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# Telephone interpreters in general practice

## Bridging the barriers to their use

### Background

Although the Australian Translating and Interpreting Service offers the world's largest free telephone health interpreter service, it remains underused. This study explores barriers for nonmedical practice staff to accessing telephone interpreters.

### Methods

Data were collected through five focus groups of 4–8 people. Participants were receptionists and practice nurses from the Australian Capital Territory and rural New South Wales attending a update on current practice issues.

### Results

One-quarter of the participants did not know about, and/or how to use, telephone interpreters. Staff cited a range of ad hoc communication strategies of dubious quality for non-English speaking patients. All participants would only contact an interpreter on the general practitioner's direction; however few recalled any cases in which the GP had done so.

### Discussion

The attitudes and leadership of nonmedical staff about the need for interpreters may be key factors in promoting the use of interpreters in the general practice setting. Misconceptions about telephone interpreters abound among general practice staff. They defer decisions about interpreter access to GPs, posing the risk that access decisions become no-one's business. A whole of system approach to increasing uptake of interpreters is required, including education of medical and nonmedical staff, incentives through Medicare, and more explicit accreditation standards.

■ **One in 6 Australians speaks a language other than English at home.<sup>1</sup> Seventeen percent of this group cannot speak English proficiently.<sup>2</sup> Australia is the only Anglophone country to provide national free telephone interpreter services to doctors. The Translating and Interpreting Service (TIS), established by the then Department of Immigration to meet the needs of postwar migrants,<sup>3</sup> now provides 24 hour translating and interpreting services 7 days a week in more than 120 languages. The service can provide telephone or onsite interpreters. In 2000, TIS introduced the Doctors' Priority Line (DPL) to provide access to interpreters for medical consultations within 3 minutes. The DPL aimed to promote uptake of telephone interpreters over more costly onsite interpreters,<sup>3</sup> and use of interpreters in emergencies and in rural areas. Although there has been an increase in telephone interpreter use by doctors, the DPL appears still to be underused. Annual telephone interpreter use by doctors has risen from 2814 (or eight per day) in 1999, to 20 382 (or 57 per day) in 2007 (Figure 1). Of the 57 calls per day in 2007, only 25 were made to the DPL for rapid access.**

Professional language interpreting improves the quality of the clinical consultation, and patient compliance with treatment.<sup>4</sup> In the only randomised controlled trial comparing telephone and onsite interpreters, doctors and patients in California preferred simultaneous telephone interpreters to onsite interpreters.<sup>5</sup> Failure to use an interpreter when needed in a medical consultation has been deemed a breach of duty of care in United States courts.<sup>6</sup>

Most research into health care interpreter use in the international literature has focused on doctors' attitudes to onsite interpreters.<sup>4,7,8</sup> A small body of Australian research has focused more broadly on the attitudes of general practice staff to interpreters. In a questionnaire answered by 46 Melbourne (Victoria) doctors, 36% stated that they

did not know how to access the DPL.<sup>9</sup> When practice receptionists and managers were asked, 39% of them were unaware of the DPL, and 30% would not contact an interpreter if asked. In a smaller study of eight GPs and five practice staff, other critical barriers to interpreter use were lack of confidence and a belief that family members may feel undermined by a professional interpreter.<sup>10</sup>

The attitudes and leadership of nonmedical staff about the need for interpreters may be key factors in creating a working environment that is supportive of interpreters. We aimed to explore in more detail the decision making processes made by nonmedical practice staff in general practice about accessing interpreters.

## Methods

### Participants

The sample was constructed as an intensity sample,<sup>11</sup> drawn from participants from the Australian Capital Territory and rural New South

Wales attending a receptionist and practice nurse update on current practice issues (participation rate in the study, 84% of attendees). Previous experience confirmed that attendees to these updates came from stable practices with relatively large patient populations, likely to be rich sources of information about the phenomenon being studied (practice level decision making about interpreters).

### Data collection

Data were collected through five focus groups of 4–8 people. Two case vignettes were presented (*Table 1*), addressing common, problematic clinical situations. Discussions were led by five facilitators on decision making processes about assessing the need for an interpreter and accessing them. The content of discussions was recorded by scribes. Two facilitators combined the records of focus group discussions and facilitators' field notes into a single record for data analysis.

### Analysis

Data were analysed for emergent themes according to grounded theory<sup>12</sup> by two researchers, working collaboratively using the constant comparator method. The first coding process explored identified barriers; the second coding process identified locus, time and purpose of decision making about interpreters.

This study was approved by the Australian National University Human Research Ethics Committee.

## Results

All 28 participants were female, consisting of 18 practice nurses, six practice managers, and four receptionists. Only 14% of participants had arranged an interpreter (telephone or onsite) in the past month.

One-third of participants nominated interpreters as the ideal way to bridge language barriers. However, one in 4 respondents, some of whom had stated that interpreters were the ideal, did not know there was a free telephone interpreter service, or how to access it. In *Case vignette 2* (a young girl presenting with her non-English speaking father), telephone interpreters were not chosen as an option initially by any participant.

### Decision making about accessing interpreters

Although most staff had an opinion on when professional interpreters were appropriate, all respondents felt the decision about getting an interpreter should be made by a doctor. This was partly because they saw this process as being a medical decision, but also because accessing an interpreter was felt to be so cumbersome that they would not initiate contacting an interpreter without express direction.

Staff were, however, willing to employ other strategies for patients who did not speak English. The most common strategy was forwarding the patient on to a bilingual nurse or doctor. The second most common strategy was ensuring there was a family member or friend as interpreter. For *Case vignette 2*, some nurses suggested that the father's consent could be assumed by the daughter's presence,

Figure 1. Annual use of onsite and telephone services from the TIS by medical practitioners in Australia, 1999–2007

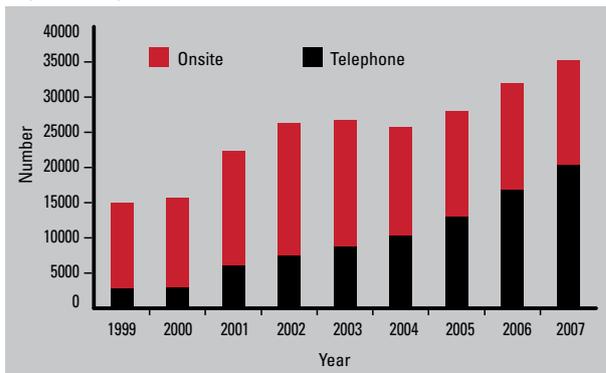


Table 1. Case vignettes used in focus groups

#### Case vignette 1

A young mother with her 10 month old child comes into the clinic without an appointment. She has an Asian complexion and has difficulty communicating her need. You take a look at her child, whom she points urgently to, and you figure that her child is not well. The doctor is walking his current patient out into the reception (and presently has no other appointments) and requests you to make a follow up appointment. The doctor will see the young mother and her child now. What actions would you take from here?

#### Case vignette 2

A middle aged man comes into the clinic accompanied by his teenage daughter. You notice that he has a funny gait as he enters, and you ask how you can help. His daughter responds in his place because he cannot communicate fluently in English. You can sense awkwardness as she starts to speak. She explains that her father has experienced pain 'down there' and needs to see the doctor. It's 15 minutes to the day's end. The doctor has just finished her last appointment. What would you do?

while others suggested that the daughter should interpret the history, but not the clinical examination. All the receptionists argued that the urgency of the clinical presentation, or the fact that it had occurred toward the end of a working day, made using the daughter as interpreter acceptable. About half the nurses expressed discomfort with the use of the daughter as interpreter, and proposed searching for subtle signs like hesitation to indicate reluctance on her part to interpret. A few raised the possibility of contacting a male relative to interpret over the telephone.

A minority of respondents did not discuss contacting an interpreter, even when patients could not communicate at all, instead suggesting for *Case vignette 1* taking the patient's temperature and pulse (nurses) or using hand signals (receptionists). These tended to be in practices where there were bilingual doctors.

### Beliefs about difficulties accessing interpreters

Common beliefs about accessing interpreters included: organising an interpreter is prohibitively time consuming; interpreters are not available out of business hours; and telephone interpreters need to be prebooked, so the service is unsuited to acute needs. Many staff reported from their own experience that establishing the language spoken by the patient was daunting. Some participants ascertained language spoken by patient by asking them to say numbers (eg. their date of birth) or by speaking another 'compatible' language which practice staff might speak. It was suggested, for example, that a Spanish speaking staff member would be able to identify Portuguese, and that a Thai speaking staff member would recognise the Burmese language. The cost of using interpreters was not raised as being barrier to either the practice or the patient.

### Beliefs about patient perceptions of interpreters

Some practice staff cited cases where patients had brought their own interpreter (family or embassy personnel) as evidence for a more general principle that family members or co-workers were preferable for patients. Some were concerned that patients might have concerns about confidentiality with professional interpreters (a concern also raised about using nonmedical practice staff as interpreters).

## Discussion

This study found misconceptions among practice staff about the accessibility and quality of the DPL, and, in some cases, a belief that patients always prefer family members as interpreters. These misconceptions lead to a set of other strategies for communication, from using bilingual doctors and staff members, to using patients' relatives, to communicating through sign language. The routine use of family members as interpreters can pose significant risks to good communication (*Table 2*).

Using bilingual doctors is the most common strategy, as was also found by Atkin and co-authors.<sup>8</sup> In our study, staff in practices with bilingual doctors frequently could not nominate strategies for patients who spoke other languages. The Royal Australian College of General

**Table 2. Potential limitations of using family members or community members as interpreters**

#### Communicative openness

- Patients may be unwilling to discuss physical concerns in the presence of family or friends

#### Threats to family integrity

- Using family members can threaten the stability of family units (eg. children interpreting in parental disputes)

#### Confidentiality

- Community members who are not professional interpreters may not respect patient confidentiality
- Breaches in confidentiality may be blamed on medical staff

#### Communication competence

- Family or friends may be unfamiliar with technical medical language
- Nonprofessional interpreters may interpret the perceived gist of the consultation, rather than the words
- Nonprofessional interpreters may encourage specific responses from patients

#### Length of consultation

- Using nonprofessional interpreters can prolong consultation time as doctors may need to repeatedly clarify key concepts

Practitioners (RACGP) accreditation standards require only that GPs and staff can state their approach to helping patients who don't speak English and have 'a list of contact numbers for interpreter services'.<sup>2</sup> Their capacity to contact these services is not specifically assessed as part of every accreditation. Our findings raise the possibility that staff in practices that rely upon the language skills of doctors may risk becoming deskilled in accessing other language services.

A recurring theme in this study was the deferral of decision making about interpreters to doctors by practice staff, including nurses. Reluctance to contact an interpreter may reflect individual practice cultures and respect for professional hierarchies. Existing Australian research<sup>7,8</sup> suggests that doctors often are unfamiliar with the DPL, and may not know how to contact an interpreter.

This study points to knowledge deficits by nurses, receptionists and managers in general practice about Australia's telephone interpreter system. Staff defer the decision making about interpreters to doctors, who may be unfamiliar with the processes needed to access interpreters; this may mean that decisions about access to interpreters become nobody's business. In the absence of a proactive approach to accessing interpreters, staff have a number of ad hoc strategies – some potentially unsafe, others deleterious to quality consultations – to communicate across language barriers.

Studies into interpreter use in mainstream health care commonly assert the need for more education about interpreters. After 8 years of marketing by TIS, the uptake of telephone interpreters by doctors remains disconcertingly low. To drive interpreter uptake in Australia,

Table 3. Suggested whole of system approaches to promoting uptake of interpreter use in medical consultations

#### Commonwealth

- Support interpreter use through a Medicare item number for using a TIS interpreter in a consultation

#### Translating and Interpreting Service

- Promote the DPL to practice staff, in addition to doctors

#### RACGP and accreditation bodies

- General practice accreditation standards should include standards that indicate a proactive, informed approach to accessing interpreters

#### General practices

- Develop practice level policies about indicators for using interpreters, including asking patients at booking if they would like an interpreter, making notes on patient files if interpreters are required, and establishing an ongoing process of receptionists and nurses being inducted into processes to contact interpreters
- Place brochures in the waiting room so that patients are aware of the service and that they can request the service if needed

it may be more effective to use whole of system approaches (Table 3). Such an approach would combine education with structural drivers such as more explicit accreditation standards about interpreters and an additional subsidy through Medicare, similar to bulk billing<sup>13</sup> or immunisation incentives,<sup>14</sup> for using interpreters.

#### Limitations of this study

Participants were drawn from a pool of practices, which had supported their staff to obtain further training. This may reflect their commitment to 'best practice' and therefore over represent practices with a favourable attitude toward interpreters. If this is the case, the true level of understanding about interpreters is likely to be lower than in this study.

#### Conclusion

Australia has the largest free telephone interpreter service for doctors in the Anglophone world. The service continues to be underused by doctors. Nurses, receptionists and practice managers have many misconceptions about interpreter quality and access. Most defer the decision about accessing an interpreter to doctors. In a busy general practice, whole of system approaches, with financial incentives, may be more effective in promoting interpreters than education programs.

Conflict of interest: none declared.

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