CHAPTER 8

The use of interpreters

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Diversity

Increasing numbers of New Zealand residents are born overseas — since 1996 the percentage has increased from 17 percent to 22 percent or nearly one in four people living in New Zealand. Between 2006 and 2026 the Asian, Māori and Pacific populations are all projected to grow faster than the New Zealand population overall,¹ and net migration will become an increasingly significant contributor to population growth.² The proportion of people from non-English speaking backgrounds is also increasing; people of Chinese origin are now the second most common group of migrants after those of English origin, and Chinese and Samoan are the most widely spoken languages in New Zealand after English and Māori. New Zealand’s immigrant population is disproportionately concentrated in the Auckland region. In 2006, over half (52 percent) of the overseas born population lived in Auckland, which was home to 32 percent of the country’s total population.

New Zealand has three official languages, English, Maori and New Zealand Sign Language (for which there are 24,000 users)³

Right to communication

Right 5 of the Health and Disability Commissioner’s Code of Rights, “Effective Communication”, includes a right to a competent interpreter.⁴ Without an interpreter many of the other “Patient Rights” are not available to a person with “limited English proficiency” (LEP).

Is any interpreter satisfactory?

Accurate complete interpreting is a difficult professional job that requires significant training. In addition good interpreting is founded on trust; the patient must trust the interpreter to hold any information confidential and trust them to accurately interpret their communication, the doctor has to trust the interpreter to be accurate, and to signal if there is any doubt as to how a phrase should be translated. The further apart culturally two languages are the more likely that concepts do not translate. For example, there is no equivalent term to schizophrenia in Somali. It requires significant practice to be able to recall all that is said in English and then accurately translate it into another language.

It is common practice for clinicians to use ad hoc interpreters: family members, friends, bilingual colleagues to aid communication with LEP patients. Table 1 lists the important linguistic and ethical problems with this approach.
### Table 1

<table>
<thead>
<tr>
<th>Linguistic problems</th>
<th>Ethical problems</th>
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<tbody>
<tr>
<td>Accuracy of interpreting, degree of English fluency</td>
<td>Confidentiality</td>
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<tr>
<td>Unfamiliarity with medical terms</td>
<td>Difficulty with talking about sensitive matters</td>
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<tr>
<td>Incomplete interpretation</td>
<td>Role conflict (e.g. abusing husband interpreting for abused wife)</td>
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<tr>
<td>Adding in advice or opinion of interpreter</td>
<td>Disrupting family dynamics; in particular the use of young children as interpreters for their parents is unacceptable.</td>
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In judging the likelihood that a professional interpreter is needed, the following issues should be considered:

- Complexity of anticipated clinical content
- Language ability of the patient
- Language ability of available *ad hoc* interpreter
- Degree of ethical risk: e.g. is the patient vulnerable with mental health issues? Is the available *ad hoc* interpreter a child? does the available *ad hoc* interpreter have a position of power over the patient?
- Sensitivity of clinical content: e.g. gynaecology, family discord
- Legal need for informed consent
- Urgency of presentation: in emergency use the best available
- Wishes of the patient
- Ability to pay for an interpreter.

It is useful to think of there being a continuum in degree of need to use a professional interpreter.

For example looking at clinical complexity, at one end it is essential: e.g. explaining a new diagnosis of cancer, gaining informed consent for a major procedure. At the other end a family member may be satisfactory: doing a repeat prescription for hay fever medication.

**Every doctor must have the ability to employ a professional interpreter if caring for a Limited English Proficiency patient**

If a patient has LEP then there will be times when care cannot be provided without a professional interpreter.
Professional interpreter: telephone vs face to face

Many organisations prefer to use telephone interpreting, predominantly because of cost. Table 2 contrasts the risks and benefits of telephone and face to face interpreting.

Table 2

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Telephone interpreter</th>
<th>Face to Face Interpreter</th>
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<tbody>
<tr>
<td></td>
<td>Anonymity of interpreter</td>
<td>Relative ease of communication including non verbal</td>
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<tr>
<td></td>
<td>Availability (for smaller language groups or at short notice)</td>
<td>Easier if needing to consult with a family group</td>
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<tr>
<td></td>
<td>Cheaper</td>
<td>More costly</td>
</tr>
<tr>
<td>Disadvantages/Risks</td>
<td>Distancing effect of the phone</td>
<td>Possible issues with confidentiality/comfort the patient and interpreter are socially acquainted or part of a small ethnic community</td>
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<tr>
<td></td>
<td>Possible background noise</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficulty in gauging quality of interpreter</td>
<td></td>
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<td></td>
<td>Lack of continuity (more likely)</td>
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</tbody>
</table>

Organisational systems required to care for LEP patients

Doctors work in organisations and there are many things at a system level that will facilitate communication with LEP patients:

- Routine collection of ethnicity, preferred language and need for interpreter data on registration
- Organisational policy on use of interpreters
- Provision of a budget for employing interpreters
- Register kept of available interpreters
- Speaker phones available (telephone interpreters are commonly used and available)
- Staff training on managing LEP patients including reception staff
- Look at all communications from the organisation to patients through the eyes of an LEP patient: do any of them need translating?
- Patient safety Incident management system flagging when language barrier may have been a factor.
Skills required

Assessing English fluency

If the patient speaks no English it is easy to work out that you need an interpreter. It is rarely helpful to ask someone if they speak English. Better is to ask open ended questions, or ask the patient to repeat back in their own words what they have understood you to have said. Even if someone has sufficient English for conversation at work they may still have insufficient for discussing complex health issues.

Working with an interpreter

Organisations providing interpreter services all offer brief advice or training on how to work with an interpreter. Some basic points are:

• Speak as if you are talking to the patient (“how do you feel” not “how does she feel”)
• Sit in an equilateral triangle so patient doctor and interpreter can easily see each other
• Speak in small “chunks”. The longer you speak without a break for interpreting, the harder it is to interpret accurately
• Avoid colloquialisms and medical jargon. Jokes are often hard to explain and risk being misunderstood.

Communicating with deaf people

Past prohibition of the use of sign language in schools means that there are significant numbers of deaf people with low levels of literacy. Written communication is not a suitable or reliable substitute for communicating with many deaf people. If you have deaf people in your practice there is a detailed guide on managing this at: http://www.odi.govt.nz/resources/guides-and-toolkits/working-with-nzsl-interpreters/index.html

Funding for interpreters

All public hospitals in New Zealand have policies and a budget for the use of interpreters, although anecdotally the budgets are constrained. Any public sector organisation can join “Language Line” (see below) which provides subsidised telephone interpreting. This includes PHOs. The three Auckland DHB’s have a fully funded primary care interpreting service. Many PHOs provide some funding through “Services to Improve Access” funding.
Availability of professional interpreters


They provide interpreters in 43 languages, and are available Monday to Friday 9am—6pm and Saturday 9am—2pm.


Interpreting New Zealand provides interpreters in 70 languages from Wellington and Christchurch, face to face, and by telephone to other regions. [http://www.interpret.org.nz](http://www.interpret.org.nz)

Uptake of professional interpreters is poor

Two New Zealand studies document that the use of interpreters is inadequate and clinical harm is likely to be happening as a result of impaired communication.\(^5\)\(^6\) Cost can be a significant barrier to using professional interpreters. Doctors working for organisations who care for LEP patients where there is no budget for interpreters have a responsibility to lobby for funding to be found.

However even if the service is free there can be a low uptake. This has particularly been noted in Australia where despite a comprehensive free interpreting service uptake is significantly lower than anticipated.\(^7\)

The main identified barriers to uptake identified were training of clinical staff and particularly training and attitudes of reception staff.\(^8\) A toolkit has been developed for use in primary care in New Zealand to address this need.\(^9\)

Summary

New Zealand has an increasingly diverse population with significant numbers of people who are not English proficient, particularly in the Auckland region. It is not possible to provide good care for an LEP patient without an interpreter, and there are some situations where a professional interpreter is essential. Current use of interpreters in New Zealand is such that it is very likely that LEP patients are being exposed to increased clinical risk. Attention to the systems in which doctors work as well as the skills and knowledge of clinicians is needed to improve this problem.
References


