an understanding what goes on in our healthcare system. Right? How we navigate in and out, they don’t
understand that. Where there is something as simple as labs, where do I go for my labs, where do I – who do I call in case I have a question in the middle of the night? Do I just come into the emergency room, or do I -?

What do I do? We who are directly working with these physicians, and in this healthcare system, we know. We have a better understanding, and we can actually advocate for the patient as well; if we see that the patient isn’t quite understanding – I know I’ve done this myself – I will ask the patient if I, for some reason see their face, I see a look on their face, I’m not sure I quite understand what you’re saying. I will ask the patient do you have a question? Do you have a doubt? Because I’m here, I can ask the doctor, so I think that really separates us a lot from the interpreter services. The other one is I believe that we try our best to deliver quality care.

And when we’re doing this, we want, again, we want to have the best outcome for this patient. Right? So, I know that I want to be effective in what I say and what I do. So, if I’m talking to this patient, I, too, wanna make sure that this patient understood and there are no question marks. So, I will actually ask the patient, after we’ve talked and I’ve interpreted, as then, so the doctor said this is what you’re going to do. What time tomorrow? Or what does he want you to do? So, I’ll ask them, and if they can let me know, and say, oh yes, yes, I’m gonna do this or I’m gonna call if this happens, then I know I got through, I got through to them.

The other one is I think we’re sympathetic with a lot of these
patients depending on whether you’re delivering, maybe not such a good message. Right? You’ve got cancer or – maybe not very good outcomes to a surgery or something. And we can sympathize or empathize with the patient and help them through this, even through our delivery when we’re interpreting the message from the doctor to them. The other one is our understanding of culture. I mean, I don’t know how much understanding these other interpreters have of the various cultures. Right? I know, for me, I try and study my population that I’m in where I’m at, and I try and learn a little bit about we have a large population of, say, Mexicans.

That is my background. My parents were born in Mexico, so I will try and understand them pretty well, as well as, say, someone from Peru, someone from Nicaragua, or Chile. I mean, there’s so many countries where Spanish is spoken, but the culture is different. So, I think, or at least myself as a nurse; I do my best to try and get that cultural understanding how cultural competent. Maybe it doesn’t half because they – maybe they just don’t know how to speak Spanish. I’ve heard them, their Spanish is very proper, very proper, and the Spanish that I typically use with my patients, typically throughout my career, has not been very proper.

I do have those occasions when I do use proper Spanish, but generally speaking, it’s not proper, but they understand what we’re trying to – the message that we’re trying to interpret for the physician. And I think overall it helps to improve our health outcome. Right? Because they feel that you made that connection again, and you’re trying to understand
them, and you’re trying to help them. So, again, but that’s us interpreting from within our facility versus someone who’s working from interpretation company and so forth.

[Crosstalk] [00:16:43]

Interviewer: Thank you. Yeah, very, very good. Now, do you think then if we get professional interpreters in a room where they use the proper or maybe a high-level Spanish? Right? They use more of that high-level language, and I don’t know; again, it’s very likely that is their training; again, I’m not familiar with it, but if they’re using proper language or more of a high level, do you think that hinders the message rather than help the message?

92720221: It can. It can. And I’ll tell you why. I’ve actually tried it using proper Spanish with some of my patients; they’re looking at me like – they’re lost, they don’t know what I – and you can see in their face they don’t know exactly what I’m talking about. So, then they look at me – what do you mean? Are you referring to this? Oh, no, that’s not what it’s called; it’s called this. And I know certain terms are called – certain body parts are called a certain way, and it’s under certain cultures, so I know that. But I want to use my proper Spanish, and I end up just using Spanish that I know they’re going to understand. And it works.

So far, knock on wood, no bad outcomes because of my interpreting. I’m using my own proper Spanish. So, I think, again, a lot of that it’s really knowing your audience, and we have an advantage because we work in this healthcare system, so we have that advantage where these
interpreters, they’re just interpreting. I mean, they’re not there, they don’t see the ins and outs, they don’t know, is this a clinic? Is this the hospital? I mean, where are we? They’re just interpreting. We have a lot more information, we can be more proactive with the patient and the physician, advocate for our patients, and we have the culture competence as well because we’ve been here, we’ve been working here, so we understand.

Interviewer: Got it. Thank you for that. Very good. Anything else before we move to maybe the next question?

92720221: No, I think that’s it.

Interviewer: What do you find challenging? I know you were saying a few things when you started the conversation; what do you find challenging? I gather from what you were saying earlier in the interview regarding having different cultures, different words for the same – one country will call a certain part of the body one way, and a different country or even a different region will call it something else, I kind of got that as maybe being one of those challenges. Am I right?

92720221: Yeah. So, what I’ve found just in previous times and I’ve interpreted is sometimes my challenges can also be that our physicians don’t understand the culture of this patient. So, although I’m interpreting what he or she’s telling me, I’m letting the patient know this is what doctor so-and-so said, and they’re nodding their head no, no, no, no. I can’t do that; my wife’s not gonna touch me like that. My wife’s not gonna remove the catheter, so I’m going back, and I’m talking to the doctor over here, so he says, well,
let them figure it out; they have to find someone then.

So, that’s challenging because I feel like I’m in the middle of both. I’m trying to deliver the message, and the doctor – this is what the doctor’s saying has got to happen because it’s Sunday, and the clinic doesn’t open until Monday, and he has to have this removed on Sunday at noon. So, that, sometimes, is challenging for me as well, has been challenging. And it’s just trying to navigate through that situation and help the doctor understand as well that because of the culture, certain things aren’t gonna happen. So, you have to make changes to the plan.

Interviewer: So, in the same sense, from what I’m getting, I know you mentioned this earlier, too, we got a [inaudible] the advocating that happens – you have that role of interpreting, and then you also have the role, that nursing role that also forces you or at least – it provides your duties to also advocate for the patient. So, you not only convey the message but you also now have to advocate for the patient, so you find that challenging the fact that the message has to be given, but at the same time, now I have to also advocate on the other side because I know more of this culture. I know it’s not as easy as what this provider is saying. The provider is saying do this when that happens in this culture, but now in that culture is very, very difficult to do that message, to convey that message.

Oh, very interesting.

92720221: Yeah. I’ve come across several situations like that; obviously, we work it out because there’s always a solution to something; you just have to think
about your different options to find that solution. But when you’re in a healthcare system where you want to save, there’s cost savings, and this is gonna cost more because of the culture. And I’ve had a physician actually tell me this. And he says 92720221 come in here. I need to talk to you. And he pulled me to the side; I’m thinking, oh boy. So, I told the patients, I said look, he wants to talk to me, but don’t worry. I said we’re gonna figure something out, let me talk to him, and then we’ll figure something out we can do, and that way, you get taken care of at the end. We want you to have a good outcome –

– and we don’t want you to come back with an infection and yada, yada, yada. Okay. So, when I talked to the physician, I actually had the physician tell me, he says I don’t care what the culture is, this is what’s gonna happen, this is what needs to happen. This is what needs to happen; they have to just figure it out because this is what’s gonna happen. So, I made some suggestions to the physician; I said look, I’ve had a similar situation, I said, not exactly, but a little different where we did X, Y, and Z. I just need to make some calls to my GA and then she can escalate and then we can – there’s calls that need to be made to do this.

Because I don’t think it’s gonna happen, and I – and this patient’s gonna come back in the ED, or worse. I mean, things can happen at home, right? Let’s try and help the patient out. If we can even schedule an appointment with the urgent care nurse to come in and the urgent care nurse can remove it, remove the, say, the Foley catheter, and do a trial in
the urgent care, this way, they’ll be at peace because the wife won’t be meddling like the patient said, and it’ll be here in the clinic at the urgent care. That way, they don’t have to wait until Monday, so he eventually said, okay, you figure it out then, fine, just do what you have to do, but he’s gotta get that removed by this time.

So, I’ve had situations like that, but again, as nurses, we advocate, we think outside the box, we have to; we are proactive, and we need to be proactive about these or should be proactive about this, at least we should be proactive, and try and find out what would help out the patient best so that they can have a better outcome. And he had just had surgery, so we’ve seen lots of instances where these patients don’t follow through, and they end up with infections, they end up with the catheter being left in there longer periods of time. So, anyway, that’s some of the challenges, I would say.

Interviewer: So, would you then say that the nursing role influences your interpreting role in a positive or negative way? What would you say to that?

92720221: I would say it’s positive because any time we advocate for our patients –

Interviewer: It’s positive. It’s a positive.

92720221: Right. It’s when you know something is not right and you didn’t do anything; you didn’t speak out is; when it’s a negative because you saw the patient, you’re physically there, you’re observing their mannerisms, their facial expressions. Some people don’t say a lot, but you can tell your demeanor changes; the family, the wife, the child, the son, the adult son,
their demeanor changes. So, I believe it's nurses, myself, I look at all of that, I mean I’m not seeing just doing, but it’s part of what we do, it’s our assessment. Right? In what we do, even when we’re interpreting, we’re still assessing the situation; we’re assessing the patient.

Are they able to receive this message that the doctor wants me to convey to the patient? He just woke up from anesthesia. Is he going to remember this? Probably not. And that’s why I let the doctor know – give me a minute, I’m going to call, I believe a wife is waiting out in the waiting area; let me call her in. So, if she has any questions, this would be a good time to have that conversation since I’m going to be interpreting. So, again, we’re advocating, right, where if you call an interpreter, he’s not gonna do that; he’s not gonna say, oh, doctor, by the way, how long has he been out of anesthesia?

Do you think he’s awake enough? Do you think that maybe we should have a family member here to listen and maybe ask questions? This is just an example. It’s like, so when you’re talking to – they’re not going to say that because that is not their role. I think for us, as interpreters, our roles they just intertwine; I mean, you can’t just do interpreter and not be a nurse – and forget you’re a nurse, you can’t do that, you’re still a nurse. I mean, I’m still a nurse, a registered nurse when I’m interpreting; that does not change. So, I feel that we, as interpreters, can make a bigger difference in our patients lives more so than the interpreter on the other line.

Simply because we have all of this to work with. Yes, it’s a lot, but
we’re used to juggling many things. Right? And again, it should just all come together and everything, our clinical judgment, we advocate, we interpret, we want improved health outcomes. Right? And re-hospitalizations, we don’t want any of that, so I want to make sure that my patients understand the message that the physician’s trying to convey. And I tell them why, not just the doctor says he wants you to do this – I actually explain to them why so that they understand, it’s not just because he wants you to do this, there’s a reason, and this is the reason why.

Interviewer: All right. So, what is your take then on family and friends? When they interpret, what is your take on that?

92720221: So, I interpret for my dad all the time, I take him to the doctor’s office, and I advocate for him; he’s my father. I’m not only his daughter at that time, but I’m also advocating for him because I’m a registered nurse.

[Crosstalk] [00:30:41]

92720221: Yes. Yes. And – yeah, lots of times if the doctors don’t know that I’m a nurse, they actually ask me, oh, are you in healthcare? Because I ask questions, I want to make sure that my father understands, it’s not, oh, you need to go this, you’re gonna go to this lab, and we’re gonna draw this, and this, and this; I need you to go pick up these pills. But why? So, I know why myself, but I want my dad to understand why. Do you understand, dad? Do you understand why he’s giving you these pills, what they’re for? So, my take on all of this is that I believe more of us are needed. It does take time out of our, obviously, busy schedules to do this,
but if you look at the grand picture, it benefits everyone in the end because we try and try and avoid again. Hospitalization, visits to the ED, visits to urgent care when if we deliver either the right message, they understand.

And so does the doctor. Because not only are we interpreting for the doctor, but we’re interpreting for the patient to the doctor, so we wanna make sure that whether it’s symptoms, that the doctor understands, and I’ve seen it lots of times where I’ve talked to patients, I end up calling them later and it wasn’t me who interpreted the first time, but they used an interpreter service. And they say, oh my goodness, they gave me these pills, but they’re not working; I’ve taken them all, I need something stronger, so I start asking more questions, I start doing my assessment, which is do when I interpret.

I interpret every day, I assess, I ask the patient questions because I wanna make sure that the doctor understands and, we’re all basically on the same page, and we’re all understanding what the issue is, and was the issue or the concern addressed before the patient leaves? And before the doctor leaves.

Interviewer: Got it. Now, I know that in your case, being a nurse, an interpreter, and also a daughter, all right? So there is that [inaudible] influence in that, but what about family or friends who are non-medical, completely just a friend or a family member they come to interpret a daughter who comes to interpret for those patients.

92720221: Oh, okay. So, I’ve seen that too.
Interviewer: What do you think of those? What do you think in that aspect?

92720221: Again, so we have the professional interpreter, we have the non-professional interpreter, then we have the RN interpreter. There are big differences. When it’s a family member, there’s a lot of emotion sometimes, and sometimes those emotions get in the way of even trying to – they don’t always or necessarily advocate for the patient, but they’re asking more for themselves rather than ask for the patient, they ask more questions just for themselves to know. So, I’ve seen that, and sometimes I don’t feel it’s proper because you’re placing this huge responsibility on someone that does not understand –

– or maybe they do, they’re nurses, and they have an understanding, a good understanding, usually, but if they don’t have medical or clinical backgrounds, I just don’t see how well they can advocate for their loved one or interpret for the doctor and really get that message across. Because I’ve seen it too, where they’ll call back, oh, we were just there a little bit ago, yeah, I was in with my father, yeah I spoke with the doctor, but my dad wants to know – so again, questions they don’t realize you’re here for your father. Dad, do you have any questions? Any concerns that you can think of at this moment? So, anyway so, I went into that as well, I don’t think it’s the best option, but if it’s your only option, it’s better than having no option.

Interviewer: Got it.

92720221: At least you get a little something.
Interviewer: Yes. Yep. Yeah. So, in a sense, very likely what I think hinders, and this is, again, as I’m listening to you, that they don’t have the medical terminology, so something that happens with medical or RN interpreters is that we not only interpret that English to another language but also the medical terminology to simple language. Right? And that’s something that maybe family members have – if the doctor talks with them in more of those medical terms and if they aren’t able to understand it, how can they convey that message to the patient effectively?

92720221: Right, and I caught it too where, again, there’s a lot more that we know as clinicians, registered nurses, where patients come in, and they’re in the recovery room, and when they wake up, they ask me, in Spanish, oh, how was my surgery? Oh, your surgery went well. There were no complications, the doctor’s very happy with the outcome, but I’ll let him come in here and talk to you. Just give yourself some time, wake up, and we’ll bring him in. But anyways, then that patient will ask me, well, my daughter and I went in to see him, and we talked to him, and she was there for me, and she asked him questions, so how many bags do I have?

And this was for, say, it was supposed to be, we’ll call it a colonoscopy, and some patients they do have to put them a little bit under sedation because they’re afraid they’re anxious, so we recover them. And so, this patient understood, and I think misunderstood, that somewhere along the lines in this conversation that they had with the daughter and the physician that he was going to have bags from a colonoscopy. What
happened? I don’t know. So, yes, medical terminology is huge we’re familiar with this; we’re fine with the medical terminology, we can explain it to them. I don’t know what happened.

And I ended up finding out what eventually happened, and yeah, he – I think the doctor was talking more later on if they were to find cancer, these are potentials remove some of the colon, etc., etc. And that, yes, you could probably have bags, but she was under the impression that he was going to get these bags. So, yes, we lose a lot in translation when family members do not understand the language, or I have some family members that believe they understand the language, but they don’t quite interpret well. So, we run into that problem. I think even for liability reasons, I don’t think it’s really a good idea to use family unless there’s absolutely no one.

But here in the United States, there’s always someone. Right? Some kind of service. If there’s no one else, there’s always some kind of professional service.

Interviewer: True. True. Exactly. All right. All right. Anything else before we move to that last question?

92720221: No, I’m good.

Interviewer: All right. So, what do you think having that interpreter, whether it’s in that room or between those two, the provider and the patient? What effect do you think having an interpreter has on that interaction?

92720221: I think like I mentioned earlier, we, as nurses – at least I, as a nurse, I try
and understand cultural competence. I try and understand the member, the background and I believe that the member sees this as a connection that we’re truly invested and interested in their health. When you have someone that understands them rather than someone, you pick up the phone, oh, okay, I’m doctor so-and-so, I need for him to come to surgery tomorrow, he needs to sign papers, yada, yada, yada. Then we’ve got another – the interpreter letting him know this, or you have a person, meaning a registered nurse, in front of you talking to you; it makes it more personable.

So, I think they see it more of a personable experience, and you remember that face, they remember you. And, again, if you can see their facial expressions, again, you can advocate. Do you have any concerns or any questions I can ask the doctor right now? He’s here, or she’s here. So, yeah, I think we can definitely do have a better effect on our patients when we can interpret for them instead. I know doctors like it too because I’ve talked to some of our doctors, and when I was in the clinic a long time ago, they would call me, and although I was really, oh, please 92720221, you understand, you explain, and I don’t have any other questions, I mean they –

When you explain to them, they seem to know what’s going on, and I don’t get anymore calls. So, I want you to come over and interpret for me. So, I think if we all just kind of worked on being able to at least reach that and help our patients and get that connection being culturally
competent, use our clinical judgment, advocate for them, it turns out to be more effective for them. And the message, I think, is conveyed more precisely.

Interviewer: Ah, and then you think it is because of that because as a nurse interpreter, those interpreters are able to detect or at least maybe even interpret that number of communication that happens between those interactions so the doctor and the patients – they do – they do have that number for communication that an RN who is also trained more on not only in interpreting but also in the nursing experience may be able to detect more of that number and those cultural aspects in the interaction. That is extremely interesting.

92720221: No, I think if all of this helps, and also if you have, say, family members are interpreting, a lot can be lost in translation, a lot. A lot can be lost. I’ve seen it happen too. So, I think we have that ability to make a better world for our patients if we’re able to interpret for them.

Interviewer: Right. All right. Very good. Wonderful. Again, very insightful I really appreciate it. Do you have anything else before I stop the recording?

92720221: No, I think I’ve pretty much said everything that I felt makes a difference in what we do, and I know I take pride in what I do and my experience, my background, and the different areas of nursing that I’ve worked in, so when I am interpreting there’s a lot that I do know, and then I’m able to help out the patient even more so because I do have that background and I can advocate better for the patient, and even help the doctor understand
more about the patient because of my background, and also because I’m trying to be culturally competent as well, and make a connection with our patients.

Interviewer: All right. Wonderful.

92720221: I thank you. That’s good.

Interviewer: Let me just stop.

92720221: The results.

Recording stopped.

[End of Audio]

Duration: 45 minutes
Interviewer: Okay. First of all, I wanted to say thank you for providing your time for this interview. I will be asking some questions, do not use any identifiers, I will be using a code for you, and the code will be 92820221, that will be the code I’ll be using. Do not use your name. Now, I’ll be asking you a series of questions, and if you don’t like the questions, or if they make you feel uncomfortable in any way, you can either skip to the following question, or you can refuse to answer the question, and none of this will change anything we’ll just move on to the next question. And if at any moment you feel uncomfortable with the interview, you can stop it. And again, that will not change anything.

Your name will not be used; this interview we are recording is only to be able to bring into a Word document, so it will be transcribed. Once it is transcribed, the recordings will be kept in a password-protected device. So, let’s begin. The first question I have is, what is your age?

92820221: Fifty-two.

Interviewer: Gender identification?

92820221: Female.

Interviewer: Ethnic background?

92820221: Mexican-American.

Interviewer: Okay. Country of origin?

92820221: U.S.
Interviewer: Languages spoken?

92820221: English and Spanish.

Interviewer: Educational level?

92820221: Masters.

Interviewer: Years in nursing?

92820221: About 20 years.

Interviewer: Okay. Years as a qualified or certified interpreter?

92820221: About 20/25 years.

Interviewer: Employer?

92820221: Currently, [HMO].

Interviewer: And your nursing role or position.

92820221: Currently, I’m a diabetic case manager.

Interviewer: Okay. All right. So, tell me one memorable experience you have had with interpreting.

92820221: Memorable experience would be – actually, yes. So, and it happens often, it’s when I have the family member brought in, or the patient brings in a family member, and when the patient is brought in by a family member and the patient assumes the family member is gonna translate. And I think I – I see this because it used to happen to me as a young kid. We don’t have that level of knowledge as a family member, so I think I always just stepped in and told the family member just say, hey, I don’t worry, I’ll translate, you could sit in here, but I’ll translate for you. And just seeing that relief in their fact that they’re like, oh, I don’t have to do it. So, I think
it’s memorable because growing up, that wasn’t an option for me –

– so I had to translate as a young girl for my mom, and there was a lot of words I just didn’t know because I was a kid.

Interviewer: Now, in this situation, do you have one specific one between a provider and one of the patients where you felt that – one that is fairly specific. Do you have one memorable one?

92820221: Well, there is; I’m just gonna speak on Spanish, we use more words to describe something than in English, so I just remember a provider wanting to rush the visit and I remember having to stop him and tell him well, she still has questions, and for you they may be yes or no, but she’s – there’s a story she’s giving me, so I have to take that story. Or I have to describe it, it’s just not easy. So, yes, the provider seemed bothered or upset or I just wanted to make sure that my patients always have the – you know that they’re getting all their questions asked, or that they have the information.

Interviewer: Mm-hmm. Mm-hmm. Now why do you think that one is memorable? What made that experience memorable?

92820221: Because my role is not just as a translator but also as a patient advocate so I was doing both. I think we do both anyways when we translate; I’ve gone through the training as a translator, and I know we’re supposed to be very objective, just translating specifically, not even looking at the patient when we do the training, but the nursing part of me I have to advocate for my patient.

Interviewer: Got it. Got it. And what separates certified or qualified registered nurse
interpreters from other types? Whether it’s from professional interpreters or from family members, friends, what do you think separates you?

92820221: And I think that would – just what I mentioned right now that we’re also patient advocates, we’re familiar with the medical terminology. I’ve heard interpreters, and they’re not interpreting – they’re just interpreting it, but they’re not interpreting the words correctly; family members don’t understand the medical terminology. The education level just that we have to translate something, and even if they’re saying the word, they might not know how to describe something. So, you have to – even if we say the correct word in Spanish, but you’re looking at the education level of your patient, and you could see that they’re confused or they don’t understand, we have to – we’re able to describe this is what the doctor means, he’s talking about this.

Whereas a family member might not. With the family members, there’s the bias; there’s the – he’s not taking – I’ve seen it – no, you translate because if I translate, I’m gonna tell you he’s not taking his medicine. He’s saying all this that you wanna hear now, but he’s not doing what he’s supposed to; there’s that. And then with the interpreter over the phone or just the paid interpreter, sometimes it’s just an education level, they’re saying the correct word, but the patient doesn’t understand.

Interviewer: So, do you think that either using the proper Spanish or high-level Spanish hinders the interpreting?

92820221: I don’t think it hinders. I think each patient is individual; I’ve had some
very educated patients who all understand it, just knowing the difference. Even in English, we just have to see the education level of our patient. Is it – if they’re at an educated level, you can say it – and if they’re not, then you have to just speak at their – what do they say – what is it –?

Interviewer: Fifth. Fifth grade. Fifth-grade level. No but do you think that most professional interpreters are always proper when they interpret? Do they use the proper language?

92820221: Yes.

Interviewer: Proper Spanish. High-level? Got it. Okay, so when it comes to the interpreters from professional interpreters and nurse interpreters, what do you think? What’s the difference between those specific ones?

Professional and RNs, registered nurse interpreters.

92820221: Like I was saying, as a registered nurse, we understand the medical terminology, whereas a professional might understand the language, but they don’t understand the medical terminology. That’s I think either friends –

Interviewer: What about with family? Or friends?

92820221: Family, again, they won’t – family or friends are gonna be biased to how they feel, even within when the doctor is speaking, I’ve seen they’ll answer for the patient. So, there’s that bias. There’s the lack of knowledge on the both of them, because none of them have medical knowledge or they might not even have the interpreter knowledge to actually translate something correctly. Something could get missed in the interpretation. So,
I feel like information does get missed.

Interviewer: So, do you think more is missed with family members or with professional interpreters?

92820221: I’m gonna go with family members because –

Interviewer: More is missed?

92820221: Yes. Because at least the professionals are required to translate word-for-word, but I feel with the family members, more is missed because there’s that bias for them, so they sometimes don’t translate everything. Sometimes I’ve seen them answer for the patient.

Interviewer: Interesting. So, when it comes to a professional interpreter, then we have more of that?

92820221: It’s controlled. It’s more controlled. It’s very controlled, and it’s very –

Interviewer: Very verbatim.

92820221: Exactly.

Interviewer: More verbatim, right. As opposed to –

92820221: There’s no feelings involved, there’s no emotions, it’s just very concrete, it’s more concrete.

Interviewer: Got it. And with family members, they can have a little more of them still in that interpretation as to how they feel or what they think of this.

92820221: Or how they feel that patient should get treated, or if they have a bias for a specific medication, or treatment or –

Interviewer: Interesting. Very interesting. Okay. Now, do you think your nursing role – in the nursing role as an interpreter do you think that role influences the
interpreting role?

92820221: Yes.

Interviewer: In what way?

92820221: Again, we were just talking as a patient advocate, and as far as me having just the medical knowledge, I – like, when I have somebody in front of me, I can pick up on visual cues, and if I could see they still don’t understand I could stop the doctor and ask the doctor to explain, and I could explain for the patient. I just feel – I try really hard for our biases not to come in and how I feel the treatment should go. But I could definitely know that we have a – we have that patient – we care to make sure that the patient gets all the information and the education. Because part of nursing is education, so I’ve been in situations where the doctors, I make sure first of all that before the doctor leaves, I ask my patient if there’s any questions, so I make sure the doctor answers them.

But when I feel like they need some extra time, I’m there to educate, so not only did I translate them, but I’m also educating them on the same point.

Interviewer: All right, so you were – if I’m getting this correctly, you would think that the nursing role influences the interpreting role in a positive way, then.

Correct?

92820221: Correct.

Interviewer: It is more of a positive influence than a negative influence.

92820221: Absolutely.
Interviewer: Being a nurse interpreter who’s that much involved. Okay. Now, what do you find challenging when interpreting?

92820221: What I find challenging is not trying to – just trying to be very unbiased and making sure that the information is given without any emotion, or just very concrete, and having the patient make the decision, and without influencing the patient one way or the other. I think that’s the challenging part.

Interviewer: Got it. So, as a nurse, what do you think are your biases when you are interpreting?

92820221: The treatment – whatever. Depending on the treatment, I have biases toward specific treatments.

Interviewer: Some treatments you don’t necessarily agree with or something that you prefer.

92820221: Yeah. I mean, an example would be, just the last example, I’m a diabetic nurse, I’m not big on medications if I could avoid them, so I’m not just gonna push over the med without making sure that my patient understands all the side effects.

Interviewer: The benefits and the risks.

92820221: And I sometimes feel that that’s missed, so I try to just interpret what the doctor’s say, it’s very hard for me not to step in as a provider, and give my educate –

[Crosstalk] [00:14:22]

92820221: The education that I would want my family member to get.
Interviewer: So if you are interpreting for a provider who is giving more of that, let’s say, recommendation on a certain medicine, and you also know that there is a negative side to that medication, so it is not – so, let’s say our provider presents that medication on a very positive view, but you also know that there is that negative view of that medication, there is that negative side. And if the provider leaves the other half of the truth, in a sense, would you feel, because of your nursing role, that you want to advocate and present the other side of the story?

92820221: Yes. Because I would want that for myself and for my family member, friend, or anybody.

Interviewer: To make an informed decision.

92820221: The most important thing is for me, as a nurse, for them to leave with an informed [inaudible] [00:15:21], so I like to present all the information.

Interviewer: Great. Very good. Now, how do you think interpreters can overcome that challenge? The challenge of not only being biased but also the need to advocate for our patients because that seems to be a challenge you’re faced with. Do you think there is any way of overcoming that challenge?

92820221: Yes. Just going into that room exactly that you’re there as a translator, I think one of the trainings I got was not even to look at the patient more like you’re off to the side and you’re having the doctor and the patient talking, and you’re not even looking – so I wouldn’t be looking at those verbal cues, and I would just be translating pretty much verbatim, very concrete.
Interviewer: Okay. All right. Now, what effect do you think having an interpreter has on the interaction between the provider and patient. Like what effect – what do you think an interpreter being in the room, what does your presence cause between that interaction?

92820221: Positive or negative between the patient and the –

Interviewer: It can be either or. What do you think having an interpreter in that room between a patient and a provider? What do you think that does to the interaction between them? What does that do? Being there, you being in that room, what effect do you think it has on the interaction?

92820221: Well, if you’re gonna ask the provider, I think it’s gonna be a positive one because they got their message across. I think just speaking with patients, they prefer the interaction in person as opposed to the – because we now have the video cameras, so they prefer – the Latin community prefers that that’s more interpersonal, but nothing – I think it’s a benefit having that person in there, but I think nothing would – I think the best case scenario would be if the provider spoke the language.

Interviewer: Directly. Directly.

92820221: Because you’re picking up – I mean a good provider could pick up on the ques and could see if somebody understood something or didn’t understand it, or they pick up some of the words, or they have a limited knowledge of the Spanish so they know and the patient has limited English, so they know what the doctor said, so there’s that. That’s positive. But I mean I think the person, I just know from the doctor’s
perspective, and just from speaking with my patients, they prefer the in-person.

Interviewer: Okay. Do you know you bring a very good point regarding if the doctor and the patient have the interaction among themselves that would be the best interaction, right? And then now you have an interpreter in the room, or we have video conference, or we have the phone. So, of course, all of them have different levels of effect in the interaction, but what do you think of a provider who is of the culture, whether it’s Latino culture in general or a provider who just learned to speak English? Do you think there will be a difference between those two? A provider who speaks the language and a provider who actually comes from the culture.

92820221: Oh, yeah. I think there’s biases too.

Interviewer: Would you suggest that -?

92820221: I think there’s the biases like you can learn a language, we could all learn a different language, but does it mean we understand that culture?

Interviewer: So, a native speaker – will you say, will have an advantage? A native Spanish speaker will have an advantage someone who learned the language?

92820221: You know what? I honestly, knowing the Latin community, I don’t think that would necessarily be an advantage because I think they’re so appreciative that they’re appreciative – you are American and you learned the language. So, I’ve seen that appreciation, I’ve seen it even with my mom, that she’s very appreciative of the doctor at least made an effort to
say a few words in Spanish. So –

Interviewer: So, they will say it is a positive – the patient will say that’s a positive as well. Interesting. All right. Anything else you would like to add to the interview? From what we’ve discussed so far, anything else, this is more of a free time to you.

92820221: I just think having someone with the medical knowledge interpreting is beneficial, is more beneficial than just an actual interpreter.

Interviewer: Yeah. Very good.

92820221: That’s just my opinion. That’s an opinion.

Interviewer: Yeah. Hey, that’s what we’re here for, and I really wanted to listen to that opinion and the opinions of others as well. I thank you for this interview, I really appreciate it, and I will be stopping this recording now.

[End of Audio]

Duration: 21 minutes
Interviewer: Okay. Good morning. Again, thank you for doing this for me today, this interview; I’m doing this research for my school; I am getting my Ph.D. degree at the University of San Diego, and again thank you for being here today. You will be assigned a code; please do not use your identifiers as city of residence or where you work specifically. You will be coded 10122-1, so that will be your code. And as we go through the interview, again, don’t use any identifiers, and this interview will be recorded; the recording will be kept in a password-protected device, it will be only used for transcription into Word, and once it is used for transcription into Word, again this interviews will not be published. If I ever decide to publish, none of this will be published, it will just be the Word documents, and again, that’s kind of all we need to do with these recordings.

If you, during the interview, you start feeling uncomfortable with any of the questions, you can always ask to skip the question and move forward to the next question. You can also, at any moment, stop the interview if you, for any reason, don’t wanna continue with the interview, just let me know; I wanna stop the interview, and then we’ll be stopping. That will not change anything, again, feel free to tell me to skip a question, or you want me to stop the interview feel free to do so. All right. Well, again – so before we start with the actual questions, I have to ask a few questions for demographic purposes, and again, I gave you a code
now. Can you please give me your age?

10122-1: Forty-seven.

Interviewer: Gender identification.

10122-1: Female.

Interviewer: Ethnic identification?

10122-1: Hispanic.

Interviewer: Country of origin?

10122-1: Mexico.

Interviewer: Years in the United States?

10122-1: Forty-seven.

Interviewer: Okay. Languages spoken?

10122-1: English, Spanish, French.

Interviewer: Educational level?

10122-1: Bachelors.

Interviewer: Years in nursing?

10122-1: Fifteen.

Interviewer: Years as a qualified or certified interpreter?

10122-1: Eleven.

Interviewer: Employer?

10122-1: [HMO]

Interviewer: And what is your nursing role or position?

10122-1: Educator. Certified diabetes educator.

Interviewer: Thank you. Now for the questions, tell me one memorable experience you
have had with interpreting that made this – I mean, one memorable experience you have had?

10122-1: Actually, recently I had a patient that on the charts was English speaking, she was coded as English speaking, but when I was conversating with her, I felt like there was a barrier in her understanding, and I just simply asked, I said, do you know by chance would you prefer if I speak in Spanish? And she said something – she said, oh, wow, I’ve been spending all my English here unnecessarily. She accepted it; she’s like I’d be happy to speak in Spanish. So, I could tell that during our conversation as I was explaining things in her native language, that she was understanding things better than when she had had the same conversations several other times in English.

And there was a lot of uh-huh, oh, oh, you know. It was like enlightening to her.

Interviewer: Now, I know that this is more of a you are talking to a person directly, right, in Spanish. Do you have any one memorable experience between a provider where you’re interpreting for a provider?

10122-1: Yes. Yes. Yes. So, it was a female patient, and I’m translating, interpreting, for the chief and it was – she was very comfortable with me and opening up a lot more than she would with the doctor and maybe a family member or the video interpreter, or telephone interpreter. So, she was even having some humor, and I was having to translate her humor and her side comments as well. And I think a lot of it, too, maybe she just felt
like she was having a conversation with me, but I had to – I’m translating everything over, interpreting it over for the doctor.

Interviewer: I see. Now what do you think made this memorable experience?

10122-1: I just – I still see her comfort level with me versus, it could be a little bit intimidating to be with a provider that doesn’t speak your language.

Interviewer: Oh, I see. I see. So, would you say there was a connection between her and you, more than between her and the provider?

10122-1: Absolutely.

Interviewer: Why do you think – what do you think made that effect?

10122-1: Well, I think also it was like – they sometimes know too a little bit of English, so they understand if you’re interpreting correctly or not, and so my level of Spanish is high, it’s skilled, and it’s fluent, so I think just her feeling like, okay. She’s spot on; she’s communicating, [inaudible] [00:06:18] what I’m saying. So, it just – I know sometimes patients get upset when there’s like, okay, somethings not going through, something’s not being interpreted, and there’s something lost here, in the message. So, I think just that –

Interviewer: So, you think you gained her trust by being very proficient in the language? You gained her trust, and then she did that?

10122-1: Yes.

Interviewer: Oh, okay. Great.


[Crosstalk] [00:06:49]
Interviewer: Do you think that if you were not – do you think that if you were not as proficient in your Spanish, she would not have connected to you as well?

10122-1: Yeah, I think so. Yeah, it’s also my personality, too.

Interviewer: Mm-hmm. Yes. Yes.

10122-1: And I think it’s my personality that comes across, and I think you will see that with different interpreters, right. Now is there warmness, is there some familiarity with – you feel familiar with certain people.

Interviewer: So, when you are interpreting, not only do you interpret the actual words, but you can probably provide some emotion during your interpreting sessions?

10122-1: Yes. Yes.

Interviewer: Now, with this provider, what was the role of the provider?

10122-1: He’s the specialist.

Interviewer: Okay. The –

10122-1: The – he’s the specialist that she was seeing.

Interviewer: Okay. So, you mentioned the chief, right, chief –

10122-1: Yeah. Also, the chief. Mm-hmm.

Interviewer: Got it. Got it. All right. Very good. Anything else you would like to share regarding that experience?

10122-1: No, some of it was, I think I remember kind of feeling like giggly too because she was saying some things that – she wouldn’t have said otherwise to him, and I had to interpret some – like little uncomfortable jokes.
Interviewer: Got it. Got it. So, that takes to the level of comfort that she felt comfortable enough to make those jokes. Interesting.

10122-1: Right. Right.

Interviewer: Good. Good. Very good connection. Now, what separates the certified or qualifies registered nurse interpreters from other types, and you can divide them, for example, what separates RN interpreters from professional interpreters?

10122-1: Well, when you, particularly in my case, the specialty that I work in, you start to also have a different level of the terminology too. The terminology and the language that you’re interpreting for, so that separates you because it’s not – you know you gotta have a QBS in reception, or a QBS in a different setting but they’re not gonna necessarily know the level that the RN is managing.

Interviewer: Mm-hmm. Mm-hmm. Now what about the RN interpreter and the family or friend? Those members when they bring the family or friends to interpret for them. What do you think separates the RN from them?

10122-1: I also think it’s the medical knowledge and the medical terminology or the condition. Right? So, it’s going to provide some limitations in the interpretation.

Interviewer: Mm. So, do you think that your role, your nursing role affects your interpreting role? And if it does, in what way?

10122-1: I do think it affects it, and it certainly enhances it and adds – like if they were dealing with a provider that was proficient in their native language.
Interviewer: Okay. Got it. Got it. Now, your experience as a nurse. If your experience as a nurse affects that interpretation role, does it affect it in a positive way? Or in a negative way? Being a nurse, do you think it is a positive then?

10122-1: It is a positive impact, and it improves the understanding and outcomes eventually for the patient. Do they fully understand their instructions? Right? Do they fully understand what the provider is trying to relay to them and asking them to do?

Interviewer: Now, you know how providers can give direct messages. Right? And as an interpreter, usually you need to just provide that direct message. Right?

10122-1: Right.

Interviewer: And, of course, a lot can be lost in that little translation if we don’t –

10122-1: Yeah.

Interviewer: – part of the other skills we have. Right? Or nurses have. Now, do you find yourself having to use a lot of those skills to provide a clearer message than the one the provider is giving?

10122-1: Yeah, I think I know what you’re saying like you have to fill in the gap. And I’m able to communicate that to the provider when I have to. Let me sidebar because I have to give additional explanation to what you just said.

Interviewer: Got it. Do you think a professional interpreter would be as effective in doing that? In filling the gaps?

10122-1: Like a non-RN, you mean?

Interviewer: Mm-hmm. Yeah. Yeah. Just those [inaudible] [00:12:03], you know, the
professional ones, the telephonic or –

10122-1: Yeah. Not necessarily. No, because they’re not in the medical field; I mean, the nurse is right they’re not.

Interviewer: That advocacy, that being an advocate, right? To a nurses – nurses can have that other role, so nurses have that nursing role, the advocate role, the interpreting role, whereas –

10122-1: Yeah.

Interviewer: Okay. Got it.

10122-1: And you’re able to identify the gaps; the professional service may not know what the gaps are.

Interviewer: Ah, yeah. Interesting. Yeah, very good. That’s true.

10122-1: It’s not that they don’t want to provide additional [inaudible] as our information. They just simply don’t – they wouldn’t be able to identify a gap.

Interviewer: Got it. Got it. Yeah, that is interesting, very interesting. All right. Anything else before we move on to the next question?

10122-1: No.

Interviewer: Okay. What do you find challenging when interpreting?

10122-1: Well, you know, I think that’s not unique just to nurses, but to any interpreter, it is just being able to set the pace between the two – the interaction, like okay, give me a chance to interpret. You know? That’s something you learn when you’re getting certified. Right? It’s just to be able to provider, please let me say this, or patient give me just a moment
to say this because they feel so comfortable they don’t wanna pause.

Interviewer: Oh, wow. It’s so interesting. So, finding that pace, and not only that, but the providers themselves tend to be for the most part, again, their going, going, going. Right?

10122-1: Yeah. Yeah. And the patient too, and the patient comes up with something because they feel like they’re just conversating with you. Right? All of a sudden, you just have to feel like bring them back to hey. Well, you’re actually conversating with the provider, and I try to, at times, just sort of like, I don’t know how to – like sidestep, right? Because I’m not in front of the conversation with you, right? Here’s the conversation between you and you, and I’m here on the side, and I’m interpreting, and I’m a pretty fast interpreter, so I can as he or she is speaking and her or she is speaking I’m going back and forth.

Interviewer: Connecting that. Connecting that –

10122-1: Connecting. Making that connection.

Interviewer: That is an interesting point you just brought up because as providers are usually in a hurry, usually. And they wanna convey that message as fast as they can, and now you’re here trying to convey that message and end up – the patient in the room they tend to prolong the conversation by maybe a lot of that. That’s actually extremely interesting.

10122-1: They wanna add; they wanna get everything in.

Interviewer: Their story. More of a little bit of a story, tell a story when the patient – when that provider just wants that answer, and they don’t wanna go
through the story of things. That is great. Very good point. You know, I
never even thought of it myself, but very good point. That’s a good way
of presenting a challenge, getting that pace, finding that appropriate pace
to where the message is being conveyed effectively, right? Without feeling
too rushed for the patient or without feeling too slow for the provider.

10122-1: Mm-hmm. Right.

Interviewer: Wow. Very good. Very good. Now, how do you think interpreters can get
rid of that challenge, the one you just mentioned? How can we be good at it? At removing that challenge?

10122-1: I think that being able to get more training, practice, and some mentorship.
Right.

Interviewer: Mm. Mm-hmm. Mm-hmm. Good. Good. Good. All right. And if it’s –

10122-1: And if it’s – yeah, you get the first initial training, it’s very generic. Right?
But if you really want to be out there and look at the proficiency of you
certified nurses, it’s like, okay, let’s do a mentor program, or let’s do a
peer program, how can we improve this? We never go back up to

[inaudible] [00:16:33] it. I think you’re certified one time, and then –

Interviewer: Just to clarify on the certification process, you get trained and then tested
and certified. And after that, there is no additional trainings no additional
in services?

10122-1: I think I’ve seen in the 11 years I’ve been doing QVS it was the initial
training, and then just recently, there was as a KP learn, but it was more
non-specific. Right? And so, what you’re saying is, okay, if t here’s a
different level, right, for a nurse as a QVS, how do we propagate that more? Right? How do we enhance that experience across the board? Then you have a different level of additional training.

Interviewer: No, and it makes a lot of sense because as RNs, right, the yearly proficiency skills that we have to demonstrate, RNs have to demonstrate, and the yearly allocations and the CEUs try to quality for a licensing not having that as interpreters, where you just get certified, and see you later. And you know, again, there is no way of having –

10122-1: Yeah. [Crosstalk] [00:17:53].

Interviewer: Yeah, there is no skilled training that you mentioned, right, that we don’t have it it’s in regards as to not only skilled training to, again, making sure that we maintain the pace, which will be amazing, and that would be a whole class in itself. Right? Just maintaining the pace, trying to control it, but also going back to interpreting messages between a provider and a person from a different region. Right? How do – if we are here with a Mexican English, that Mexican-American English, but then we have someone from the Caribbean or somebody from the South American area, even from someone from Spain. Right? We don’t have that training, or RN interpreters don’t have the training as to what do we do in those situations?

How do we approach it? What words do they use for different things. Right? It can also be very beneficial to the RN interpreters?

10122-1: Yeah.
Interviewer: Yeah. Very good. Very good. All right. Anything else before we go on to the next one?

10122-1: Mm-mm. No.

Interviewer: All right. So, what effect do you think having that interpreter? You mentioned that that very direct communication between a provider and a patient, right? Just between the two of them, and now you are here on the side, right? Now you are in that interaction, even though you’re to the side, how do you think that having you there in that room how does it affect the interaction between the provider and patient?

10122-1: It bridges. It bridges the gap.

Interviewer: Mm-hmm. Mm-hmm. In what way do you think it bridges that gap? What gap are we bridging? Or your bridging?

10122-1: Yeah. We’re bridging the lack of understanding each other, the clarity for the patient, the clarity for the doctor to understand what the patient is communicating. So, it’s able to bridge between the two.

Interviewer: Got it. Besides that, language bridge, do you think you, as an interpreter, are you bridging anything else? Any other gaps being filled by your presence?

10122-1: Culture.

Interviewer: Yeah. Can you elaborate on that?

10122-1: Yeah. You bring in your own cultural experience to translate, right? Not only their words but their cultural experience. How can they – they might say a word, or I ate Menudo, and maybe the provider doesn’t know what
that is, and so you have to bridge, well, it's a soup, you know, and it does have carbohydrates. And it’s got, I mean, it’s got some protein, but it has got a lot of carbohydrates and a lot of fat. So, maybe you have to bridge, how does that effect the glucose for the patient when they have Menudo, right? So, you bring in your cultural awareness of what they’re sharing.

Interviewer: Mm-hmm. Very good.

10122-1: Oh, I had a [speaking Spanish], and how do you explain to the provider, oh a [speaking Spanish] is a pastry it’s not just I had bread, no it’s got a lot of sugar, it’s sweet, it’s a sweet pastry. Right?

Interviewer: Very interesting, that’s a great point. You know, being able to bridge culture as well to allow the provider to see that other side of the communication as opposed to – like you said, it’s not as simple as you’re saying, oh, let’s say, for example, the patient says I ate Menudo, someone can just say she said she had some soup. Well, it’s not as simple as soup, right? It’s not just soup, there is all of this stuff that comes with that soup.

10122-1: The [inaudible] [00:21:56] tells you the contents.

Interviewer: Whereas a provider from a different culture can just think of soup as vegetable soup. Right? In a different culture.


Interviewer: Wonderful. That is a wonderful insight. Very, very good. Well, anything else regarding this, the questions, or anything you would like to add?

10122-1: No.

Interviewer: Well, all right, I wanna thank you again for doing this for me; it was very
insightful, I truly appreciate your time, and I will be stopping recording
now.

[End of Audio]

Duration: 23 minutes
Interviewer: All right. Thank you very much for being here today. I am, again; I appreciate the time. This interview will be recorded today. This recording will be kept in a password-protected device, no identifiers will be used during the interview, and that is, again, just to protect you; all of this recording is just so that I can transfer and transcribe everything into a Word document. But again, if this ever gets published, your image, your video, the sound, none of this will be published. And I wanna tell you, too, that during the interview, if you at any moment feel uncomfortable with a question, you can ask me to skip to the next question. If at any moment you feel that you need to stop the interview, the same, just feel free you can tell me I wanna stop the interview, and nothing will change; we just stop the interview.

Okay, so the code I’ll be giving to you just – again this is just for identifying purposes. Your code will be 10122-2, so that’s gonna be the code that I’ll be using for you. And again, don’t use any identifiers, anything that possibly can identify you individually, and we’ll get started. So, before we begin with the actual questions for the research study, I need to ask you some demographics, and again this is just for data purposes. But what is your age?

10122-2: Twenty ’86.

Interviewer: Okay. Gender identification.
Interviewer: Ethnic identification?
10122-2: White and Hispanic.

Interviewer: okay. Country of origin?
10122-2: U.S.A.

Interviewer: Languages spoken?
10122-2: English and Spanish.

Interviewer: Education level?
10122-2: Associate degree [inaudible].

Interviewer: Okay. Years in nursing?
10122-2: Three.

Interviewer: Years a qualified or a certified interpreter?
10122-2: Three.

Interviewer: Employer?
10122-2: Los Angeles County.

Interviewer: And your nursing role or position?
10122-2: ICU staff nurse.

Interviewer: Okay. Great. Great. Okay. So, we’ll get started in with one – the first question I have for you is tell me one memorable experience you have had with interpreting.

10122-2: I would say the most memorable experience that I’ve had with interpreting is when you interpret for a patient and the provider, and then afterwards, the patient is really grateful that you were there, and somebody was over
special concerns. Memorable.

Interviewer: Yeah. Now, do you have one specific one?

10122-2: I mean, when I used to work in a GI clinic, and so the provider went out to see patients, he was a [inaudible] [00:03:19], and he would often see cirrhosis patients and HepC patients. So, I remember one lady she came in, and she was a HepC patient, she wasn’t really understanding the disease process and the treatment for it, so the doctor asked me to kinda assist in translating basically let her know what the plan was, which made her feel a lot more comfortable, a lot more at ease, which is one of like specific one I can recall.

Interviewer: Okay. What do you think made this a memorable experience?

10122-2: Because I kinda felt that the patient was – that it made the patient feel more at ease, and I could that as part of the healthcare team, I feel that’s something that we all strive to do in different ways, but it felt good for me to be able to help her out in that way, which I think is unique to the nurse interpreter role or experience I would say.

Interviewer: Now, what do you think made the patient comfortable with that interaction? What specifically that made it – that made her – was it a female?

10122-2: Yeah, it was a female.

Interviewer: What do you think made her comfortable, though, with the interpreting session?

10122-2: I think because it made her comfortable because she felt like there was
somebody there who, number one, understands her, number two, is able to
translate what she wants the provider to know about how she’s been
feeling, or what her provider wants her to know. So, not only was it – I
imagine it was nice to have somebody who understands for her and could
advocate for her in that way. But also just somebody who was there with
her, and kind of as a if I gotten like the similar comfort that patient gets
from family members, but having someone there that speaks her language,
I imagine, could have been comforting as well for her.

Interviewer:   Got it. Got it. Anything else you would like to share regarding that
door experience?

10122-2:   No. That would be it.

Interviewer:   Okay. Now, what do you think separates the RN, the qualified, certified
RN interpreters from, in this case, let’s make it from, let’s separate the
question. What separates RN interpreters from professional interpreters?

10122-2:   I would say one of the things that separates the RN interpreters from the
professional interpreters is that oftentimes when your translating as an RN
certified interpreter, you’re usually talking about this about things a little
bit more like medically complex, and I think it’s helpful to have a little bit
of a background knowledge of what they may be talking about, and how to
really interpret instead of translating. Right? So, I think that’s one part of
it. Another part of it is as nurses we’re supposed to be advocates for the
patient. Right? And I feel that sometimes if the patient is for whatever
reason not in total agreeance with the treatment plan, and they tell you, oh,
well, tell doctor this.

And then you tell the doctor, and maybe they don’t get the response that the patient was hoping for, and they kinda put you to like, oh tell – you kind of become in the middle, and as a patient advocate, it kinda of brings a part little bit of role strain. It’s like you’re part of the care team as the nurse, but then you’re also there as the advocate and if the patient feels like you’re not advocating for them, then – I don’t know, it kinda just feels, like I said conflicted in that way. I’m not sure if the [inaudible] [00:07:28].

Interviewer: Mm-hmm. Mm-hmm. No, it does. So, you don’t think a professional interpreter will have the same level of advocacy as an RN?

10122-2: I think that they want the best for the patient and would advocate for them, but to the same level or to the same degree as like an RN, I would guess and say no.

Interviewer: Oh. Mm-hmm. Mm-hmm. Now, what do you think separates the RN interpreter from family or friend interpreters?

10122-2: Some of them lean toward the professional interpreters, and the families may or may not have the same level of health literacy as the RN and may not be as informed of like the treatment plan and stuff like that. Was there something else I wanted to say about -? Yeah, I would say that’s probably the main thing.

Interviewer: Do you think there is any more emotion involved in the interpreting from the professional, the nurse, or the families? Where do you think emotions
can probably affect negatively the interpreting of the session?

10122-2: I think that definitely, if I was to rank the three experience, the most emotional would be the family interpreter, then the second I would say will be the RN interpreter because oftentimes and then there would be the professional. Because oftentimes the nurse has been working with this patient for a little while, a little bit more invested in their treatment plan and stuff like that. And then I know interpreters they kinda just go from patient to patient, so they don’t have the opportunities like the RNs do. But yeah, to answer your question, I think that sometimes the but it’s the families being the most emotionally charged, I guess you would say [inaudible] [00:09:39] experience.

Maybe because sometimes I feel like the families are frustrated just like the patient is with what’s going on with their health status, and so they oftentimes be translating for the patients as – oh, the doctor says that they wanna do this to you. And I feel like the tone of how different treatment options that are offered also has something to do with how receptive the patient is or how often they are to try whatever treatment it is. And I feel like if the family members, the one translating or interpreting, and they say they wanna do this to you, and they come and makes the patient, oh, do I want a tube stuck down my throat, or do I want this?

So, I think that may negatively affect interpreting and overall quality delivery of care from that side.

Interviewer: So, there may be – yeah, so there may be a little more of that number
where communication that can be communicated to the patient is a family member or friend is there, there may be some number of ques, right, guiding that message, and maybe even affecting the way the patient responds to the session. Well, that is an interesting point you bring up. All right. Now, do you think your nursing role, being the nurse and then interpreting because you have those two roles now, you are a nurse, but you’re also an interpreter, do you think the nursing role influences that interpreting role in a positive or a negative way?

10122-2: I would say positive – in a positive way to just go back to the feeling that as nurses, you advocate and – [Crosstalk] [00:11:54]

Interviewer: The advocating. Mm. Mm-hmm.

10122-2: And aside from advocating, you’re also responsible for educating patients and stuff like that. So, it’s definitely within our – within our, I guess, tools that we use to do our jobs, I guess. Say positively.

Interviewer: Yeah. So, going back the good point you bring up is having role of being a nurse, having the role of being an advocate interpreter, educator, right, so there is multiple roles playing – or having an effect in that conversation, in that interpreting session, right? And do you find any conflict in regards to those roles, being an advocate being a nurse being an interpreter, being an educator.

10122-2:: I feel like as an educator, you may educate the patient on the newest guidelines say this, so we should aim for this, right, but then as the – I guess caregiver as well, you’re there to listen what their concerns are. And
sometimes their concerns are resistant to what you’re trying to educate them on, but as the caretaker, you still wanna be able to communicate – the interpreter role is so you wanna be able to communicate their concerns with the provider, and kind of – also at sometimes I feel like you have to mitigate disagreements between the provider and the patient, because, again, that same role conflict, you’re there as the advocate but also the interpreter, but also you’re part of the care team like from a medical standpoint.

So, I definitely see role conflict amongst all those roles, and that’s a [inaudible] [00:13:49] experience.

Interviewer: Very good. Very good. Anything else you would like to add before we move on to the next question?

10122-2: I would say that’s pretty much it.

Interviewer: Okay. Sure. Now, what do you find challenging when interpreting?

10122-2: So, one thing that I find challenging while interpreting is sometimes the provider will start talking and just talking, talking, and doesn’t give you a break to translate in pieces. That’s something that is hard, but harder than that would be that same conflict I spoke on a little bit earlier about the role conflict essentially and when the patient doesn’t agree with certain parts of the care plan. So, I would say being the caregiver, the advocate, the interpreter, and then also the nurse, the renderer of the treatments, I guess.

Interviewer: Yes. Got it. Now, how do you remove the challenge, let’s say, for example, keeping the pace. Right? The doctor is giving a message that
he’s coming a very fast pace, and maybe the patient needs much more
slower, how do you remove that challenge? How do you make sure that
the pace is -?

10122-2: Yeah. So, like you said not only dividing at times, you remember what the
doctor stated, and you also like he’s still the patients he starts to kinda
process it, and also depending on what the patients learning style – like
how ready they are to learn, like how bit of a learner they are at that point.
But if the provider is going too fast, I’ll probably say hey, do you think
you can slow it down a little bit I wanna make sure that the message is
clearly and fully received by the patient.

Interviewer: Oh. Now what about when a patients goal and the providers goal, when
their goals conflict when they do not agree? How do you remove that
challenge?

10122-2: At that point, I – at that point, I just try my best to make sure that the
messages of each person are – of each people are clear just so that the
cause, I’m trying to troubleshoot what’s the true reason there’s a
disagreement here. Maybe one person’s understanding of what the
situations a little bit different than the other persons; so I think number one
trying to make two understandings, getting to meet somewhere in the
middle or as close to that situation calls for and – I think that’s about all I
could do, at least all I can think of.

Interviewer: Sure. Sure. Anything else before we move on to the next question?

10122-2: No, [inaudible] [00:17:13].
Interviewer: Okay. Now what effect do you think having you in there? Now remember, so we have the provider, the patient, there is that interaction, but now there is a third person in there, which in this case is you. What effect do you think that has on that interaction? So, the interaction between the provider and the patient, now it’s you in the middle too, or to the side. What effect do you think has on that interaction?

10122-2: I think overall, the patient’s comfort level is increase; I think the patient now feels more open to let the doctor know about an additional symptom they were having; maybe they weren’t as comfortable with the provider. But I think also, what goes into it is how well the patient – I was gonna say how well the patient is able to trust that. Not only are you gonna translate for them, but you’re also gonna advocate for them, but also I feel that especially if the provider, well obviously if your translator the provider doesn’t speak Spanish, but I feel that sometimes when you’re translating for patients, they get more comfortable and then instead of answering the providers questions in yes or now, they’re now answering in – well, yeah, but also when I was a little girl –

– it’s often a little bit more time-consuming, even the provider is getting mad; okay, tell her yes or no. And then as the interpreter, you’re like so-and-so the provider says yes or no questions, like okay, so that changes that dynamic a little bit. But yeah.

Interviewer: So, you think that being there, that patient’s comfort level goes up. Right? And then, of course, the responses by the provider can also make that
comfort come down. But besides the language barrier that, I’m assuming that’s why you say by their comfort level goes up because now there is that language barrier is kind of removed between that provider and that patient. But do you think there is any other reason why that comfort level goes up on the patients side? So, if they don’t have that very good comfort now there is you in there, now they feel more comfortable.

Besides the language, is there anything else that is increasing that comfort level?

10122-2: I think in addition to the language barrier, it’s also having somebody there with you. Sometimes, people, they get like certain forms of like why [inaudible] when they’re there with the provider, even if you’re not a nurse, even if you’re family member like any person just to be with them while they’re with the provider, maybe they’re already a nurse if they don’t come to the clinic very often or see doctors often in general. So, I think having somebody with them also contributes to the increased comfort level.

Interviewer: Oh, okay, just the presence by itself can also increase the comfort level. Now, do you think that when the doctors get a little – and they start saying, okay, tell him it’s yes or no, just answer yes or no, is that because – what do you think that is, though, that the patient wants to provide, let’s say background to a symptom, a story to a symptom, but then the provider say, well yes or no answers. And again, you presented a great point that that decreases the comfort level of those patients when they say, do you
know what, just yes or no. How can an interpreter improve that? How can an interpreter make that better so that the comfort on the patient side doesn’t drop when the provider is saying, hey, yes or no answers? What can interpreters do so that that comfort level of the patient doesn’t drop because of their interaction? What do you think interpreters can do?

10122-2: Well, I think in this situation you can go one of a few ways; I think the first way you can go with this is by letting the provider know this is, oh, and I think the patient wanted to express this, or which they may or may not be well receptive to that. But that’s one thing you can try, and then the second thing you can try is – the other segue you may go is kinda a lightly, kindly, but firmly telling the patients is oh you don’t have the provider wants you to just say yes or no if you’re able to. And then, so, it’s not as harsh, they may still drop [inaudible] but hopefully not as much as this – a little bit more he says yes or no answer. So, actually, if they see the provider, their non-verbal communication of like – sometimes these doctors they have no shame.

They’re like – they facially like show that they’re annoyed or kind of like bothered; and the patient’s obviously they’re gonna see that, so I think that also gets used to the decrease, even if no matter what the interpreter does, I think.

Interviewer: I see, so you think some of that number or that communication by the provider can create a little bit more of a barrier in that interaction. And you don’t think there is much we or an interpreter can do if the provider is
providing that barrier, right? It’s more of a – what’s the word I’m looking for? If a provider non-communication, I’m sorry - non-verbal communication creates a wall. It is very hard for the interpreter to drop that wall? Will you agree? Or do you think there is a way for us to drop that wall if a provider's non-verbal communication is creating barriers?

10122-2: Well, in that situation, I think it may depend, honestly – I think for nurses at least, it may depend honestly how comfortable you are with that provider, how well you know the. Because if you know them pretty well, then you can kinda say – you can kinda say something like – give them some sort of cue that what they’re doing is decreasing the patient’s comfort level. But if you’re not that comfortable with them to tell them something like that, in that moment – in that moment, I would say that there’s probably not much else that you can do.

Interviewer: Got it. Got it. That is an interesting point, an interesting point. All right. Anything else you would like to add to anything, anything else that’s in your mind that you would like to add?

10122-2: No, I think that’s about it.

Interviewer: Okay.

10122-2: Thank you.

Interviewer: Hey, I appreciate it. So, I will be stopping the recording now, and then I will be talking to you off the record.

[End of Audio]

Duration: 26 minutes
Interviewer: All right. Well, thank you for participating. Thank you for being here. Definitely excited to have you; I wanna hear about your experience today, but before we begin, I just wanna let you know this is being recorded; the recording is only for transcribing – for transcribing into Word. Your identifiers nothing will be published, and this recording will be protected in a password-protected device. You will not be called by your name, you will be called by a code, and the code you will be given is basically today’s date, 10322/1, so that will be your code, and that’s how I’m again identify this video or this recording. If at any moment you feel uncomfortable with any of the questions, you can always just skip the question, ask me to skip it if you don’t wanna answer that question.

If at any point you feel uncomfortable with the interview, you can always stop it immediately, and then we will stop the interview. Nothing will change; everything will remain the same. So, feel free to stop the interview or clarify my questions if you need any. Okay?

10322/1: Okay. I just got an alarm I have 10 percent of my battery so let me connect it real quick. Okay?

Interviewer: Sure. Yes.

10322/1: But you can go ahead and start.

Interviewer: All right. Thank you, now I will be asking a few questions, and these are
more for demographic purposes, but your age?

10322/1:  You said my age?

Interviewer:  Yeah. How old are you?

10322/1:  I’m 40 years old.

Interviewer:  Okay. What about your gender identification?

10322/1:  I am male.

Interviewer:  Okay. Ethnic identification?

10322/1:  Hispanic.

Interviewer:  Country of origin?

10322/1:  Born in United States.

Interviewer:  Languages spoken?

10322/1:  Spanish and English.

Interviewer:  Educational level?

10322/1:  I have my master’s degree.

Interviewer:  Years of nursing.

10322/1:  Practicing 13, as a nurse 14.

Interviewer:  Okay. Years as a qualified or certified interpreter?

10322/1:  Thirteen.

Interviewer:  Employer?

10322/1:  [HMO].

Interviewer:  And your nursing role or position?

10322/1:  My current role is a staff educator.

Interviewer:  Great. All right. So, we will start with the first question and tell me one
memorable experience you have had with interpreting? Just anything that comes to mind that is a memorable experience.

10322/1: Probably at the beginning when I first was in nursing school. I was actually in the OB/GYN department and felt that because I was a male nurse that females felt uncomfortable, and when I actually interpreted for them, because a lot of the staff did not know English, they were so happy to hear that I could explain everything that was going on with them. And that I immediately having to call somebody else, so even the husbands and the wives they both wanted me in the room to explain what was going on.

Interviewer: Okay. Now, do you have one specific one? One specific case you remember?

10322/1: Recently a couple weeks ago, I was passing by, I saw a call light in the room; and I went into the room, and the patient just was very frustrated, and since I’m not – I’m a staff educator, so I’m not normally in scrubs, so I just let them know I am a nurse I can help you out if you need it, so that’s when the patient was comfortable enough to discuss everything she needed in Spanish.

Interviewer: Okay.

10322/1: She explained to me her situation, how she has troubles with the family, plus the diagnosis, and what was best for her care. So, I actually – I was passing by, and it took about 20 minutes to get out the whole story and give the explanation to her primary nurse. Because her primary nurse did not know Spanish as well.
Interviewer: Got it. Got it. Now, do you have one with a provider when you had to interpret between a provider and a patient?

10322/1: Yeah, I had an experience when I was a staff nurse where they call you over, and they want you to explain. A lot of times, they go too fast, but the provider I had was really understanding. I told him can you just break it down a little slower so I can explain to them and not do it too fast. And they were good.

Interviewer: Okay. What do you think makes that experience a memorable experience, then?

10322/1: Just that the provider was willing to work and understood because it’s a barrier of communication that they were willing to slow things down and explain; they showed me that their patient was first, and they were okay with slowing things down, so they could understand a little bit better.

Interviewer: Now, why – is the fact that it’s memorable because that provider was understanding of maybe decreasing the speed, but again, would that imply then that most providers are not? They don’t take their time when it comes to interpreting. I think sometimes, because I’ve heard people use the language lines, and they’re not explaining everything the way they’re supposed to. Even the interpreter I’ve heard, so the fact that the provider was willing to go ahead and to slow down – when I interpret, I usually have them, and I try to talk to them before we even start interpreting. My expectations of that situation we didn’t have an opportunity to talk before I interpreted.
They just kinda pulled me in as I was coming out of another patient’s room, but there was no conflict in expressing hey, you know what, slow down a little bit. So, just sticking to my mind because I didn’t have that conversation beforehand.

Interviewer:  So, is that your practice to have a preparation talk with your providers before you go in the room?

10322/1:  I usually do just to remind them, please talk to the patient, and I’ll interpret everything you’re saying, including things you don’t want me to say, but I’m gonna say exactly what you tell me like if you’re talking to the patient.

Interviewer:  And do you do a debriefing at the end of the conversation with the provider or with the families at all? Do you do any kind of post-interaction meeting with any of them.

10322/1:  No, actually within, that – any time I interpret, I actually ask if they have any questions for them, if they don’t, the doctor has any questions, then we kinda just stop right there, and then everybody goes their own way.

Interviewer:  Okay. All right. Now, anything else you wanna add to that experience before we move on to the next one?

10322/1:  No.

Interviewer:  All right. What separates the certified or qualified registered nurse interpreters from the other types? And let’s break it down a little bit. I had it as a one single question, but let’s break it down. What separates the qualified or certified registered nurse interpreters from professional
interpreters?

10322/1: That they’re part of the organization versus calling outside of the service area. For me, a qualified professional means I know the language, and I know the information that they’re giving versus just translating one from one language to another; I also know the profession and conditions, I guess I could say.

Interviewer: Do you see that as a plus?

10322/1: I definitely do.

Interviewer: Yeah. That being a provider who works for the organization to be able to interpret rather than an outside entity. [Crosstalk] [00:08:01]

10322/1: Yes.

Interviewer: Got it. Now, when it comes to your knowledge as a nurse, and you have that nursing role, and then you have the interpreting role – now, with the nursing role, right, and this comes from me being myself a nurse, then here comes the advocacy, right, you are also an advocate, so you really have multiple roles when you are in that room. Now, do you think that your nursing experience influences your interpreting experience? Does it influence it in any way?

10322/1: I think it does just because the nursing experience – well, the fact that you are a nurse and you’re right then and there next to a possibility of being used as an interpreter, it puts you a little bit more exposed. And I think it does help. It helps being a professional and being part of the interpreter services.
Interviewer: Okay, do you think the professional interpreters are as effective in communicating the message to the patients? Are any interpreters? Do you think it’s the same level of effectiveness?

10322/1: I don’t think it in terms of professional versus regular interpreter. I think it is more to the person who’s interpreting because they’re both the professional, but just the regular interpreter, I think, can do a really good job. I just have probably bad experiences where hearing people not interpreting correctly.

Interviewer: Oh, okay. Got it. So, you are more at a personal level whether that interpreter is effective or not, regardless of whether their known as professional interpreters.

10322/1: Correct.

Interviewer: Hmm. Okay. Interesting. Now, what separates a [inaudible] [00:09:50] interpreter from family members or friends who come to interpret?

10322/1: I think families and friends probably show a little bit more emotion in terms of if they hear something bad, they might not wanna communicate that with the family member. Or if they don’t understand something, they might not know how to express that either. So, a professional interpreter or a professional interpreter would know what to communicate and how to communicate it as well.

Interviewer: Got it. Now the RN interpreter and the – so if there is emotions, you don’t think that as a nurse you may have emotions involved too when you’re interpreting?
No. I haven’t had – just caring for the patient, you can get emotional, but when you’re interpreting, you wanna make sure that they have all the information, so maybe just an extra touch of caring when you’re given the communication, but you’re still gonna give all the information that you’re supposed to give.

So, there is a little bit of a risk having a family interpreting that they may not convey the full message, there may be – [Crosstalk] [00:10:59]

Correct. Because even sometimes, I’ve seen where young or underage family members try to interpret it, they don’t even know the language that their lingo of medical terminology or what they’re explaining, so the communication and the message is not correct.

Got it. Hmm. Interesting. Now – so then, what do you find challenging? It seems that you are alluding to that already, but on my next question is, really, what do you find challenging when you interpret? What is the most challenging?

Probably the time that it takes you away from your regular work. It’s because a lot of times, you’re qualified bilingual interpreter; they can pull you at anytime from whatever you’re doing. Yes, they have in place things that they’re supposed to cover you while you go interpret, but a lot of times, everybody else is busy as well. So, the challenging part is being available and not getting behind with your regular work.

All right. So, if I’m understanding this correctly, the challenges you have your role; your main role is nursing. Right? And now you have this extra
role on top of that nursing role, but the nursing role in itself is extremely busy, and now you also have this interpreting role that you also need to – again, perform. Right?

10322/1: Right.

Interviewer: How do you think – what do you think is the best way to overcome that challenge, then?

10322/1: Probably if they know they’re gonna need interpreters, all they have somebody actually cover the person that’s gonna interpret.

Interviewer: Okay. And that is also in itself challenging, because then now you need someone to have that to cover you, but then you need that person to more of a – be more of a floater so that their work is not effected by covering you because you are now covering for [inaudible] [00:12:58] interpreting. Again, it’s definitely a challenge. It’s just I’m trying to – do you have any idea how that can be? Would it be floating staff that would be covering you when you are interpreting, and they can bring a floater in to –

10322/1: It depends on the role that you’re doing. I personally, right now, I don’t have – as a staff educator, I don’t have patients under me, so it’s easier for me to do this role, but as a staff person is more difficult.

Interviewer: No, I completely understand that because that’s kinda one of the other; as you are again pointing out, the challenges can be different depending on your nursing role. So, depending on that nursing role if you’re on the floor, if you’re in the ICU, if you are as an educator, or maybe even a case
manager, the management of your time on top of having this, being an interpreter, it can also vary. Right? The challenges that you face can vary from the challenges that another interpreter may be facing.

10322/1: Yes.

Interviewer: Time is definitely one of those.

10322/1: Mm-hmm.

Interviewer: Okay. Now, what effect do you think having you so you have the interaction between a provider and a patient. All right? So, there is that interaction back and forth, but now we add the third person, right? What effect do you think having you in that room.

10322/1: I’m sorry. You cut off. Say that again. You have the –

Interviewer: So, if you have the interaction –

10322/1: Sorry you got cut off; you said you have the provider and the patient.

Interviewer: Yeah, so if you have the provider and the patient – can you hear me now?

Okay. Yeah.

10322/1: Yes.

Interviewer: Okay. So, if you have the provider and patient interacting, there is that interaction there, and now you are that third person, which is, in this case, you, now there is a third person to interpret. Right? What effect do you think it has – what effect does having you in that room – what affect do you think that has on that interaction, the interaction between the patient and the provider?

10322/1: I think it does make it better because at least the patient knows that they’re
understanding everything the provider’s saying, and the provider understands everything is interpreted appropriately based on the qualified interpreter.

Interviewer: Got it. So, you think that having you as an interpreter as a third person enhances the interaction?

10322/1: Yes.

Interviewer: It doesn’t hinder it?

10322/1: I don’t think so because that means they’re understanding what each one is saying instead of agreeing to everything that they’re not understanding.

Interviewer: Okay. So, besides the language, what you’re doing is breaking the barrier-breaking the barrier of language, is there anything else that having that interpreter improves in that interaction besides just the language?

10322/1: No, I think you’re getting the message across, so I see that’s the main point.

Interviewer: The main point is the language.

10322/1: Mm-hmm.

Interviewer: Sounds good. All right. Now, do you have anything else to add to this? This is more of that free time, just in case you wanna add anything to that experience. Your experience as an interpreter and, again this is more of that just free time for you to express if you have anything.

10322/1: No. I think it’s a good service to have, probably better than having somebody over the phone that you can’t actually see.

Interviewer: Oh. Okay. You bring up a very good point. So, you think there is also a
difference in having that person in the room to having them on the phone.

Let’s say it is you who’s interpreting for another provider, a patient, and a provider. Let’s say it is you, but one is in person, you’re in the room with those two other people, and one is on the phone. What do you think of those two interactions? What is your take on those?

10322/1: I think you’re still gonna get the message across, except it’s not the same versus them being in person. I think personal effect you lose a little bit of it.

Interviewer: Mm. So, you think that actually hurts the interaction?

10322/1: Possibly. It makes it more of a special interaction for the patient when all parties are involved, I believe, and present.

Interviewer: Now, what advantage do you think it has on you – for you to be present in person?

10322/1: The non-verbal cues that the patient may give that they’re not understanding, or they’re [inaudible] [00:17:42], I mean, I can probably seek clarification. And I probably won’t be able to see if I wasn’t.

Interviewer: Got it. So, the non-verbal communication is super important. That’s what I’m understanding. Interesting. All right. Anything else you would like to add?

10322/1: No.

Interviewer: All right. I appreciate this, I will be stopping our recording now, and I’ll be talking to you off the record. Okay?

10322/1: Okay.

[End of Audio]

Duration: 19 minutes
Hi, thank you for doing this interview. I am working on my PhD research study on RN interpreters. So, I appreciate your time. I will be calling you 11222022-1. That will be your code. Don’t use any identifiers, your real name, your real place of work or where you work exactly. I will be asking a few questions. This meeting is being recorded. It will only be for transcription purposes. I will be using the audio part of this interview to submit for my transcription.

None of this will be – if I do decide to publish my findings, your name, no identifiers will be disclosed. And again, so you have a code number I will be assigning to you just for identification purposes. And now with my questions. What’s your age?

Thirty-three.

Gender identification?

Female.

Ethnic identification?

Hispanic.

Country of origin?

United States.

Languages spoken?

English and Spanish.
Interviewer: Educational level?

11222022-1: Masters.

Interviewer: Years in nursing?

11222022-1: Oh, goodness, six years.

Interviewer: Years as a qualified or a certified interpreter?

11222022-1: Four.

Interviewer: Employer:

11222022-1: [HMO]

Interviewer: And your nursing role or position?

11222022-1: Case Manager.

Interviewer: Okay. All right, so tell me one memorable experience you have had with interpreting.

11222022-1: I think the memorable one is when I first started at my current, I guess organization. I became a qualified bilingual interpreter and I was working in home care. So, I think there just because you are on your own just have a lot of experiences with people that don’t speak English. So, I feel like it was very beneficial. And one particular time because most of the other nurses did not speak Spanish, so they would actually request me to go to see them. And typically, where I worked at it was like you would only have certain cities and you only saw [inaudible] [00:02:43] members in that certain area.

But I would have to be going back and forth everywhere
because there just was a need for more Spanish speaking nurses.

But, I do remember in the beginning there was one time where I had to go with a family and they all spoke Spanish and the member I was gonna go see was just wound care and stuff like that. But, I remember them telling me that they were grateful that finally they had someone that spoke the same language as them. Because they felt like if they used another form like if their family member would talk on their behalf.

I remember she told me that basically she felt there was missed communication or maybe her knees were really — or there was some type of confusion. So, once we were able to start doing everything for her wound and all that, then I was definitely able to help get that taken care of. And then she was happy. She was happy with what had happened. And that was one of the first cases that I had and it was a very specific one too because that was in the beginning where I actually had my supervisor go out with me too. Which did not speak Spanish. So, it was nice to just be able to help the member.

Interviewer: Got it.

11222022-1: Yeah.

Interviewer: Do you have a memory of one where a provider asked you to interpret for them? Do you have one like that?

11222022-1: Oh, as a qualified interpreter, no, not as a qualified interpreter.
Before starting in this organization, yes, but not – it wasn’t
technically, a qualified. It was just like, “Okay, interpret for me.”
But, I didn’t have to take a test or any to be qualified.

Interviewer: Now when you did do one even if you were not certified at that
time, can you tell me a little bit more about those experiences
between a provider, a patient, and you being the interpreter?

11222022-1: Yeah. So, actually when I worked in hospice. So, the doctor would
sometimes come out in the home and they didn’t speak Spanish so
I did have to interpret. And it was I mean; it felt a little bit different
in the beginning just because you’re trying to say their needs. And
then sometimes one talks faster or says a lot of information versus
the other one. So, you’re just trying to communicate back and
forth. But I feel like, yeah, I mean that was – in hospice I would do
a lot of that with a team like [audio cuts out] [00:05:25].

Interviewer: Do you have a memorable one? One that sticks out?

11222022-1: Honestly, not really. Not, I mean the only thing is really like when
they’re in hospice and we have to go through the post and stuff
and kind of explain what’s being said and so they are – at that
point you’re able to really let the patient know, explain what the
doctor’s saying exactly. Or if they have that confused face you
catch on that. So, I feel like if I wasn’t there they might not, you
know cause I’m like, “Do you understand?”, I would ask that.

So, I feel like if I wasn’t there, maybe they would just feel
like okay, okay, right. Like I don’t feel like they’d say anything or be like, “Can you explain it to me more? Can you give me more details?” Because just by looking at them I would be like, “Wait, I don’t thing they understand what that means.” So, that’s the only thing I can really think of.

Interviewer: Now would you say then that you being in the room when you were, let’s say going through that interpretation session, that you will pick on more that what was being said verbally? You would pick on more than that?

11222022-1: Oh yeah. Yes. I mean because you see what they’re saying but you can also see their facial expressions. And sometimes they say yeah, they get it, but it doesn’t look like they do. Or maybe they have more question but they’re maybe just culturally don’t want to ask for more information. So, yeah, definitely pick up on those other cues, yeah.

Interviewer: Okay. So, what do you think separates the qualified or certified nurse interpreter from – let’s divide this question a little. Let’s say a certified or qualified registered nurse interpreter from let’s say professional interpreters? What separates them?

11222022-1: I feel like as a nurse you just in medically ways and like in we’ll be working; I feel like we understand more. We understand more of the medical terminology or I also feel like we also know if something is said or asked if they mean it in a certain way versus
like you take it as how they’re saying it, it may not actually be that’s what they’re asking or saying. So, I feel like no I think this is what they’re say but of course, you ask. I also feel like as far as being a qualified interpreter I did learn a lot from going to the classes.

Before you know, you talk to them as if you’re talking to them directly, not like – it’s kind of like they should be talking to each other but you’re just kind of saying what they’re saying versus being like I’m having a conversation with and I’m having a conversation with you. So, I did learn a lot from that too.

Interviewer: Okay. Now what separates an RN interpreter from the family member or a friend who comes to interpret?

11222022-1: I feel like sometimes what I’ve seen too, is like friends or family sometimes I feel like they might not fully understand what’s being said, especially when it’s medical terms. Or they add their own assumptions to it. Or even I feel like sometimes they might not say everything. Or you know, they just kind of say a small piece of it. Or the idea of it, maybe. But they’re not very too detailed.

Interviewer: Now, do you think that your nursing role influences your interpreting role in any way?

11222022-1: Sometimes I feel like just because we know more, I feel like we do say what’s being said, but I also feel like if you think the patient still doesn’t understand or it looks like they may have more
questions and are maybe just too shy to ask or just culturally don’t want to ask, or you know certain members, they have like these superstitions of certain things. And you’re like, “Wait, I don’t think you understand”. So, I do feel like sometimes you might be like, “Do you understand exactly what was being said?”

Do you need more information?” and then of course letting the whoever else know, “Okay, can we explain this more in detail?” versus just being like, “Oh, you need to do this” and then be like, “Okay” and then they’re like, “No, I don’t want to.” It’s like, “Okay, explain why” or “Can you explain to them why exactly you’re stating that?” versus just saying you just want them to do this just because. So, I feel sometimes in that sense, I could put like, “Are you sure? Do you understand what they’re saying?”

Yeah.

Interviewer: So, if they believe a little more in the supernatural world they can come with some superstitions. Do you think you can bring them more into that scientific more of the medical aspect of the treatment, right, because sometimes they do have that belief system. And again, more of that supernatural belief as opposed to that medical approach. So, you will bring them into that?

11222022-1: Exactly.

Interviewer: Got it, got it.

11222022-1: Exactly too. Sometimes, even with their beliefs as far as even with
doctors. They’ll just be like, “The doctor just wants more money you know. That’s why they keep giving me all these things.” And it’s like, “Wait, hold on, let’s have him explain to you better, like why”, you know. But I do understand too sometimes when people do go to the doctors it’s very fast. They’re like, “Oh, take this, this for this and that.” But, it’s not explained to them, why they’re doing that. So, I feel like sometimes all just some people just don’t ask.

And they’re like, “Well, I don’t know why I’m taking that. That’s what the doctor said.” Or, “I’m not gonna take that because I don’t know why they keep giving me more medicine.” So, I do feel like sometimes when it comes to that point I do try to be like, “Hey, you should ask more questions. You shouldn’t just be like okay or no I’m not”, you know.

Interviewer: Oh, so in a sense with your nursing role it seems that you have some influence in the pace of the interaction. You can slow it down a little bit more since it may be too fast between the doctors and those patients that slow down the pace.

11222022-1: Yeah, I try to. Just because I always wanna make sure that whatever the member chooses or that they understand. And they know – basically be educated. I feel like that’s important. And sometimes, doctors do this all the time, so to them it’s nothing, it’s like, “Oh, okay”. I feel like maybe sometimes they don’t understand that the person may have this certain disease or
something but doesn’t mean they really know what that means or what it is. Also, I feel like just the education part of it’s important.

Interviewer: Got it, got it. Now what do you find challenging when interpreting?

11222022-1: What I find challenging is the slang or the dialects or sometimes just the meanings of words can change between – it’s all Spanish, but it’s like different meanings. So, sometimes I’m like, “Okay, hold on let me see what this is” or you know. Or sometimes a lot here, I feel like in the U.S. it’s not always proper Spanish that our members speak, of course cause a lot of them, I mean they probably didn’t even complete high school or middle school. A lot of members it’s like just entry.

So, I feel like when we are being trained in interpreting and all the words of that book that we have, the proper words and all that. Sometimes I feel like I have to think, okay I have to tell them, but then you can kind of hear it, where they’re like what are they talking about. So, you kinda have to use their form of whatever word is. And sometimes I feel like it is a lot of slang words here. I don’t feel like it’s actually proper Spanish. So, I find that challenging sometimes.

Interviewer: Okay. How do think interpreters can help in removing or at least overcoming the challenge?

11222022-1: Yeah, I think honestly, for me it’s mostly been just speaking to all
the members, I kinda picked up on words or things that they’ve said. And I do ask them, “Can you describe that to me?” or “Are you talking about this?” And honestly, it’s just difficult. So, now I’ve picked up words that I didn’t even know meant the same thing. But, I’m like, Oh, wait that’s a way of people saying it too. It's not just what I thought it was. But, I think that’s a hard one because there’s just so many out there. It’s very hard to keep up with the slang of it.

Interviewer: And of course, being from different origins even within the Hispanic population, right?

11222022-1: Yes.

Interviewer: Those words and the slang can change from one region to another region too, so.

11222022-1: Exactly, yeah.

Interviewer: Okay. Now what do you think – what effect do you think having you, the interpreter, so there is that provider and the patient. What effect do you think you being there has on this interaction?

11222022-1: I mean, me specifically, I feel like I – well my hope is that by the end of their conversation that the patient will get all the information and education that they may need. And I also hope that they feel more comfortable with the provider as well. You know, just feeling safe from this provider and knowing that the provider knows exactly what their wish is for whatever the – I guess appointment was for. Just to build that trust between both of them as well.
Cause I do have members of course, that have doctors that don’t speak the same language as them. And sometimes what I hear is, “They don’t understand what I’m saying. They don’t get what I’m trying to say.” So, I’m just hoping that whoever is interpreting I’m hoping is able to kind of help with that gap of misunderstandings or to help them build that relationship between the member and the doctor.

Interviewer: So, if I get it correct, it’s you think that being there, you being in that interaction, you’re helping with building trust. Is that correct?

11222022-1: Mm-hmm.

Interviewer: So, you see it – you see the presence of an interpreter as positive then? As a positive as opposed to a negative?

11222022-1: I do feel like it’s a positive thing because I feel like even – ‘cause I do have some members that understand a little bit of English, but just can’t really communicate or maybe don’t understand it you know, fully. And I feel just when that happens or if you have a family member for example a lot of things are missed. So, at least having an interpreter it’s always gonna be positive but of course, depending I feel like on what interpreter you get, of course it could be good or it could be very good. But either way I still feel like it is a positive thing. Because you know that whatever’s being said is being interpreted correctly.

Interviewer: Okay.
Interviewer: Got it. Yeah, well. Good, good. Thank you very much. And do you have anything else to say about this before I stop the recording?

11222022-1: No, no. That’s it.

Interviewer: Okay.

[End of Audio]

Duration: 18 minutes
Appendix B

IRB Approval Form

Mar 25, 2022 8:17:47 AM PDT
Byron Batz
Hahn School of Nursing & Health Science


Dear Byron Batz: The Institutional Review Board has rendered the decision below for IRB-2022-387, Lost in Translation: The Lived Experience of Nurse Interpreters in the Clinical Setting.

**Decision: Approved**

Selected Category: 7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Findings:

Research Notes:

Internal Notes:

The USD IRB requires annual renewal of all active studies reviewed and approved by the IRB. Please submit an application for renewal prior to the annual anniversary date of initial study approval. If an application for renewal is not received, the study will be administratively closed.

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

The next deadline for submitting project proposals to the Provost’s Office for full review is N/A. You may submit a project proposal for expedited or exempt review at any time.

Sincerely,

Eileen K. Fry-Bowers, PhD, JD
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