

## Research papers

# Improving interpreting in clinical communication: models of feasible practice from the European project 'Migrant-friendly Hospitals'

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### ABSTRACT

Non-local language speakers, especially migrant populations and ethnic minority groups, often cannot communicate with their clinicians adequately to receive necessary information about their care. Members of the clinical staff often do not understand their patients' needs, and so do not receive all relevant information from the patient. This paper presents a report from nine European hospitals which worked together to improve communication between non-local language speakers and clinical staff by developing, implementing and evaluating professional interpreter services. The work was part of the Migrant-friendly Hospitals Project. The article outlines different strategies to improve clinical communication with migrant and ethnic minority patients such as telephone interpreting, face-to-face interpreting, intercultural mediation and written material as supportive information,

and presents an evaluation of their effectiveness from the perspective of the providers and the patients in the hospitals concerned. This evaluation was based on a benchmarking design that included a pre- and a post-intervention staff survey and a post-intervention patient survey. In general, evaluation results of the pre- and post-intervention staff surveys showed that the implemented measures proved to be effective for both groups of stakeholders. The paper closes with recommendations for a concerted hospital quality management response to the problem of language barriers in clinical communication.

**Keywords:** client-provider communication, clinical encounters, ethnic minorities, hospital setting, intercultural mediation, interpreting services, language barriers, migrants

## Introduction

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The provision of culturally and linguistically appropriate communication in healthcare poses considerable challenges to health policy and frontline service provision alike. Hospitals in particular are consulted by an increasingly diverse clientele (Hampers and McNulty, 2002; Yeo, 2004). As a consequence, there are language barriers between specific patients and providers: patients coming to the hospital may not be able to speak and/or understand the local language, and staff may not be able to communicate in the patients' mother tongue or a common language. This frequently leads to communication problems and misunderstandings that may negatively affect clinical encounters and treatment outcomes.

Clinical encounters are defined as client-provider communications occurring as part of diagnosis and treatment and which involve the negotiation of explanatory models between physician and patient (Pirbhai, 2003). In clinical encounters it is important that relevant clinical information is elicited from and conveyed to the patient in a correct and appropriate manner as a prerequisite for both clinical decision making and the establishment of trust between the two parties concerned. Effective communication is an essential part of successful treatment and in securing patients' co-operation. Furthermore, it plays an important role in assessing pain and prescribing adequate medication (Cleeland *et al*, 1997; Brown *et al*, 1999).

Language barriers are a major obstacle in providing effective health services; they have adverse effects on accessibility, quality of care, patient satisfaction and patient health outcomes (Bischoff, 2003; Murphy, 2004). For example, language-related communication difficulties are associated with a higher rate of resource utilisation for diagnostic testing (Waxman and Levitt, 2000; Hampers and McNulty, 2002) and an increase in the likelihood of unnecessary invasive procedures (Bard *et al*, 2004); they negatively affect the continuity of care (Sarver and Baker, 2000; Yeo, 2004; Brotanek *et al*, 2005), and they create a barrier to the use of preventive services (Woloshin *et al*, 1997). Miscommunication can also lead to substantial extra costs in the provision of services: more time resources are required for routine encounters in the treatment process, leading to longer periods of stay (John-Baptiste *et al*, 2004) or additional organisational burden for the staff (Drennan, 1996). Moreover, delays in the treatment process or clinical decisions based on inaccurate information can result in poor treatment outcomes. In addition to threats to patients' health and quality of life, these delays also bear the risk of actual liability costs for the healthcare institution (Bischoff, 2003).

## Addressing the language gap

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Healthcare institutions have devised responses to these communication barriers in order to provide effective services to their linguistically diverse clientele. In the past, however, these responses have relied heavily on the *ad hoc* use of bilingual staff or patients' family and friends to bridge language gaps. Such reliance carries several risks, including the likelihood of poorer healthcare due to inadequate communication and undesired health outcomes.

In recent years, however, many hospitals have seen the need to go further to ensure that quality care is provided to all patients. Professional strategies to facilitate communication between patients and providers have proven effective in improving service quality and outcomes for migrant and ethnic minority patients who face language barriers in utilising health services (Tocher and Larson, 1998; Jacobs *et al*, 2004), the most effective approach being the introduction of professional medical interpreters (Jacobs *et al*, 2004). In addition to their language competence, professional interpreters have a strong medical vocabulary and specific communication skills, as well as an understanding of the ethical issues involved in their role (Bischoff *et al*, 2003). While the cost of hiring interpreters or contracting their services from outside agencies may present barriers to their employment, a study in the US showed that the annual cost of interpreters per patient was compensated by significant improvements in patients' service use, compliance and health outcomes (Jacobs *et al*, 2004).

The type of interpreting support provided differs significantly in terms of the healthcare systems concerned, the demographic make-up of communities, and the type of services provided (Schulze *et al*, 2003). For example, a hospital serving a clientele that has a high proportion of people who speak a specific language may benefit from hiring full-time interpreters. Another hospital with the same number of non-native speakers of many different languages will not be able to provide on-site service for everyone. In this case, making arrangements with freelance interpreters would seem to be the more feasible option. Hospitals that have to provide emergency services may benefit most from telephone interpreting services or may need translated material to support clinical communication.

## A European perspective

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With increases in global migration flows, the challenges posed to healthcare by cultural and linguistic diversity are likely to intensify. This calls for a concerted response and an expansion of the evidence base

for effective strategies to address language barriers across a range of services and specific local circumstances.

The Migrant-friendly Hospitals Project (Box 1) represented a wide spectrum of hospital services, ranging from large metropolitan university teaching hospitals to small-town community hospitals, with diverse migration situations in their catchment areas and different levels of experience in serving populations with limited proficiency in the local languages.

The project provided a range of solutions that were developed and implemented based on a combination of local needs assessments at the different sites, and a systematic review of effective interventions (Bischoff, 2003).

In the needs assessment, communication was identified as the most prominent area of concern in dealing with migrant and ethnic minority populations in clinical routines. The development of effective services to bridge the language gap between providers and diverse patient groups was therefore a central focus in the project. The emphasis in the project work under discussion here was on interpreting in clinical communication; that is to say, on conveying medical information across language barriers in spoken conversation, with the presence of an interpreter either in person or in a remote setting connected via telephone, video or other media.

## Aims

Nine hospitals in Denmark, Finland, Greece, Spain, Ireland, Italy, The Netherlands, Sweden and the UK co-operated to improve clinical communication with

migrant and ethnic minority patients (see Box 2). Altogether, 37.9% of the clinical staff in these hospitals, including doctors, nurses, therapists, social workers and clerical workers, reported daily contact with this patient group; another 28.5% reported contact two or three times per week. The aims of this part of the Migrant-friendly Hospitals Project were to ensure:

- the provision of professional interpreter services whenever necessary to ensure good communication between non-local language speakers and clinical staff
- that patients were informed about the language services available and how to access them
- that clinical staff were empowered to work competently with interpreters to overcome language barriers and obtain better outcomes
- the provision of education materials for patients in non-local languages.

## Interventions

In order to enhance clinical communication between staff and migrants, the participating hospitals implemented different measures to develop new and/or improve existing interpreting services.

Measures were planned according to the individual needs of each hospital. In some cases, no interpreting services existed, so those hospitals developed an entire plan for service development and implementation. More commonly, though, measures focused on improving existing services to increase their efficiency and effectiveness. Taking into account specific hospital

### Box 1 The European project 'Migrant-friendly Hospitals' (MFH)

The MFH project (2002–2005) was sponsored by the European Commission, DG Health and Consumer Protection (SANCO) and co-financed by the Austrian Federal Ministry for Education, Science and Culture. The project aimed at improving the impact of hospitals on health and the health literacy of migrants and ethnic minorities. Pilot hospitals from 12 member states of the European Union collaborated, and the Ludwig Boltzmann Institute for the Sociology of Health and Medicine at the University of Vienna acted as coordinator. The project therefore had access to a wide range of experts and several international organisations and networks. The project aimed to foster attention on the issue of migrant-friendly, culturally competent healthcare and health promotion, putting the issue higher on the agenda of hospitals and health policy in Europe. At the same time, the project compiled knowledge and instruments relevant for everyday practice to support hospitals in their quality development. The main strategy was to select three common problem areas on the basis of a systematic needs assessment in the 12 pilot hospitals, to implement and evaluate specific evidence-based interventions, identified on the basis of a systematic literature review, and monitor the overall organisational development process towards migrant friendliness initiated in the project, using the MFQQ (Migrant-friendly Quality Questionnaire), an instrument developed in the project. The three subprojects were 'Improving interpreting in clinical communication' (A), 'Migrant-friendly information and training in mother and child care' (B) and 'Staff training towards cultural competence: enabling hospital staff to better handle cross-cultural encounters' (C). For detailed information on instruments and results see the final report on the MFH project, Krajcic *et al* (2005), at [www.mfh-eu.net/public/home.htm](http://www.mfh-eu.net/public/home.htm)

## Box 2 The composition of the subproject group

The subproject group consisted of the following nine hospitals:

- Kolding Hospital, Vejle-Kolding, Denmark
- Turku University Hospital, Turku, Finland
- Hospital 'Spiliopoulou Agia Eleni', Athens, Greece
- Hospital Punta de Europa, Algeciras-Cádiz, Spain
- James Connolly Hospital, Blanchardstown, Ireland
- Presidio Ospedaliero della Provincia di Reggio Emilia, Reggio Emilia, Italy
- Academic Medical Center of the University of Amsterdam (AMC-UvA), The Netherlands
- Uppsala University Hospital, Psychiatric Centre, Uppsala, Sweden
- Bradford Hospitals NHS Trust, Bradford, United Kingdom.

This hospital group was scientifically co-ordinated and supported by Beate Schulze (October 2002–February 2004) and Sonja Novak-Zezula (February 2004–March 2005), Ludwig Boltzmann Institute for the Sociology of Health and Medicine; Lourdes Sanchez, Manager of Interpreter Services at the Massachusetts General Hospital, USA, was the subproject's expert consultant.

structures and processes, different types of interpreting services were implemented: telephone interpreting, face-to-face interpreting, intercultural mediation, and/or written material as communication aid.

Two models of good practice that were developed and implemented in the project framework are described below to illustrate the type of specific solutions applied (see Boxes 3 and 4).

## Evaluation design

A pre- and a post-intervention staff survey and a post-intervention patient survey were conducted using a benchmarking learning and evaluation design.

Hospital staff were questioned twice, once in a baseline survey in February 2004 ( $n = 479$  in seven hospitals), and a second time in a further survey in June 2004 ( $n = 282$  in six hospitals) after implementation of the measures. One hospital did not conduct the second staff survey because the intervention employed extended until after completion of the project.

Medical and nursing staff were asked, in a standardised written questionnaire, about their experiences of encounters with patients who had a limited command of the local language, and about how they (the staff) rated the quality of the available interpreting services. They were also asked to provide information on how they thought interpreting support should be improved. In the second survey, there was an extra question about the extent to which the individual work situation had improved as a result of project measures.

Three hospitals conducted a post-intervention patient survey ( $n = 42$ ) parallel to the second staff survey in June 2004. Following a clinical encounter involving an interpreter, patients were interviewed about the

attendance of the interpreter, their ratings of the interpreter's work, the encounter with the doctor and their views as to how interpreting support should be improved.

In a third evaluation step, project managers at the hospitals answered a short questionnaire which asked them to assess the extent to which the measure could be implemented, to list both enabling factors and obstacles in the implementation process, and to provide information on the sustainability of the measures.

## Findings

### Staff survey

Analysis of the pre- and post-intervention staff surveys showed that the interventions, such as the sound-station, were effective. Comparison of the baseline and second staff surveys showed that the uptake of professional interpreting increased by 20.2%, with a concurrent decrease of nearly 10% in interpreting provided by adult relatives and friends (see Figure 1). However, a 2% increase was observed in the use of children, under the age of 18, as interpreters.

In addition, the quality of interpreting services was evaluated more positively after the interventions were introduced. Interpreters were said to be available in a timely manner and more frequently than they had been in the baseline survey (+17.5%). Furthermore, an improvement was noted for all defined quality indicators for interpreting services, such as introduction and role explanation by interpreters (+10.8%), accurate transmission of information (+6.8%), clarification by interpreters (+7.7%), clarification of cultural beliefs (+10.5%) and the identification of patients' further needs by interpreters (+7.3%). There was an improvement in the

### Box 3 Good practice experience 1: telephone interpreting in Denmark

As in most European countries, society in Denmark has become ethnically diverse. Denmark's Kolding Hospital has a patient population that speaks a large variety of languages. A spot check showed that interpreters for 16 different languages were commissioned in 2002/2003 alone.

In the course of the needs assessment, both patients and staff mentioned communication as the most problematic issue. The hospital had used face-to-face interpreting but the Department of Paediatrics received many acutely ill children and interpreters were often needed at very short notice, a requirement that face-to-face interpreting cannot fulfil. In addition, face-to-face interpreting resulted in the hospital having to pay large amounts for the interpreters' transportation costs.

The Migrant-friendly Hospitals Project aimed to improve interpreting services for clinical communication between migrant patients and staff by installing a soundstation.

The soundstation was a hands-free telephone with three loudspeakers and had the following advantages:

- interpreting services could be established at very short notice
- no transport costs are incurred, because the interpreter did not need to travel to the hospital
- the sound quality was better than that of an ordinary telephone
- there was more direct contact between the staff and the patients because the interpreter wasn't in the room
- the patients appreciated the anonymity that is not possible with face-to-face interpreting.

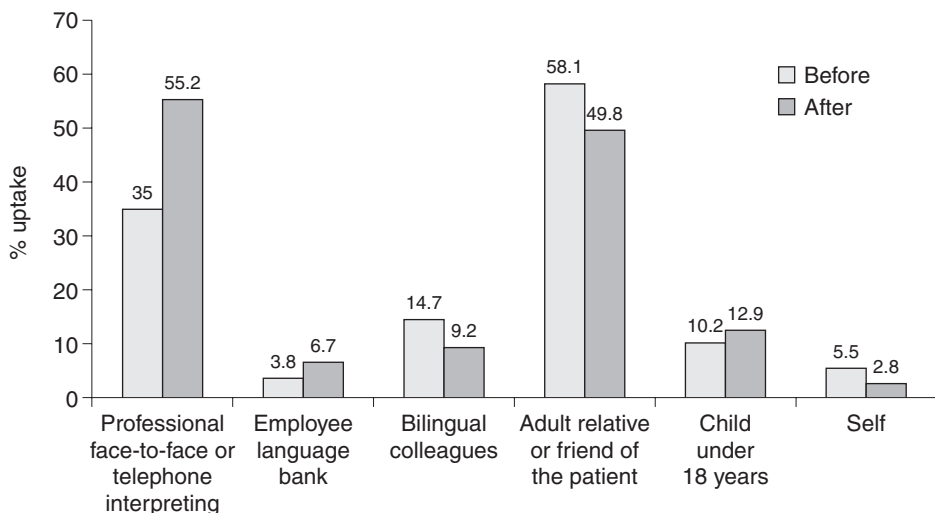
Questionnaires were filled out by the staff before and six months after the soundstation was installed. The findings were:

- the staff used a professional interpreting service in almost 20% more cases, instead of relying on an adult relative or friend of the patient
- 30% of the staff considered their working situation to have been improved following the installation of the soundstation
- more than 80% of the staff rated the quality of interpreting provided by the hospital's interpreting service as good or very good.

The soundstation is now used to an even greater extent than these results show and with groups other than acutely admitted child patients. It is now used with inpatients and at discharge. A concerted effort was made to spread the news about the service, the result being that the remaining departments of Kolding Hospital – and other hospitals too – have shown great interest in the soundstation.

In summary, improving clinical communication between migrant patients and the staff is no longer an effort limited to the Department of Paediatrics.

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**Figure 1** Resources used to facilitate communication with patients with limited command of the local language, before and after implementation of measures

#### Box 4 Good practice experience 2: mediation services in Italy

Italy regarded a service of intercultural mediation as being as important as an interpreting service. The difference between interpreting and intercultural mediation lies in their role description. Intercultural mediators not only translate the words of the patients but also contribute their profound knowledge of the patients' culture because they are themselves from the same ethnic group.

An intercultural mediator is able to accompany encounters between migrants and the social context in question, fostering the removal of linguistic and cultural barriers, the understanding and the enhancement of one's own culture, and access to services. They assist organisations in the process of making the services offered to migrant users appropriate (Regional Decree of Emilia-Romagna, N.152, 10 November 2004).

The Migrant-friendly Hospitals Project was characterised by two different phases.

- *Phase 1*: a three-month period of implementation at the hospital in the district of Guastalla, where an Indian intercultural-linguistic mediator was employed for the speakers of Urdu, Hindi and Punjaabi.
- *Phase 2*: the creation and implementation of an intercultural-linguistic mediation service for the whole province of Reggio Emilia, including both hospitals and district services. External social associations were involved in order to foster community participation.

Lessons could be learned from the following findings:

- difficulty in finding (trained) intercultural mediators, especially among the Chinese population
- the need to create appropriate and recognised training programmes for intercultural mediators
- the need to define quality standards for intercultural mediation, interpreting and translation
- the tendency to consider the use of intercultural mediators as a panacea for the management of intercultural healthcare
- the risk that health staff will delegate social tasks to the intercultural mediators
- a tendency to continue using informal interpreters such as family members, particularly in emergency departments
- the need to develop a policy for culturally competent communication.

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overall rating of interpreting services; the proportion of those judging the service to be excellent or very good increased by 21.3% and 54.9% of the staff members stated that the work situation had improved because of the interventions employed.

On the other hand, patients were less satisfied with direct doctor–patient communication: only 31.7% strongly agreed (14.6 % agreed) that the doctor talked directly to them rather than to the interpreter when giving or asking for information, but 48.8% disagreed and 4.9% even strongly disagreed.

#### Patient survey

Analysis showed high levels of patient satisfaction with the performance of hospital interpreters: 78% of patients strongly agreed that, with the interpreter's help, they understood all the medical information (the other 22% agreed); 83% strongly agreed that the interpreter assisted them in relaying important (lifestyle) information to the doctor (17.1% agreed). In general, ratings concerning the doctor's performance were also very high: patients felt that doctors took time to talk with them (70.7% strongly agreed/29.3% agreed), showed sensitivity to their cultural beliefs and needs (68.3%/29.3%), encouraged them to ask questions (68.3%/29.3%) and worked together with the interpreter to make sure they understood everything (67.5%/30.0%).

#### Evaluation of implementation

The interventions can be categorised in four groups:

- development/improvement of face-to-face interpreting
- development/improvement of telephone interpreting
- development/translation of written material as supporting communication
- implementation of intercultural mediation.

It was not possible to identify one specific measure as a model of best practice. In fact, the combination of the local situation, involved partners and the concrete measures seemed to be the determining factor for the

acceptance, feasibility and the effectiveness of interventions.

Implementing the interventions turned out to be a difficult task. Local project managers had to adjust their strategies, make compromises and demonstrate considerable flexibility. Four interventions were implemented completely, eight to some extent, and two not at all. Two-thirds of the interventions were difficult to implement because of factors such as lack of acceptance and utilisation of the service, lack of sufficient time, and logistics. Only four could be easily implemented and these are described in Box 5.

From the project managers' point of view, the aims of the project were very worthwhile. All of the interventions that were implemented will be continued. Three have become an established part of the hospitals' service, four will be adapted and then included in service routines, and five will even be extended.

## Discussion

The evaluation confirmed existing international knowledge and experience about improving the quality of interpreting services in hospitals (Jacobs *et al*, 2004; Bischoff *et al*, 2003). Hospital co-operation within a scientifically supported benchmarking approach proved to be feasible and effective. Despite the huge diversity of healthcare systems, hospital and departmental structures, and migrant population characteristics, all partner hospitals had to handle very similar problems.

Comparability of data and experiences was, on the one hand, assured by a central benchmarking evaluation of procedures with questionnaires, guidelines and documentation sheets as standardised tools, and there was a central analysis of survey data on the basis of detailed documentation of the diverse evaluation

### Box 5 Measures that could be implemented easily, from the project manager's point of view

#### 1 Development, launch and evaluation of a 'language bank' list

*Problem:*

Lack of knowledge about and use of an existing language bank that includes many multilingual staff members

*Aim:*

Staff take advantage of the resource represented by multilingual staff members when it is difficult to obtain a professional interpreter

#### 2 Staff training course covering the following issues: importance of interpreter services, interpreter's responsibility, contacting interpreter services, communicating via interpreters

*Problem:*

Lack of knowledge regarding the interpreter system, especially the costs

*Aim:*

Staff use interpreter services as an integral part of high-quality healthcare

3 A **written information resource file** was developed for all hospital departments, comprising (1) a newly developed protocol for staff on how to access interpreters, (2) patient confidentiality forms, (3) interpreter evaluation forms for staff to complete, (4) pictographs in 11 foreign languages and (5) 'point-to-talk' sheets for patient requests and discomforts in 20 different languages. The file also contained evaluation forms for staff who used the file to assess its usefulness

*Problem:*

Staff and patients expressed an urgent need to address the issue of communication difficulties

*Aim:*

Support hospital staff in intercultural multilingual communication

#### 4 Implementing an **interpreter service** for three languages, available from 08:00 to 22:00 for the staff of one partner hospital

*Problem:*

Doubts about the qualification of the interpreters for the task required; organisational problems encountered when multilingual employees are required to act as interpreters, thus interrupting the fulfilment of their primary duties

*Aim:*

Provision of high-quality interpreting service for the main migrant groups

procedures. On the other hand, a high degree of flexibility was allowed concerning the individual design of procedures for conducting the surveys, for selecting target groups and for planning and implementing the measures.

In order to ensure the viability of the benchmarking group and to support the hospitals' processes of learning from one other, a co-ordinated schedule for central project steps was necessary, and there was a clear need for information about the context of each partner's work in order to allow for a determination of where each partner ranged in the group of hospitals. The design, the services of the project's expert consultant as a practical advisor, and scientific support and co-ordination all proved to be essential for the

success of the benchmarking. Box 6 presents an account of some of the concrete difficulties faced, taking as an example the pilot hospital in Spain.

## Conclusion and recommendations

The experiences of nine pilot hospitals across Europe show that the central steps in setting up interpreting services in a hospital setting are:

- 1 obtaining both symbolic and practical support from management

### Box 6 The Spanish partner hospital's experiences

We experienced constraints in adhering to the Migrant-friendly Hospitals Project time frame for the development, implementation and evaluation of the intervention. Last but not least, the absence of a budget for the implementation was a very sensitive issue!

In response to these conditions we chose to promote the use of written documentation and to help to improve the linguistic abilities of the staff, this being the faster and more affordable of the feasible options.

We focused on learning about and clarifying resources already existing within the organisation. Very useful resources often remain within office or departmental limits, unknown and thus unused by the rest of the organisation. We discovered a large number of very useful and well-developed multilanguage documents that had already been created and were in use, but which had not been distributed beyond the immediate context.

By networking within the Migrant-friendly Hospitals Project and beyond, we also found tools already in use in other organisations, and integrated or adapted these to our local situation. After doing so, we focused on making the resources visible to the hospital and the clients through promotion, by contacting key persons within service and by monitoring the outcomes. The resources were then allocated to the most effective places in the organisation, making them available to the members of staff who were in direct contact with the migrant patient populations.

We continue to look to the future, aiming to place the interpreting on a higher level of priority on the agenda of our continuous professional education (CPE) department. Language classes for healthcare providers have been included regularly in the CPE programme, and cultural diversity training for staff was piloted within the Migrant-friendly Hospitals experience. Nonetheless, none of these measures can be seen as a substitute for a clinical interpreting service.

Clinical interpretation services have moved higher in the hospital organisation's agenda and have become a relevant issue among staff. The interpreters' services are now requested more often – in fact, demanded. More communication tools have become available – at a reasonable cost – and even more tools are being developed in different services in our hospital, these efforts having spread beyond the immediate Migrant-friendly Hospitals' umbrella. The goal of the interpreting services has shifted from the 'should' to the 'must' list – for staff, clients and managers. However, building up a clinical interpreter service from scratch is a long-term goal. In our hospital, changing staff and management orientations with regard to interpreting services was set as an initial goal, because only this makes the other necessary changes within the organisation feasible, e.g. new service protocols, quality controls, material and human resources, partner alliances, and of course ... budget allocations.

Viewed out of context, a clinical interpreting service appears to be a major investment, but we must compare the cost of its implementation to the costs of its non-implementation. First, non-implementation always results in financially higher costs in the big picture, and secondly, it is plainly unacceptable in political and human terms.

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- 2 establishing central co-ordination of interpreting services, and hiring an interpreting co-ordinator or appointing staff from within the hospital to control the budget, track volume increase and assure quality of service
- 3 choosing appropriate interpreting resources, for example, employee language bank, telephone interpreters or face-to-face interpreters, either from external interpreting agencies or from in-house professional clinical interpreters
- 4 training for interpreters and clinical staff
- 5 marketing of the service to increase awareness and visibility
- 6 a systematic approach to the production of policies and guidelines and to the translation of written materials.

Further, the outcomes of the project reveal the central prerequisites for the successful and sustainable implementation of measures to improve the quality of clinical communication with migrant or ethnic minority patients. There are several preconditions that have to be met in order to improve clinical communication for migrants consistently:

- linguistically adequate clinical communication has to be integrated into a hospital's general policy on diversity. As an important step, the needs and assets of all stakeholders – including both users (patients, relatives, community) and providers (staff) – should be monitored. The outcomes of implemented interpreting services, as well as the structures and processes that influence access to interpreting services and their quality, must be monitored
- services and processes have to be sustained by becoming mainstream and not relying on local champions alone. In other words, an organisational development process should be initiated, supported and monitored by those responsible for hospital leadership, overall management and quality management. It is necessary to invest in both the medical interpreters' and clinical staff's developing skills and competences regarding the effective performance and use of interpreting services
- adequate political and managerial will and funding have to be assured. Adequate resources – working time, financial resources, and qualification – must be provided if changes are to be realised. By providing legal and financial support and by formulating organisational aims, health policy must provide a framework in order to make the development of interpreting services on the hospital level relevant and feasible.

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#### CONFLICTS OF INTEREST

None.

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