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Why do we not use trained interpreters for all patients with limited English proficiency? Is there a place for using family members?

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Abstract. Australia and New Zealand both have large populations of people with limited English proficiency (LEP). Australia's free telephone interpreter service, which is also used by New Zealand through Language Line (LL) but at a cost to the practices, is underused in both countries. Interpreter guidelines warn against the use of family members, yet the lack of uptake of interpreter services must mean that they are still often used. This paper reviews the literature on medical interpreter use and reports the results of a week-long audit of interpreted consultations in an urban New Zealand primary health centre with a high proportion of refugee and migrant patients. The centre's (annualised) tally of professionally interpreted consultations was three times more than that of LL consultations by all other NZ practices put together. Despite this relatively high usage, 49% of all interpreted consultations used untrained interpreters (mostly family), with more used in 'on-the-day' (OTD) clinics. Clinicians rated such interpreters as working well 88% of the time in the OTD consultations, and 36% of the time in booked consultations. An in-house interpreter (28% of consultations) was rated as working well 100% of the time. Telephone interpreters (21% of consultations) received mixed ratings. The use of trained interpreters is woefully inadequate and needs to be vigorously promoted. In primary care settings where on-going relationships, continuity and trust are important – the ideal option (often not possible) is an in-house trained interpreter. The complexity of interpreted consultations needs to be appreciated in making good judgements when choosing the best option to optimise communication and in assessing when there may be a place for family interpreting. This paper examines the elements of making such a judgement.

Additional keywords: care of limited English proficiency patients, communication barriers, interpreter services, translating.

Introduction

Background

Communication between clinicians and patients is of crucial importance to good medical care; complaints about care often arise more from poor communication than from medical errors (Health and Disability Commissioner 2004). Language barriers can only add to the issue, and a body of literature has shown that they have significant effects on health outcomes (Flores *et al*. 2002; Cohen *et al*. 2005). The use of trained interpreters has been found to result in better outcomes (Jacobs *et al*. 2001, 2004; Flores 2005; Karliner *et al*. 2007) and guidelines for their use are necessary to ensure consistency and quality of care. Such guidelines for 'best practice' are now found in many medical organisations (American Medical Association; Association of American Medical Colleges; Office of Ethnic Affairs 1995; Paras 2005; Auckland District Health Board 2006; Australian Health Industry Collaboration Effort 2006; Australian Institute of Interpreters and Translators Inc. 2006; Miletic *et al*. 2006; NSW Department of Health 2006; Camplin-Welch 2007; Ismailovich 2007; Minnesota Department of Health 2007) and are important to protect patient rights, guide clinicians and establish an interpreter-friendly environment (Diamond *et al*. 2009). Most state that trained interpreters should be used with all limited English proficiency (LEP) patients, without reference to the complexities and logistics that may affect the ability to do so.

Australasian context

Interpreting services have been established by governments in both Australia and New Zealand to respond to the growing numbers of migrant populations with limited English proficiency.

Australia has readily available telephone interpreters through the national Translating and Interpreting Service (TIS) – a service

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that is free of charge for Medicare consultations, making it 'the world's largest free telephone interpreter service for doctors' (Phillips 2010). Other services that can provide face-to-face interpreting are available at a local level, some of which are also free (Phillips 2010).

In New Zealand, Language Line (LL) largely uses the interpreters from TIS and is the only subsidised accredited interpreting service available for primary care – but practices must pay a fee for service. There are other unsubsidised providers of both face-to-face and telephone interpreting. There is no dedicated budget available for the use of interpreters, although there are some small discretionary funds available. Unlike Australia, New Zealand has no accreditation system for interpreters, who work in a completely unregulated environment (Clark 2009).

While there are differences in the provision and funding of interpreting services in each country, they are significantly underutilised, both in Australia (Huang and Phillips 2009) and in New Zealand, where there were just 404 interpreted consultations in primary care by LL in the year to June 2010 (Diana Clark, pers. comm.). In both countries, untrained interpreters, such as family members and friends, are relied upon to an undesirable extent.

Relationship between guidelines and practice

There is a significant gap between interpreter guidelines and practice in both Australia and New Zealand, regardless of the differences between them and the fact that the lack of funding relevant in New Zealand applies to a much smaller degree in Australia.

This study aims to contribute to the literature that informs guidelines on the use of interpreters. Other studies compare different types of interpreters (trained and untrained) using quantitative and experimental methodology (Kuo and Fagan 1999; Fagan *et al*. 2003; Garcia *et al*. 2004; Gany *et al*. 2007; Crossman *et al*. 2010; Nápoles *et al*. 2010), but their value for informing practice for a particular individual consultation is compromised by the complexities of studying interpreted consultations: the lack of homogeneity among interpreters (trained or otherwise), variations in complexity of clinical material, clinical setting, and other variations among patients and clinicians. There are few studies that examine actual practice (Karliner *et al*. 2004) or that examine the complexities of choice of interpreter at an individual level (Schenker *et al*. 2008).

This article first examines the literature on issues with different types of interpreting, particularly in relation to the use of family and friends as interpreters, and then presents an audit of interpreter use at a NZ practice with high numbers of LEP patients. Finally, it draws conclusions about the guidelines and policy for interpreter use based on actual practice.

Literature review

Statements that family or friends should be avoided except as a last resort are found in institutional policies but also in much of the relevant academic literature (Riddick 1998; Lee *et al*. 2002; Green *et al*. 2005; Aranguri *et al*. 2006; Huang and Phillips 2009; Jacobs *et al*. 2010; Phillips 2010).

The risks of using family members or other untrained interpreters are well documented. Pauwels (1995) divides these into two categories: linguistic and ethical, with some overlap between the two. Linguistic problems include uncertainty about language ability, lack of knowledge of medical terminology (Flores 2006; Ho 2008), and language ability being affected by stress (Haffner 1992). These may lead to inaccuracies and/or omissions. Other linguistic issues may be additions to what has been said (offering advice or opinions), and selectivity as to what to translate. These latter problems are particularly related to the likely unfamiliarity of the family member with the difficult task of interpreting and may also lead to an individual being unwilling to lose face by admitting to difficulties. Such problems have the potential to lead to clinical error and liability (Flores *et al*. 2003).

Ethical problems include issues with confidentiality and privacy (Flores 2006; Gadon *et al*. 2007; Ho 2008; Diamond *et al*. 2009), difficulty with sensitive discussions (such as matters of sexuality or abuse) (Flores 2006), changes to the family dynamics in terms of power when members take on different roles (Ho 2008), adverse effects if non-adult children are used (Jacobs *et al*. 1995), and family members imposing their own agenda and/or priorities (distorting communication and affecting patient autonomy) (Office of Ethnic Affairs 1995; Flores 2006; Ho 2008). The latter can include offering advice and may be characterised as role conflict (Diamond *et al*. 2009).

There is also a literature that questions the notion that family members should never be used. One study reported family interpreters feeling that they had a significant advantage over trained interpreters because of their relationship of trust, background knowledge and ability to keep the matter 'in the family' (Greenhalgh *et al*. 2006). Ho (2008) argued similarly from a theoretical viewpoint, noting that linguistic problems do not apply in every case and that patients can benefit from the deeper involvement of their family members. Other studies, even some that argue strongly against the use of untrained interpreters, acknowledge that although family interpreters may have their own agenda, they can add crucial contextual information (Leanza *et al*. 2010), may have a 'comforting and calming influence' (Wiener and Rivera 2004) and that patients are often very satisfied with family interpreters, and recommend that their use should be more seriously considered (Kuo and Fagan 1999). In fact, bringing in a trained interpreter where a family member has been used may in some circumstances create more problems than it solves, such as severe anxiety in an elderly patient (Parnes and Westfall 2003).

Some of the risks associated with family interpreters may also exist for trained interpreters, particularly in New Zealand, with its lack of interpreter accreditation. Some may also bring their own agenda to the task and may not translate each turn at talk as it occurs, but try to make the interaction more 'efficient' by conducting their own question and answer sequence with a patient (Bolden 2000) or, for example, insisting on a direct 'yes' or 'no' answer to a question (Angelelli 2004), despite the fact that it is not unusual for patients in monolingual medical consultations to give indirect answers that can still build up a picture of patient's problem (Hale 2007). They have also been found to act as gatekeepers at times by selecting what the doctor will hear (Davidson 2001). These may be issues that can be addressed through interpreter training, but in reality, clinicians usually lack

information on the training a particular interpreter may have and thus how much they can be relied upon for accurate and ethical interpreting. The use of trained interpreters is often coupled with the philosophy that interpreters should be totally neutral and function as 'conduits' to simply translate each participant's utterances. This view has been critiqued in the literature, with our search locating 49 publications (dating from 1984 to the present) that address the complexity of the role of the interpreter, in publications in the fields of medicine, medical ethics, nursing, social science, anthropology, applied linguistics and interpreting. The principle of impartiality or neutrality, including the acceptability of advocacy or advice-giving, is an area of controversy in interpreter standards of practice around the world (Bancroft 2005). Others also question whether such neutrality is actually possible (Kaufert and Putsch 1997; Ho 2008).

It is increasingly accepted that an interpreter may need to take on more than one role (Beltran Avery 2001; Li *et al*. 2010) and that quality of interpreting should be judged on more than just translation accuracy (Robb and Greenhalgh 2006). A recent suggestion is that the role should be incremental, 'mov[ing] from the basic conduit function to that of cultural brokering in an unobtrusive manner when necessary' (National Council on Interpreting in Health Care and American Translators Association 2010: p. 5). Studies have found interpreters do take on other roles but often fail to make these role variations transparent (White and Laws 2009), as they should be (Messent 2002; National Council on Interpreting in Health Care and American Translators Association 2010).

Whatever role an interpreter takes, trust in the interpreter by both the clinician and the patient is of fundamental importance (Robb and Greenhalgh 2006; Hsieh *et al*. 2010). Continuity of interpreter from one consultation to another is important for building a relationship of trust and can give room for an extended interpreter role (Fatahi *et al*. 2008; Blignault *et al*. 2009). Continuity, trust and extended roles can be reasons that family members may be preferred by patients (Edwards *et al*. 2005; Bhatia and Wallace 2007) although other studies have found patients to prefer trained interpreters (MacFarlane *et al*. 2009).

A problem with a policy excluding family interpreters is that although the risks outlined are real, they do not necessarily apply in every case. A shortcoming in the literature is that generally it does not take account of the different medical contexts in which interpreting occurs. While in an emergency department, there may be great urgency and complexity and no background knowledge of the patient at all, a primary care situation where a family has built up a strong relationship with clinicians for many years and where some consultations may be routine is quite different. The appropriateness and effectiveness of a family interpreter in each context will be very different, while also depending on the individuals involved.

Despite the acknowledged risks, many studies have found that family interpreters remain widely used in many situations (Auckland Area Health Board 1990; Chan *et al*. 1999; Gerrish 2001; Kuo *et al*. 2007; Atkin 2008; Garrett *et al*. 2008; Diamond *et al*. 2009; Ginde *et al*. 2009). Doctors often normalise the fact that trained interpreters are underused and often lack awareness of the difficulties and risks, learning of these only through experience (Diamond *et al*. 2009). Indeed, the cost and logistics of using trained interpreters may mean that they will never fully replace untrained interpreters (Li *et al*. 2010). Given these facts, clinicians need to receive training in the use of both trained and untrained interpreters (Chen and Jacobs 2007; Rosenberg *et al*. 2007; Leanza *et al*. 2010). Patients must also be made fully aware of their options and have opportunities to experience trained interpreting, as families might not realise the benefits when family interpreting has apparently been working for them (Blignault *et al*. 2009).

This literature indicates that interpreter policies run the risk of oversimplifying the issue of choice of interpreter. On one hand, they ignore the potential benefits of family interpreters, and on the other hand they presume that all trained interpreters are equally good when there are differences between telephone, on-site and in-house interpreters and, at least in New Zealand, a lack of an accreditation process means that quality is variable. In fact, interpreter use can at times be problematic with all types of interpreter (Li *et al*. 2010).

Context of study

This small-scale study audited actual interpreter use for 1 week at Newtown Union Health Service (NUHS), Wellington – a primary health care setting with a high number of LEP patients. Patients with a refugee background make up 25% of the patient register of ~6000 (Newtown Union Health Service 2008). NUHS has had a specific program for the care of refugees and new migrants since its inception in 1987 (James 2007) and has been a leader in the use of interpreters in primary care in New Zealand, with negotiated funding for the past 18 years. Interpreters of various types are regularly used and clinicians report a high level of awareness of the issues.

The interpreter services available include on-site interpreting from a trained Assyrian and Arabic in-house interpreter (for the past 10 years) and trained Somali interpreters who are contracted in when required, as well as telephone interpreting available through two services: 'Language Line' and 'Interpreting New Zealand' (a local interpreter provider and training organisation, covering 70 languages). An experienced bilingual Samoan nurse is occasionally used. In the absence of trained interpreters, family members and friends of patients are used.

While there is no explicit staff training program in the use of interpreters, a 'refugee team' comprising a nurse, a doctor, a social worker and the in-house interpreter meet regularly and pass on their skills and knowledge to other staff, leading to what is considered a good level of skills, experience and awareness among all staff. A stable workforce for the past 7–8 years has enabled this to develop.

Method

During a period of 1 week, all clinicians – seven doctors (GPs), eight nurses and four midwives – at the practice were given a written questionnaire to complete for every clinic they ran, mostly half-day sessions of either booked or drop-in ('On the Day' or 'OTD') appointments. The questionnaire (Appendix 1) included questions about how many interpreters were used, what type of interpreter (including family member or friend) was used and why, how well it worked and why, and if there were patients with whom an interpreter could have been used but was not and why. The study complied with the NUHS research approval process.

Percentages of interpreted consultations and types of interpreters were calculated, and where appropriate, 95% confidence intervals are given. In addition, written clinician comments on reasons for their choices and ratings of efficacy were analysed qualitatively into categories. While most questions required a binary yes or no answer, clinician comments were analysed to create mid-categories such as 'okay' or 'maybe'.

Results

In total, 47 questionnaires were completed for the 50 clinics conducted during the week (a 94% return rate). The number of patients seen in each clinic ranged from 2 to 47. An interpreter was used in 53 out of 378 patient consultations (14%), and an interpreter was needed but not used for a further 14 patients (4%). A trained interpreter was used in 26 consultations. Eighteen interpreted consultations were drop-in (OTD) consultations (34%), and the remaining 35 were booked (66%). The languages interpreted are shown in Table 1. The highest proportion is for Assyrian or Arabic speakers (45% combined), the group for which an in-house interpreter is employed.

Types of interpreters used

Table 2 shows how many interpreters of each type were used, with family members being the largest single group (49%), proportionately more family members used in OTD Clinics (83%) than in booked appointments (31%).

Figure 1 shows the comparison of the use of trained and untrained interpreters as groups, showing an even division of usage in general, but a marked difference between usage in booked and OTD clinics, with untrained interpreters much more common in OTD clinics.

Table 1. Patient languages interpreted during 1 week at Newtown Union Health Service, Wellington

Language	Number of interpreted consultations ($n = 53$)
Assyrian	19 (36%)
Somali	9 (17%)
Arabic	5 (9%)
Dari	4 (8%)
Samoan	3 (6%)
Mandarin	2 (4%)
Tigrenian	2 (4%)
Armanic	1 (2%)
Armenian	1 (2%)
Cambodian	1 (2%)
Unidentified Chinese language	1 (2%)
Thai	1 (2%)
Not recorded	4 (8%)

Clinician perception of efficacy

In general, clinicians felt the interpretation had 'worked well' or 'okay' in most cases, including all the OTD interpreted consultations. Table 3 shows that the in-house interpreter was consistently effective and that family or friends were often also effective but much more frequently in the OTD clinics.

Reasons for choosing a particular service

Table 4 summarises the reasons mentioned for interpreter choice. The availability of family members was the most commonly cited reason.

Why did clinicians feel that their use of an interpreter worked well?

Family members

Clinicians felt these interpreters worked well because of the clinical presentation (i.e. simplicity of appointment, including follow-up visits), an existing good relationship with the family where it has been established that this works, or their ability to give more information.

In-house interpreter

The 100% positive rating was felt to be because of the established rapport between the in-house interpreter and the patients, her professionalism and her competence as an interpreter.

Telephone interpreters

These trained interpreters were also valued for their competence and experience when they worked well.

Why did clinicians feel that their use of an interpreter did not work well?

Family members

Reasons for problems with this included: difficulty with roles, especially if a child is the interpreter; complexity of the consultation or difficulty of topic; lack of language ability; cross-gender interpreting; and lack of complete interpretation. Most of the problems occurred in booked clinics, where the clinical presentation tended to be more complex.

Table 2. Number of interpreters of each type used during 1 week at Newtown Union Health Service, Wellington
CI, confidence interval; OTD, on-the-day clinic

	Type of interpreter (95% CI)			
	Trained		*Untrained*	
	In-house	Phone	Family/friend	Staff nurse
Total ($n = 53$)	15 (28%) (17–42)	11 (21%) (11–34)	26 (49%) (35–63)	1 (2%) (0–10)
Booked ($n = 35$)	14 (40%) (24–58)	10 (29%) (15–46)	11 (31%) (17–49)	0 (0%) (0–8)
OTD ($n = 18$)	1 (6%) (0–27)	1 (6%) (0–27)	15 (83%) (59–96)	1 (6%) (0–27)

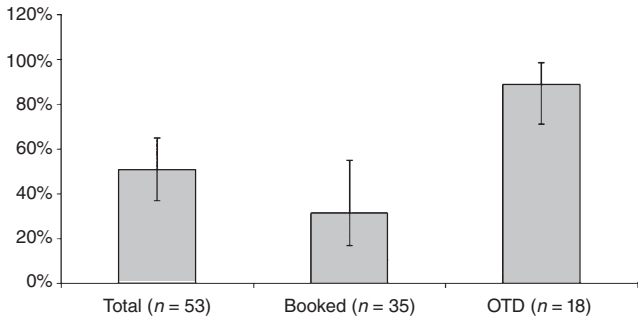

Fig. 1. Percentage of interpreters who were untrained (family, friends or staff nurse) during 1 week at Newtown Union Health Service, Wellington. Error bars represent 95% confidence intervals. OTD, on-the-day clinic.

Telephone interpreters

These were rarely used, but difficulties were sometimes found with background noise with this method.

Did clinicians feel that an alternative service would have worked better?

In 21% of interpreted consultations (11; CI = 11–34%), clinicians felt that an alternative would have worked better than the family members or phone interpreters used. No alternative was ever preferred to the in-house interpreter. The main reasons for desiring an alternative were for want of greater efficiency and more time, and better language skill.

When no interpreter was used, could an interpreter have been used?

For 14 of the 43 consultations for which this question was answered (33%; CI = 19–49%), the clinician responded affirmatively. The reasons that interpreters were not used were patient choice, borderline need based on language ability, initial misjudgement of need, clinical presentation (e.g. interpreter not being used for simple follow-up appointments), time constraints (not pre-booked consultations) or oversight.

Discussion

The results of this audit confirm that trained interpreters are greatly underutilised, representing a major breach of the right to adequate communication in the New Zealand Health and Disability Commissioner (HDC) Code of Rights (Health and Disability Commissioner 1996). Even though trained interpreters were only used in about half the interpreted consultations, if the numbers of professionally interpreted consultations in this week were extrapolated to a full year (1352 consultations), NUHS would have used in a year three times more consultations than Language Line provided for primary care in all New Zealand (Diana Clark, pers. comm.). Even if the week studied was not representative and the average usage is much lower, this still

Table 3. Ratings for types of interpreter used during 1 week at Newtown Union Health Service, Wellington – did they work well?
CI, confidence interval; OTD, on-the-day clinic

Rating	Percentage of consultations (95% CI)							
	Total (*n* = 53)	Type of interpreter						
		Untrained (*n* = 27)		Trained in-house (*n* = 15)		Telephone (*n* = 11)	
Yes	74% (60–85)	65% (44–83)		100% (82–100)		55% (23–83)	
Booked (*n* = 35)	66% (48–81)	Booked (*n* = 11)	36% (11–69)	Booked (*n* = 14)	100% (81–100)	Booked (*n* = 10)	50% (19–81)
OTD (*n* = 18)	89% (65–99)	OTD (*n* = 16)	88% (62–98)	OTD (*n* = 1)	100% (5–100)	OTD (*n* = 1)	100% (5–100)
Okay	13% (5–25)	23% (9–44)		0% (0–18)		9% (0–41)	
Booked (*n* = 35)	14% (5–30)	Booked (*n* = 11)	36% (11–69)	Booked (*n* = 14)	0% (0–19)	Booked (*n* = 10)	10% (0–45)
OTD (*n* = 18)	11% (1–35)	OTD (*n* = 16)	13% (2–38)	OTD (*n* = 1)	0% (0–95)	OTD (*n* = 1)	0% (0–95)
No	13% (5–25)	12% (2–30)		0% (0–18)		36% (11–69)	
Booked (*n* = 35)	20% (8–37)	Booked (*n* = 11)	27% (6–61)	Booked (*n* = 14)	0% (0–19)	Booked (*n* = 10)	40% (12–74)
OTD (*n* = 18)	0% (0–15)	OTD (*n* = 16)	0% (0–17)	OTD (*n* = 1)	0% (0–95)	OTD (*n* = 1)	0% (0–95)

Table 4. Reasons for choosing a particular type of interpreter during 1 week at Newtown Union Health Service, Wellington
CI, confidence interval; OTD, on-the-day clinic

Reason for use	Type of interpreter (95% CI)		
	Family member (*n* = 26)[A]	In-house (*n* = 15)[A]	Telephone (*n* = 11)[A]
Availability (e.g. 'came in with patient' or for an OTD clinic)	14 (54%) (33–73)	6 (40%) (16–68)	
Precedence ('has interpreted before')	3 (12%) (2–30)		2 (18%) (2–52)
Family choice/request	3 (12%) (2–30)	3 (20%) (4–48)	
Booked that way	3 (12%) (2–30)	6 (40%) (16–68)	2 (18%) (2–52)
Short consultation only	1 (4%) (0–20)		
Quality of interpreting	2 (8%) (1–25)	4 (27%) (8–55)	1 (9%) (0–41)
Short notice			2 (18%) (2–52)
Language availability			2 (18%) (2–52)

[A]Note that numbers do not add to total because more than one reason could be cited for each interpreter choice.

represents much higher usage than other practices. In Australia, 41 360 interpreted GP consultations were accessed through TIS in the calendar year 2010 (Joshua Smith, pers. comm.). A rough comparison of this with NUHS's annual usage of trained interpreters would show NUHS's usage to be approximately 1/8th that of the national figure for Australia (adjusting for population size, though ignoring other probable differences in measurement and comparability). This is a further indication of significant underusage of interpreters in Australia.

The second finding is that even in a practice with relatively high interpreter use, family and friends were used in about half of the interpreted consultations. These were often rated by clinicians as successful, but it is important to note that this was mostly in OTD clinics, where the problems are often more straightforward (coughs and colds, minor trauma, off-work certificates) to deal with. While some booked appointments also used family interpreting successfully, it is clear that the success of family interpreters is dependent on their being used in very closely proscribed circumstances, i.e. in situations where clinical complexity is low, the untrained interpreter's language ability is sufficient, there are no ethical issues with the particular person interpreting (e.g. a child is not used) and the patient is happy with the choice. The study thus shows that clinicians with experience in the use of interpreters believe that there is a place for family interpreters in limited circumstances.

The ideal interpreter, suggested by both the audit and the literature, is a face-to-face trained interpreter who has an ongoing relationship with the clinicians with whom they work. In addition to their high level of training and ethical standards, they provide the extra benefits of continuity, the building up of trust with clinicians and patients, and the possibility of providing cultural advocacy as well as just literal interpreting.

Given that this ideal is usually not feasible, and that other trained interpreters are also not widely used, the status quo for most practices is that LEP patients present with an untrained interpreter to help them. The decision on when to decline this help may be much more complex than 'best practice' guidelines imply and clinicians need to understand how to make good judgements on interpreter choice, case by case.

In Australia, the availability of fully funded telephone interpreters means that there will be few consultations where using this service is not the best option. However an understanding of the issues involved in making the judgement will enable clinicians to decide when a face-to-face interpreter would be better and what the clinical risk might be if, for some reason, they cannot use a telephone interpreter. In New Zealand, the ability to make such judgements is even more important in the context of financial constraints – 'better practice' is the best that can be achieved. A framework for making such judgements is presented below.

Framework of issues to consider in making interpreter decisions

Issues that clinicians need to consider in deciding on the best interpreting option on a case-by-case basis include the following.

Interpreter availability

Telephone interpreting is by far the best option with respect to availability, but this does need to be weighed against the costs (in New Zealand) and the disadvantages of telephone interpreting: lack of continuity and personal relationship, need for interpreting of body language, patient intolerance of phone use and possible problems with background noise. Face-to-face interpreters are more expensive and likely to be more limited in availability.

Language ability

English proficiency of the patient (and of the proposed interpreter if an untrained interpreter is considered) must be assessed. In addition, the language to be used for interpreting is a consideration – does the proposed interpreter (trained or untrained) speak the patient's native language, or their second language? Do they share the same dialect? This may affect the quality of the interpreting.

Familiarity with patient and family interpreter

A clinician can judge the English ability of an LEP patient (or family interpreter) over several consultations and determine with some accuracy what their language competence is (and their appropriateness as an interpreter, if relevant).

Vulnerability of the patient

Patients from a refugee background or from a background that includes the likelihood of trauma are challenging to manage. Failure to use a trained interpreter is likely to make useful discussion of trauma issues impossible. Such issues are only likely to be able to be addressed with continuity of care and development of trust in both the clinician and the interpreter.

Clinical presentation

This is important for several reasons – the complexity may affect how much language is needed, and the nature of the issue may make it necessary to consider the gender of the interpreter and the relationship to the patient, factors that may rule out any consideration of use of family members for some sensitive discussions. Urgency of need may lead to using 'the best available'.

The wishes of the patient

This includes issues of trust and confidentiality, and any stress or anxiety that insisting upon professional interpreting may bring – keeping in mind that patients should be made aware of the availability and ethical standards of professional interpreters.

The patient's need for advocacy and/or ongoing support

This may make the use of a family member more advantageous if someone suitable is available, although there is nothing precluding using a trained interpreter and having the family member present also.

Seeking informed consent

Any consent gained without the use of a trained interpreter cannot be adequately informed and would not stand up in court if challenged. A trained interpreter must always be used if informed consent is required.

Use of children

Non-adult children should not be used as interpreters owing to the high risk of both linguistic and ethical issues, i.e. with the quality of the interpreting (due to their limited medical vocabulary and health literacy) and the ethical issue of requiring a child to take on such a potentially stressful role.

Other issues that may influence the decision include the level of health literacy of the patient and the confidence and competence of the clinician with the cultural group concerned.

Limitations of the study

This is a small study of one practice for only one week and the number of telephone interpreted consultations was too small to draw strong conclusions. Although there was a high response rate, it is not known how representative this particular week was. The practice studied is not a typical one, having higher awareness of interpreting issues than most. The effectiveness of the interpreting was only assessed by the clinician and is likely to be an overestimate – we did not investigate patient or interpreter perspectives, or clinical outcomes.

Conclusion

Trained interpreter use in New Zealand primary care is woefully inadequate, and is also a problem in Australia. The low uptake of interpreters in New Zealand is significantly affected by a lack of budget, although the fact that NUHS has been able to overcome this to a significant degree shows that it is not an adequate explanation. In Australia, cost is a very minor factor in the low uptake. We do not understand why this low uptake persists.

Use of trained interpreters with LEP patients is cited as best practice in all the guidelines but is rarely followed. The ideal option suggested by our study (an in-house trained interpreter) is not likely to be a reality for various logistic and financial reasons. Given this, it is important to make a considered judgement of what the best available option is. The framework we have developed is to assist in this judgement, and to try to minimise the likelihood of harm when the ideal is not used – i.e. to advocate 'better practice'.

The use of interpreters must be vigorously promoted. Mandatory practice systems need to be introduced to ensure that all LEP patients are identified and their native language is documented. All practices must have known systems for contacting interpreters for all the languages that their patients speak. Staff need to be well trained and given authority to employ interpreters when appointments are made for patients identified as needing them (rather than leaving it up to the clinician). In New Zealand, more funding needs to be provided to pay for interpreting costs. Training in the use of the above framework could help clinicians to make clear and considered judgements on what options will result in adequate communication in different situations and to understand the limited circumstances in which there may be a place for family interpreting. Further research on patient perceptions of interpreting and the adequacy of interpreting is also needed to better understand this issue.

Without significant changes, patients with limited English proficiency will continue to get inferior health care, and clinicians will be exposed to greater medico-legal risk.

Conflicts of interest

None declared.

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References

American Medical Association 'Office guide to communicating with limited English proficient patients.' Available at http://www.ama-assn.org/ama1/pub/upload/mm/433/lep_booklet.pdf [Verified 15 October 2010]

Angelelli C (2004) 'Medical interpreting and cross-cultural communication.' (Cambridge University Press: London)

Aranguri C, Davidson B, Ramirez R (2006) Patterns of communication through interpreters: a detailed sociolinguistic analysis. *Journal of General Internal Medicine* **21**(6), 623–629. doi:10.1111/j.1525-1497.2006.00451.x

Association of American Medical Colleges 'Guidelines for use of medical interpreter services.' Available at http://www.aamc.org/students/medstudents/interpreter_guide.pdf [Verified 4 October 2010]

Atkin N (2008) Getting the message across-professional interpreters in general practice. *Australian Family Physician* **37**(3), 174–176.

Auckland Area Health Board (1990) Report of the Working Party on Interpreting Services. Cartwright Implementation Taskforce. Auckland Area Health Board, Auckland.

Auckland District Health Board (2006) 'The interpreter service.' Available at www.adhb.govt.nz/downloads/services/interpreter-manual.pdf [Verified 4 October 2010]

Australian Health Industry Collaboration Effort (2006) 'Better communication better care: provider tools to care for diverse populations.' Available at http://www.iceforhealth.org/library/documents/ICE_C&L_Provider_Tool_Kit.10-06.pdf [Verified 27 May 2010]

Australian Institute of Interpreters and Translators Inc. (2006) 'AUSIT guidelines for health professionals working with interpreters.' Available at http://www.ausit.org/pics/HealthGuide08.pdf [Verified May 2011]

Bancroft M (2005) 'The interpreter's world tour: an environmental scan of standards of practice for interpreters.' Available at http://www.hablamosjuntos.org/resources/pdf/The_Interpreter%27s_World_Tour.pdf [Verified 4 October 2010]

Beltran Avery M-P (2001) 'The role of the health care interpreter – an evolving dialogue.' (National Council on Interpreting in Health Care: Washington, DC) Available at http://data.memberclicks.com/site/ncihc/NCIHC%20Working%20Paper%20-%20Role%20of%20the%20Health%20Care%20Interpreter.doc [Verified 8 July 2011]

Bhatia R, Wallace P (2007) Experiences of refugees and asylum seekers in general practice: a qualitative study. *BMC Family Practice* **8**, 48. doi:10.1186/1471-2296-8-48

Blignault I, Stephanou M, Barrett C (2009) Achieving quality in health care interpreting: insights from interpreters. In 'The Critical Link 5: quality in interpreting – a shared responsibility'. (Eds S Hale, U Ozolins and L Stern) pp. 221–234. (John Benjamins: Amsterdam)

Bolden G (2000) Toward understanding practices of medical interpreting: Interpreters' involvement in history taking. *Discourse Studies* **2**(4), 387–419. doi:10.1177/1461445600002004001

Camplin-Welch V (2007) 'Cross-cultural resource for health practitioners working with culturally and linguistically diverse (CALD) clients.' (Waitemata District Health Board and Refugees as Survivors NZ Trust: Auckland)

Chan I, Lloyd T, Tong K (1999) The use of interpreters by South Auckland GPs. *The New Zealand Family Physician* **26**(4), 52–56.

Chen A, Jacobs E (2007) Providing care to patients who speak limited English. In 'Medical management of vulnerable and underserved patients: principles, practice, and populations'. (Eds TE King and MB Wheeler) pp. 265–274. (McGraw-Hill: New York)

Clark D (2009) Passage to professionalism. In 'Interpreting in New Zealand: the pathway forward'. (Eds D Clark and C McGrath) pp. 23–30. (The Office of Ethnic Affairs (Te Tari Matawaka): Wellington)

Cohen AL, Rivara F, Marcuse EK, McPhillips H, Davis R (2005) Are language barriers associated with serious medical events in hospitalized pediatric patients? *Pediatrics* **116**(3), 575–579. doi:10.1542/peds.2005-0521

Crossman KL, Wiener E, Roosevelt G, Bajaj L, Hampers LC (2010) Interpreters: telephonic, in-person interpretation and bilingual providers. *Pediatrics* **125**(3), e631–e638. doi:10.1542/peds.2009-0769

Davidson B (2001) Questions in cross-linguistic medical encounters: the role of the hospital interpreter. *Anthropological Quarterly* **74**(4), 170–178. doi:10.1353/anq.2001.0035

Diamond LC, Schenker Y, Curry L, Bradley EH, Fernandez A (2009) Getting by: underuse of interpreters by resident physicians. *Journal of General Internal Medicine* **24**(2), 256–262. doi:10.1007/s11606-008-0875-7

Edwards R, Temple B, Alexander C (2005) Users' experiences of interpreters: the critical role of trust. *Interpreting: International Journal of Research & Practice in Interpreting* **7**(1), 77–95.

Fagan MJ, Diaz JA, Reinert SE, Sciamanna CN, Fagan DM (2003) Impact of interpretation method on clinic visit length. *Journal of General Internal Medicine* **18**(8), 634–638. doi:10.1046/j.1525-1497.2003.20701.x

Fatahi N, Hellstrom M, Skott C, Mattsson B (2008) General practitioners' views on consultations with interpreters: a triad situation with complex issues. *Scandinavian Journal of Primary Health Care* **26**(1), 40–45. doi:10.1080/02813430701877633

Flores G (2005) The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review* **62**(3), 255–299. doi:10.1177/1077558705275416

Flores G (2006) Language barriers to health care in the United States. *The New England Journal of Medicine* **355**(3), 229–231. doi:10.1056/NEJMp058316

Flores G, Rabke-Verani J, Pine W, Sabharwal A (2002) The importance of cultural and linguistic issues in the emergency care of children. *Pediatric Emergency Care* **18**(4), 271–284. doi:10.1097/00006565-200208000-00010

Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ (2003) Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* **111**(1), 6–14. doi:10.1542/peds.111.1.6

Gadon M, Balch GI, Jacobs EA (2007) Caring for patients with limited English proficiency: the perspectives of small group practitioners. *Journal of General Internal Medicine* **22**, 341–346. doi:10.1007/s11606-007-0311-4

Gany F, Leng J, Shapiro E, Abramson D, Motola I, Shield DC, Changrani J (2007) Patient satisfaction with different interpreting methods: a randomized controlled trial. *Journal of General Internal Medicine* **22**, 312–318. doi:10.1007/s11606-007-0360-8

Garcia EA, Roy LC, Okada PJ, Perkins SD, Wiebe RA (2004) A comparison of the influence of hospital-trained, ad hoc, and telephone interpreters on perceived satisfaction of limited English-proficient parents presenting to a pediatric emergency department. *Pediatric Emergency Care* **20**(6), 373–378. doi:10.1097/01.pec.0000133611.42699.08

Garrett PW, Forero R, Dickson HG, Whelan AK (2008) How are language barriers bridged in acute hospital care? The tale of two methods of data collection. *Australian Health Review* **32**(4), 755–764. doi:10.1071/AH080755

Gerrish K (2001) The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers. *Journal of Advanced Nursing* **33**(5), 566–574. doi:10.1046/j.1365-2648.2001.01674.x

Ginde AA, Clark S, Carmargo CA (2009) Language barriers among patients in Boston emergency departments: use of medical interpreters after passage of interpreter legislation. *Journal of Immigrant and Minority Health* **11**(6), 527–530. doi:10.1007/s10903-008-9188-5

Green AR, Ngo-Metzger Q, Legedza ATR, Massagli MP, Phillips RS, Lezzoni LI (2005) Interpreter services, language concordance, and health care quality. Experiences of Asian Americans with limited English proficiency. *Journal of General Internal Medicine* **20**(11), 1050–1056. doi:10.1111/j.1525-1497.2005.0223.x

Greenhalgh T, Robb N, Scambler G (2006) Communicative and strategic action in interpreted consultations in primary health care: a Habermasian perspective. *Social Science & Medicine* **63**(5), 1170–1187. doi:10.1016/j.socscimed.2006.03.033

Haffner L (1992) Translation is not enough: interpreting in a medical setting. *The Western Journal of Medicine* **157**(3), 255–259.

Hale S (2007) 'Community interpreting.' (Palgrave Macmillan: Hampshire)

Health and Disability Commissioner (1996) 'Code of health and disability services consumers' rights.' Available at http://www.hdc.org.nz/media/24833/brochure-code-white.pdf [Verified 10 June 2010]

Health and Disability Commissioner (2004) Decision 03HDC06973: General Practitioner, Dr B – an accident and medical clinic. New Zealand Health and Disability Commissioner, Auckland.

Ho A (2008) Using family members as interpreters in the clinical setting. *The Journal of Clinical Ethics* **19**(3), 223–233.

Hsieh E, Ju H, Kong H (2010) Dimensions of trust: the tensions and challenges in provider–interpreter trust. *Qualitative Health Research* **20**(2), 170–181. doi:10.1177/1049732309349935

Huang Y-T, Phillips C (2009) Telephone interpreters in general practice – bridging the barriers to their use. *Australian Family Physician* **38**(6), 443–446.

Ismailovich B (2007) 'Working with medical interpreters.' (Health Assist Tennessee: Nashville, TN)

Jacobs B, Kroll L, Green J, David TJ (1995) The hazards of using a child as an interpreter. *Journal of the Royal Society of Medicine* **88**(8), 474P–475P.

Jacobs EA, Lauderdale DS, Meltzer D, Shorey JM, Levinson W, Thisted RA (2001) Impact of interpreter services on delivery of health care to limited-English-proficient patients. *Journal of General Internal Medicine* **16**(7), 468–474. doi:10.1046/j.1525-1497.2001.016007468.x

Jacobs EA, Shepard DS, Suaya JA, Stone E-L (2004) Overcoming language barriers in health care: costs and benefits of interpreter services. *American Journal of Public Health* **94**(5), 866–869. doi:10.2105/AJPH.94.5.866

Jacobs EA, Diamond LC, Stevak L (2010) The importance of teaching clinicians when and how to work with interpreters. *Patient Education and Counseling* **78**(2), 149–153. doi:10.1016/j.pec.2009.12.001

James K, Ed. (2007) 'Health for the people: Newtown Union Health Service, 20 years on.' (Steele Roberts: Wellington)

Karliner LS, Perez-Stable EJ, Gildengorin G (2004) The language divide: the importance of training in the use of interpreters for outpatient practice. *Journal of General Internal Medicine* **19**(2), 175–183. doi:10.1111/j.1525-1497.2004.30268.x

Karliner LS, Jacobs EA, Chen AH, Mutha S (2007) Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research* **42**(2), 727–754. doi:10.1111/j.1475-6773.2006.00629.x

Kaufert JM, Putsch RW (1997) Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language, and power. *The Journal of Clinical Ethics* **8**(1), 71–87.

Kuo D, Fagan MJ (1999) Satisfaction with methods of Spanish interpretation in an ambulatory care clinic. *Journal of General Internal Medicine* **14**(9), 547–550. doi:10.1046/j.1525-1497.1999.07258.x

Kuo DZ, O'Connor KG, Flores G, Minkovitz CS (2007) Pediatricians' use of language services for families with limited English proficiency. *Pediatrics* **119**(4), e920–e927. doi:10.1542/peds.2006-1508

Leanza Y, Boivin I, Rosenberg E (2010) Interruptions and resistance: a comparison of medical consultations with family and trained interpreters. *Social Science & Medicine* **70**(12), 1888–1895. doi:10.1016/j.socscimed.2010.02.036

Lee LJ, Batal HA, Maselli JH, Kutner JS (2002) Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. *Journal of General Internal Medicine* **17**(8), 641–645. doi:10.1046/j.1525-1497.2002.10742.x

Li S, Pearson D, Escott S (2010) Language barriers within primary care consultations: an increasing challenge needing new solutions. *Education for Primary Care* **21**, 385–391.

MacFarlane A, Dzebisova Z, Karapish D, Kovacevic B, Ogbebor F, Okonkwo E (2009) Arranging and negotiating the use of informal interpreters in general practice consultations: experiences of refugees and asylum seekers in the west of Ireland. *Social Science & Medicine* **69**(2), 210–214. doi:10.1016/j.socscimed.2009.04.022

Messent P (2002) From postmen to makers of meaning: a model for collaborative work between clinicians and interpreters. In 'Working with interpreters in mental health'. (Eds R Tribe and H Raval) pp. 135–150. (Brunner-Routledge: Hove, UK)

Miletic T, Piu M, Minas H, Stankovska M, Stolk Y, Klimidis S (2006) 'Guidelines for working effectively with interpreters in mental health settings.' (Victorian Transcultural Psychiatry Unit, Melbourne.) Available at http://www.vtpu.org.au/docs/interpreter/VTPU_GuidelinesBooklet.pdf [Verified 11 July 2011]

Minnesota Department of Health (2007) 'Working with medical interpreters (Minnesota Refugee Health Provider Guide).' Available at http://www.health.state.mn.us/divs/idepc/refugee/guide/11interpreters.pdf [Verified 11 August 2010]

Nápoles AM, Santoyo-Olsson J, Karliner LS, O'Brien H, Gregorich SE, Pérez-Stable EJ (2010) Clinician ratings of interpreter mediated visits in underserved primary care settings with ad hoc, in-person professional, and video conferencing modes. *Journal of Health Care for the Poor and Underserved* **21**(1), 301–317. doi:10.1353/hpu.0.0269

National Council on Interpreting in Health Care and American Translators Association (2010) 'What's in a word? A guide to understanding interpreting and translation in health care.' (National Health Law Program) Available at http://www.nyhq.org/doc/Page.asp?PageID=DOC000312 [Verified 4 October 2010]

Newtown Union Health Service (2008) Annual Report. Newtown Union Health Service, Wellington.

NSW Department of Health (2006) 'Interpreters – standard procedures for working with health care interpreters.' Available at http://www.health.nsw.gov.au/policies/pd/2006/PD2006_053.html [Verified 4 October 2010]

Office of Ethnic Affairs (1995) 'Let's talk: guidelines for government agencies hiring interpreters.' (Office of Ethnic Affairs (Department of Internal Affairs – Te Tari Taiwhenua): Wellington)

Paras M (2005) 'Straight talk: model hospital policies and procedures on language access.' (California Health Care Safety Net Institute) Available at http://www.safetynetinstitute.org/content/Upload/AssetMgmt/Site/Publications/documents/StraightTalkFinal.pdf [Verified 4 October 2010]

Parnes BL, Westfall JM (2003) An elderly woman with severe anxiety associated with anticipated use of an interpreter. *The Journal of the American Board of Family Practice* **16**(3), 255–256. doi:10.3122/jabfm.16.3.255

Pauwels A (1995) 'Cross-cultural communication in the health sciences.' (Macmillan Education: Melbourne)

Phillips C (2010) Using interpreters – a guide for GPs. *Australian Family Physician* **39**(4), 188–197.

Riddick S (1998) Improving access for limited English-speaking consumers: a review of strategies in health care settings. *Journal of Health Care for the Poor and Underserved* **9**, 40–61.

Robb N, Greenhalgh T (2006) "You have to cover up the words of the doctor:" the mediation of trust in interpreted consultations in primary care. *Journal of Health Organization and Management* **20**(5), 434–455. doi:10.1108/14777260610701803

Rosenberg E, Leanza Y, Seller R (2007) Doctor–patient communication in primary care with an interpreter: physician perceptions of professional and family interpreters. *Patient Education and Counseling* **67**(3), 286–292. doi:10.1016/j.pec.2007.03.011

Schenker Y, Lo B, Ettinger KM, Fernandez A (2008) Navigating language barriers under difficult circumstances. *Annals of Internal Medicine* **149**(4), 264–269.

White K, Laws MB (2009) Role exchange in medical interpretation. *Journal of Immigrant and Minority Health* **11**(6), 482–493. doi:10.1007/s10903-008-9202-y

Wiener E, Rivera M (2004) Bridging language barriers: how to work with an interpreter. *Clinical Pediatric Emergency Medicine* **5**(2), 93–101. doi:10.1016/j.cpem.2004.01.007

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Appendix 1. Questionnaire about interpreter services given to all clinicians (doctors, nurses and midwives) to complete for every clinic they ran during 1 week at Newtown Union Health Service (NUHS), Wellington

What are the barriers to interpreter use in NUHS?

How many patients did you see in the clinic? _____.
What type of clinic was it? e.g. Nurse/GP, Booked/OTD_____.
Did you use an interpreter (including family member) for any patients? Yes No.
If yes, how many?_____.
For each consultation that an interpreter was used, please answer the questions on the following page.
What service was used? _____.

- Language line
- Wellington Interpreting Service – sit in or via telephone.
- Sit in interpreter employed by NUHS
- Family member, who? E.g. mother, brother. . .
- Other

What language?_____.
Why did you use this service? _____.
Did it work well? Yes No.
If not, why? _____.
Do you think an alternative service would have worked better? Yes No.
Which service, and why?
Were there any patients that you could have used an interpreter for but didn't? Yes No.
Why not?

e.g. Unavailable.
Time consuming.
Used an interpreter for initial consultation with patient but patient's English is sufficient for follow-up visit.
Patient preferred not to have interpreter.
Not arranged.
Rare language and difficult to arrange.
Cost to practice.
Initially assessed English as being sufficient, but on hindsight could have used an interpreter.
Other reason.