Matching non-English speaking patients and bilingual staff within wards or units
Report No. 2

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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For additional copies please contact:

Centre for Applied Nursing Research
South Western Sydney Area Health Service
Liverpool Health Service, Locked Bag 7103,
Liverpool BC NSW 1871
Telephone +61 2 9828 6537 Fax +61 2 9828 6519

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Service Models Steering Committee:

Ms Lee Lin Boon	Manager, Health Care Interpreter Service (HCIS) SWSAHS
Ms Jacqui Clark	Employee Services Manager, Liverpool Health Service
Professor Hugh Dickson	Deputy Director, Division of Medicine
(replaced by)	Liverpool Hospital
Dr. Friedbert Kohler	Director, Braeside Hospital
Ms Sandy Eagar	Clinical Nurse Consultant, Clinical Practice, Campbelltown Hospital
Ms Monica Hourmozi	Registered Nurse (RN), Fairfield Hospital
Ms Sylvia Lyneham	Alternating representatives Health Care
Ms Vesna Suljic	Interpreter Service (HCIS), SWSAHS

Multicultural Health Research Team - Cathy Noble, Clair Matthews, Professor Maree Johnson, Associate Professor Anna Whelan (Klinken), Soufiane Boufous.

Introduction

Shared language is paramount to a successful encounter between a health professional and their patient. Language skills are required by the patient to communicate their health problem to a health professional and by the health professional to appropriately assess and intervene. Health communication is also greatly influenced by the cultural interpretation of health and illness (Lipson, 1996). Limitations in shared language or cultural understanding may affect the willingness of patients to access and participate in services (Minas, Stuart, & Klimidis, 1994). These problems are also associated with increased costs (Baker, Parker, Williams, Coates & Pitkin, 1996; Hampers, Cha, Gutglass, Binns & Krug, 1999). Although direct communication with a health professional in the patient's language is proposed as the best possible health communication (D'Avanzo, 1992; Office for Public Management, 1996; Lawrenson, Leydon, Freeman, Fuller, Ballard, & Ineichen, 1998), the opportunities for this to occur remain limited.

Interpreters play a major role in negotiating communication between non-English speaking patients and health professionals, but meeting the increasing demand for interpreters has also created difficulties. Minas et al. (1994) suggest that in some countries interpreter services are already inadequate. This lack of availability of interpreter services is frequently referred to by writers in the area, with the warning that this would lead to the inappropriate use of family members or other support staff (Ebden, Bhatt, Carey, & Harrison, 1988). The assumptions implicit in these statements are that the use of family members and other support staff is always inappropriate (Cambridge, 1999; Pochhacker & Kadric, 1999). What became apparent from the observations, from Report 1 in this series, was the important role that family and carers played in the management of the client. This caused these researchers to further analyse the data to review the impact of family on care and to investigate these assumptions.

In contemporary Australian health systems, including SWSAHS, there exists a potential resource within our bilingual staff (Minas et al., 1994; Johnson, Noble, Matthews & Aguilar, 1998, 1999). Problems with matching the potential language skill with the patient need have been identified some years ago, with limited solutions being posed (Minas et al., 1994; Musser-Granski & Carrillo, 1997). This study focuses on how to locate bilingual staff in close proximity to NES patients and builds upon the foundation work of the previous studies.

The studies presented in Report 1 defined and refined the roles and functions of bilingual health staff in health communication. Substantiated tools were provided to assist managers in selecting the right communicator for the right communication task. Exploration of the nature of health communication between bilingual health staff and NES patients proposed that the elements of what patients want from communication with health professionals, were present within some limitations. Similarly, the context of communication was reviewed and the scope of language used by health professionals was found to be mainly social or everyday words with technical language interspersed within the interaction. Doctors readily used everyday language with their patients, and nurses also mainly used everyday language. However, the interaction contexts

were different, whereby complex health information exchange was nearly always the purpose of medical interactions, nurses framed their communication in a far more social context whilst undertaking a task.

With these understandings confirmed in actual health communication interactions, the way is now clear to review how a ward or unit could be vigorous in attempting to locate bilingual health staff with the right language skills in close proximity to the NES patient with the language need. This matching has remained an unanswered question for some time (Minas et al., 1994). There has been no research that has investigated the locating of mainstream positions (as distinct from ethno-specific positions) in an organised manner to meet the language needs of NES patients. This inability or difficulty alluded to by Minas and his colleagues (1994) has resulted in the task being discounted as impossible, with so few bilingual staff available with the appropriate language skills, and the overwhelming belief that it could not be done within the existing system. These researchers acknowledge that there is a limited number of bilingual health professionals with appropriate language skills, but without at least exploring what opportunity for matching exists, there is certainly not going to be any future opportunities created, unless through serendipity.

These researchers originally sought to uncover the service model or models that could be used to match staff to patient need based on language. Minas and his colleagues had called for 'service models and administrative arrangements' that could support language skill usage in clinical settings (Minas et al., 1994, p.257). Upon reflection, the research team now chooses terms such as strategies or approaches that may be useful in matching language skill with patient need in inpatient wards and units, rather than the term *model*.

Nearly all studies previously undertaken by this research team emphasised the positive aspects of using a second or subsequent language for a staff member (Johnson, Noble, Matthews & Aguilar, 1998; Johnson, Noble, Matthews, Aguilar, 1999; Matthews, Johnson, Noble & Klinken, in press, 2000). This viewpoint was inevitably tempered by cautionary tales of difficulties from the staff member's perspective. These difficulties came from two main areas: monolingual staff requesting communication facilitation in communication encounters beyond the scope of the bilingual staff member's professional boundaries or language proficiency and bilingual staff feeling as though they are acting 'out of policy' (Johnson et al., 1999, p.338).

It was also important to note that contradictory findings had been uncovered between the two studies. The Language Audit noted a reasonably high frequency of language skill use in patient encounters by staff; 173 (37%) bilingual staff members (Johnson et al., 1998), although for far more social interactions than expected. However, there was also a similar proportion of staff who *rarely* used their language skills (37%). In contrast, the transcripts of the focus groups implied that matching happened very frequently and that there were active systems and subsystems that supported the location of language skill to match patient need (Johnson et al., 1999). Analyses of the focus group data also provided direction as to the nature of such a system or approach.

These approaches derived from the focus groups included the 'tiered system' idea 'whereby a simple problem requiring an immediate response was best managed by available staff' and complex explanations needed for consents were best managed by interpreters or bilingual doctors (Johnson et al., 1999, p.339). Other suggestions (derived from existing examples) included language skills exchange between health professionals (Johnson et al., 1999). There were also examples of clusters of languages located where needed (Johnson et al., 1999). This team set out to explore these (assumed) existing approaches and also became active in promoting approaches where systems did not exist.

Objectives

Therefore, the study objectives were to:

- describe strategies or approaches that identify and locate bilingual staff within close proximity to NES patients in the inpatient setting such as a ward;
- describe strategies or approaches that identify and locate bilingual staff within close proximity to NES patients in the emergency room setting;
- review what staff issues or other factors support or impede the opportunity for matching bilingual staff with NESB patients;
- explore the role of the family and carers in the health care setting; and
- outline what organisational processes support or impede the opportunity for matching (data required, workforce and recruitment issues) bilingual staff with NESB patients.

Methods

Although this study uses a qualitative approach, which has been more particularly discussed in the Methods Section of Report No. 1 (Study 1a), additional information is derived from the experience of the research staff within the study sites. As noted previously the research team has strengthened the research design, wherever possible, by using multiple methods, that is, focus groups and interviews with staff and telephone interviews with patients. These approaches have been taken to provide an intensive view of matching within a ward or unit, which may be accidental or deliberate.

Study Design

The study design was a case study approach where, in this case, the wards or units are the case studies. The wards and units represented varying hospital settings. Data were sought from 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 (6 weeks or more) after they were discharged to home. This report focuses only on the ward or unit experience and a small pilot study of NES patients.

Selection of Study Sites and Procedure

Site selection followed a two stage process: the first stage involved calling for expressions of interest and the second was based on an examination of existing data sources.

Site selection based on Expressions of Interest

The selection of case study sites required the units to be willing to participate and to actively support the research process. As Morse (1991:132) stated: *"Good informants must be willing and able to critically examine the experience and their response to the situation…must be willing to share the experience with the interviewer."* Expressions of interest to participate in the project were called for in September 1998. Forms and letters explaining the project were sent to General Managers in the three hospital sites with linguistically diverse populations (Fairfield, Liverpool and Bankstown-Lidcombe) which were then forwarded to service managers. Fourteen units responded and the nominated contact person in each of the 14 units was asked a series of questions to assess their existing service model:

- What is their existing system, if any? How long has the system been in place?
- Number of bilingual staff? What languages do they speak?
- What client languages are most frequently seen?
- Has there been any evaluation of the system?

Site selection based on a review of existing hospital data sources

The selection of the study sites likely to have high proportions of bilingual staff and also high proportions of bilingual patients was central to the research objectives. The researchers sought assistance from the wards and units directly. In addition to this the research team consulted the Division of Planning and extracted data on hospital separations from SWSAHS. These data were then grouped into Service Related Groups (SRGs). An examination of the SRGs for the various hospitals highlighted the fact that these data were too crude for the purposes of site selection based on language concentrations, but were a source of information relating to the issue of languages spoken by patients for a Divisional Head or General Manager. An example of the data is presented in Appendix 1.

From the information gained, a purposive sample was chosen for the case studies[1]. After consideration by the Reference Group and the researchers, three sites were selected for the initial study. The criteria for selection explicitly included:

[1] Purposive sampling is a strategy in which the researchers' knowledge of the population and its element is used to handicap the cases to be included in the sample (Lobiondo-Wood & Haber, 1998). This means researchers adopt certain criteria to choose a specific group and setting to be studied (Holloway & Wheeler, 1996). According to Hammersley & Atkinson (1983) the criteria for sampling must be explicit and systematic.

- High concentration of bilingual staff and clients/patients from non-English speaking backgrounds[2].
- Willingness of staff and Nurse Unit Manager/Medical Director to participate in study.
- Variety of settings that influence patient interactions: that is, short-term/sub-acute, long-stay, and unplanned/acute/emergency.

The final selection of units included a long-term rehabilitation ward (study unit 1) and a sub-acute medical ward (study unit 2). Although no Emergency Department site had expressed interest, it was considered crucial to the study that such a site be included. When approached, one Emergency Room (ER) (study unit 3) generously agreed to participate.

Study Unit Characteristics

After selection of the three units, a semi-structured interview was held with the Nurse Unit Manager (NUM) and/or Medical Director to determine the study unit features.

Systems to match staff and patients

In the three case study units, it was apparent that there were no formalised or explicit systems operating to match the language skills of staff with NES patient need. While data on NES background - country of birth and language spoken at home - were collated routinely for inpatient statistics collection (ISC), there was no visible display of this information within the unit while the patient was being cared for in the units.

For the purpose of this study, the units analysed their patient data to determine the major languages they encountered. The research assistant received information from clerical staff about current admissions of NES patients. Most nurses were only aware of the language of the patient if they had cared for them individually. In some cases, they were not aware of the specific language spoken; as we were told by one nurse: *"she [a NES patient] speaks an Asian language"*.

Methods of communication with NESB patients used in study units

The only ward which regularly used the HCIS was the long-term rehabilitation unit where interpreters were routinely called for case conferences with families and patients. This unit had conducted its own research into cultural variations in the understanding of the specific rehabilitation process (Mohr, Redman & Simpson, 1997). However, all units did use bilingual health staff to communicate with patients, some had word or picture charts, and occasionally interpreters were called if a consent was required or discharge information was needed to be communicated.

Bilingual staff in study units

Although all case study units had bilingual staff, none had an updated, formal system to identify these staff, their language/s or their proficiency. There were, however, high numbers of bilingual nursing staff in the units: 14/28 staff (50%)

[2] The possibility of a match with bilingual staff and NES patients was crucial to assess the effectiveness of any approach.

in study unit 1; and 10/22 staff (45%) in study unit 2, were bilingual. There were, however, only a small number of staff with language skills likely to meet patient needs on the units because of the languages they spoke. Study unit 3 had 22 bilingual staff, mostly doctors with a range of languages (See Report 1 for more details).

When requested, managers were able to go through staff lists and confirm languages with individual staff members. This led to some surprises for the managers who now had updated details of languages spoken, for the purpose of this study. Information on languages spoken by nurses was entered as a field to the ProAct rostering system in one of the units.

As previously described, several sets of data were obtained from the units, to achieve the objectives of this study:

- Transcripts from three focus groups and four one-to-one interviews;
- Transcripts from four patient telephone interviews; and
- Fieldnotes from research staff involved in the project;

Focus Groups

A focus group of monolingual and bilingual staff from each of the units was conducted.

Table 1: Focus group participants

Ward/Unit	Staff	Languages spoken
1	9 nurses	Lao/French/Thai (1) Czechoslovakian (1) Tagalog (1), English (6)
2	6 nurses	Cantonese (2), Vietnamese (1) Persian (1) English (2)
3[1]	3 doctors 2 nurses	Arabic/Russian (1) Arabic (1) English (3) 1 doctor and 2 nurses

[1] Due to workload issues, this group was interviewed individually.

Focus groups were audio-taped. The inventory and questions included:

- The benefits to patients of bilingual staff
- Cultural issues and understanding
- Use of language – appropriate and inappropriate use
- Workload issues for bilingual staff
- Value of language assessment
- Policy on interpreter use versus what happens on ward
- Other methods for communicating with NES patients
- Usefulness of bilingual staff to ES staff
- Feedback on draft policy issues

The moderator and scribe took additional notes that were cross-checked against the audio-tapes. In the Emergency Room site one-to-one and small group discussions took place. These were not audio-taped, but notes were taken by two researchers and cross-checked after transcription. Focus groups in the two ward sites took place over 45 minutes during the afternoon shift changeover period.

One-to-One Staff Interviews

One-to-one interviews with staff were conducted in:
Case study unit 1 – with the Nurse Unit Manager and social worker.
Case study unit 2 – with the Nurse Unit Manager.
Case study unit 3 – with the Medical Director, Nurse Unit Manager, and two bilingual doctors.

These interviews were not taped but transcribed and field notes written up immediately after.

Patient Telephone Interviews

The patient's perspective was assessed by a telephone interview on or after 6 weeks from discharge. From experience with previous studies (Mohr, Redman & Simpson, 1997; Marshall & While, 1994) it was expected that the size of this group would be small and that loss to follow-up would be high. However, the magnitude of the problem was somewhat unexpected. Twenty inpatients were contacted by bilingual research assistants during their stay in hospital, however only four patients agreed to sign the written (translated) consent. Research assistants rang the homes between three and five times at various times of the day, before final contact was made – in all cases during the evening.

Four interviews were completed with patients speaking Arabic (2) and Vietnamese (2). A semi-structured interview schedule was used which contained the following questions:

- length of stay in hospital;
- English language proficiency;
- difficulties with communication experienced in the hospital;
- did they speak with bilingual health staff, interpreters or anyone else in their language;
- were there any times when using their language with other health staff was a problem;
- were they able to find someone to ask (in their language) when they needed help; and
- would they recommend the hospital to relatives or friends.

Bilingual research assistants were given training on the procedure of conducting interviews and observations, particularly on how to take notes of conversations, verbatim (See Report 1a). Extensive notes were written on the form under the question headings, during the telephone interviews by the research assistants. These were then transcribed immediately into texts.

Reference Committee

As noted in Report 1, a committee to guide the research was established, made up of the research team, representatives from the Health Care Interpreter Service, a nurse-manager, and a Medical Director of a rehabilitation unit who was also bilingual, a bilingual nurse, and an employee services manager. This committee provided feedback and advice on all stages of the study design.

Ethics approval was sought and obtained from the SWSAHS Ethics Committee in March 1999. Verbal consents were obtained from staff and patients with written, translated consents obtained from patients participating in the follow-up telephone survey.

Results

Focus Groups and Interviews with Study Unit Staff

Issues for Nurses

A number of specific issues about communication with NESB patients were raised in the two focus groups with nurses, which clarified the feelings and attitudes of bilingual nurses as well as English-speaking nurses. These views influence the feasibility and implementation of service models and potential for matching.

Benefits of having bilingual staff

The benefits of bilingual staff were identified by nursing staff as: improved communication, saving time and having a better empathy and cultural understanding of patients. The benefits of family being there were also identified in the third response.

> *You can express your problems better when you have got a bilingual staff member. People tend to tell you about their problems and ... they feel more comfortable to talk in their own language … you know … Well it does save time to use a bilingual staff. It also makes it easier… you communicate better with patients.*

> *Yes, I talk for myself. From my experience where I come from, we are flexible. I mean I do understand that people do different things, and that they like different things. I try to be more flexible, I try to understand, you know. You try to work from the heart you know.*

> *For some patients, for example, Arabic patients – they insist that all family members should be there; doesn't matter what, you know. It's not very practical, but to me, I understand that. I understand because I am from the Middle East too. I do not understand Arabic, because I am X, but I do understand the importance of the family. I understand that people need their family around them … especially in hospital. So although it is difficult to have many people around, I try to compromise and keep as much as I can. Family are important to the patients.*

> *Sometimes they [family] also help you with the patient; they help you understand a bit more …*

Problems for bilingual nurses

The problems for bilingual staff were also immediately raised by another bilingual nurse in response to the positive response above.

> *I mean sometimes you get asked to help with a patient who speaks [language], but often it is not really your patient … You will be doing*

something and somebody might come and ask if you can help … It is not always easy.

I think there are benefits, but there's a downside to it. What if, say someone asks to do a consent, it is sometimes difficult to say no … Sometimes it is better to ask an interpreter to do it. It takes a long time to get an interpreter … so bilingual staff are asked to do the consent to save time … But it is difficult … sometimes you just don't know if you should do it. Sometimes you are just too busy to do it.

Nurses assist doctors with consents because of perceived or actual lack of availability of interpreters

The issue of patient consents by nurses was considered important and one that caused concern and conflicts. This RN had nursing qualifications from her home country and was able to explain the procedure to the patient as she would to an English speaking patient and the nurse felt comfortable about it. However, the medico-legal situation is still unclear and without a formal policy to clarify the appropriateness of conducting consents outside of the direct care role conflict will continue to occur.

It happened to me before not only within the ward but also between wards. One day someone called me from another ward to translate for an X patient who wanted to have open heart surgery. The doctor needed me to help convince the patient that he does not really need open heart surgery and that angioplasty is ideal in his case. After explaining to the patient what the doctor said, he agreed to sign written consent for angioplasty.

The issue of consents was tied to the perceived availability of interpreters. Nurses made comments on this, but it seemed that they rarely called interpreters themselves.

When patients express problems, I am happy to "translate". It saves time to work out the problem. A couple of times doctors have asked for me and X (indicating bilingual colleague) to help with consents and not to use an interpreter … They say the interpreter is not available – it often takes 24 hours for booking …

[Interpreters] are usually called for different things. Discharge, explaining a procedure. They often do that on the phone. Yes, the patient comes to the phone and sort of talks to the interpreter and the doctor at the same time.
(Her colleague replied): Yes they don't have to come here because it often takes time for an interpreter to come, so doctors often use the telephone service …
(Another colleague interrupted): It is not used very often though. (There was agreement to that.)

There are few interpreters available and the doctors have to wait. But doctors do use interpreters as well as the diabetes educator and allied health; nurses don't call them.

You need to book, sometimes you need to do that a day or two before.

Therapy staff do use interpreters a lot when they have meetings with family, and they organise the interpreters a couple of days before. They are used very often.

We have used TIS [Telephone Interpreter Service] for X and it worked quite well. Often nurses wait until the family member arrives … Often families can cause problems if too many [members are present].

Other ways of communicating with NES patients

Nurses were asked what other methods they used to communicate with patients who had little English, specifically if they used any language aids.

The ones we have, I did not find very practical …You always find a way of communicating with patients without using them [picture charts]. I do not think they are very good. (This was followed by a discussion from other staff who were not aware of the picture charts.)

Sometimes we get the family to write things down in their language in the picture book.

The family help communicate, or we will be using sign language.

Sometimes we phone the family at home, because the patient is upset. It is not just language is the problem, but they need to hear a familiar voice. This is not only for patients who don't speak English, but for all our patients.

Patient allocation system for nurses

One of the most important issues for the researchers to understand in order to develop approaches or strategies in existing services, was how NES patients were allocated to nurses, and the decision making process relating to this. For the two case study wards, one unit was divided into two sections; the other, into three sections. The patient allocation systems varied; in one, it was done by the NUM; in the other, by the team leader on the shift. The most important factor in allocation was the perceived equality of sharing 'heavy' patients.

It is actually the Nurse Unit Manager who does do the allocation, but she is very flexible … I mean we can swap patients between us. It depends … I mean the most important thing is that we get an equal share of heavy patients …

We decide on the state of the patient, highly dependent, less dependent and so on. So yes, highly dependent patients, we make sure we have an equal share of these types of patient. You just try to make it fair for everybody.

Sometimes we do [take language into account] but it depends on the rest of the patients. I mean it depends on the level of dependency. Sometimes you try to take language into account if the nurse wants to. But in our ward, most patients cannot speak anyway, so I don't think it matters that much.

Barriers to matching LOTE patients with bilingual nurses

When asked if matching LOTE patients to the bilingual nurse would solve communication difficulties, there was no agreement among bilingual staff, with most indicating that it would increase their workload. In one case, the bilingual staff member was not allocated the matched patient during his entire two week stay. The basic issue seemed to be the perceived increased workload and emotional demands from such patients.

They would come to me for every little problem they have. They'll be running to me and you can't say no. I know I can't say no. Sometimes they ask you things like ring their family, ring departments outside the hospital. Just things like that … I mean they just ask you to do everything for them. It is just so hard.

I mean you spend a long time with them and you still have to look after other patients as well … you know.

Sometimes it could be conflict … you know. Sometimes they want something and it can be against you …

They ask for everything … you have to tell the family what is happening and all …

Yes, they tend to rely on you for everything. I mean they ask for everything and they want you to be with them all the time.

Issues for Doctors in the Emergency Department

A number of issues emerged from the interviews with ER doctors, such as consents, the role and use of interpreters, the demands of the emergency setting, matching of NES patients to bilingual doctors and the inflexibility of policies in general.

Consents are important

In the ER setting, consents tend to be the responsibility of the surgeon or team, however the study unit had numerous bilingual doctors, and they were often requested to assist doctors on the wards with consents. Because of the nature of ER, it would not be reasonable to expect ward staff to replace the bilingual ER doctor. This led the Medical Director to contain this practice:

> *We do not do consents for other teams/doctors. It is the responsibility of the team doing the operation/procedure. The ER doctors do not have the knowledge of specific complications for all operations and it is unfair and dangerous to get them to do it. But [bilingual ER doctors] are often asked to consent a patient. We have agreed that they can only do it if the other doctor who is responsible for treatment is there as well … This is an important medico-legal issue … Yes, an interpreter would be as useful in that setting … Yes, it is costly for our unit to lose the time of a doctor, especially if there are two doctors there to do a simple consent when one is actually acting as an interpreter.*

Language and culture are important to assessment and diagnosis

It was considered important that interpreting be as close to word for word as possible, as this was vital for understanding.

> *Diagnosis is actually derived from a story given by the patient not just clinical findings. An interpreter must not alter that story or it could affect the diagnosis.*

It was also considered important for doctors and interpreters to have optional or alternative words when it appears that patients are not understanding. Recently the ER had two cases of poisoning with Traditional Chinese Medicine treatments.

> *Not just to ask "Do you take any medications?" and if they say no, accept it. For example, many Asian cultures have herbal and alternative treatments but would not consider them as "medications". Therefore the question should be posed as "Do you take any medications – you know, pills, potions…*"

Examples were given of routine questions asked which cause problems for some NES patients – for example "Do you have any allergies" is a standard history taking question. In Vietnamese, one doctor told us, there is no word for allergy. Also "Have you had vaccinations for tetanus etc" is often greeted by such patients with a lack of understanding. When the doctors or nurses try and explain

it (in English) it only causes more confusion. There was laughter as the doctors described how nurses would point to their bottom and say "injection" and the patient would become anxious and say "No, no injection" thinking the nurse was about to give one.

The role and skills needed of interpreters in health communication

Doctors recognised that the level of language (register) was important and that interpreters need to be skilled in detecting that.

> *Interpreters may need to stop and ask a doctor to explain what they are saying, or to indicate that the patient is not understanding – [in the case of the doctor not communicating well]. But they need to translate the technical words in several ways to ensure that patient understands – for example, if a doctor says "gastroscopy" the interpreter should tell the doctor 'I will translate that into "a tube will be passed to look at your stomach"'.*

It was noted that doing that would take a high degree of skill and understanding and it would be hard to expect it from all interpreters. It may require additional training so that interpreters can be given experiences in real life situations.

Interpreters are seen as strangers to the ER environment. Doctors considered that there is a real practical focus to health interpreting on wards and that ER, in particular, is different to outpatient clinics and office settings. For example, there was an instance told of how one interpreter fainted at the sight of blood. It transpired that she had a refugee background and had psychological trauma to deal with herself, which had never come up in her training.

> *You need specially trained interpreters for law and health. They have a course at UNSW - English for health professionals - which the interpreters should do. It would help. Interpreting is a skill you learn on the job.*

There was a perceived need to be as flexible as possible in ER. However in relation to psychiatric patients, doctors considered it really important to *"use trained and culturally attuned interpreters"*.

> *The unit would be loathe to use anyone else, especially family, as there is too much room for error and miscommunication. Gynaecology is less of an issue than psychiatry, at least they can still talk coherently generally.*

It was considered that access to interpreters was not going to be easily resolved. Teleconferencing was not considered appropriate in ER with its open plan and lack of privacy. However, it was acknowledged that if interpreters are not used, and doctors try to communicate with patients, they may get the *"glassy eyed smile or nod"* which indicates that there is little or no understanding.

> *It is vital that a doctor can pick up on this and find another way to communicate. They need to recognise that "they are not getting through" and try something else.*

Emergency Room is different

A number of specific points were raised about why ER is a special case in regard to using interpreters. Timing is important. There is generally no time to wait for an interpreter, even if only 2 to 3 hours. But interpreters also must understand that they may need to be around for about an hour to accompany the patient for several tests, x-rays, or theatre, not just for the doctor's interaction.

> *ER staff will use anybody to communicate with a patient – not complex or technical explanations, but to just ask "What's the problem? What's the story?" Doctors just need a basic start to communication to get enough information to treat. Other tests/signs will also allow treatment – for example, if high blood pressure is present on admission, they will do something about that regardless of language or who is there to interpret. You may borrow people for a minute or two or may make do with relatives.*

> *If trained in their own language, bilingual staff will have complex and technical language. However it is important to find out the level of complexity of the task and information required. For example, we will use an X-ray technician to identify a problem even if they only have social language. It is better than nothing and immediate. You need to be flexible in ER.*

Patient allocation systems for doctors

The researchers raised the issue that while there were a large number of bilingual staff, there were several occasions when a patient of the same LOTE was not seen by the bilingual doctor. We asked if it were possible to be more explicit in allocating patients to the matched bilingual doctor. Numerous reasons were given for why they could not allocate all LOTE patients to the corresponding bilingual doctor. The primary reason was that it was considered unfair. It was claimed that it could affect the doctor's career pathway by not gaining experience needed in general cases, and therefore was considered unreasonable to match bilingual staff. *"You cannot allocate all 20 Arabic speaking patients to Dr A and have the other doctors sitting there doing nothing!"* A nurse who had just arrived for a cigarette outdoors, added that *"it is not fair and we [nurses] would not ask a doctor to see a patient just because of their language"*.

Another reason given was that it was important to *"build tolerance and skills to cross boundaries for all staff."* Most ER staff were said to have developed *"tricks and skills, one-liners"* to communicate with NES patients. It was also stated that ER cases often require an assessment by experienced and senior doctors and this had to be taken into account when allocating patients.

> *It is not just the language, but also the competence and experience of the doctor which is important. If a patient has chest pain they should get the most experienced doctor, not the junior doctor who speaks their language only to find out two hours later that they had a chest pain in!*

Health professionals were said to be under pressure – *"they need to get interpreters there as quickly as possible"*. The severity of the case was seen as

more important and allocation to bilingual doctors happens only as a secondary issue.

> *You must deal with the medical situation first. The system works on a continuous and co-operative basis. It is also not just language, but gender also. ER tries to make allowances but staff have to go by medical priorities.*

Another nurse comments that they assess the severity and then ask whichever doctor is available to see patient. They are not going to wait to allocate them to a LOTE doctor. However if a bilingual doctor was seeing another patient and there was an urgent case in his LOTE, they might pull him in briefly to help. But they would not try and allocate all patients to the bilingual doctor.

The importance of language

Dr A tells a story of Dr X who is a specialist who he saw giving discharge information to an Arabic speaking patient. The patient kept saying "yes, yes". When Dr X left, the patient signalled Dr A and said *"What did he say, what did it mean?"* Dr A called back the specialist and told him the patient had no understanding at all of what he said. Dr X was amazed and said *"But he kept saying yes"*. Dr A repeated the instructions from the specialist to the patient.

Barriers to language use

It is also difficult to allocate bilingual staff to patients when there are local issues to worry about. Dr A tells of how he was assisting an English-speaking doctor to treat a religious man speaking a LOTE. This patient had an STD and Dr A could not tell him and refused the English-speaking doctor. *"I cannot tell him this – it is not appropriate and he will be shamed for me to tell him"*. Another story was told by a local nurse who had trouble in her community later because she knew the stories of patients.

Simple information may seem complex to patients unfamiliar with how health systems work.

Doctors pointed out that often instructions were not complex or technical but simply required an understanding of the system. They would be happy to use a cleaner or anyone to say in the LOTE *"Phone this number when you get home and make an appointment"*, rather than risk having the patient misunderstand their English. *"The policy may say this is wrong, but it works for us."*

> *What you need to communicate with patients is why there are delays and what they need to do when they leave. This does not require highly technical or complex language, but you need to be able to say it and have them understand -"When you leave here [ED] you need to take this prescription to the chemist. Then you need to make an appointment with your own GP or with a specialist in one week". What often happens is that they turn up at the specialists in a week, but did not book. So it is the ideas about the system that need to be communicated and this can be difficult for some patients to understand - both English speaking and non-English speaking patients.*

One practical solution was suggested:

> *It would be really useful to have a discharge letter giving simple summary advice – translated. This condition X is likely to last for x days. For example, if you are no better, come back to ER or go to your local doctor (GP). Take tablet A, x times a day for x days.*

Language testing and policy

There were mixed feelings about the usefulness of a language test for bilingual doctors. A number of reasons were given for this.

> *In reality I don't think you are going to get staff to rush in and volunteer. They may feel threatened by doing the test or cannot see the point. They are going to use their language anyway. Verbal testing is not enough. What are you going to test? How good a doctor they are? If you are testing communication skills, that is directly linked to how good a doctor they are, and is part of being a doctor. It will be difficult to test it. It is going to be important to separate testing language skills from communication skills. How reliable will the assessment be? I am being a devil's advocate here … It may be better getting another bilingual doctor to administer it.*

> *It is important to get a more flexible policy on communicating with patients - the Health Care Interpreter policy is so prescriptive. There needs to be a feel that language skills are valued and encouraged, not worrying about what the "party line" is. In ER you take whatever and compromise on languages - which is better than nothing. It is enough to get us through. The policy should not be rigid.*

Patient Telephone Interviews

The following responses to a semi-structured interview are presented.

Four patients consented to the follow-up interview and were contacted some six weeks after discharge, by telephone. Bilingual research assistants conducted the interviews in their LOTE. Three of the four patients had little or no English skills, with only a few words, such as yes or thank you.

The health system is an infrequently visited place, for many patients. In a person's own home and local community, there is a system of communication in existence prior to their becoming a patient in hospital. When there are complex issues requiring high level English skills, and system negotiation skills, many patients simply rely or call upon the bilingual and bicultural skills of relatives or friends. These data suggest that when a NES patient comes to hospital, these same communication support persons and systems are used to negotiate the health system. The overwhelming impression from the four patient transcripts is that, without the family's presence, patients felt isolated and unable to communicate.

Primarily the language and health system negotiator, the communicator for the patient, is the family member

All patients interviewed suggested that although there were other language support persons, the family member was perceived as the most important one to them. In one case the patient proposed that she would not go to hospital if the family was not available to be there for them.

> *Case 1: (Arabic) … most of the time my sons and daughters in law and their kids were there to translate for me you know …*
> *The hospital would have been terrible without them that is for sure … Ah, look as I said I don't know if I would have gone to the hospital if I was on my own.*
>
> *Case 2: (Arabic) … What do you mean … I mean because most of the time my kids or my husband were there to translate for me when I could not be understood …*
>
> *Case 2: (Arabic)… I was lucky to have my family around me all the time …*
>
> *Case 3: (Vietnamese) …Yes, he [my son] told the doctor or nurse what I wanted to know and explained to me what they said.*
>
> *Case 4: (Vietnamese/Teochew) … Yes. Our daughter was there every time when the big doctor came. I did not talk to anybody in the hospital. I only talked to my daughter.*

Difficulties with communication existed when the family member was not available

Consistent with this viewpoint, the small number of patients interviewed, emphasised that when this primary language support person (family or friends) was not available, miscommunication, limited communication, or delayed communication (until the family member was available) occurred.

> *Case 1: (Arabic) … But sometimes when they are not there I just use sign language to communicate with nurses and it does not always work.*
> *… I could not ask questions about my condition or something like that. I had to wait for my family to translate…*

> *Case 2: (Arabic) … but sometimes especially at night and you are by your own it is a different story. One day after I had the operation, I had a terrible pain and I was hot (temperature). It took a while to tell the nurse what I felt ... I had to use my hands, few words in English but she did finally understand me she gave some tablets … told the doctor about it … I mean it was confusing when different doctors told different things but everything was great …*

> *Case 3: (Vietnamese) … I wanted to tell Doctor about my sickness but didn't know how to say it. I could not explain anything about how I felt …*
> *Yes, I just said thank you when I know they do not understand me.*
> *… I don't know. Nurses and doctors all spoke English. I did not know what they were saying.*

Difficulties with communication existed when the family member was available

Miscommunication also occurred when the family member was available and the patient seemed to accept this (one case only). There were also situations when having the family member as the communicator was not perceived as beneficial.

> *Case 2: (Arabic) … I have also had a small problem when my husband translated for me before the operation when I had to sign the form. But I don't think that it is actually his fault. I don't think the doctor did explain very well. Because I know my husband, his English is very good - everyone tells him that. Anyway the surgeon told my husband that he is not going to take my breast out and he's only going to take a bit of the tissue. Afterwards my niece was there to translate for another doctor who told her that they are going to take the whole breast out. I was then confused, I asked the surgeon again and that is when he called an interpreter to translate and explain to me again that all they are going to do is to take the cancerous bit and leave my breast alone (laughs).*

> *I mean sometimes it is a bit humiliating to ask your own kids to translate for you. There are things you don't want your kids to know about you. You know what I mean.*

Accepting responsibility for communication

One of the interesting comments made by one patient related to accessing interpreters suggested some acceptance of personal responsibility for English language skills and health communication.

Case 2: (Arabic) … You know she gave me her business card and … she was great.

Interviewer then asked "Did you ask for the interpreter after that?"

Case 2: (Arabic) … No I did not, I did not need an interpreter afterwards and it just does not feel right to ask … I mean after all it is my fault I don't speak English. I do not understand why the hospital needs to provide an interpreter. Don't get me wrong, I think it is fantastic to have an interpreter around, but I just could not bring myself to ask for one … I should … start learning English you know …

Talking to someone in your own language is always good

These patients supported the positive nature of the experience of talking in their own language with bilingual health staff. They do, however, convey the idea, that this "talking" is somewhat of a social event, and represented very little contact with the staff member.

Case 1: (Arabic) … of course it is beneficial (laugh) when you are in a foreign land and you are my age of course I tis really good …

Case 2: (Arabic) … my husband knows a nurse who works in the hospital, he came one day and visited me, but he was not working in the same ward …
… talking to someone in your own language is always good especially if you don't speak that much English … it was nice when that nurse X, my husband's friend visited me, he was nice and it just makes [me] a bit more confident.

Case 3: (Vietnamese) … Male nurse who walked past with a trolley one day … He had chatted with me for a while. Yes, when I saw him I felt very glad. It was really nice to hear someone talking in Vietnamese.

Case 4: (Vietnamese / Teochew) … Once a week. [I spoke with doctors and nurses in my own language]. Yes. [It was good]

There was one patient who recalled speaking with another patient who was bilingual. This patient stated that this other patient "*explained things to [me] … sometimes*".

Important health information communicated by interpreters

All patients contacted recalled seeing an interpreter in the hospital. Some had contact with an interpreter on several occasions. In all these cases, there is a positive response to the service. However, one patient referred to delays in the service.

Case 1: (Arabic) … Nobody from my family was around at that time. Anyway the interpreter came along; she was a wonderful lady she explained everything to me in detail … She was very good …

Case 2: (Arabic) … I have also had an Arabic interpreter before and after the operation, she was a lovely lady she made a lot of things clearer for me.

Case 3: (Vietnamese) … No I have never called one [an interpreter] - The doctor booked them … a maximum of five times.
[After being visited with interpreter] [It] calmed me down, felt better, glad because I was able to understand everything that the Doctor said.

Case 4: (Vietnamese/Teochew) … It was very good to have an interpreter to explain how to do exercise, but booking time was long … We could not get the interpreter immediately.

Importance of family and friends visiting, calling for flexibility in visiting hours.

One patient lamented restrictions to visiting hours and others conveyed the importance and value placed on their presence. As most of these patients heavily relied on family for communication, and also as another patient stated that it is *"the others [family] duty to be there for you…"*, flexibility in visiting hours and being there for the patient was important.

Case 1: (Arabic) … I don't know, I wish my family could come and visit me any time they want especially in the mornings. I wish the rules were a bit different.
… they were there by my side keeping company and translating for me. The hospital would have been terrible without them that is for sure.

Case 2: (Arabic) … when you are sick you just need your people around you. I would have been lost without them.

Case 3: (Vietnamese) … My son could only be there at visiting times. When he was not there I could not do anything.

It was also interesting to hear NES patient's perceptions of what 'Australian' patients do in relation to family visiting.

Case 1: (Arabic) … The lady sharing my room with me was very nice, never minded them [lots of family visiting]. She used to chat with my daughters-in-law, shared our food, everything.

Case 2: (Arabic) … I had an Australian woman with me in the same room and I was amazed how she did not have many visits. Maybe she did not have a big family.

Language support systems used by NES patients

These data were suggestive of the use of a range of language supports, including family and friends (primarily), other bilingual patients, interpreters and at a minor level, other bilingual health staff. They seemed to equate bilingual health staff with a social interaction whilst the detailed health information is spoken of as being delivered by the interpreter.

Discussion

This study was seeking to identify the processes or strategies that were likely to facilitate health communication between patients and staff speaking similar languages. Two perspectives were sought: the staff's viewpoint of language use and second, the patient's viewpoint and their experiences with all the communication support services whilst in the health service. Limited data were able to be obtained from both perspectives, but in particular, the difficulties in obtaining written translated consent from patients for this study were considerable. However, these data do give some indication of the potential areas to consider in larger studies, as well as some understanding of future developments in policy and health service management.

The difficulties inherent in strategies to deliberately or accidentally match patients with bilingual health professionals were quickly seen in the study units, although how these difficulties or opportunities occurred varied. Three wards or study units were selected that represented short-term hospital stays, long-term hospital stays, and brief consultations in the Emergency Room.

Determining Patient Need and Available Bilingual Staff Potential at Ward/Unit Level

The first issue for all units, an issue immediately experienced by the research team, related to understanding the extent and nature of the patient language need and also how to determine the potential staff language skills. The researchers confronted this problem by examining Service Related Groups data from the inpatient statistics. Although this did supply a gross interpretation of patterns of language use and country of origin of patients in particular Divisions and hospitals, it failed to provide precise enough data for researchers and therefore, is unlikely to be helpful to unit managers. It became apparent that only data collected at unit level was likely to be helpful.

Similarly, knowing which languages were spoken by staff, was not routinely collected information at ward level, but was collected sporadically within one Division. The participation in this study by one unit, has prompted this unit to now store such information. Data management systems such as ProACT were proposed as a possible approach to storing such information on the ward or unit area and to be used as a tool for allocating staff to particular patients or knowing where the staff are that speak specific languages for use in critical situations, such as patient distress or to contact the family.

Matching Systems or Approaches: Ward and Unit Experiences

Ward experience

To understand whether a system was active was somewhat misleading. Indeed, the researchers were looking for deliberate action on behalf of staff and managers versus an accidental occurrence. This difference in perspective on the question may account for the fact that no deliberate action or approach was found, although accidental matches were identified. In this small study, there

was no evidence on these ward units, or indeed, most other units interested in participating in this study (14) that a formally recognised system of 'matching'; existed. There were, however, informal processes used, within certain situations.

The opportunities for matching in inpatient settings may be less common than was thought in earlier studies within SWSAHS (Johnson et al., 1998, 1999), although this study only directly involved three wards/units and has knowledge of 14 wards or units. Focus group attendees in the 1999 study came from across the area, and similarly, the 1998 language audit involved most bilingual staff in the health service. The short and long stay wards observed are also known to have lower numbers of NES people using their service. Johnson et al. (1998) also noted a dearth of bilingual staff speaking the main languages of hospital users, namely Vietnamese and Arabic speaking patients.

These informal processes that did exist were uncoordinated in nature and distinctly an afterthought. These processes also were covert rather than overt, which is not surprising given that language use by staff has, from their understanding, been actively discouraged. From the focus group data it could be said that language would always be a secondary consideration. Certainly, allocation of patients for health staff was related to the dependency of the patient, the level of complexity of the health problem and associated with the health professional experience or need for such experience. What was evident, was that where possible, as a secondary consideration, language was used to allocate, only after all the other primary considerations were addressed.

Emergency unit

Although this general understanding was supported in a form for the Emergency Unit, there were some clear exceptions or intricacies to this general understanding. Medical staff, in particular, referred to the ability to gain an understanding of the patient's health problem with limited communication, when the problem had definite physical manifestations and further tests that could provide supporting information. Medical staff, also were very clear to emphasise that where mental health issues were involved, an interpreter was necessary.

Bilingual Nurses and the Organisation of their Work

Nurses work differently from medical staff and this was an important consideration. Nurses work in teams and care for a group of patients within a defined geographical area. This would suggest that the best possible approach for nurses, one that is not disruptive to the overall normal flow of work practices, would relate to an increased presence and increased opportunity for NES patients and bilingual staff but not explicit *matching* (this is not a caseload model of work). Indeed, this intermittent somewhat social contact, described by the small number of patients in this study, suggests that this contact is appreciated despite being limited. Staff, on the other hand, continued to raise concerns about increased workload and burden associated with NES patients' acknowledgement of the staff member's language skill. Nursing staff in particular considered that NESB patients were "heavier" on several dimensions and most were not very supportive of explicit matching. These issues had been identified in previous

studies (Johnson et al., 1999), and may also contribute to why language use is avoided by some staff. Controlling the burden experienced by these nurses is critical to the continued success or encouragement of second language use.

It is likely that with high concentrations of bilingual nurses with language skills that are similar to the high concentrations of patient need, increasing occasional contact would be possible. It is also likely that as numbers of staff increase, this occasional contact in the patients' language will also increase, and there may be a corresponding lowering of burden for a particular nurse.

Also, the clear concerns voiced by nursing staff related to communication facilitation in areas beyond their professional boundaries would support the need for clear and enforceable guidelines on the issue of bilingual nurses not participating in consents.

Bilingual Doctors and the Organisation of their Work

Doctors have a caseload, that is, essentially a doctor is responsible for a patient, usually for the length of the hospital stay or term of the doctor. Within a unit, such as an Emergency Department, doctors are located within a confined geographical area, and involved in consultations. It is likely that with high concentrations of bilingual doctors with language skills that are similar to the high concentrations of patient need, that matching would occur frequently by accident. This infrequent accidental event was evident. Matching by language, within low concentrations of medical staff with the required language skills, would require fundamental changes to the normal working processes of the unit. Doctors expressed concerns about professional and career discrimination and limits to skill development if patient allocation based on language was to occur. Similar to nurses, they also believed it would affect workload detrimentally. The question remains, if higher concentrations of the required language skills are desirable, how would that best be achieved.

Other Issues

Family Members are Key Communicators for both Staff and Patients

Nurses, in this study, rarely used interpreters and agreed that family members were the most available and useful means of communication with patients. It was considered that the type of information they were communicating did not require the specialist services of an interpreter.

Consistent with this viewpoint, there were several examples of family members being involved either directly or indirectly in communication on behalf of the patient. Patients greatly appreciated having family members who could act as their primary communicator in the hospital. Although several untoward events occurred, this small number of patients was extremely supportive of the appropriateness of families within the health service, and indeed, even suggested that they would not come to the hospital if their family were not able to be there for them. These patients perceived that if the family were not available,

miscommunication, limited or delayed communication occurred. A much larger study of NES inpatients is required to confirm these findings.

Staff members and interactions in Report 1 of this series, have emphasised the need for flexible policy in relation to family members acting as communicators. Although there is a need for caution, particularly in relation to medico-legal issues such as consent, there is a call for judicious use of family members in a limited and prescribed range of situations. These data, and the interactions examined in Report 1, suggest that the use of family members is a frequent and necessary occurrence in many cases, with benefits for both staff and patients. Flexibility in policy was often emphasised by staff. Inflexible policy does appear to result in staff acting covertly 'out of policy' but being constantly aware and concerned about this. This finding confirms previous research reported upon by the researchers (Johnson et al., 1999).

Policies relating to families' roles in health service delivery may be an important starting point to unravelling the possibilities. Other policies already in place within the health system, for example those relating to 'rooming in' for patients of children may provide important insights that could inform policy in this regard.

Interpreters Remain a Valuable Resource to both Health Staff and Patients

The value of interpreters was acknowledged, but also the barriers to access noted by health professionals: timeliness, knowledge of the needs of the specific unit, being perceived as a stranger to the unit. Patients acknowledged that these staff members were the deliverers of important health information (from their perspective) and their services were very positively received. One patient suggested that such services should not have to be supplied, because language was the patient's responsibility. Patients could also distinguish, albeit from their experiences, that interpreters should only be used for conveying complex health information such as the outcome of surgery, consents, and treatment options. They did not perceive these staff should be available for other more general issues. This understanding seems consistent with staff views, in particular, nurses' views. There was considerable variation in the number of times the patients actually saw an interpreter, and there was also a reluctance to call them from the patient's perspective.

These findings suggest that the nature of information that is required to be obtained or given may influence the type of interpreter service supplied. For instance, the need for complex health information to be obtained and given in a timely manner, in the Emergency Room, would suggest that interpreters need to be located within or close to the area, should there not be bilingual staff rostered on duty.

Limitations

The difficulties of undertaking cross-cultural research within health environments have severely limited the sample size of the patient group in this study. The costs associated with using bilingual research staff with a range of

language skills have also limited the scope of this study. However, this preliminary work does provide opportunities for larger studies and the possibility of a rich understanding, particularly from the NES patient's perspective.

This study focused on an intensive examination of systems of matching within three study units in mainstream health services, and has highlighted that occasional and accidental engagement of NES patients with bilingual nurses is positive for both the patient and nurse. Data on patient languages or staff languages does not appear readily available at unit level and the assessment of language proficiency is the topic of study in Report 4 in the series. At all times, language remains a secondary consideration; the severity of the patient condition, the skill of the health professional and the need for clinical experience, are the predominant considerations on which patient allocation and contact occurs. Increasing the opportunity for such engagement is closely related to raising the concentration of staff with specific language skills based on the concentration of patient languages seen in the unit. This does however, emphasise the need for very focused and targeted Human Resource Management plans that are unit-based, rather than general strategies to promote a multicultural experience within health care.

However, we conclude by adding that if the nature of the work undertaken by the unit does not preclude the problems identified here or can be overcome, there are basic actions which managers could take to improve the frequency with which NES patients have the opportunity to be cared for by health staff speaking their language. These include:

- Identifying the language needs of clients on admission or pre-admission and displaying it so that all staff are aware;
- Identifying and documenting the languages and proficiency of staff, updated at regular intervals;
- Defining roles and clarifying with staff how language can be used, including bilingual staff and interpreters;
- Language assessment of staff and providing further skills training;
- Matching language needs of clients with available bilingual health staff;
- Training and discussions about the boundaries of using bilingual staff;
- Recruitment and selection issues of bilingual staff; and
- Valuing and recognising bilingual staff.

Recommendations

The following recommendations are made:

1. That a further study be undertaken with NES patients, on the role of family in communication during the hospital stay. That such a study be used to inform policy and practice relating to accommodating family visitors in the hospital setting, and on appropriate use of family members as communication facilitators.

2. That other strategies to improve the availability of interpreters in inpatient settings in a timely manner be supported.

3. That SWSAHS managers be guided through policy on processes and strategies to use that will improve the frequency with which NES patients have the opportunity to be cared for by staff speaking their language. Such policy should address:
   - Identifying the language needs of clients on admission or pre-admission;
   - Identifying and documenting the languages, proficiency, availability and willingness of staff;
   - Defining roles and clarifying with staff how language can be used, including bilingual staff and interpreters;
   - Training and discussions about the boundaries of using bilingual staff;
   - Language assessment of staff and providing further skills training;
   - Matching language needs of clients with available bilingual health staff;
   - Issues pertaining to the recruitment and selection of bilingual staff; and
   - Valuing and recognising bilingual staff.

4. That consideration be given to a policy on community language use for staff, inclusive of family participation in communication, as follows:

POLICY STATEMENT FOR CONSIDERATION

Roles and functions of bilingual health staff and other potential communicators in the health care setting

Community language use in direct care

Bilingual staff members should be encouraged to use their community language in the provision of direct client care in the normal course of their work.

This language use should be considered within the following understanding:

- The scope of the language required (social terms or technical health terms) must not be beyond the language competence of the staff member;
- The language proficiency of the staff member has been assessed and is known to the staff member;
- The context or situation in which the staff member is using the language skill is within the boundaries of the normal scope of practice for that profession, supported within hospital policy.

Community language use in communication facilitation

Bilingual staff members should be encouraged to use their community language in the provision of indirect client care and communication facilitation support for other health professionals, within in the normal course of their work.

This language use should be considered within the following understanding:

- The scope of the language (social terms or technical health terms) required must not be beyond the language competence of the staff member;
- The language proficiency of the staff member has been assessed and is known to the staff member and this is told to the person requesting communication facilitation;
- The context or situation in which the staff member is using the language skill is within the boundaries of the normal scope of practice for that profession, supported within hospital policy.

Health Care Interpreters

Health Care Interpreters remain an essential part in health communication.

If bilingual health staff with appropriately assessed language proficiency at a complex level and working with the patient in a direct care role are unavailable, then it is essential that Health Care Interpreters are present during interviews or discussions with the client/patient with regard to the following situations:

- Admission
- Medical histories; assessments and treatment plans
- Medical instructions
- Consent for operations, procedures, treatment and research
- Pre-operative and post-operative instructions
- Psychiatric assessment and treatment
- Counselling psychological assessment
- Discharge procedures and referral
- Speech therapy
- Sexual assault, physical and emotional abuse
- Death of a patient and bereavement counselling
- Health education and promotion programs
- Explanation of medication
- Mental Health review Tribunals and Magistrates' enquiries

In situations, where a HCI is not available on site, telephone interpreting may be a viable option (NSW Health, 1994).

In cases of emergency, when a HCIS or a TIS interpreter may not be available and a non-professional interpreter, bilingual staff member with social language proficiency or family member is relied upon, service providers must ensure that the Health Care Interpreter Service is called as soon as possible to ensure that

accurate information has been communicated and the medical history is accurate (NSW Health, 1994).

Interpreting is a professional skill and bilingualism does not imply the ability to interpret at a professional level. It is important to note that bilingual staff are not appropriately trained in professional interpretation but are able to facilitate communication within prescribed limitations of language proficiency and context of interaction.

Bilingual health staff

As bilingual health staff are not professionally trained as interpreters, it is essential that bilingual health staff wishing to use their language skill have their language skills assessed on entering the health service. This assessment does not impart or presume to imply any endorsement of a staff member having professional interpreting skills. Language proficiency assessment, using valid tools or other acceptable means of verification of language skill (such as obtaining professional qualification in country of origin), should be undertaken by all bilingual staff if they intend either deliberately, or suspect that they will unintentionally, use their language skills in patient communication. This assessment should occur within their orientation phase with the health service, under the supervision of the sector Multicultural Health Services Manager with Employee Services Managers. This supports and protects the bilingual health staff member, the health service, and the patient. This also affirms the professional process of interpreting and the unique expertise of trained interpreters within the health care setting.

Special Cases

Medical Officers

Bilingual medical officers are encouraged to use their community language in direct care and communication within clinical situations (given the conditions of community language in direct care or communication facilitation are fulfilled), if and only if, they occur within their scope of expertise and within the realm of their professional practice.

Situations in which this may occur include:

- Medical histories; assessments and treatment plans
- Medical instructions
- Consent for operations, procedures, treatment and research
- Pre-operative and post-operative instructions
- Psychiatric assessment and treatment
- Counselling psychological assessment
- Discharge procedures and referrals
- Sexual assault, physical and emotional abuse (if applicable)
- Death of a patient and bereavement counselling
- Health education and promotion programs

- Explanation of medication
- Mental Health Review Tribunals and Magistrates' enquiries

In general, medical officers are encouraged to use their language skill in assisting non-English speaking patients in medical assessment and medical treatment (requiring a social and technical language proficiency). For example, medical officers can assist other medical officers with medical history taking for a non-English speaking patient on admission. However, *medical officers with limited social language skills in their second or subsequent language, should not use this limited language skill to undertake consents or assist in communication facilitation in consenting another medical officer's patient.* This represents a situation of a medical officer going beyond their scope of language skill, but nonetheless performing with their realm of professional practice supported under hospital policy.

Nurses

Bilingual nurses are encouraged to use their community language in direct care and communication facilitation within clinical situations (given the conditions of community language in direct care or communication facilitation are fulfilled), if and only if, they occur within their scope of expertise and the realm of their professional practice. These situations may include:

- Nursing Admissions
- Nursing histories; assessments and treatment plans
- Nursing instructions
- Nursing pre-operative and post-operative instructions
- Psychiatric nursing assessment and treatment
- Counselling or psychosocial assessment (if applicable)
- Nursing discharge procedures and referrals
- Sexual assault, physical and emotional abuse (if appropriate)
- Deterioration in patient's health
- Health education and promotion programs
- Explanation of medication

In general, nurses are encouraged to use their language skill in assisting non-English speaking patients in their normal activities of daily living (requiring a social language competence) and also health education or treatment activities supportive of recovery or long-term health maintenance (requiring a social and technical language competence). For example, nurses can assist other nurses with wound care instructions for a non-English speaking patient on discharge. However, *nurses do not facilitate in consents for doctors* (this is beyond the scope of professional practice supported under hospital policy) and would only conduct consents where they do so in their usual role (for example, hepatitis B vaccination).

Bilingual Family Members Wishing to Assist in Health Communication

Many cultural groups and non-English speaking patients, believe that their family members (who speak English and their language), should play an

important role in their relative or significant other's care, whilst in hospital. The bilingual family member also often holds this belief. This role may include assisting in communication when their family member is in hospital or on their return to their community or home. As in any family situation, it is important to allow for family members to assist in care, particularly where there may be gains in appropriate treatment or long-term adherence with health care interventions. Bilingual family members may therefore play a vital role in assisting in communication associated with activities of daily living (showering, dressing etc) or social or everyday communication (giving directions as to how to get an appointment with a service).

Family members may be used to assist in meeting communication needs of NES patients in immediate and/or life threatening or potentially life-endangering situations that may include:

- Medical histories; assessments and treatment plans;
- Medical instructions or interventions.

However, it is critical that **an interpreter is arranged within 24 hours of such an event,** to ensure that the information has been conveyed appropriately and understood by the patient correctly and independently of the family member.

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Appendix 1

Number of LOTE and Overseas Born (non-English speaking countries)[3] separations by SRG as a percentage of total SRG separations. SWSAHS 1996-1997.[4]

SRG	LOTE separations		NESC separations	
	No.	%	No.	%
Obstetrics	3856	23.1%	6117	36.6%
Renal Dialysis	3245	26.7%	5191	42.7%
Gastroenterology	1835	17.5%	3012	28.7%
Miscellaneous Surgery	1316	14.2%	2264	24.5%
Cardiology	1321	17.7%	2604	34.9%
Respiratory Medicine	1114	14.1%	1548	19.6%
Medical Oncology	986	17.3%	1909	33.5%
Gynaecology	885	16.8%	1632	31.1%
Orthopaedics	843	12.3%	1619	23.5%
Urology	715	20.5%	1322	37.8%
Neurology	608	15.5%	937	23.9%
ENT	436	15.1%	467	16.1%
Miscellaneous Medicine	434	12.1%	753	21.0%
Ophthalmology	396	25.5%	555	35.7%
Colorectal Surgery	369	20.5%	642	35.6%
Renal Medicine	388	23.9%	572	35.2%
Plastic & Reconstructive Surgery	231	12.2%	394	20.9%
Upper GIT Surgery	323	22.2%	548	37.7%
Haematology	321	15.7%	605	29.6%
Perinatology	294	17.9%	N/A	
Vascular Surgery	156	15.3%	287	28.2%
Breast Surgery	154	23.2%	251	37.9%
Endocrinology	124	17.2%	191	26.5%
Psychiatry	113	13.5%	186	22.2%
Head & Neck Surgery	99	36.8%	141	52.4%
Neurosurgery	89	12.7%	140	20.0%
Dermatology	77	14.4%	129	24.2%
Rheumatology	54	17.8%	79	26.1%
Cardiothoracic Surgery	46	18.6%	85	34.4%
Immunology/HIV	39	13.6%	58	20.3%
Dentistry	15	4.5%	39	11.8%
Rehabilitation	13	15.1%	16	18.6%
Drug & Alcohol	10	6%	27	16.3%
Total	**20908**	**18.4%**	**34322**	**30.1%**

[3]The definition of OSB NESC can be found in Mohsin et al 1997. Language spoken at home data is generally poorly collected in hospital statistics, hence the lower numbers. However, country of birth may also be an under-representation of language needs.

[4] The % in each row is of the total separations for the specific SRG. For example, in row one, 3,856 LOTE separations represent 23.1% of the total patient separations in the Obstetrics SRG.