Health communication between non-English speaking patients and bilingual staff within our health services Report No. 1

This report is part of a series of documents:

Report 1 Health communication between non-English speaking patients and bilingual staff within our health services. ISBN 1 875 909 89 3
Report 2 Matching non-English speaking patients and bilingual staff within wards or units. ISBN 1 875 909 90 7
Report 3 Bilingual staff in mainstream healthcare: Policy development for NSW Health Services. ISBN 1 875 909 91 5
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TABLE OF CONTENTS

List of Figures

List of Tables

Acknowledgements

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Study 1a Roles and Functions of Bilingual Health Staff

Introduction

Multiculturalism in Australia, and more particularly in our health services, has prompted health services to initiate, sustain, and evaluate a range of language support services. The South Western Sydney Area Health Service (SWSAHS) has more than one-third of the resident population aged five years and over speaking a language other than English at home (LOTE) (1996 Census, Australian Bureau of Statistics). The Area Health Service has responded in a number of ways to the increasing and dynamic pattern of linguistic diversity within its population. It has an established specialist Health Care Interpreter Service, a Translations Service, designated multicultural health staff (such as ethnic health workers, ethnic obstetric liaison officers, bilingual counsellors), and a number of designated positions for bilingual staff in mainstream services (for example, Mental Health, Youth Health). These services, and the selection of the best configuration of approaches to meet non-English speaking (NES) patients' needs, is considered within the context of how to provide the best possible services within existing resources (both financial and personnel). Fundamental questions are posed as a result of this approach.

- What are the resources available with a particular focus on personnel?
- What are the roles and functions of these bilingual or multilingual health staff and how can they best be engaged in their work?
- Do these specialised services meet the health communication needs of NES patients?

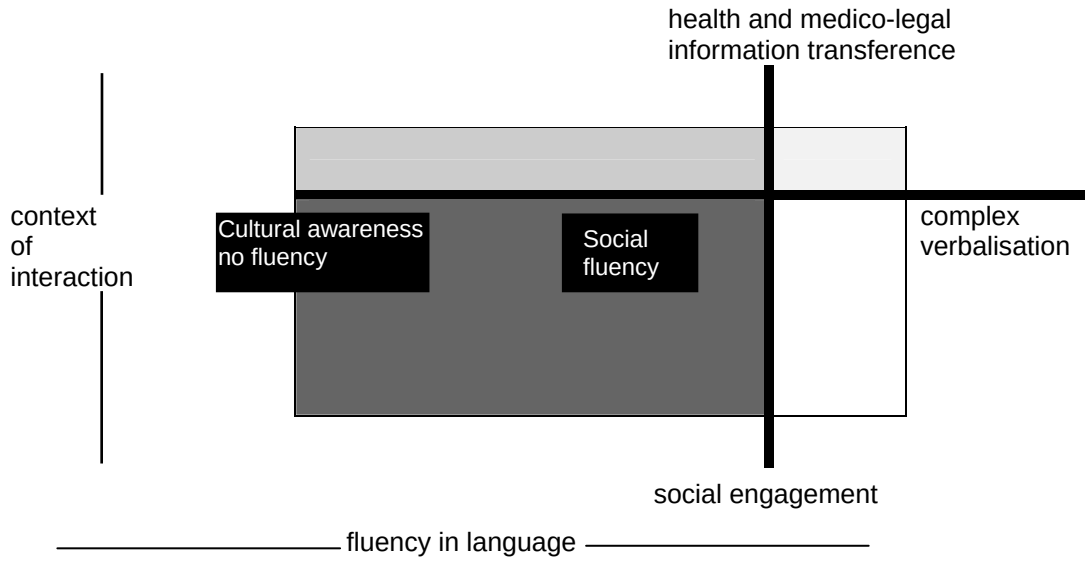
This research team, throughout a series of research studies, has sought answers to these questions in a deliberate approach to knowledge development in this area. First, the undertaking of a Language Audit of all staff within SWSAHS in 1996 identified that 31% of health staff were bilingual (Johnson, Noble, Matthews & Aguilar, 1998). Some 3,186 staff responded to the survey questionnaire of 5,877 staff; with 76% of bilingual staff participating in the study (Johnson et al., 1998). Most bilingual staff were nurses (42.4%), with smaller numbers of allied health staff (16%), hotel and support staff (7.3%), and medical staff (5.7%). These bilingual staff were from a broad range of clinical practice, with major areas being medical (11.7%), surgical (8.4%), aged care (7.3%), child and youth (6.1%), and mental health (5.7%) (Johnson et al., 1998).

One of the major findings of this language audit was the high frequency of language use in patient encounters; 173 (37%) bilingual staff members and 47 (90.4%) multicultural health staff, including interpreters, used their language skills weekly or more frequently (Johnson et al., 1998). There was also a high proportion of staff who *rarely* used their language skills (37%); reflecting a lack of opportunity for contact or limited need, reported upon in other studies (Minas, Stuart & Klimidis, 1994). This language audit and the examination of its findings confirmed the potential value of bilingual health staff not formally recognised in the above responses by the health service. The survey also identified the situations in which these language skills were used by bilingual

staff: simple conversation (17.6%), giving direction (13.1%), identification of problem and giving explanation (11.5%), taking a medical history (8.7%), consent (11.9%), ongoing treatment (9.1%), and education (8.3%). This pattern of situations reflects a predominance of 'everyday' language use (Bourhis, Roth, & MacQueen, 1989) or more social language, with limited use of complex technical health language necessary in medical history taking, consent, treatment and education. This pattern would also reflect the high proportion of staff who were nurses, who have previously been identified as major users of everyday language in patient communication (Bourhis et al., 1989).

It was also important to understand how bilingual and monolingual (English only speaking) staff perceived second language use within the healthcare setting. Further research was undertaken by asking questions of 18 focus groups representing disparate staff groups (monolingual and bilingual) derived from the 792 staff who wished to discuss the topic on the initial language audit. This qualitative study emphasised the positive aspects for the patient in using their second or subsequent language, but also proposed the need for policy that reflected this activity and protection for health workers from inappropriate exploitation of language skills (Johnson, Noble, Matthews & Aguilar, 1999). These data also provided an opportunity to develop a frame of reference that depicted bilingual health communication. The Bilingual Health Communication Model intersected two continuums: one reflecting a range of language skills from no fluency but cultural understanding to complex technical language skills or verbalisers (such as used in consents for surgery) (Johnson et al., 1999). The second continuum related to context of interaction ranging from social engagement to health and medico-legal information transference (See Figure 1). Finally, one of the more disquieting findings was an underlying tension between bilingual health staff and interpreters about their roles and functions in health communication for NES patients. In particular, bilingual health staff often referred to themselves as 'interpreting' when the example given was not interpreting. This suggested that there was role confusion evident from their perspective and a lack of understanding of the nature of interpreting.

Figure 1: **Bilingual Health Communication Model: A Matrix of Fluency and Context of Interaction**



Role delineation is an important aspect of human resource management (Nankervis, Compton & McCarthy, 1993). Professional qualifications often play a major part in defining discrete roles and functions, which in this context would refer to language proficiency. The high level of occupational specialisation with distinct occupational socialisation in health services (Birnbaum & Somers, 1998; Southon & Braithwaite, 1998) as well as potential medico-legal implications in relation to health communication supports the need for precise delineation in this context (Riddick, 1998; Zulueta, 1995). Secondary analysis of the initial transcripts from 18 focus groups provided this research team with the opportunity to describe potential roles of bilingual staff (Matthews, Johnson, Noble, Klinken, in press, 2000). Seven key features were proposed as the distinguishing features of bilingual communicators within the health setting: the scope of language use, language proficiency, the nature of the communication or interaction, the nature of the contact and relationship to the patient, responsibility for the patient, and the relationship with other health care providers (Matthews et al., in press, 2000).

There is considerable understanding of the roles and functions of bilingual staff both from other writers and researchers and also from our own experiences within this and other surrounding health services. Bilingual health staff have been described within Australian and North American literature as working within a diversity of roles. These include direct caregiver, where bilingual staff use their language other than English (LOTE) in their 'normal' role; as a co-worker providing communication support to monolingual colleagues; and as a cultural advocate or broker, developing and testing health programs within their language or cultural group (Barbee, 1987; Fong & Gibbs, 1995; Fuller, 1993; Jezewski, 1990; Johnson et al., 1999; Mitchell, Malak & Small, 1998). These are all important roles within a health care organisation.

A brief overview of interpreters and multicultural health workers and their roles within the health care setting provides valuable background information to this study.

Health Care Interpreter Service

The Health Care Interpreter service (HCIS) was set up within the health system in NSW in 1977. Interpreters are employed to directly transfer information, in a triadic relationship between the health professional and the patient. Interpreters are generally accredited to be proficient in their language other than English at National Accreditation Authority for Translators and Interpreters (NAATI) paraprofessional level. Interpreters also have interpreting skills and are trained in medical terminology.

In SWSAHS, the HCIS provided 97,820 occasions of service in 1998/9, with 65% provided in the hospital setting, mostly in outpatient services (SWSAHS, 1999). Inpatient usage accounted for only 9% of total occasions of service (Boon, 2000). Most interpreter services were provided face-to-face (61%) or

through block bookings (31%). Only 4% of services were provided by telephone (Boon, 2000). Although interpreter services are well developed they cannot satisfy the growing demands for their services, let alone be expected to provide the day-to-day social and health-related communication that reduces the isolation felt by patients with limited English language proficiency.

Multicultural Health Staff

Multicultural health worker positions were introduced in NSW during the mid 1970s to improve access to services and equity in service delivery. However, the past 8 years has seen the employment of multicultural health staff who not only have this community role but also work directly within mainstream units, for example in maternity services or in the cardiothoracic unit, in a paraprofessional role. Staff are usually employed to work with a specific language or cultural group. This may be through casework, referral mechanisms, providing information, conducting health promotion campaigns, consulting to mainstream staff, and advocating on behalf of clients.

The *SWSAHS Health Plan for NESB Communities in South Western Sydney* (1995) identified that, although interpreters and multicultural health workers provided important services, language barriers still remained a critical impediment to the provision of appropriate medical and nursing care, within mainstream hospital services. There is increasing recognition that providing appropriate bilingual staff within the health care setting is crucial for optimal patient care.

In summary, this language audit found that (in 1996) 928 staff, or 31% of staff reported that they were bilingual or multilingual; 42% were nurses. Most bilingual staff used their other language at work (62%) and some 37% used their language weekly or more frequently, although most used their language in 'social' contexts rather than for diagnosis and treatment. Focus groups found that there was some confusion about 'being out of policy' when using their other language, and some bilingual staff felt that their language skills were undervalued by managers and co-workers. This research resulted in a proposed Bilingual Health Communication Model with two main components - language proficiency and the context within which the language assistance is required - giving a matrix of fluency and context of interaction (Johnson et al., 1999). It also described roles of bilingual staff with seven key features (Matthews et al., 2000). The limitations of these two studies were that they were derived from the recall of health staff of patient situations but not actual patient encounters. This study seeks to validate the Bilingual Health Communication Model and the roles and functions of bilingual health staff and provide some guidance to managers and staff about how to select the best communicator for specific patient situations.

Objectives

The specific objectives of this study were to:

a) confirm the Bilingual Health Communication Model proposed by Johnson et al (1998) in terms of the two continuums, language use and interaction context, in health care interactions;
b) describe the roles and functions of bilingual health communicators (bilingual nurses and doctors, interpreters, multicultural health staff within health care interactions);
c) provide a simple tool to clearly define roles and functions of bilingual communicators in the health care setting;
d) describe methods for selecting the best possible bilingual communicator for specific health care situations;
e) substantiate the roles and functions structure proposed by Matthews et al (2000) - scope of language use, language proficiency, nature of communication or interaction, nature of contact and relationships, responsibility for the patient, relationships with other health care providers in health care interactions; and
f) give direction to health services and NSW Health policy on bilingual health professionals' language use in health care;

Methods

A qualitative approach was used, based upon the principles of ethnography. The main feature of ethnography is participant observation in a naturalistic setting, not in a researcher-controlled environment. Observations become starting points for in-depth interviews that clarify the understanding of what has been observed. An example of this approach is Becker's classic study (1961) of new doctors in the hospital setting which began with observation, then questioned them about what was observed through unstructured qualitative interviews. In our study, researchers completed the field notes from the observations by having informal conversations with participants to understand what had been said. Germain (1993) states that while there might be discrepancies between words and actions (observations and interviews), these differences should be evaluated and explained.

Because of the exploratory and complex nature of the investigation, this ethnographic methodology was the best approach to achieving the study's aims. We also accepted the viewpoint that at least three cultures are involved in interactions with patients - the health professional's culture, the patient's culture and the context in which the interaction takes place (DeSantis, 1994).

Denzin (1989) has proposed that qualitative research is strengthened when it is 'triangulated,' that is, that multi-methods are used to gain an in-depth understanding of the phenomenon in question. Several such methods are described – participant observation, interviews, case studies, focus groups and written and visual material (Denzin and Lincoln, 1994) throughout the series of reports relating to the overall study. Based on these assumptions, our study was

designed to observe interactions first, and following reports will explore the views of bilingual staff and patients in focus groups and interviews.

Study Design

The study design was a case study approach in varying hospital settings consisting of a direct observational study of patient-bilingual health professional interactions; focus groups of bilingual and English-speaking staff; one-to-one interviews with unit managers and bilingual staff and follow up interviews of NES patients on discharge home. This report focuses only on the bilingual interactions with patients.

Selection of participants for observation

Languages selected

The major languages spoken in SWSAHS were identified from the latest census data. A purposive sample of bilingual health staff who spoke the major languages used by patients - Vietnamese, Arabic, Cantonese, Mandarin or Spanish - was selected. This was to increase the opportunity for matches, and to allow for training of appropriate bilingual assistants for specific languages. The sample for observation was initially bilingual doctors and nurses (and their associated NES patients), but it became apparent that in order to more precisely distinguish the nature of communication with LOTE patients, performed by the various communicators (as discussed in the Bilingual Health Communication Model (1997) and the Matthews et al (2000) description of roles), other bilingual staff needed to be included. Consequently, bilingual staff included were doctors, nurses, interpreters, and multicultural health staff. The patients selected were part of the communication with the relevant bilingual staff member.

Selection of bilingual health professionals

Bilingual communicators and their languages were identified by Unit Managers. They (and their subsequent NES patients involved in the interaction) were selected from a range of possible staff with diverse language skills. Table 1 shows the number, language spoken and category of bilingual staff from the study units (more comprehensively described in Report 2 of this series) including a rehabilitation unit, a sub-acute medical ward and an emergency room. There were only two staff in the Rehabilitation unit who spoke the selected languages, five in the sub-acute medical ward, and ten in the Emergency Room.

All staff on units received a study protocol and were invited to ask questions during staff meetings in each unit attended by researchers. Verbal consents were obtained from all staff participating in the focus groups and in particular, bilingual staff who agreed to participate in the observation study. No staff refused to participate in the study.

Table 1: Staff category and languages spoken in units involved in the study

(excluding interpreters and multicultural health staff).

Ward Unit/Area	Bilingual Staff	Languages spoken
Rehabilitation Unit	10 nurses	Arabic/Assyrian/Armenian (1)* Spanish (1)* Tagalog (3) Lao/French/Thai (1) Czechoslovakian/French (1) Croatian (1) Macedonian (1) Hindi (1)
Sub-acute Medical Unit	13 nurses	Cantonese (3)* Vietnamese (1)* Spanish (1)* Tagalog (2) Hindi (1) German (1) Persian (1) Polish (1) German/Hindi/Punjabi (1) Sign (1)
Emergency Room (ER)	13 doctors 4 nurses *Not included in study* *3 clerical staff (Macedonian, Greek, Polish/German)* *2 wardsmen (Maltese, Czechoslovakian)*	Vietnamese (5)* Arabic/Russian (1)* Arabic (1)* Tagalog/Spanish (1)* Cantonese (1)* Mandarin (1)* Polish/German (1) Greek (1) Hindi (1) Turkish (1) Korean (1) Italian (1) Hokkien (1)

* indicates staff in selected languages.

Language proficiency

Those who chose to use their language skills and participate in the study had either completed their professional training in their LOTE, had NAATI qualifications or had their language proficiency assessed by independent bilingual raters. The bilingual raters had been trained in testing bilingual people for the volunteer interpreter project, for the Sydney Olympic Committee Organising Group (SOCOG). The bilingual raters either had degrees in

Language or Interpreting, or NAATI qualifications. They had been trained by the University of Western Sydney, Division of Language and Linguistics, who co-ordinated the testing of the volunteer interpreter project. All bilingual health staff who were tested were rated as having the highest level language proficiency, with only one who had migrated to Australia as a young child, being at a lower social level. The procedure was that bilingual staff were then to be matched when a patient of the same language group was admitted.

Data Collection Procedure

A list of patients with the selected LOTEs was obtained twice weekly by researchers from the two case study wards. This list was then compared to the roster of the bilingual staff in order to identify matches. Once a match was identified, researchers contacted bilingual staff to negotiate an appropriate time to inform the patient about the project and observe interactions. If a verbal consent was given by the patient to the bilingual staff member, researchers were contacted and a translated written consent form was available to be completed in the unit prior to observation.

While all patients agreed to have interactions observed, most refused to sign the written consent, either because they did not want to be followed up or they felt uncomfortable signing the form. This has been described as a common difficulty in cross-cultural research (Mohr, Redman & Simpson, 1997).

Difficulties in matching patients with bilingual staff members were related to the need for the rostering system (for the purposes of the study) to identify and allocate staff to patients, on the basis of shared language. The generally short inpatient stays were also an issue. For example, where a LOTE patient may have been admitted for tests over a period of 2 to 3 days, matching the bilingual health staff member may have been impossible. These health staff, or perhaps the bilingual research assistant, may not have been working that day. When the staff member returned, the patient may not have been allocated to the bilingual staff member.

In the case of the emergency ward, researchers obtained the rosters of bilingual staff and spent a period of three to four hours at different times of the day in the unit in order to identify potential matches and observe interactions. A total of 50 hours was spent in observation in the unit.

The SWSAHS Ethics Committee approved this study. Consents were sought from staff and patients to participate in this research. Patients and staff were informed of their right to refuse to participate. Data were stored with no identifying features.

Selection of other bilingual staff

Interpreters, ethnic obstetric liaison officers (EOLOs) and multicultural health staff in the selected major languages were identified by their managers and

invited to participate. Separate meetings were organised to explain the purpose of the study, seek their participation and negotiate appropriate times to observe interactions with clients in a variety of settings – in-patient wards, hospital outpatient clinics, community and home.

Data Sources

Data sources included field notes and transcripts from observations of 65 interactions of 19 bilingual staff.

Observation Procedure

Researchers observed interactions between bilingual staff and patients in their natural settings. Observer-as-participant was the method adopted by the research team. This means, according to Gold (1969), that the observer is known to the participants as a researcher, but does not take an active part in the events. This may lead to what Dane (1990) refers to as 'reactivity effects' that cause changes in the participants' behaviour because they know they are being watched. In other words, the awareness of being observed is likely to influence participants to behave in ways they would not normally behave. While reactivity effects cannot be fully eliminated, Grbich (1999) argues that researchers have found that it is not always possible for people to change their normal behaviour and sustain it for long periods. They have noticed that, after a while, the observer can become 'part of the furniture'. This was found to be the case in this study, as one interpreter described it *"It felt funny at first, then I got used to it… we have so many students coming around with us, that you get used to being watched*." In the ER setting, the role of unobtrusive observer (Kellehear, 1993) was adopted as more appropriate to the busy setting.

Events to be observed were selected by the researchers and an observation sheet was developed which included the main elements to be recorded. This sheet included describing the time period observed, what is happening, the location and staff category of all persons involved in the interactions, lines depicting the transmitter and receiver of the communication and the direction of the communication. Content of the interaction, as well as non-verbal behaviour, was recorded. At the end of the interaction the researcher spent a short time confirming what was communicated or discussed, from the staff or patient perspective.

Training of bilingual assistants

In the early observation of interactions, one research assistant (Arabic and English speaker) was used to observe interactions, and it became apparent that the quality of the observation was enhanced when the research assistant also spoke the language under observation and English. Subsequently, three bilingual workers were recruited who spoke Cantonese/Mandarin, Spanish and Vietnamese. A training session introduced these observers to the objectives and methodology of the project and addressed issues inherent in the conduct of the observations, such as how to transcribe interaction data whilst the encounter was taking place. Exemplars of observations that included the main areas to be

recorded were distributed and ethical considerations were explained. As far as possible verbatim recording was expected, although the difficulties of doing this were recognised and have been noted by other experts using these techniques (Silverman, 1997).

Transcripts of the interaction observed were derived from field notes and observation sheets as soon as possible after the episode. These were transcribed in English and sent to the research assistant and project manager, who sought clarification on any issues that were not clear from the transcript. In some cases, research assistants had to clarify that some words or sentences were said in English, not the LOTE.

Definition of an Interaction Unit

An interaction unit was defined as the period from when the health professional approached the patient to when the staff member left the room or bedside. The breakdown of ward or unit, staff member involved and language used for the 65 interactions is presented below. In summary, there were 19 bilingual staff observed in 65 interactions with patients.

Table 2: Description of the bilingual communicator and languages spoken within interactions.

Bilingual Communicators (staff category)	**Number of interactions**	**Languages spoken in interactions**
1 Registered Nurse 1 Social Worker (case conference)	2	Spanish (1) Cantonese (1)
4 Registered Nurses	10	Vietnamese (4) Cantonese (3), Spanish (3)
3 Doctors	10	Arabic (6) Vietnamese (4)
5 Interpreters	27	Cantonese (6) Vietnamese (4) Arabic (10) Spanish (7)
2 Ethnic Obstetric Liaison Officers 3 Multicultural Health staff	11 5	Spanish (4) Cantonese (7) Arabic (1) Vietnamese (3) Cantonese (1)
TOTAL = 19	**65**	

The content of the 65 interactions is described in Table 3. The content of the interactions was categorised into nine different. These categories were based on delineations used in the initial quantitative language survey of staff to determine in what contexts staff perceived they used their language skills. These categories have been used extensively within interpreter services. Some interactions were coded for more than one category, so the number of occasions does not tally to 65.

Table 3: Content of interactions (N = 72).

Type of content	Number of occasions this occurred within all interactions	Percentage
Identification of a problem related to treatment or condition	5	6.9
Explanation of procedure or treatment	8	11.1
Assisting with procedure	2	2.8
Taking medical history and assessing medical condition	19	26.4
Consent for treatment or procedure	8	11.1
Consent for release of information	2	2.8
Ongoing treatment	7	9.7
Education	20	27.8
Counselling and therapy	1	1.4
TOTAL	**72**	**100**

Limitations

Variability in communication styles is to be expected amongst all health professionals. Therefore, although 19 bilingual staff members and their patients and/or health professionals were observed, these staff members may not represent the depth of this phenomenon. In addition, the number of observations was limited to matched interactions which may not have captured the more social or ‘chance’ interactions with patients. However, time and budget constraints for bilingual research assistants did not permit extensive periods of time to be spent on the wards, waiting for such encounters.

The study received ethical approval for participant-observation methods, however, the quality would have been improved if video-taping of interactions had been possible. However, the research team felt that this would be very difficult in busy ward settings and the likelihood of gaining staff and patient consents were major considerations. The experience of staff on these units and increasing familiarity with this study may allow for such work in the future. While qualitative methodologies may be subject to criticisms of subjectivity or lack of rigour, every effort has been made to minimise bias and to validate reliability of interpretations.

Data Analysis

Data were collected and analysed simultaneously. Content analysis took place from the beginning of the observations and interviews, using NUD*IST (Non-numerical Data Indexing Searching Tool). The process of analysis involved the following steps described by Fielding (1993):

- Ordering and organising the collected material (observation, transcriptions).
- Re-reading/review of the data collected.
- Breaking the material into manageable pieces (i.e. naming of events, places, happenings and other instances of phenomena).
- Building, comparing and contrasting categories (i.e. developing a coding system).
- Searching for relationships and grouping categories together.
- Identifying and describing themes, regularities and patterns.
- Interpreting and searching for meaning.

In our analysis, there were frequent movements backwards and forwards between different steps. After the recording of the first observations, transcripts were read, organised and coded by the team. In the first instance, transcripts were coded by one team member using the themes previously identified by the team. After development of a coding system, researchers went back and re-read the transcripts of the data collected, creating new categories or regrouping existing ones. This regular coding process allowed for clarification of major themes and issues emerging from the data.

Reliability and Validity Issues

Muliple coders were used to detect instances of ambiguity, inconsistency and simple coding errors (Silverman, 1997). This was done by using each team member to re-code 8 to 10 interaction transcripts independently of the original coding. An inter-rater reliability score was calculated for each of the four other team members. This was calculated on agreement of codings and a percentage generated from this for an interaction. Scores ranged from 76% to 87% with an inter-reliability average of 80%. These differences in coding interpretations were discussed by the team, in order to reach consensus.

Results

The following section presents actual textual material and themes on the observation data from bilingual nurses and doctors, interpreters and multicultural health workers. They are described under the seven themes previously identified by Johnson et al (1999) and Matthews et al (2000). These are the scope of language use, language proficiency, the nature of the communication or interaction, the nature of the contact and relationship to the patient, responsibility for patient, and the relationship with other health care providers.

Bilingual Doctor-Patient Interactions

Ten interactions were observed for three doctors. All occurred in the Emergency Room. Languages were Arabic and Vietnamese.

Scope of language use

The language use of bilingual doctors predominantly reflected complex technical requirements such as conducting medical examinations, eliciting a medical history from patients and explaining tests and procedures, with some social language or everyday language use interspersed within the interaction. The movement between the two registers of language confirms the use of a continuum and movement between the two levels. However, there were many examples of a progressive approach to language use; beginning in everyday language, becoming more complex and returning to everyday language on terminating the encounter. The complexity referred to was more related to the use of words, rather than complete conversations, that would not appear in everyday conversation. There is intermittent insertion of technical words.

Culturally-specific greetings and expressions were used, such as *"God willing"* and *"May God give you strength"*. Doctors also used 'everyday language' in communicating with LOTE patients, rather than the more highly specialised medical register adopted when communicating with other health professionals. For example, the explanation of a potential diagnosis from English was transmitted by the bilingual doctor as *"We have examined your ECG and we are suspecting an endocarditis, which is an infection of the membrane that covers the heart."* There was also lexical transference (Pauwels, 1995), that is use of terms in English interposed into the LOTE communication such as the word, *"laminectomy"*, explained immediately after in the LOTE as *"an operation on your back to fix the bulging disc"*.

Language proficiency

Two of the doctors observed had completed some part of their training in their LOTE or had NAATI qualifications. The other doctor took the independent language test and scored in the highest range. This meant that these doctors could easily use both social and complex language within the one interaction. This occurred even when the context of the interaction was quite complex such as performing an assessment or diagnosis.

Nature of the communication or interaction

Communication was mixed between *direct* with patient, mostly eliciting a history or conducting a physical examination, and communication facilitation for a colleague or *indirect* but within a dyadic communication with the patient. Where communication was direct with the patient, doctors conducted their medical assessment as they would in English.

This interaction, Scenario 1, is an example of social and technical language use in a complex context of interaction. The nature of communication is direct and dyadic meaning that two persons are involved in a direct face to face communication. In this case, the bilingual doctor is the direct care provider. The example also follows the classic introduction, opening lines, and close-ended questions typical of biomedical interactions. The patient's response was clear in its description of the symptoms experienced.

Scenario 1: Direct communication

Doctor	I'm Doctor A, how are you feeling?
Patient	I'm feeling a bit better, thanking Allah!
Doctor	Could you tell me exactly when did you have the pain for the first time?
Patient	Yesterday at about 9.30 at night I felt "heaviness" in my chest which gradually moved upward to my neck and along my left arm.
Doctor	How long did it last?
Patient	About half and hour and then it disappeared gradually.
Doctor	Have you ever had this "heaviness" before?
Patient	No never. But I have been feeling weak for the last couple of months. I felt that I lost some of my fitness…you know, like I started having difficulty breathing when climbing stairs or doing housework…I also had like ants crawling over my body every now and then.
Doctor	OK, who referred you to emergency?
Patient	This morning I was very dizzy, I could hardly see anything around me, so my daughter took me to the GP who asked me to do this cardiac test…
Doctor	(interrupting patient) ECG?
Patient	Yes, that one.
Doctor	(after examining patient silently and while still looking at the ECG) I have to discuss your situation with a colleague and then you will probably need to see a cardiologist.
Patient	Thanks doctor, I really appreciate this. May God give you strength!

On other occasions, bilingual doctors were able to assist their colleagues in finding out information for diagnosis and treatment. In these cases, they were not the direct care provider but rather acted as *communication facilitators* involved in indirect communication, and not undertaking the process of formal interpreting. This was observed in the way in which they worked with the client, adding questions that were related to the assessment just as they would had they been responsible for the patient. The bilingual doctor then summarised the information for their monolingual colleague. This is quite distinct from the role of an interpreter as it was characterised by a dyadic interaction and can be seen to add a second clinical opinion.

In the following example, Scenario 2, Doctor A asks a number of questions, in the LOTE, as he would if the patient were his or her responsibility, then summarises the information for the admitting English-speaking doctor. The two doctors communicate in English. This is an example of communication facilitation, using direct and dyadic communication with the patient and a monolingual doctor.

Scenario 2: Communication facilitation

Doctor A	(using gaze and eye contact with patient) Hi, I am Doctor A. I am here to help with the language. How are you?
Patient	(looking distressed, in pain trying to smile) I am OK, I guess. Thanks god!
Doctor E	(addressing Doctor A) I just want to know some information about her abdominal pain.
Doctor A	(looking at patient) Mrs. M, could you tell me how long have you had the pain for?
Patient	About three days ago?
Doctor A	OK, was it sudden or progressive?
Patient	I guess it was sudden. I was in the kitchen when I felt this pain here (pointing to the right lower part of the abdomen). It was like someone stabbing me with a sharp knife.
Doctor A	First time you had it, how long did it last?
Patient	It always comes for about 15 minutes each time, then goes.
Doctor A	So once it has gone, you don't feel anything?
Patient	No I don't, but if I press this area (putting her hand on her lower abdomen) it feels tender. Sometimes it is quite painful.
Doctor A	(pausing for a while) What time of the day do you usually have the pain?
Patient	Different times really, but it often happens after a meal.
Doctor A	(turning towards Doctor E) The patient has an intermittent pain on the right of the pelvic area which lasts for 15 minutes and often occurs after a meal.

Summarising information thus far

Doctor E	How long has she had it for?
Doctor A	Three days, She said that she was in the kitchen, three days ago when she felt a stabbing pain.
Doctor E	OK, can you ask when did she have her last periods, it might be a case of ectopic pregnancy.
Doctor A	(turning to patient) When did you have your last period?
Patient	About six weeks ago.
Doctor A	Have you had a pregnancy test done?
Patient	(looking surprised) Pregnancy test? No.

Summarising information again

Doctor A	(addressing Doctor E) About six weeks ago and she didn't have a pregnancy test.
Doctor E	OK, thanks A. Before you go could you tell her that we will need do a pregnancy test and have an ultrasound.
Doctor A	(looking at patient, smiling) Mrs M you will need to do a pregnancy test, and an ultrasound, television test you know, and you will probably need to have a blood test as well.
Patient	(nodding her head) OK thanks.
Doctor E	Thanks a lot A.
Doctor A	Doctor A left the room, leaving Doctor E with the patient.

Nature of the contact

As in any Emergency Room setting, interactions were of short duration, with doctors entering and leaving after brief encounters, usually two to three minutes. This meant that the contact was likely to be of short duration.

Relationship to the patient

In this study we observed the benefits of bilingual patients being able to communicate their signs and symptoms directly with the health professional. Bilingual doctors were able to conduct their medical assessment using their LOTE, and effective communication took place. The interaction shows the patient able to ask questions directly of the bilingual doctor and being answered directly, without communicating through the English-speaking treating doctor. In some cases, there is a suggestion that the bilingual doctor may extend the clinical case discussion as well as providing language assistance. This could extend the role beyond the current communication. In general, however, one would expect the relationship to be limited. This is related more to the nature of the Emergency setting and does not preclude rapport being developed and the patient being followed up at a later stage by the bilingual doctor.

Scenario 3 is an example of social and technical language use, with the bilingual doctor acting as communication facilitator in a dyadic communication with the patient and then with the English-speaking doctor. The contact was intermittent and the bilingual doctor acted as a consultant to the monolingual doctor.

Scenario 3: Communication facilitation and consultation between doctors

Doctor E	(eye contact with patient, then with Doctor A, in English) I know we have talked about this before but could you tell me when have you first had the pain in your back and your leg?
Doctor A	(looking at patient, in LOTE) Can you talk a bit about your pain and when did it start?
Patient	Well I used to work in a nursing home. One day I just hurt my back lifting one of the residents. Then the pain gradually got worse, went down my leg. I went to the doctor; I had many X-rays done. I have also had a scan done.
Doctor A	When did the accident happen?
Patient	About six months ago.
Doctor A	Has your doctor been talking to you about having an operation?
Patient	Yes, but he said I just need to go to the physio for a while and then we see.
Doctor A	(looking at Doctor E, in English) It started six months ago, when lifting a patient at a nursing home. The pain gradually got worse. He has had a scan done and his doctor referred him to a physiotherapist.
Doctor E	So what happened next, I mean why is he here?
Doctor A	(to patient, in LOTE) So tell me exactly why are you here now?
Patient	This morning I tried to move, but I couldn't. My back was so painful. I couldn't feel my left leg either. I was very scared and my brother brought me here to the emergency.
Doctor A	Was your leg numb before today?
Patient	Yes, I had numbness in my leg since the beginning, but today I could not really feel it. It was really terrible (beginning to look very anxious). Will I lose my leg?
Doctor A	(putting his hand on patient's shoulder) No, you will be fine…Just try to relax (turning to Doctor E, in English). He could not get up this morning, his back was painful and he could not feel his left leg, which was numb since the accident.
Doctor E	(looking at patient, in English) Now, have you done anything in the last few days that might have caused what happened - like lifting something or just bending too much?
Doctor A	(to patient, in LOTE) Did you lift something or bend for a long time in the last few days?
Patient	(shaking his head) No, I spend most of the time just lying on a hard mattress. I did not do anything and could not do

	anything.
Doctor A	No, he didn't, he spends most of the time lying on a hard mattress.
Doctor E	I am going to examine him, but you know he will need an MRI. And we will see…probably surgery.
Doctor A	(to patient, in LOTE) Doctor E is going to examine you. You will probably need another scan done – MRI. Then we will be able to make a decision. You might need surgery.
Patient	What sort of surgery?
Doctor A	Well, we don't know yet? But it may be an operation on your back to fix the bulging disc. It is called a *laminectomy* (in English). Actually do you have the X-rays and scan here with you?
Patient	Yes I do, I have shown them to Doctor E.
Doctor A	OK I will see you later.
Patient	*Thanks doctor.* (in English)
Doctor E	Thanks A. I will need to talk later.
Doctor A	(shaking his head, smiling while leaving patient with Doctor E).

Responsibility for patient

Responsibility for the patient was mixed in the ER setting, with bilingual doctors sometimes being the admitting doctor with direct responsibility for the patient, such as in Scenario 1 where the doctor is the health care provider. In others, they were called in by English speaking colleagues, who had direct responsibility; in those cases, they acted as communication facilitators. This is exemplified in Scenarios 2 and 3.

Relationship with other health care providers

Bilingual doctors acted either as the admitting doctor, or as communication facilitator for colleagues, acting as a consultant to a fellow doctor, sharing the responsibility for the client and in doing so, generally assisting in providing health care to the patient. These relationships are all evidenced in Scenarios 2 and 3 above.

Bilingual Nurse-Patient Interactions

Eleven interactions were observed, 10 of these interactions were on the short-stay ward, and one on the long-stay unit. Languages included Vietnamese, Cantonese and Spanish.

Scope of language use

The scope of language used included the full range from simple, such as greeting patients and their families, to more complex language such as explaining the use of a glucometer and procedures such as angioplasty. Compared with doctors the context of interaction was usually more limited, not because of proficiency, but because medico-legal transference is not normally part of the nurse's role. However, there was one example of a nurse conducting a consent on behalf of a doctor.

Language proficiency

Two nurses had completed their nursing qualifications in their LOTE. In the language test, two nurses scored at the highest proficiency level, and the third was assessed at a 'social' level.

Nature of the communication or interaction

Interactions were mostly direct with patient and family, however nurses were also observed to assist doctors in explaining procedures, when requested. In the case of explaining an angioplasty, the nurse was familiar with the procedure and did not interpret word for word for the doctor; rather she explained the procedure, adding correct information even before the doctor had said it. She was able to transmit the questions asked by the patient and answer on behalf of the doctor. This still remains a dyadic communication approach. However, in this case, she acted as a *communication facilitator*, not as an interpreter. The RN understood the procedure, was confident in her language proficiency and would have been able to explain the same procedure in English as well as in the LOTE.

Nature of the contact

All nurse interactions were on the ward units where patients were admitted for a few days or in the case of the long-stay unit, for some weeks. Both units used team nursing, so contact with patients was of short duration (intermittent), such as administering medications, taking vital signs or answering patient buzzers. Both units were busy, with little time for talking at length to patients or families. Nursing work was characterised by mostly brief interactions focused on achieving a specific task. This was less the case for the rehabilitation ward where the contact may have been over a period of weeks rather than days as in the short-stay medical ward, however task-oriented nursing was still the main form of patient contact.

Relationship to the patient

There was evidence of relationships *developing throughout the course of care* as seen in the following example.

Scenario 4 is an example of social language with occasional technical language use in a dyadic communication. The relationship was developing throughout the course of care, and the nurse was the direct care provider.

Scenario 4: Direct communication

RN	(giving the patient medication and checking his chart) How are you today Mr X?
Patient	I am feeling all right. Frankly I do not know why I am still here.
RN	You will be going home soon…
Patient	Is that a fact or are you just guessing (laughter).
RN	No, I heard you are going to be discharged in the next couple of days. Now these are your tablets. These ones are the antibiotics and these are the pain killers.
Patient	(after taking his medication) This is my daughter… (pointing to the visitor sitting on the right side of the bed). She is in the last year of high school and she wants to go to Uni to become a nurse so she can look after her dad (laughter).
RN	That is great (addressing visitor). Which Uni do you want to go to?
Visitor	I'm not sure yet. I would like to go to Sydney Uni -we'll have to wait and see.
Patient	She is very good - I am very proud of her.
RN	That is very nice, OK I will leave you now. Call me if you need me. OK? I'll see you at dinner-time anyway. (addressing visitor) See you, good luck.

The following example (Scenario 5) demonstrates some of the potential problems of using nursing staff to interpret. The reader should compare the differences in the transmission of information from this example with the examples provided in the interpreter transcripts in the next section in this Report. This example explores the situation of a nurse informing a patient about a procedure. In a sense, the question would be whether a nurse would describe the procedure for an angioplasty for an English speaking patient. If the answer is no, because of medico-legal aspects of care, then a bilingual nurse would not be considered the best communicator in this instance.

It is also likely that the patient, nurse and doctor have perceived that the nurse has performed an interpretation, when indeed this would not be strictly correct.

Scenario 5 is an example of technical language transference with some social language use with the nurse facilitating communication between a doctor and his patient. The interaction is direct, dyadic, intermittent, likely to be limited, with no direct responsibility for the patient evident.

Scenario 5: Communication facilitation

Doctor	The procedure is called angioplasty, it is a simple procedure that aims at widening the blocked artery causing you all these problems.
Nurse	The operation is called angioplasty, it is very simple and it will widen the blocked artery.
Doctor	All we are going to do is to introduce a catheter with a balloon on the tip through your groin area and then steer it to the obstructed area under radiology.
Nurse	A tube will be inserted through your groin and will be directed to the blocked area under radiology. On the tip of the tube there is a balloon which will be inflated and will widen the area.
Doctor	The tube will then be inflated and will widen the obstructed area of the artery.
Nurse	(Smiling) I have just told him that. *Interaction continues.*

Responsibility for patient

Most interactions were of nurses who had some responsibility for the patients, who were on their allocated part of the ward. In some cases, bilingual nurses offered to do the medications for LOTE patients even while they were not on that team. In one example, the bilingual nurse could see a problem with understanding, so dealt with it immediately. This observation involved a nurse on her rounds checking medication charts, after hand-over. By noticing and responding to a patient need, the nurse both shared responsibility for the patient and assisted in providing advice and patient education through her LOTE. In this case, the patient said hello in English and pointed to a glucometer. The nurse replied hello in the shared LOTE and the patient showed pleasure and joy at hearing his language. He continued the interaction in the LOTE saying that when he was admitted that morning, another nurse had explained to him in English how to use the glucometer *through his family,* but he could not remember all the details. He added that he did not really understand fully when it was explained to him the first time. The bilingual RN explained the machine and when it was to be used and asked him to repeat all the information. After he successfully did that, they engaged in social communication, with jokes and laughter on both sides. The patient told the observer that *"It is wonderful to know that someone who speaks [the language] is looking after me. I hope you [RN] will keep checking on me every now and then."* The RN added that she would keep an eye on him even if he were not in her section.

In this case the use of family to explain a technical procedure once was not effective communication for the patient. Such information often needs to be relayed several times to be fully understood and ideally the patient should be observed performing the procedure to ensure it is correct. Given the language

problems, even though the patient did speak some English, it was important to check the patient's understanding. The fact that a bilingual nurse was there to reinforce the first explanation was a chance event that proved beneficial for the patient's understanding.

Relationship with other health care providers

Most nurses worked as teams, with bilingual nurses occasionally being asked to assist another nurse or doctor to communicate with a patient, or explain something. At times bilingual nurses participated in a shared responsibility for the client by directly providing information to a patient that was not theirs. In the glucometer observation above, this information was provided without a formal request being made by a monolingual staff member and indeed without the other staff member's knowledge. The bilingual staff member was able to increase the patient's understanding.

Other Themes from Observations

Benefits and problems with family as communicators

Family members were often present in observations with patients. They performed a number of roles, such as acting as advocates for their family member, providing information to staff, informing their understanding of the patient as a person (their likes and dislikes) and giving a cultural and political context to the patient, and as helpers with physical activities such as feeding.

In Scenario 6, the RN is communicating directly with the patient's daughter [the patient had had a stroke] who was able to add information about the patient which assisted in appropriate treatment and effective communication. The information about her father's likes and dislikes is not something that health staff can find out if staff have not been able to assess the patient's ability to communicate in any language. Once the RN had made the assessment that the patient had difficulty feeding himself, the daughter indicated that she was keen to be involved in assisting with feeding her father. This recognised the importance of family in caring tasks, as well as freeing the RN to continue on her rounds.

Scenario 6: Positive family communication

RN	How are you today?
Patient	(nods head, no speech)
RN	I am here to give your medication, and help with lunch. Can you sit up please? Here I will give you a hand (slipping two pillows behind patient's back).
	Now look at all this nice food (uncovering plates on the table in front of patient). I am going to put your medication into the soup, is that OK?
Patient	(shaking his head)
RN	(to visitor) Does he understand Cantonese?
Visitor	Yes, he does. He does not like the soup though. He is very fussy about his soup. (laughter)

RN	Can I mix it with his dessert then? (addressing the patient) Do you like apricots?
Patient	(nodding his head)
RN	(while giving medication) When did this happen?
Visitor	Last weekend, he was watching television in the afternoon when it suddenly happened.
RN	Are you his daughter?
Visitor	Yes.
RN	You are not Chinese?
Visitor	No actually we are from Cambodia but we did live in China for 12 years.
RN	(putting the spoon in the patient's hand) Do you want to give it a go now? (Observes the patient for a minute. The patient found it very hard to feed himself) (addressing the daughter). Do you want to give him a hand or you want me to do it?
Visitor	No I would love to do it - that is why I am here. Thanks.
RN	OK, bye Mr H. Enjoy the rest of your meal. I'll be back in a couple of hours.

While it has been well documented that relying on family members can be problematic or even dangerous, particularly when communicating for diagnosis and assessment (Ebden, Bhatt, Carey, & Harrison, 1988), observations of patients and staff interactions emphasised the benefits of appropriate use of family members. In Scenario 7, the visitor alerts the RN to the problem a patient had sleeping, and acted as an advocate on this occasion.

Scenario 7: Family as advocate, over-reliance on bilingual health staff

RN	How are you today?
Patient	I am not feeling very well. I am in pain.
RN	Is it the chest pain, it hasn't got any better has it?
Visitor	(patient's husband) She was just telling me how she could not sleep yesterday because of the pain.
RN	Did you tell someone?
Patient	I tried but no one could understand me…you know how it is.
RN	You need to try to use sign language next time.
Patient	I do not know how to do that.
RN	You have to try next time. I will go and get some medication.

Scenario 8 is also an example of the family member as advocate for the patient who waited inappropriately to report potentially serious symptoms to a bilingual nurse. The nurse picked up the conversation and enquired if there was a problem, which allowed the patient to explain his concern. In this instance, the RN gives the patient instruction on how to handle the situation better in the future.

Scenario 8: Family as advocate, over-reliance on bilingual staff

RN	(smiling) How are you today?
Patient	(smiling) nodding her head
RN	I'm here to give you your medication. Lunch is also on the way.
Patient	(smiling and sitting up in bed) You said lunch is coming?
RN	(nodding her head) Yes, you also need to take your medication.
Visitor	(patient's daughter – who was sitting on the chair got up and whispered a few words to the patient).
RN	(looking at the visitor and then at the patient) Is everything OK?
Patient	Actually I just wanted to tell you that I had this terrible pain in my chest early this morning.
RN	What sort of pain?
Patient	A stabbing pain, it was terrible. It lasted for like 5 minutes and it stopped me from breathing.
RN	Has it happened before?
Patient	No, not really, but it was awful.
RN	(looking at patient and then at visitor) OK, I will tell the doctor about it but if it happens again tell someone. Don't wait until you see me. Now take these tablets. Leave the green until lunch, have it while you are eating.
Patient	Thanks, that pain really was terrible (while taking medication and drinking a glass of water).

Interpreter Interactions

Twenty seven interactions were observed in a variety of settings including inpatient wards, Aged Care Unit, doctor's rooms, Community Health Centres and homes. Languages observed were Arabic, Vietnamese, Cantonese and Spanish.

Scope of language use

Interpreters working in the health system complete training in medical terminology, ethics and patient confidentiality as well as continuing in-service education in specialty health areas. They are usually able to communicate at the highest level of the continuum, across a range of specialty areas requiring specific terminology.

In the interactions observed there was a mixture of social and technical language, reflecting the style of the health professional in the interaction. As in other interactions, communication was opened by social language, moving into technical language then concluding with social language. There was use of culturally specific greetings and expressions interspersed throughout communication, such as *"God willing"* and *"May God give you strength"* and *"God willing everything will be all right"*.

Language proficiency

In NSW, health care interpreters have to be accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) at paraprofessional or professional levels, and have professional interpreting skills; some have tertiary-level interpreting qualifications.

Nature of the communication or interaction

All communication interactions with interpreters were triadic, which involved formal interpreting for other health professionals such as midwives, physiotherapists, hospital doctors and medical specialists. Interpreters generally performed close to word for word interpretations especially in situations that required some precision, for example, speech therapy and counselling a mental health patient.

Interpreters were generally used to transmit information or seek information from patients, and to clarify issues. The *nature of the contact is intermittent* although in some cases there is some familiarity between the interpreter and both staff and clients. It is clear from the examples seen, that the *responsibility for care* rests *with the health care provider*, however, these examples suggest that both the patient and the provider are the clients.

Scenario 9 is an example of indirect communication which is triadic and intermittent. The interpreter has no direct client responsibility for the patient, and the health care provider and patient appear as clients equally.

Scenario 9: Triadic communication relating to health intervention and education

Physiotherapist	*A physiotherapist came and addressed the interpreter.* Hello I am R, I have called you to give me a hand with Mr. B. We want to get him up, but we find it very hard to communicate with him.
Interpreter	OK? Let's go and see him, actually I have met him before, just two days ago. (When entering the room, the patient was sitting back in his armchair).
Interpreter	(standing in front of the patient, eye contact present, smiling) Hello Mr. B, you look brighter today.
Patient	(eye contact present, looking distressed, shaking his head) Yes, well I am not feeling brighter.
Interpreter	You look better than two days ago when I last saw you anyway. Now I am here to help the physiotherapists to get you up. (She then looked at the physiotherapists and nodded her head).
	The two physiotherapists placed a walking frame in front of the patient and positioned themselves on both sides of the patient.
Physiotherapist	(looking at the interpreter, facial expression neutral). Could you please tell him to put his hands on the arms of the chair keep his feet flat on the ground, lean forward, bottom in!
Interpreter	(standing in front of the walking frame, looking at the patient). Mr. B, could you please put your hands here (pointing at the armchair), feet flat on the ground and try to get up.
Physiotherapist	Use your hands to push.
Interpreter	Put your hands on the armchair and push. *(interaction continues…)*

Nature of the contact

Contact with patients was intermittent, brief and limited to the interaction they had been requested to assist with. This is to be expected, as generally bookings are made by health professionals or clerical staff through the HCIS central office and job requests are allocated to the appropriate interpreter.

Relationship to the patient

Interpreters have a limited relationship with the client, although in the inpatient observations, one interpreter indicated that she had been called to interpret for the patient before. Interpreters, while engaging with patients, made efforts to maintain a professional demeanour. In one interaction with a jovial couple, the interpreter struggled not to laugh out loud at their jokes, teasing and quips, but translated them faithfully. She also would not be drawn into personal conversation with the patient and wife, while the dietitian was looking for translated brochures. In this instance, the interpreter was deliberately limiting her relationship with the clients.

In a few interactions, the interpreter acted to empower the patient by encouraging them to exercise their right to an interpreter. In another, the interpreter explained to a mother on her first visit to a speech therapist with her son, that *"Any questions you want to ask, I'll interpret for you. Usually many questions would be asked at the first assessment."* By providing this additional information the interpreter not only gave permission for lots of questions to be asked, but also indicated it was a normal part of the interaction.

Responsibility for patient

There were no observations of interpreters independently taking responsibility for the patient. The role of the interpreter is not as a direct care provider and therefore this would not be expected. However, the interpreter must document the interaction in the patient's medical record.

Relationship with other health care providers

The health care provider is the client and there is usually a direct communication of information between the health professional and the patient through the interpreter in a triadic relationship.

In Scenario 10 the interpreter enters into the exchange with little disruption to the normal expected flow of conversation for such an encounter.

Scenario 10: Direct communication of information between the health professional and the patient through the interpreter relating to medical assessment

Doctor	(standing on the left side of the bed, looking at the patient, eye contact present, smiling) Hello Mrs G, ready to go home?
Interpreter	(standing on the right side of the bed, looking at the patient, facial expression neutral) Are you ready to go home?
Patient	(sitting on the edge of the bed, smiling, looking at the doctor) Yes, if I can I would love to.
Interpreter	I would love to.
Doctor	Are you still bleeding?
Interpreter	Are you still bleeding?
Patient	Not today. I have checked this morning, just a little bit last night
Interpreter	Not today, a little bit last night.
Doctor	Ok, I will just examine you quickly to see if everything is OK.
Doctor	(addressing the interpreter) Could you pull the curtains please? (The doctor asked the research assistant to leave the room at this stage).
Doctor	(after examining the patient) Everything is OK, I think you can go home tomorrow.
Interpreter	The doctor thinks that everything is OK and that you can go home tomorrow.
Patient	(nodding her head and smiling at the doctor) Thank you.

There was however, an example of a component of an interaction where the interpreter took on responsibility for ensuring that additional health information was provided.

This was an interaction between a monolingual midwife and the patient, where the interpreter *"reminded the midwife about a Pap smear test that she had not mentioned"*. It was clear from this interaction that the interpreter was familiar with the setting and information being transmitted, and indeed, acted as an initiator of providing important health information that the health professional had omitted.

The role of families and carers

The following example in Scenario 11 highlights a very important but subtle understanding about how health professionals, patients and their families,

perceive and utilise health interpreters. The preference for direct family member interaction when treatment or compliance with treatment is being negotiated as a subtext of the interaction highlights the vital role family members can play in negotiating treatment and acting as advocates for their relatives. In this case it is the son who creates meaningful communication between the patient (his mother) and the doctor, by asking questions at the appropriate time.

Scenario 11: Understanding how health professionals, patients and their families, perceive and utilise health interpreters; medical diagnosis and treatment

Doctor	(looking through papers in the file) Mrs C had an operation – mastectomy with removal of all breast tissue and some lymph nodes. The lump removed was 2.5 centimeters, approximately one inch.
Interpreter	(looking at Mrs C and son) You had an operation that removed one of the breasts and some lymph nodes. The lump removed was 2.5 centimetres, approximately one inch.
Doctor	(looking through papers) The cancer is grade 2, not 1, not 3 but 2 – in the middle. Lymph nodes not involved.
Interpreter	(looking at Mrs C and son) The cancer is grade 2. Lymph nodes not involved.
Son	The cancer has not spread to lymph nodes?
Interpreter	The cancer has not spread to lymph nodes?
Doctor	No, not to the lymph nodes. Within the 21 lymph nodes removed, not one was involved with cancer.
	The interaction continues…
Doctor	(looking at the son) I recommend that she take a tablet. It is a tablet normally recommended for someone at her age group, with a cancer a little bit bigger than normal. The tablet is taken once every day, has some side effects... some good things and some bad things. Let's look at the bad things first. Most important bad thing is, it can increase the chance of cancer of the uterus. The chance is small, it can also increase the chance of blood clot in leg, but very small.
Interpreter	(looking at son and Mrs C) The doctor recommends Mrs C to take a tablet. It is a tablet normally given to someone of Mrs C's age, with a cancer a little bit bigger than normal. The tablet is taken once every day. The tablet has some good things and some bad things. It can increase the chance of cancer of the uterus. It also has small chance of increasing blood clot in leg.
Doctor	(looking at the son) The good things are that it can help to decrease the chance of cancer, decrease chance of cancer in the other breast, decrease chance of heart problem and osteoporosis.

Interpreter	(looking at son and Mrs C) The good things are that it can help to lower the chance of cancer, lower chance of getting cancer in the other breast, getting heart problem and osteoporosis.
Son	(in English) Will her blood pressure be affected?
Doctor	(looking at the son) Usually people don't get this problem. (Handing over a booklet). This tells you more about the tablet. Read it and explain to your mother. Think about this and decide next week.
Son	(Son takes the booklet then turning to his mother explains what the doctor said in Mandarin.) *(Son and mother having conversation in Mandarin)* (looking at the doctor) My mum said no need to wait one week, she would like you to give her the tablet now.
Doctor	(looking at the son and Mrs C) I don't want to start you on the tablet as yet, I would like you to think about this a little more and we discuss this next week when you come back.
Son	(turning to her mother to explain what the doctor just said).
Doctor	(looking at the son) Do you still need an interpreter next week, will you be coming with your mum?
Son	(looking at the doctor) Yeh, it's OK.
Doctor	Good, I see you next week then.
Son	Thank you.
Mrs C	Thank you.

In this encounter it is the son that asks the question *"is it spread?"* that helps the doctor move out of medical jargon and into the use of the everyday language of the client. In doing this, the son has clarified what the doctor meant by both the grade of the cancer and the lack of involvement of the lymph nodes. It also provides the opening for meaningful communication between the doctor and patient. Later in the encounter the discussion occurs directly between the doctor and the patient's son, the interpreter no longer providing the link. The son is able to directly negotiate the treatment for his mother because of his ability to speak English, his knowledge of his mother's needs (directly discussed with her at the interview) and an ability to communicate in his mother's language. It also highlights the importance of consulting with key family members about treatment options. This is more important in some particular cultural groups.

This observation shows how family can and do provide vital communication roles that result in positive health outcomes. These roles need to be defined, easily identifiable and incorporated into patient care.

Multicultural Health Staff Interactions

Eleven interactions were observed for ethnic obstetric liaison officers (EOLOs) and five interactions of multicultural health workers in a variety of settings (cardiac rehabilitation unit, postnatal wards, antenatal clinic, Community Health Centres and homes). The languages observed in the interactions were Arabic, Vietnamese, Cantonese and Spanish.

Scope of language use

Multicultural health staff used a wide range of language, and were able to explain complex and technical procedures directly. For example, multicultural health staff were observed to converse socially with clients and their families, as well as conduct a health education class explaining more complex medical information about the physiology of the heart and the effects of heart disease in the everyday language of the patients.

Language proficiency

Multicultural health workers have their language assessed during the recruitment interview by a member on the selection panel who is proficient in the appropriate LOTE. Some multicultural health staff have gained medical, midwifery or nursing degrees in their home countries which are not recognised in Australia and are proficient in their LOTE; other multicultural health staff will be NAATI accredited.

Nature of the communication or interaction

Scenario 12 provides an example of a direct communication between the EOLO and her patient. The EOLOs rarely act as word for word interpreters, but sometimes act as communication facilitators in a dyadic interaction for other health care providers. In Scenario 12, an EOLO was present with a midwife who was booking in a new client. At the start of the interaction, she acted as communication facilitator asking the patient for information and transmitting it to the midwife. While the midwife was on the telephone for ten minutes, the EOLO took the opportunity to directly communicate with the client, by answering questions and continuing with collecting information.

Scenario 12: Direct communication, EOLO and patient.

Midwife	*The midwife asks the patient to show her Medicare card and proof of residential address.*
EOLO	Can we have your Medicare Care please?
Client	No, I lost my Medicare Card and I haven't got a replacement yet.
EOLO	If you don't have a Medicare Card, we can't book you in. Do you understand?
Client	Yes, I understand. Maybe I can have the new card in 2 weeks. (transmitted to midwife)
Midwife	OK, I'll book her in now. But tell her, she'll have to bring her Medicare Card next time.

The midwife puts information on the computer and the EOLO continues to explain why the Card is needed. After this, the midwife takes a booking over the telephone for about ten minutes. The EOLO continues to communicate directly with the client. The EOLO asks personal details from the client (date of birth, country of birth and so on). She later gives this information to the midwife in English. The midwife makes another appointment for the client that the EOLO transmits to the client. Both EOLO and client walk out of the interview room together, with the EOLO continuing conversation.

Nature of the contact

Multicultural health staff may run antenatal classes, or patient education sessions in the LOTE, which means that they see clients over a period of weeks and hence contact may be of *short or long duration*. For example, some EOLOs may have seen a client through several pregnancies and births. In one observation a client approached the EOLO in the antenatal clinic and said: *"Hello, I am X. Do you remember me?"* with the EOLO replying *"Oh, hi, how are you. I haven't seen you for a long time."* Multicultural health staff may be asked to give one-off information sessions to an existing group and the contact will be limited. For example in Scenario 15 the multicultural health worker conducts an information session on rehabilitation after heart surgery.

Four observations involving EOLOs were focused on their completing forms such as the Initial Antenatal Assessment Form and postnatal depression scale. In one lengthy observation, a midwife, interpreter and the EOLO were all there to obtain information from the woman in an antenatal clinic. The midwife started by asking routine questions that were translated directly by the interpreter. The EOLO is mostly silent and removed from the main interaction between midwife, interpreter and woman; she is taking notes during this interaction. It is only when the midwife leaves after a lengthy encounter, which is continually interrupted by the woman's young daughter, that the EOLO initiates questions. The answers from the women are brief in comparison to the lengthy communication with the midwife and interpreter, including an example of empathy from the midwife and interpreter, in the excerpt shown below.

Scenario 13: Example of empathy

Midwife	(referring to daughter playing up) It must be hard for her not to understand anything.
Interpreter	(in English) Poor little girl – so many changes in such a short time. A new country, a language she does not understand and far from her family. (to mother in LOTE) Did she leave her grandparents behind?
Mother	Yes, and for both sides she is the only child.

Compared to this is the excerpt of the interaction with the EOLO that was much more focused on the task of completing the questionnaire (Scenario 14).

Scenario 14: EOLO, direct care

EOLO	Did your mother support breast-feeding for babies?
Woman	(looking at EOLO) Yes.
EOLO	Did your husband's mother like the idea of breast feeding for your baby?
Woman	Yes.
EOLO	What is your daughter's name?
Woman	C. (she responds quickly and anxiously looks at the midwife since she has started to explain about her next ultrasound.)

Relationship to the patient

Multicultural health staff, in general, present a more personal interaction than interpreters with clients, and appear to have a closer relationship with clients. For example, sharing personal stories about migration experiences when obtaining information for the Initial Antenatal Assessment Form (Scenario 16).

Some of the observations showed that multicultural health staff also acted as a **'**bridge' between Australian culture and systems and that of the patient. In one observation of an EOLO, she explained to the woman that "*Here in Australia we encourage mothers to be independent. That means that right from the start, the mother will be responsible for looking after the baby."* The woman replies "*Oh really, that sounds quite hard."* The EOLO responds "*No, it's not hard. Midwives in the postnatal ward will tell you what to do. That is the way it is in hospitals in Australia. They encourage independence."* The patient replies that *"Oh things are very different in X. In X, when you just had a baby in a hospital, nurses would look after the baby for you until you were ready to go home."*

Scenario 15, a health education session with a multicultural health worker running an outpatient class, shows that she consistently encouraged questions from the patients and their partners. The session was lively with many questions asked, the understanding of patients was checked with positive responses from patients. Her descriptions of culturally appropriate food were appreciated by the patients. This multicultural health worker had been a doctor in her own country, although her qualifications had not yet been recognised in Australia. The benefits of her advanced medical knowledge and direct communication with the group, allowed for correct information to be passed on, and were similar to the role of bilingual doctors, nurses and allied health staff on the wards.

Scenario 15: Multicultural health worker, education session, direct communication

Multicultural Health Worker (MHW)	For those who have not met me before, my name is X. I am a doctor from Y. I have been practising in Y for 20 years. During the last two years I have been working with Z health services. (addressing one of the patients, eye contact, smiling) I have not met you before, when did you have the operation?
Patient A	November, 1997. I had a bypass.
MHW	How is life now, do you do exercises?
Patient A	Life is beautiful! I walk for two hours every day and do work around the house.
MHW	That is excellent. It is very important to do exercise after the operation. Having a good diet is as important. I am from Y and I know that you are all from Z, but as you know food in most W countries is the same - very, very fatty.
Patient C	But very delicious. (Laughter from group in general)
MHW	What about Mr L? How is your diet going?
Mr L	My wife is looking after me very well I think.
Mrs L	I only cook white meat, chicken and usually grill them.
MHW	Do you take the skin off the chicken? Hello Mr D. (another couple arrive for the session)
Mrs L.	Yes I do.
MHW	Excellent. What about you Mr C?
Mr C	I have similar stuff, but I usually have this Iraqi dish which consists of chicken, rice and vegetables.
MHW	Sounds great, how do you cook it, or maybe how does your wife prepare it? (group laughter)
Mr C	It is all boiled – the chicken and the vegetable – all boiled. *Discussion about diet and specifics continue, including discussion about culturally appropriate foods such as kebabs. The multicultural health worker then moves on to discussion about cardiac rehabilitation.*

MHW	Can anybody tell me what do we mean by cardiac rehabilitation? I am asking especially people who are here for the first time.
Patient E	Exercising the heart or training the heart.
MHW	A word for word translation from English will mean "fixation of the heart" but since this does not make sense, cardiac rehabilitation would be the "health of the heart". It is about training the heart to function in a healthy way after the operation. Now the heart is a muscle which works a bit similarly to an "engine". It is different than other organs such as kidneys, liver which are not a muscle and are not as essential as the heart. You can see that the heart is the central "engine", so we need to look after it so it can work in perfect conditions, especially after we have had cardiac surgery. (Holding up a plastic model of a heart) Now, the heart is a big as your fist. It is situated in the middle of the chest and is pointed towards the left.

A description of the heart and functions follows which is interrupted by a patient.

Patient A	Is this similar to the valve they have inserted during the operation.
MHW	Yes, it is of a smaller size but it is similar...
	This is followed by a lengthy description of the role of valves and rheumatic fever…
MHW	Overweight and high blood pressure can also be detrimental to the heart.
Patient C	How does blood pressure cause heart disease? I have heard that high blood pressure is not good for your heart. Why?
MHW	It's pretty simple. Imagine a hose connected to a tap. If you put your finger on the end of the hose and turn the tap on, you are increasing pressure which may cause the walls of the hose to become dilated and might even cause rupture. So when the blood pressure is high, it affects the blood vessels, the hose, which affects the heart as well. When blood pressure is high, it can cause rupture and that is the case of stroke for example. OK? Does this answer your question?
Patient C	(nodding) Yes.

The session continues with discussion about cholesterol, angina and other risk factors.

Responsibility for patient

Multicultural health staff share responsibility for clients with other health care providers, and they often share information about the client's progress. In the scenario provided above, the multicultural health worker is acting as a direct care provider. This worker also acted as an advocate for the patients offering to talk to the dietitian to clarify any further information the patients required. In another observation, the multicultural health worker was a case manager who acted as a communication facilitator for a health professional to conduct some tests on the patient, while also organising details of respite care, such as diet and transport. On a number of occasions, multicultural health workers encouraged clients to ask questions of health professionals, or to join support groups and play groups.

Scenario 16 is an excerpt from a longer interaction where the multicultural health worker is taking information about the family and answering questions from the child's father at the same time. It is an example of direct communication that is dyadic and is likely to be a continuing relationship. The multicultural health worker appears to have shared client responsibility with other therapists in the centre. In this excerpt, the multicultural health worker shares her personal story and makes suggestions about an intervention, as well as answering the father's practical questions.

Scenario 16: Multicultural health worker, direct communication

Father	(pointing at child) My daughter is 2 years old, but she can't speak.
MHW	My daughter had this problem too. You'd better bring her to the paediatrician. Bring her to join the playgroup where she can play with other children.
Father	Playing? How about teaching? Does it cost?
MHW	Are you working?
Father	(sounding embarrassed) Actually I work at home…hmmm..sort of..
MHW	If your income is below $520 a week you may get a subsidy. They charge $15.50 for 3 days or 20 hours. So about $5 a day – not much.
Father	Could you give me the address?
MHW	(handed father her business card) I also have a parents support group meeting next Tuesday. I'll give you a brochure about that. Do you mind if I give your address to X to invite you to join the group?

Relationship with other health care providers

The observations did provide evidence that multicultural health workers have a different relationship to patients/clients and they often transmit information without being told by health professionals as direct care providers. They often act

as consultants for other health care providers, and assist in health care provision through communication as well as have a shared responsibility for clients.

This study was limited to observations of five multicultural health workers in 16 interactions, and hence did not capture the range of encounters possible. Further research on the nature and content of health communication by these workers with clients in the community and hospital would be valuable.

Discussion

Patients with limited English proficiency rely upon the communication skills of bilingual health staff and interpreters. This study of 65 health care interactions involving doctors, nurses, interpreters and multicultural health staff, has provided a unique opportunity to explore the roles and functions of each of these staff members within a range of normal health care encounters and interpretation opportunities. Findings from other studies undertaken by this research team were derived from staff recall of events. These findings required support or refuting in a series of actual patient encounters.

Bilingual Health Communication

The Bilingual Health Communication Model, consisting of two continuums (language skill and interaction context), was supported. However, the perception that most medical interactions were technical was not supported, with considerable evidence of the use of everyday language usage aimed at enhancing meaning for patients of technical medical terms. Characteristics of normal medical consultations were present, where pleasantries occur first (social exchange), everyday language being used, then a gradual increasing use of more technical terms interspersed with everyday language words, concluding the interaction with everyday greetings (Heath, 1986). There are, however, subtle differences in the proportion of technical language used by doctors compared with nurses and allied health staff, with slightly more technical language in the conversation of doctors.

Another aspect of the model proposed a continuum from social engagement to health and medico-legal information transference, the implication being that these interaction contexts uniquely occurred in interactions, that is, either it was a social engagement interaction or a medico-legal information transference event. Indeed, the exploration of these interactions demonstrates that one interaction can contain several different contexts. However, there does seem to be a pattern of beginning with social engagement progressing to information transference and then return to social engagement.

Roles and Functions of Bilingual Communicators

Many of the key features of the roles and functions of bilingual communicators - bilingual health professionals, interpreters and multicultural health staff - proposed by Matthews et al. (2000) were supported, although some suggestions for improving the typology are apparent. For bilingual health professionals, whether acting in direct communication or communication facilitation, the composition of language scope is social and technical for both nurses and doctors with slightly differing proportions of each used. The qualifications outlined are consistent with this experience, and confirm the language proficiency proposed in the typology. The characteristics included a discrete category for nature of contact and relationship. It would seem from these interactions that only one category may be required to convey the meaning in the delineation of roles in many wards or units. The authors propose that both categories remain, but it is

likely that either one or the other will be more useful to managers and staff. Another category is required in the patient/client responsibility section for bilingual communication facilitator, that is indirect care provider.

Similarly, the understanding that the health care provider is the client of the interpreter does not seem to match the 'real-life' experience. It would seem that the interpreter often perceives that both the provider and the patient are their clients. Interpreters use their health experience and knowledge to add value to interactions. They do this either directly to the patient or through a gentle reminder to the health professional. In all observed cases presented, this acted to improve the patient's understanding. Also interpreters often provided additional information to empower patients both within the health care setting generally and within individual interactions, acting as advocates for patients, resulting in positive outcomes for both the patient and care provider. Multicultural health staff had characteristics of bilingual communicators and the need for a separate category for these staff was not demonstrated. Table 4 (over the page) presents, in a simple format, the roles and functions (within health communication) of bilingual communicators within the healthcare setting.

Benefits of Bilingual Communication Facilitators

A number of benefits can be identified in using bilingual health staff to communicate with patients who have little or no English. These include the obvious benefits to the patient of having a health professional who can understand them and converse with them directly. This reduces the sense of isolation and alienation in the foreign environment of a hospital, when the patient is often vulnerable and fearful. Nursing staff in particular, are rostered on wards on 8 hour shifts covering 24 hours of the day, and have the most contact with patients. In this study, bilingual nurses were observed to provide patients with comfort and reassurance in their LOTE, in the course of their normal duties. This had the advantage of being direct communication, without requiring complex or technical proficiency in the LOTE. This form of psychosocial, therapeutic communication is not expected to be provided by interpreters, due to the limitations on their time dealing with other clinical communication settings.

Table 4: Characteristics of bilingual communicators and their communication.

	Interpreters	Bilingual or multilingual communication facilitator
Scope of Language Use	Formal interpretation (includes written and verbal consent)	Social Social/Technical Written and verbal consent within scope of professional practice.
Language Proficiency	NAATI accredited[1]	Qualifications from overseas Or NAATI accredited[1] Or Social language Proficiency (self assessed) [5] Complex language Proficiency (formally tested) [5]
Nature of Communication/ Interaction	Triadic Communication[2]	• Dyadic[3] communication • Direct communication between care giver and client
Nature of the Contact	Intermittent	• Intermittent and continuous • Expected to be of short duration • Expected to be of long duration
Nature of the Relationship to the Client	Limited	• Limited • Developing throughout the course of care • Beyond the current episode of care
Patient/Client Responsibilities	No direct /indirect client health care responsibilities Patient Advocate	• Direct care provider • Case Manager • Advocate
Relationship with other Health Care Providers	Health care provider is client	• Consultant[4] • Shared responsibility for clients • Assists in health care provision through communication

[1] Paraprofessional or Professional Level.

[2] Triadic three way communication, where the facilitator assists two other parties to communicate; the direct lines of communication are between persons other than the facilitator.

[3] Dyadic meaning two persons involved in direct face-to-face communication. There may also be another person present but not directly involved in the communication.

[4] Consultant gives advice to other health care staff.

[5] Specific instruments to test social and complex health language are currently being developed by these and other investigators.

Selecting the Right Communicator for the Right Communication Task

The issue that remains is how to apply the conceptual understanding of the Bilingual Health Communication Model and roles and functions of bilingual communicators in a ward situation. The application may appear somewhat simplistic and intuitive to a great extent. For instance, if a monolingual doctor requires a patient to be informed prior to written consent to a procedure then the

most complex interaction context is health and medico-legal information transference, requiring complex technical language verbalisers, that is either an interpreter or a medical officer with appropriate language proficiency. Whereas, a nurse who wishes to explain discharge wound instructions to a family member is in a health information transference situation, where another nurse with technical language proficiency could be the best communicator. These researchers would also propose that although family members have not been included in the Table, there are situations presented in this research that suggest that family members are also important bilingual communicators and advocates for their families. In many examples, where the role has been circumscribed to health information relating to compliance with treatments in particular, they have been preferred by both the patient and doctor.

The use of family members remains a contentious issue and has been related to the lack of interpreters. Cohen and colleagues' study of GPs in the United Kingdom (1999) highlighted that even when general practitioners (GPs) knew they should not be using children as interpreters for adult family members, there were still occasions when they did. The reasons given, as one GP described it, are similar to the views we have encountered in the course of this study.

> *I think the advocates [bilingual] are in short supply. The problem is, the consultations we have with people who require advocates are sufficiently sporadic. It is difficult to have an advocate when you want one, that is the problem. It is just not practical to arrange for an advocate to be around at a specific time during the week when a patient who can't speak English is going to have their peptic ulcer or their back sprain or whatever it is, just organisational difficulties.* (p.168).

Normal Duties

This study has contributed to a greater understanding of how bilingual staff actually use their language in the hospital setting. Nurses and doctors were observed performing their normal duties and tasks. The only difference was that it was conducted in a LOTE. The style and type of interaction varied as would be expected of any individual health professional - some staff are better communicators than others.

In some cases, bilingual health staff had a higher level of proficiency, meaning they could conduct all their normal duties as doctor, nurse, allied health professional or counsellor in a language other than English. The patient-health professional interaction was not mediated through a third party and direct communication took place, saving time and opportunities for miscommunication. However, the key issue for staff and their managers to consider is the understanding of their language proficiency and how to limit usage to that level. This is consistent with the views of Baker et al (1996) of health staff who had some understanding of Spanish, but limited proficiency in complex or health related vocabulary; resulting in situations of miscommunication with adverse consequences. The authors (all physicians) recommended that institutions

required policy that precisely relates language proficiency to scope of language and situations when language could be used. This research team, is currently undertaking such research in order to provide some answers to these questions (presented in Report 4 of the Series).

This study emphasises that staff should use their language skill in a range of activities that reflects two important aspects: 1) their professional standards of practice, and 2) their LOTE proficiency. Undertaking communication facilitation roles beyond their professional scope of practice, is at its simplest understanding, acting out of the role that the hospital supports. This is a simple message easily conveyed at hospital orientation programs, in a manner that is supportive of language use within the right context. The development and availability of simple language assessment tools is a necessary part of this understanding, and the current research is hopeful of providing such tools in the near future.

In conclusion, a process and tool has been provided for managers and health staff to identify communication situations and select appropriate communicators. Although most bilingual communicators are conscious of circumscribing their role to reflect their professional boundaries and their language skills, instances may still occur if policy is not provided to protect staff and avoid negative consequences. Further analyses of these interactions, to identify whether the key characteristics of 'good' or effective health communication are evident, is the focus of the following study (Study 1b).

Study 1b: Exploring health communication for NES patients and bilingual staff.

Introduction

The aim of health services is to provide a quality healthcare experience and outcome for all patients who seek and receive such service. In an effort to determine how best to spend limited resources, health services have focused on how best to assess whether hospitals are meeting the needs of its health consumers, by seeking and obtaining patient perspectives (Draper & Hill, 1995). A comprehensive review of patient satisfaction and tools to assess such satisfaction, undertaken by Draper and Hill (1995), highlighted that there were five common themes throughout the considerable body of consumer research. The first referred to communication, being treated with respect, and being involved in decision-making. Related issues to these major areas were also noted as informed consent, privacy and access to interpreters. Patients also wanted information, verbal and written, and also in other languages. Other issues, such as discharge planning, with patients wanting more involvement of family or carers, were also important to patients. Finally, the professional nature of the health team was important, suggesting positive responses to multidisciplinary teams, good teamwork and good communication between professionals. Many of these issues are beyond the scope of this study, but the issue of communication and information giving and seeking, will be explored in-depth, within the particular context of non-English speaking patients and bilingual health staff. It is noteworthy that complaints relating to communication issues represent 11.2% of all health service complaints in New South Wales, the third most common problem area (1993-1994 reported complaints data, Draper & Hill, 1995).

Considerable understanding about what patients would like from their health services, such as the issues defined thus far, has been derived from the Consumer Health Forum (1994). This Forum, which sought views from all groups including vulnerable groups, clearly identified that non-English speaking (NES) patients experienced considerable communication problems. Draper and Hill provided specific statements about what were the particular facets of communication. These were considered to include: *"the dialogue between consumer and health professionals, most importantly the main doctor, communication between the treating team and family members or carers; and communication between professionals working in different settings…"* (Draper & Hill, 1995, p.17). Being able to access interpreters was critical to NES patients.

Only one study was reviewed that focussed on the use of interpreters: the SA North West Suburbs Health and Social Welfare Council and The Migrant Health Service 1993 (Draper & Hill, 1995). The major points outlined by Draper and Hill's review of this study were: interpreters were predominantly used in hospitals, when an interpreter was not available patients were told to bring a friend. There was also high satisfaction, although concerns were raised about people refusing interpreters because of confidentiality issues and issues relating

to 'fullness and adequacy of interpretation'. Patients expressed the need for 'specialised interpreters' such as for older persons and mental health. Draper and Hill (1995) also noted that the study identified the need for more bilingual workers, and 'flexibility' in choice of interpreter (p.18).

Another area of interest demonstrated from Draper and Hill's (1995) review, was the identification of issues of satisfaction associated with specific health professionals. Draper and Hill (1995) suggest that there can be definable aspects of how patients perceive satisfaction with professionals and they use the example of the inpatient study of NSW in 1993 to 1994 to develop characteristics of satisfaction with the service of nurses and doctors. For nurses, concern, respect, caring and personalised attention, attention of nurses to condition, information and communication of nurses and skill of nurses were seen as important aspects. Similarly, for doctors, information and communication, concern, respect and personalised attention, attention of doctors to your condition and skill of doctors were identified.

All these issues are critical to South Western Sydney Area Health Service (SWSAHS) with more than one-third of the SWSAHS population aged five years and over, speaking a language other than English at home (LOTE) (1996 census, Australian Bureau of Statistics). The 10 major languages spoken by NES patients in SWSAHS include Vietnamese, Arabic, Italian, Spanish, Cantonese, Greek, Croatian, Serbian, Filipino and Macedonian. Although the need for bilingual health staff is evident from both the patient and health professional perspective (Draper & Hill, 1995; Minas, Stuart & Klimidis, 1994), there has been reported an inability, or at the very least, considerable difficulty, in locating or matching the patient with the health staff member with the relevant language skill (Minas et al., 1994).

A cross-sectional survey of all health staff within South Western Sydney Area Health Service comparing language skills of staff with population needs, identified that 31% of health staff were bilingual or multilingual (Johnson, Noble, Matthews & Aguilar, 1998). However, the predominant languages spoken were Tagalog (Filipino), Cantonese, Hindi, Spanish, Vietnamese and Italian. Thirty-seven percent of bilingual staff used their language skills at least weekly, mainly in situations of simple conversation and giving directions. Many nurses (397) were bilingual, but not all in the predominant languages required by patients. Small numbers of doctors were identified as bilingual with language skills likely to meet patient needs. This study also identified that multicultural health staff (including interpreters) played major roles as communicators within the health service using their language skills twice as frequently in terms of daily use. Forty-eight percent of the multicultural health staff (including interpreters) (42 staff) used their language skills more than once a day compared to only 3.1% of the bilingual staff. Forty-seven multicultural health staff (including interpreters) (90.4 %) used their language skills once or more a week compared to the 173 bilingual staff (37%) using their language skills once or more a week (Johnson et al., 1998).

These studies in SWSAHS identified that opportunities for NES patients to communicate with bilingual health professionals existed and were likely to be infrequent communication events compared with interpreter and NES patient communication events. Also the studies implied that both communication events were likely to be perceived by NES patients as positive experiences (Johnson et al., 1998). Further qualitative research was undertaken by the research team using a cross-section of health workers, resulting in confirmation of the positive experiences (Johnson, Noble, Matthews & Aguilar, 1999), but also noting concerns from staff about increased workload and the setting of boundaries with NES patients. These conclusions were drawn from the recall of focus group participants which may or may not have reflected 'real-life' situations. The need for direct observations of communication encounters was highlighted by this work (Johnson et al., 1999).

Although there has been considerable research into the nature of health communication between patients and doctors and nurses (Bottorff & Morse, 1994; Bottorff & Varcoe, 1995; Emanuel & Emanuel, 1992; Heath, 1986; Morse, 1991; Roter et al., 1997), no research had been undertaken which examined the actual experiences of NES patients and bilingual health staff (nurses and doctors) and interpreters, within the English speaking health system in Australia. The examination and comparison of these experiences between the various bilingual communicators may not only provide valuable information on how such communication transpires, but also provide an opportunity to assess how well these communication encounters result in meeting the needs of NES patients. Differences in these experiences of direct communication to the more indirect communication of interpreters can also be explored and evidence sought of critical features of communication that patients are seeking.

Health Communication

Health communication is the fundamental unit of all health care interactions. Similarly, a series of nurse-patient or doctor-patient interactions result in the formation of clinician-patient relationships. Communication has been described as 'a message that is sent, received, and understood' (Schroeder et al., 1999, p.175). A commonly held view is that communication is a form of information transfer, that is, a transmission model of communication. The predominant approach of this transmission model is known as the *sender-receiver* model, with five components that assist or detract from effective communication: the source, receiver, channel, feedback and a message (Laswell, 1948).

Other viewpoints reflect the flow of information rather than the components. In the transmission model, the flow of information can be one-way or two-way. One-way communication is quicker, easier and more uncomplicated than two-way communication, and gives control to the sender (or source), whilst two-way communication allows for the sharing of control. In the health setting, one-way communication is often used to give doctors' or nurses' orders, end of shift reports, written memos, public announcements, and client education (Bradley & Edinberg, 1990). However, it can be problematic when the receiver does not

understand the message, and therefore may not comply. In the case of patient education, particularly about ongoing health problems that require monitoring and self-assessment, the patient must understand clearly what they need to do, when and how. They need to be actively involved, and to be able to ask questions that clarify their understanding. This two-way process is slower, and requires listening and flexibility on the part of the sender to modify messages.

Clinician-patient interactions are a form of social interaction and potentially, share the same theoretical origins as any other social interaction. Social interactions have been explained by the theoretical understandings of symbolic interactionism (Manis & Meltzer, 1978). A major premise of this theory is that human behaviour and interaction are carried on through a series of symbols and the interpretation of the meaning of these symbols by the interacting parties (Argyle, 1969; Fichten, Tagalakis, Judd, Wright & Amsel, 1992; Heath, 1986; Kihlgren, Kuremyr, Norber, & Bran, 1993). Major features of interest in dyadic social interactions include the language used, and the nonverbal behaviour and the meaning that these symbols hold for the participants. Argyle suggests that the nonverbal symbols are used to 'express emotions and interpersonal attitudes' (1969, p.120).

Cross Cultural Communication Issues in Health

It has been well documented that patients with little or no English, experience even greater communication problems than English speakers during health care interactions (Candlin et al., 1974; Shaw, 1997a; Shaw et al., 1997b; Shuy, 1981, 1983; West, 1984; D'Avanzo, 1992; Elder, 1990). Whilst these problems may be due to a range of factors, it is generally agreed that language barriers are a major cause of miscommunication (McNamara, 1990; Pauwels 1991, 1995; Minas et al., 1994) and can result in poorer health outcomes for patients. Inability to communicate with health providers is considered as an obstacle to primary, emergency and inpatient hospital services.

The consequences of failure to overcome the language barrier have been investigated and documented in a number of studies. Poor exchange of information can lead to misdiagnosis and/or poor understanding for the patient of their diagnosis and treatment (Woloshin et al., 1995). Limited communication in the diagnostic interview, may lead to increased reliance upon tests, or conversely a failure to recognise the need for a particular test (Baker et al., 1996). There is evidence of a higher rate of resource utilisation - increased use of diagnostic tests and length of stay - in Emergency Departments, associated with a language barrier between provider and patient (Hampers et al., 1999). Poor understanding of diagnosis and treatment may affect compliance with treatment. Language barriers have also been associated with patient dissatisfaction, poor clinical outcomes and ineffective patient education (Hampers et al., 1999). Issues about consent continue with it being highly questionable that consents obtained without adequate bridging of the communication gap, through professional interpreters, are informed (Hampers et al., 1999). Increased work and stress for staff was found in an American study of the impact of language barriers on residents.

Increased length of workdays, increased daily stress and reduced teaching effectiveness were all evidenced (Chalabian, 1997). Isolation created by the inability to communicate with health workers or others has been noted within the hospital environment and in the community (Chalabian, 1997). Limited use of health services has been documented in Australia and overseas, stemming from both language barriers and cultural differences (Hampers et al., 1999).

From this litany of potential problems there are clearly many advantages for both patients and health services to improving communication between health providers and NES health consumers. What remains to be considered is how best we can address the issues within existing or diminishing resources?

Bilingual Health Communication: Bilingual Health Professionals and Interpreters

To assist in resolving these problems further, a conceptual understanding of how bilingual health communication occurs was sought. This need to understand how bilingual workers (bilingual health professionals, support staff, or interpreters) communicated with NES patients was the basis of previous work undertaken by some members of this research team (Johnson, Noble, Matthews & Aguilar, 1999). A conceptual model for bilingual staff/patient encounters was described that identified that there were four major groups of bilingual staff that represented a configuration of fluency level (no fluency but cultural awareness to complex verbaliser) and interaction contexts (social engagement to complex health care information transference). The interaction contexts defined in that study were similar to those in monolingual interactions within hospital settings (Bourhis, Roth, & MacQueen, 1989), although presented as language rather than interaction context. The reason that interaction context is varied in this situation is that bilingual health workers may be the direct carer or may be simply providing communication support to another worker. Bourhis and colleagues (1989), using a social psychological analysis of communication patterns, identified differing registers adopted by health professionals and patients in hospital. These registers were classed as ‘medical language’ and ‘everyday language’. They found that doctors perceived that they used everyday language when communicating with patients, but this was not the patient’s perception. Nurses emerged as communication brokers, mediating the communication of doctors and patients.

From the SWSAHS study (Johnson et al., 1998) the majority of bilingual staff were described as social engagers using social language skills. Participants in this study reinforced the importance of social interactions and conversations with patients within our health care systems. This Bilingual Health Communication Model also supported a small group of staff who had language skills that allowed transfer of complex health care information and management of medico-legal issues. These staff had often obtained their professional qualifications in their country of origin. The research team noted that further research on actual patient interactions was critical to confirming this interpretation of bilingual communication. Health care interpreters, whose main task is to interpret health

communications, usually possess complex language proficiency, accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) in a particular community language. They are also trained in medical terminology and 'operate under a code of professional ethics placing healthcare interpreters within the 'voice box' type, the health professional having biomedical content knowledge and controlling the exchange of information' (Matthews, Johnson, Noble & Klinken, 2000). Interpreting is a process whereby the sense and intent of what is being said by the health care professional is conveyed whilst preserving the content (Phelan & Parkman, 1999). Vasquez and Javier (1991) describe this process as deciphering two linguistic codes. Other definitions of interpreters and interpreting processes have been derived from health experiences. Hatton and Webb (1993) describe a 'voice box' interpreter where information is translated word for word; an 'excluder' interpreter, where the interpreter is predominant over the professional; and a 'collaborator' interpreter, where control of the conversation travels between the interpreter and the practitioner (Hatton & Webb, 1993). Interpreters deliver the message rather than focus on the meaning of the message. The responsibility for the outcome of the communication remains with the health professional (Matthews et al., 2000). Interpreter communication occurs within triadic communication encounters (providers, clients and interpreters). These practices have led to several researchers confirming that language and culture are important aspects of evaluation and treatment processes (Janetti, 1998). Further training of interpreters in specialised fields such as psychiatry and rehabilitation in order to enhance the quality of the services provided is suggested (Acosta & Cristo, 1981; Altarriba & Santiago Rivera, 1994; Dikengil et al., 1993; Westermeyer, 1990). Similarly, patients are seeking a 'fullness' in interpretation (Draper & Hill, 1995).

The use of both accredited interpreters and ad hoc interpreters (untrained bilingual employees, family and friends) for a variety of medical settings has led to issues being raised about the potentially negative effect on the provision of good health care (Cambridge, 1999; Diaz-Duque, 1989; Ebden et al., 1988; Jentsch, 1998; Pochhacker & Kadric, 1999; Putsch, 1985; Vasquez & Javier, 1991). This study will provide an opportunity to closer examine interpreter interactions with NES patients and health staff and explore both the positive and negative aspects of interpretation.

In summary, effective communication is the central concern of our research, a concern for health equity and access for all patients. At best, it is hoped that the health service is meeting the community needs of both the English speaking and NES patients. The need for flexible, innovative forms of cross-cultural communication is vital, as effective communication is at the heart of the clinician-patient interaction. Without it, clinicians risk misdiagnosis, over-reliance on expensive tests, poor compliance with treatments and possible medico-legal challenges.

While there has been research and development in ethno-specific and community-based services, less attention has been given to the hospital setting.

Yet, for people with little or no English, the period of hospitalisation can be one of isolation and fear, worsened by the lack of communication with staff and other patients. They are removed from their family and community support networks, and have to fit into hospital routines with regulated visiting hours. They are generally sick and more vulnerable than they would be if they were healthy and at home. How do these people communicate while in hospital? This issue of health communication within the bilingual health staff and NES patient experience is the focus for this report.

Aims

The aims of this study are to:

a) describe the nature (information seeking and obtaining by NES patients, participation in decision-making, evidence of concern, respect and caring, and personalised attention, attention to the patient's condition) of the health communication between bilingual doctors and NES patients in acute settings;
b) describe the nature (information seeking and obtaining by NES patients, participation in decision-making, evidence of concern, respect, and personalised attention, attention of nurse to patient's condition) of the health communication between bilingual nurses and NES patients in acute settings; and
c) describe the nature (fullness and adequacy of interpretation, interpretive processes, specialised interpretation) of the health communication between NES patients, interpreters and health professionals.

Methods

Qualitative data derived from 65 health communication interactions with bilingual staff and their patients, including bilingual doctors, nurses, interpreters and multicultural health staff were analysed using secondary data analysis techniques. Staff who participated came from diverse language groups. The sample characteristics of the staff and patients are fully described in Study 1a.

Content analysis was undertaken using Non-Numerical Unstructured Data Indexing and Searching Theorising (NUD*IST). The original coding of data described in Study 1a was the basis for subsequent coding. Further codes and exemplars were added to highlight the shifting emphasis to the nature of the health communication.

Results

Bilingual Doctor-Patient Interactions

Ten interactions were observed within the Emergency Room. Languages spoken were Arabic and Vietnamese.

The following framework, derived from the previous reviews of what patients want in health communication will be used when reporting on interaction transcripts. It will be discussed in the framework of NES patients seeking and obtaining information, participating in decision-making, and that health staff convey concern, respect, and personalised attention, as well as doctors demonstrating attention to the patient's condition. *The nature of the health communication*

From the ten bilingual doctor-NES patient interactions, all occurring in the Emergency Department, it was apparent that most of the patient-doctor interactions observed were related to complex health information transference or exchange. Bilingual doctors used their languages other than English (LOTEs) to conduct medical examinations, elicit a medical history from patients and to explain tests and procedures.

Doctors also used 'everyday language' in communicating with LOTE patients, rather than the more highly specialised medical register adopted when communicating with other health professionals.

> *"You will need to do a pregnancy test and an **ultrasound, television test** you know, and you will probably have to have a blood test as well."*

Another example was in the explanation of a potential diagnosis in English that was then transmitted by the bilingual doctor as only the word endocarditis was said in English, the rest in the LOTE - this is lexical transference.

> *"We have examined your ECG and we are suspecting an **endocarditis*** (in English*) which is an infection of the membrane that covers the heart."*

Concern, respect, and personalised attention, attending to patients condition

One bilingual doctor said he deliberately commenced all interactions in English, even with LOTE patients, so he could assess the level of English proficiency before assuming the patient wanted to communicate in the LOTE. Once he ascertained that the patient was more comfortable in the LOTE he would *"slip into using [the language]"*. This would be an example of *personalised attention* for the patient.

Similarly there is evidence of *respect* and recognition of cultural origins. There was use of culturally specific greetings and expressions, such as *"God willing"* and *"May God give you strength"*.

This transcript below demonstrates *conveying concern* within an episode where the bilingual doctor is acting as a communication facilitator for another doctor (English speaking). It would also be conceivable that the patient would see this as very personalised care, that is, doctors speaking in his/her language and the attention of two doctors.

Doctor	I am actually here to help doctor E, you know the doctor you saw in the admission, to translate for him in X. Can you speak English?
Patient	Just a bit, enough to get by you know, but not much. (smiling).
Doctor	(putting his hand on the patient shoulder) OK. So we will be back soon.

Attention of doctor to patient's condition is evident within this interaction focusing on medical assessment and diagnosis. Of particular interest, is the sense that the doctor is responding and following the leads that the patient, who is experiencing pain, is giving.

Doctor	I am Doctor C. I'm just going to ask you a few questions about your condition, if you don't mind.
Patient	Yes, sure.
Doctor	When was the last time you had the pain?
Patient	Today at lunchtime, about one o'clock.
Doctor	Can you describe it to me? Where it starts. Does it move from one area to the other?
Patient	It usually starts here (pointing to the middle of his chest) and moves to my shoulder.
Doctor	You said usually, how often does it happen?
Patient	Today I had it twice in the morning at around 10 and then at lunch time, but I had it pretty much regularly during the last 4 months. I have had three operations to extract air from my [lungs]…

This following example demonstrates several features of health communication with the bilingual doctor being a communication facilitator. Such issues as *information seeking and obtaining by NES patients, concern, personalised attention, and attention of doctors to the patient's condition* are evident from the transcript.

Doctor E	So what happened next, I mean why is he here?
Doctor A	(to patient, in LOTE) So tell me exactly why are you here now?
Patient:	This morning I tried to move, but I couldn't. My back was so painful. I couldn't feel my left leg either. I was very scared and my brother brought me here to the emergency.
Doctor A	Was your leg numb before today?
Patient	Yes, I had numbness in my leg since the beginning, but today I could not really feel it, it was really terrible *(beginning to look very anxious)***.** Will I lose my leg?
Doctor A	*(putting his hand on patient's shoulder)* No, you will be fine…Just try to relax. (Turning to Doctor E, in English). He could not get up this morning, his back was painful and he could not feel his left leg, which was numb since the accident.

Bilingual Nurse-Patient interactions

Eleven interactions were observed on a short-stay medical ward, and long-stay rehabilitation unit. Languages included Vietnamese, Cantonese and Spanish.

The following framework will be used when reporting on interaction transcripts: *information seeking and obtaining by NES patients, NES patients participating in decision-making, nurses conveying concern, respect, a sense of caring and personalised attention, and nurses demonstrating attention to the patient's condition.*

The nature of health communication

During the interactions examined there was a spread of both social language use, such as greeting patients and their families, and complex health information such as the purpose of tests. Most health communication appears to occur whilst a task is being undertaken whether this is assessing the patient, taking a blood sample or administering a medication.

The following interaction demonstrates *information seeking and obtaining by NES patients, concern, respect, caring and personalised attention by nurses.*

RN	(standing in front of the bed, looking at the patient and smiling) Good morning Mr.R. Did you have a good sleep last night?
Patient	(sat on the edge of the bed when he saw the RN coming towards him). It was not too bad S (patient seems to know the RNs name). This person (point to the bed next door and talking softly) was snoring all night (smiling).
RN	Ah OK, what about your medication? Did you have your medication this morning?
Patient	Yes, I had the other nurse give [me] the tablets.
RN	So everything is OK?
Patient	Yes, except I want to go home as soon as possible, I have promised my grandson to take him to watch soccer game next weekend. But I am not sure if I am going to make it.
RN	Which game and when is that?
Patient	Manchester game you know (smiling), next Sunday.
RN	I think you will be out of here by then.
Patient	Do you think so? I am feeling better. Really.
RN	I don't think you will stay here more than four days but I am not sure exactly how long? I have to go now; I will see you at lunchtime for your medication.
Patient	Bye, Bye

The following interaction demonstrates *evidence of information seeking and obtaining by NES patients, and nurses conveying concern, respect, and care, as well as personalised attention and attention of nurses to the patient's condition.* There is also an account of what has been called 'false reassurance' towards the end of this example.

Patient	Can I have something for this temperature? It is running me down.
RN	We need to know how it is this morning first (handing a thermometer to the patient).
Patient	(Returns thermometer to nurse after a minute or so).
RN	OK it is pretty high – it is about 40. The doctor will probably prescribe some antibiotics for you. I was asked to take a blood sample, so we will know the reason for your high temperature.
Patient	I had one yesterday.
RN	(preparing needle and tube) That was for a different thing – that was to see if your liver works. OK. Can you pull up your sleeve please? (took blood sample, labelled tube and wrote on chart). OK, do you need anything?
Patient	My daughter is supposed to come visit me yesterday but she did not turn up. I am worried about her. Could you please ring her up? When you have time?
RN	OK, have you got the number?
Patient	(handing with a shaking hand the number on a piece of paper). Thanks. I hope she is OK. Her name is F – it is on the paper.
RN	Don't worry- she will be all right. I will get back to you.

Evidence of *information seeking and obtaining by NES patients and nurses caring and providing personalised attention* was also apparent from this transcript of an interaction.

RN	How are you today?
Patient	I'm all right.
RN	I am here to give your medication. (administering a nebuliser to the patient) Can you sit up for me please? Would you like a hand?
Patient	Yes, I'm feeling weaker every day.
RN	(while helping the patient to sit up) Do you need another pillow?
Patient	No… do you know when I will be able to go home?
RN	I am not sure, but I have heard that it is going to be pretty soon.
Patient	(after nebuliser is finished) What is the day today?
RN	Thursday…I'll see you at lunchtime.

Evidence of nurses conveying *concern, caring and personalised attention, attention to the patient's condition, assisting in negotiating the health system, learning how to get help at appropriate times* was also apparent from this transcript of an interaction.

RN	(looking at the visitor and then at the patient) Is everything OK?
Patient	Actually, I just wanted to tell you that I had this terrible pain in my chest early this morning.
RN	What sort of pain?
Patient	A stabbing pain, It was terrible. It lasted for like 5 minutes and it stopped me from breathing
RN	Has it happened before?
Patient	No, not really, but it was awful.
RN	(looking at the patient and then at the visitor) OK, I will tell the doctor about it but if it happens again tell someone don't wait until you see me. Now take these tablets. (handing the tablets) …
Patient	Thanks, that pain was really terrible (while taking medication and drinking a glass of water afterwards).

Interpreter-Bilingual Health Professional-Patient Interactions

Twenty seven interactions were observed in a variety of settings – inpatient wards, Aged Care unit, doctor's rooms, Community Health Centres and homes. Languages used included Arabic, Vietnamese, Cantonese and Spanish.

The nature of health communication

Interpreters are mainly involved in complex technical health information transference, with the majority of the interactions being related to consents for procedures and/or surgery, clarification of misunderstandings between health professionals and patients, explanation of tests and assisting in health education.

All communication interactions with interpreters were triadic, which involved formal interpreting for other health professionals – midwives, RNs, dietitians, physiotherapists, speech therapist, hospital doctors and medical specialists (surgeon, cardiologist and neurologist). An interpreter could have acted as a 'collaborator', allowing exchange of control of the conversation between the interpreter and the practitioner, a 'voicebox' translating information word for word or an 'excluder' where the interpreter takes over the conversation and leaves the professional out.

Enhancing the fullness or completion of the interpretation, and being able to have an interpreter were key issues from a patient perspective identified in the introduction.

Interpretation - 'voicebox' interpretation process

In the main, most interpreting interactions were a reflection of the 'voicebox' form of interpreting, although the application of just one discrete interpreting style was not always possible. There is some evidence of short periods in the interaction where there is a change in process (that is, changing to 'collaborator' or 'excluder'). An exemplar is provided to allow the reader to experience the 'voicebox' method. The content of this interpretation focuses on explaining diagnosis and associated tests required.

Doctor	(standing in front of the patient bed, looking at the patient, eye contact present, facial expression neutral). I am doctor H, and I am here to talk to you about an angiogram, a test we need to do to find out what is wrong with your heart.
Interpreter	(sitting on a chair on the left side of the bed, leaning forward towards the patient). This is doctor H. She is here to talk to you about a test which will show you heart's problem.
Patient	(lying in bed, looking at the doctor, facial expression showing exhaustion). I have no energy doctor.

Interpreter	She has got no energy.
Doctor	That is because your heart is not functioning very well.
Interpreter	Because your heart is not working very well.
Patient	They told me I have a blood clot, but I think it is to do with my nerves.
Interpreter	She was told she had a blood clot, but she thinks that is to do with her nerves.
Doctor	Yes, we do suspect that you might have a blood clot. That is why we need to do the test, so we can find out for sure.
Interpreter	Doctors suspect that you have a blood clot, they need the test to show them if there is one for sure.

Additions, changes and omissions

Interpreters generally performed word for word interpretations especially in situations that required some precision such as in speech therapy and counselling a mental health patient. However in some instances, they *added* words and phrases to improve understanding. In one observation, a midwife is going through routine discharge information, explaining breast-feeding to a patient and says*: "Remember that the baby's mouth should be wide open and that he should be sucking on the whole nipple."* This was translated to: *"Remember what we said before. The baby's mouth needs to be wide open so the baby can suck on the whole nipple**, not only the darker area but the brown area as well**."* In another interaction with a 70 year old woman, the RN said *"You will need to have a pelvic ultrasound done."* This was translated to: *"You need to have a test for your lower abdomen area. It is like a television which will show the doctors what is wrong. Can you see what I mean? The same test pregnant women have."*

What is also interesting is that the use of the term 'television' for 'ultrasound' is exactly the same term used by doctors in previous interactions described. In a sense, it is the knowing of the lay term used by the health professional for the technical procedure that is what the interpreter needs to know and use if necessary, as has occurred in this situation.

There was evidence of a *change* in emphasis by changing the phrasing of a question. The midwife asked, *"This is a hepatitis B brochure. Actually do you want to immunise your child?"* This was translated to *"You want to immunise your child don't you?"* to which the patient said *"yes, yes"* and the interpreter continued adding information that the midwife had not said, *"This is the jaundice brochure – as you see it is written in [language]**. You need to immunise your child at birth, second month and sixth month.**"* The interpreter then reminded the midwife about a Pap smear test that she had not mentioned. It was clear from this interaction that the interpreter was familiar with the setting and information being transmitted, and indeed, acted as an initiator of information when it was omitted by the health professional. While this is not the strict role of the interpreter, it was of benefit to the patient. The concern would be for a health professional who is not aware that this is happening, and if

information is altered or incorrect information is being transmitted. By reminding the health professional in English, the midwife was then able to add this information which was then translated back to the patient. In this instance it was better than the interpreter just adding that information, without the health professional knowing that it had occurred.

On another occasion, an interpreter reminded the health professional about information that was missing or inaccurate. While weighing a patient, the dietitian says *"Your weight is 120.8."* The interpreter looks at the balance and asks the dietitian *"Sorry, how much is his weight…120.8 kilos?"* The dietitian looks at the balance and says *"Oh no, sorry, I meant 130.8 kilos."* This subtle correction was not interpreted for the patient, and the interpreter was able to rectify the mistake with no loss of face for the health professional. She did not translate the error, but sought clarification from the health care provider first.

Clarifying misunderstandings

Interpreters were generally used to *transmit routine information* or *seek defined information from patients*. However there were some significant observations where they had been used to *clarify misunderstandings*.

In the following exemplar, the patient requested that she speak with the doctor with an interpreter present because two doctors had told her different things. It transpired that the consent for surgery had not been done with an interpreter, but rather through the husband. The result was confusion for the patient. In this example, the interpreter explains the patient's right to an interpreter without being told to (addition). The surgeon arrives and the situation is clarified. This observation shows how the inappropriate use of family (to gain patient consent) can become a major problem for the patient.

Clarifying misunderstanding. Reinforcing patient's rights to an interpreter.

Patient	The other day the surgeon said he is going to take out the lump in my breast. But yesterday another doctor told me, told my husband actually, that he is going to take the whole breast.
Interpreter	The surgeon told me he is going to take the lump off my breast. Yesterday another doctor told my husband that he is going to take off the whole breast.
Doctor B	Was there an interpreter when you signed the consent form? *Translated word for word*
Patient	No, my husband translated for me. *Translated.*
Doctor B	OK, I will have to ring the surgeon and ask him to come and clarify this matter. (Doctor leaves the room to call).
Interpreter	(moving to left side of bed, looking at patient) The doctor is going to call the surgeon and ask him to come and clarify this. (moving closer to the patient and bending over towards the patient). ***You should have asked for an interpreter the day you had to sign the operation's form.***
Patient	Well I did, but the surgeon said that they could not get one and that it would be OK for my husband to interpret for me.
Interpreter	**Access to an interpreter is your right. If you insist they will have to get an interpreter.**

In the following example, an interpreter was called to resolve a misunderstanding with a patient and his family and nursing staff on the ward. The interpreter is used by the doctor and nurse unit manager to explain the problem, which is a classic situation confronting many non-English speaking patients – too many visitors according to hospital policy. The interpreter is able to give the patient a voice in this situation and there is increased understanding on all sides – the patient, the nursing staff and doctor. Without the interpreter acting as a clear word for word 'voicebox' in this situation, the misunderstanding may have been perpetuated. Instead there is a mutual resolution and understanding, and both points of view are clarified. The example is an important one for hospital services to consider.

Clarification of misunderstanding with nursing staff

Doctor	(frowning and talking rather loudly to patient) OK we need to clarify a few things. First of all you can only have two visitors at a time. The nursing staff said that you had around fourteen people yesterday. *Translated.*
Patient	(looking at interpreter, frowning and looking upset) OK but I want it to apply to all patients in the hospital, not only me. *Translated.*
Doctor	That is true. What we are saying, is if you have ten visitors, you can go outside and talk to them as much as you want. *Translated.*
Patient	I know that, but yesterday it was different. *Translated.*
Doctor	OK, now the medication. The staff thought you were in pain so they went and got the medication from the cupboard and prepared it for you, but you refused to take it. This type of medication is very important you know, that is why we keep it in a safe place. But by refusing to take it, it was just wasted. *Translated.*
Patient	I did not ask for a medication. I asked for a doctor. *Translated.*
Doctor	The staff were just worried about you because you were crying and they thought you were in pain. *Translated.*
Patient	(looking at doctor, shaking his head, then looking down).
	There was considerably more dialogue on several other issues, but there is a sense that the miscommunication was resolved satisfactorily for all parties concerned. This is evident from the concluding comments.
Doctor	I hope everything will go smoothly in the future. I hope you will have a nice stay from now on.
Interpreter	**God willing! Everything is going to be OK from now on.**
Patient	The main problem was that I could not understand them and they could not understand me. I think language was to blame. (smiling)
Interpreter	**I think language is to blame (smiling). We could not understand each other.**
Doctor	OK we will book an interpreter for your meeting with the social worker, probably tomorrow. Bye (Doctor and NUM leave).
Patient	(to interpreter) Thank you very much. May God guide you.

Promoting access and encouraging patients to seek assistance.

The following example demonstrates how interpreters seek to act as an advocate for NES patients and encourage patients to seek assistance when needed.

Interpreter	(standing in front of the patient's mother, eye contact present, smiling) Good morning, my name is E. I am the X interpreter, I am here to ask you if you need any assistance with interpreting.
Patient's mother	(looking up at the interpreter, facial expression neutral) Hello... No I think I am all right.
Interpreter	Do you speak English?
Patient's mother	Yes I can manage.
Interpreter	(handing a business card) This is my business card, don't hesitate to call me whenever you feel like you are having trouble with language. You know that access to an interpreter is one of your rights.
Patient's mother	(looking at the card and then at the interpreter, smiling) Thank you, God bless you.
Interpreter	(smiling) That is OK. Call me anytime.
	As the interpreter was leaving, the patient's mother called her.
Patient's mother	E, actually I am wondering if you can help with a small problem?
Interpreter	Yes what is it?

This interaction resulted in a problem being identified, even though the patient was hesitant to access the service initially. An appointment was ultimately made for the patient with the relevant service. This demonstrates an active role in promoting patient rights, and also the interpreter acting as an advocate for the patient within the health service.

Discussion

This study has sought to explore health communication by using two major frameworks derived from research findings of patients' experiences with health communication and health staff. The compilation of patient satisfaction experiences by Draper and Hill (1995) has greatly influenced the selection of the components within this framework used to examine bilingual health professional communication with NES patients. This initial framework proposed that patients (including both English only speakers and NES patients) had a set of expectations of what "good" health communication should be. These were: communication (dialogue between consumer and health professionals, particularly the main doctor; communication between the treating team and family members or carers; and communication between professionals across settings), being treated with respect, and being involved in decision-making. Related issues to these major areas were also noted as informed consent, privacy and access to interpreters. Additionally, specific facets of communication were defined for specific health professionals: nurses were associated with facets of information seeking and obtaining by (NES) patients, participation in decision-making, evidence of concern, respect and caring, and personalised attention, attention to the patients condition; whilst doctors were associated with facets of information seeking and obtaining by NES patients, participation in decision-making, evidence of concern, respect, and personalised attention, attention to the patient's condition. Issues for interpreters included completeness of interpretation, confidentiality and access (Draper & Hill, 1995).

The content of the interactions examined here, was similar in scope to that reported in a large study (Johnson et al., 1998) within SWSAHS identifying 487 situations of language use. However, the percentage of interactions relating to assessing a medical condition was much higher in this study (26.4% versus 8.7%). There was also a high percentage of interactions relating to education (27.8% versus 8.3%).

Nature of Health Communication

The Bilingual Health Communication Model (Johnson et al., 1998), developed from the recall of interactions by bilingual staff, proposed that there was a continuum of social language to complex technical language used in bilingual communication. This major premise was supported in the data from transcripts of actual bilingual communication events or interactions. Differences between health professionals were apparent. For example, doctors used a combination of everyday language and some complex technical health language relating to assessment and diagnosis in this case because of the setting of the interactions. There were also examples of doctors using 'everyday' terms for complex technical procedures. For nurses, the language use was far more of a social nature with all medical terms being delivered in 'everyday' language. Interpreters were involved in the full range of language use, but nonetheless, predominantly in the complex technical area or exchange. This binary model of language (although referred to as social and technical) being presented here, has been noted by other researchers of health communication (Bourhis et al., 1989).

Overall, there would appear to be more use of everyday language than would have been expected by the researchers.

The overall tenor of the medical and nursing interactions were supportive of two-way communication as proposed by Bradley & Edinberg (1990). Indeed, it may be that the nature of the interaction, that is medical assessment and diagnosis, is likely to promote such a form of communication.

There was a limited range of health communication events for both the nurses and doctors, with nurses mainly reflecting communication occurring when undertaking a task. This idea that communication opportunities for nurses are prompted by the need to undertake a prescribed task is well documented by several authors (Athlin, Norberg, Asplund, & Jansson, 1989; Bottorff & Morse, 1994; Bottorff & Varcoe, 1995). In the medical interactions, most reflected the nature of the medical work in the Emergency Department, and will not represent the full range of interaction possibilities in medicine.

Bilingual Health Professionals Meeting the Health Communication Needs of Patients

The impetus for this study was to describe the nature of bilingual health professional communication and interpretation communication. Although much is known of what happens in monolingual health communication, no research had confirmed either the quality or nature of the communication within a bilingual context. The reasons that this might be different include the indirect nature of communication (bilingual health professional as a communication facilitator not direct caregiver) and the possible variation in language proficiency. This study has demonstrated, although in a small number of comprehensive interactions, that most of the key components of communication that patient's are wanting, are present in bilingual health communication events with health professionals. Evidence has been presented of information seeking, initiated by the patient, and responded to by both nurses and doctors. This may be perceived as arguably limited in scope. There is also evidence of expressions of concern, respect, personalised attention, and attention to the patient's conditions.

For nurses, there are also examples of caring. Although these are subjective attributes of communication, the exemplars presented allow the readers to make their own judgement, beyond these researchers interpretations. This approach, rather than the use of somewhat complicated theoretical frameworks, was taken because of its accessibility to patients, health staff, and service managers. The sense that these are normal expected forms of health communication, irrespective of the fact that they are occurring in another language, is an important finding. There are some glaring omissions however, relating to decision-making. This was identified as a critical component of communication. There was one example of this decision-making process in an interaction between a doctor, the patient and the patient's son. In this case the doctor asked the son to take some information home, to read and think about it before discussing the treatment to be given at their appointment next week. The small number may be because of

the scope of the interactions included, or the frequency of opportunities for decision-making to be included; or it may reflect an underlying problem with the knowledge of health professionals on how to include decision-making processes in everyday health communication or the differing attitudes of NES patients to decision making processes and the role and status of the doctor.

There is also some evidence of false reassurance in several of the transcripts. This was an aspect of communication that was noted by patients and clients as unsatisfactory (Draper & Hill, 1995). The explication of assurance and empathy in health communication is beyond the scope of this study, but is an area for further consideration and research.

Interpreters

Interpreter health communication was consistent with guidelines and standards in terms of content or situations in which they are used; assessment and diagnosis, consents and explanation of procedures. A surprising number of the interpreter health communication interactions were also related to miscommunication occurring because either an interpreter was not available or not requested by staff or the patient. These data suggest that miscommunication, in the absence of other bilingual health staff, could be quite widespread. No episodes of NES patients who were not accessing some bilingual staff member were included in this study. The consequence of miscommunication was that there was considerable distress for staff and patient and considerable effort put into bringing the interpreter, the patient and family (on one occasion), and the staff together to resolve the conflict. Although this occurred in only select cases, there is a sense that the recording of interpretation requests for clarification of misunderstandings, would be a worthwhile exercise for interpreter services managers and should be reported to the Area Multicultural Advisory committee.

Although there was ample evidence of interpreters using the 'voicebox' form of direct interpretation, there were also examples of positive aspects of omissions, changes, and additions to the direct instruction of the staff member. The 'voicebox' form of interpretation remains the implicit standard for professional interpreters, although both patients and in some cases here, interpreters also, provided good examples of fullness of interpretation (including necessary information if it is omitted by staff or correcting minor errors of staff). There was also evidence of interpreters gaining and using knowledge of local specialty terms and practices to the patient's advantage. The use of the term "television" for "ultrasound" was an interesting example. This was the same everyday term used by doctors in interactions described in report 1a. In a sense, it is the knowing of the everyday term used by health professionals for the technical procedure that is what the interpreter needs to know and use if necessary. This is beyond the perceived practice standard of 'voicebox' interpretation, but does reflect ideas of 'fullness of interpretation' or perhaps presenting the message to the patient in the right form so it can be understood. In essence, the enforcement of 'voicebox' interpretation, in all contexts, even when medico-legal issues are not involved, may not be in the best interests of the patients or staff.

There are a range of limitations, associated with this research, that need to be noted by the reader. First, this research uses techniques derived from observation research and human ethology. These techniques use limited sample sizes and extensive transcripts to derive ideas and premises. These small sample sizes could contribute to interpretations of data that do not reflect the broader range of possible health communication interactions. Similarly, these interactions have not included situations where NES patients have not had access to bilingual staff. This is an important area of further research. Also, research into English speaking patients' experiences with health communication would provide important data for comparison, and confirmation of equitable and satisfactory health communication from the patient's perspective.

In conclusion, the basic facets of preferred health communication in English speaking health services have been found in bilingual health communication. This 'normal' or consistent health communication has been found where NES patients have accessed the services of bilingual health professionals either in direct communication or when assisting the communication of other monolingual health staff. Similarly, the interpreter interactions also reflect NES patients accessing their services. This presents a very positive picture of health communication for NES patients. However, the incidence of interpreters being requested to clarify misunderstandings, some of medico-legal issues, suggests that when either bilingual health staff or interpreters are not being used, miscommunication rather than communication may occur, perhaps at an unacceptable level. These preliminary findings suggest that quantifying the incidences of clarifying misunderstandings, by using a specific category within interpreter referral data, may provide important information as well as an excellent measure of the state of health communication for NES patients within SWSAHS or other health services. Further health communication research with NES patients who do not access bilingual health staff of any kind, and English speaking patients, with our health service is recommended.

Recommendations for Study 1

The following recommendations are made:

1. A clear framework for more efficient use of bilingual communicators be developed according to their respective roles and attaining the best outcome for the patient.

2. That SWSAHS adopt and implement policy covering the following issues:
   - Ensuring that bilingual staff's use of their LOTE skills is appropriate to their level of English language proficiency.
   - Ensuring that health staff do not call upon their LOTE speaking colleagues to act outside of their level of language proficiency.
   - Compliance with the Standard Procedures for Use of Health Care Interpreters (NSW Health, 1994) is continually promoted and monitored throughout the health service.

3. That the HCIS develops a specific category within their data system to report instances of calls to clarify misunderstandings. This should be reported annually to the Area Multicultural Advisory Committee.

4. That the interpreter inpatient pilot be funded to continue in the major languages used within hospitals within SWSAHS.

5. That other strategies to improve the availability of interpreters in inpatient settings in a timely manner are explored.

6. That training should be provided to bilingual communication facilitators and interpreters to enhance their advocacy role.

7. Further research be conducted into:
   - Health communication with NES patients who do not access bilingual health staff of any kind.
   - A comparative study of NES and ES patients' experience of equitable and satisfactory health communication.
   - The explication of assurance and empathy in health communication.

8. That as part of the implementation of the NSW Health Council report within SWSAHS, the involvement of patients in decision making within their care plan, be reviewed.

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