Health care interpreters: A physiotherapy perspective

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Communication is the greatest barrier in health care provision for people of non-English speaking backgrounds. The New South Wales Health Standard Procedures stipulate that the Health Care Interpreter Service must be used in consultations with clients who cannot fully comprehend English. This study explored the attitudes, thoughts, and feelings of physiotherapists toward health care interpreters and their service. Interviews and observations were conducted at three different hospitals. Six physiotherapists were interviewed in total. The results showed physiotherapists did not collaborate with health care interpreters for all consultations with clients of non-English speaking backgrounds. Physiotherapists were found to be largely negative in their attitude toward the health care interpreter service. Suspicion and distrust of interpreters, time constraints, and the perceived cost of the service were major themes identified in the interviews. Physiotherapists need to be aware that failure to collaborate with interpreters may result in litigation should there be reason to contest the validity of treatment consent or warnings given. [Lee TS, Lansbury G and Sullivan G (2005): Health care interpreters: A physiotherapy perspective. Australian Journal of Physiotherapy 51: 161–165]

Key Words: Communication, Immigrants, English, Culture

Introduction

Australia is a multicultural country and provides an ideal setting to study interactions between health care providers and consumers from non-English speaking backgrounds. Twenty-four per cent of Australia’s population was born overseas and more than half of these residents were born in a non-English speaking country (Singh and de Looper 2002). Twenty per cent of the Australian population speak a language other than English at home. Of these languages the three most common are Chinese (2.1%), Italian (1.9%), and Greek (1.4%) (Singh and de Looper 2002). Australia’s diversity, especially over the past few decades, has made intercultural communication an everyday experience in many workplaces.

The 1995 State of the Nation Report (Travaglia et al 1995) identified communication as the greatest barrier in health care provision for people of non-English speaking backgrounds. Language barriers have been shown to affect quality of care in nursing and medicine adversely (Sherraden and Barrera 1996; Stein and Fox 1990). Physiotherapists rely heavily upon the communication process during consultations to convey instructions, explanations and feedback. In particular, professional interpreters are crucial in consultations where the physiotherapist needs to obtain a background of the treated problem, medical history, screen red-flags, obtain informed consent, give diagnoses, explain treatment, give warnings, and obtain feedback. In NSW physiotherapists need to abide by the ‘Standard Procedures for the Use of Health Care Interpreters’ stipulated by the Health Department of New South Wales (New South Wales Health 1994):

Health care providers are required to disclose all relevant information regarding treatment, method, any risks associated with treatment, any side-effects or adverse outcomes prior to commencing treatment. It is essential to communicate this information to non-English speaking background patients through a professional health care interpreter. (Item 3.1)

Consent for treatment may not be valid if it is obtained through a child or family members, other clients, visitors or non-accredited staff acting as interpreters. (Item 7.5)

All Australian states have requirements regarding the ethical use of health care interpreters. In addition to following standard procedures, physiotherapists should be familiar with the guidelines for effective collaboration with professional interpreters listed in Table 1. Effective collaboration with an interpreter reduces language and cultural barriers, and

Table 1. Guidelines for effective collaboration with professional interpreters.

- The interpreter should be briefed on the objectives of the consultation and introduced to the client by the physiotherapist.
- The optimal position for seating should be triangular, so that the physiotherapist, client, and interpreter can see each other.
- The client is reassured that all information discussed will remain confidential.
- Questions should be directed to the client, not the interpreter. Similarly, eye contact from the physiotherapist should be directed to the client if appropriate.
- Sentences should be brief and sufficient pause be allowed for interpreting.

(Adapted from Pauwels 1995)
interpreters were purposefully chosen and invited to physiotherapists who had experience with health care participants who can provide extensive information regarding Purposive sampling is used in qualitative research to select in terms of background, education, area of work, sex, and age. quantitative study, one aim of which might be to produce which are insightful and could be used as the basis of a larger exploratory. As such it has produced preliminary findings of the study. It needs to be emphasised that this study was account provided by the interviews and increased the validity reported in interviews. These supplemented the second-hand interviews to allow a deeper understanding of the interaction opportunistic observations were recorded in addition to the semi-structured interviews. Due to the serious legal and social consequences that could result from nonverbal communication or the use of amateur interpreters, there is a need to facilitate the correct method of collaboration with interpreters by all physiotherapists. This study aimed to identify and evaluate the attitudes, beliefs, and perceptions of physiotherapists toward interpreters. The study was part of a larger project examining how physiotherapists interact with clients of diverse ethnic origins.

Method

Qualitative research methods using semi-structured interviews were utilised in this study. An advantage of this method is flexibility to pursue lines of inquiry that arise during an exploratory study such as this one, thereby maximising validity (Minichiello et al 2004). An interview guide was formed after the first interview to allow the interviewer to concentrate on a broad list of topics relevant to the study (Table 2). The interview guide was subsequently refined with each interview to focus on new issues raised. Semi-structured interviews allowed the researcher to direct the interview, yet adapt questioning and clarify ambiguous issues.

Opportunistic observations were recorded in addition to the interviews to allow a deeper understanding of the interaction being studied, and to gain insight into actions that were not reported in interviews. These supplemented the second-hand account provided by the interviews and increased the validity of the study. It needs to be emphasised that this study was exploratory. As such it has produced preliminary findings which are insightful and could be used as the basis of a larger quantitative study, one aim of which might be to produce generalisable results (Minichiello et al 2004).

The aim of sampling was to maximise the range of informants in terms of background, education, area of work, sex, and age. purposive sampling is used in qualitative research to select participants who can provide extensive information regarding the area of interest (Patton 2002). In this study, five physiotherapists who had experience with health care interpreters were purposefully chosen and invited to participate in the study by the researcher. One physiotherapist volunteered herself. All physiotherapists participated voluntarily. Ethics approval was obtained from the University of Sydney Human Ethics Committee.

Observations and interviews were conducted at three hospitals located in Central Sydney, Northern Sydney, and Hunter Area Health Services. The physiotherapists who participated in the study ranged from 26 to 53 years of age. Five were female. Three physiotherapists were born overseas, immigrating to Australia between six and 27 years ago. The experience of the physiotherapists ranged from one year to 22 years. Two of the physiotherapists trained abroad, in countries where English is widely spoken, one interstate, and three were from the University of Sydney. Pseudonyms are used in this report to maintain confidentiality of participants in the research. A good rapport had already been established with participants, Beryl, Jane, Meg, Dean, and Kim, prior to the interview as the interviewer had worked in their Physiotherapy Department during her student placement. Gillian was the only physiotherapist who was unknown to the interviewer prior to the interview. Hence, a few additional minutes were spent before the interview to introduce the study, build rapport and dispel any discomfort she may have been experiencing. Each interview lasted for an average 45 minutes.

All taped interviews were transcribed into a word processing program. Themes were identified and coded. A profile of each interviewee was created and a log was kept containing a description of how each interview was arranged, notes on the interview process, and follow up data. Each interview was analysed to identify the content of the interview. Comments relevant to the research were discussed and emerging ideas noted. Hence, interview questions at subsequent interviews were pertinent to the main issues that emerged from previous interviews. Data analysis followed the method recommended in Browne and Sullivan (1999) to maximise the rigour and trustworthiness of the results.

Results and Discussion

The interview responses regarding health care interpreters and their services were mostly negative. Generally, the physiotherapists who participated in this study collaborated
with professional health care interpreters for initial treatments and subsequent major reassessments, such as every fourth session. The physiotherapists interviewed in Sydney metropolitan areas collaborated with professional interpreters on average once per month, while physiotherapists interviewed in the Hunter region collaborated with interpreters once every few months. Some physiotherapists preferred to use communication strategies other than professional interpreters when treating non-English speaking clients. The order of preference of communication strategies for these physiotherapists was usually as follows. Their first preference was to collaborate with a family interpreter. When family members were unavailable, nonverbal communication or bilingual staff were often used. Only when a consultation was unsuccessful with nonverbal communication, or when bilingual staff were unavailable, would professional interpreters be utilised. As Jane said:

We have very few patients here that we have to actually get to the point where we need an interpreter.

In this case, ‘getting to the point’ meant exhausting all other possible options such as family interpreters, bilingual staff, and nonverbal communication.

**Distrust and suspicion of interpreters** Physiotherapists were particularly suspicious about professional interpreters’ ability to transmit intended messages accurately. Four physiotherapists suspected error in the interpreter’s transmission of the message by comparing the length of the sentences from the interpreter with that of the client or physiotherapist. Most physiotherapists thought interpreters lengthened or added to their interpretations, whilst one physiotherapist suspected interpreters shortened the statements.

I ask the patient one sentence and I can hear their conversation I am sure for more than one sentence. (Kim)

It’s the way the patient says a few words and then she (the interpreter) will interpret an awful lot out of those few words. So, it’s a cultural thing but it doesn’t look like she is directly interpreting what they’re saying. (Meg)

Now I don’t know whether it’s because of the differences in the language because of the length of words but they always seem to say a bit more than what you think they say. (Dean)

The length of sentences or words does not reflect interpretation accuracy. The message may sound longer or shorter simply due to language differences. The distrust and suspicions from physiotherapists may be explained by the appearance of collusion between the interpreter and the client simply through shared culture and language (Hatton and Webb 1993). It may also be explained by the fact that it was difficult for physiotherapists to develop rapport with different interpreters allocated for each session with the same client. Physiotherapists need to understand that health care interpreters are bounded by a strict code of ethics, similar to that of their own profession. Interpreters are required to remain impartial and neutral in all situations. They may not allow personal preferences, religious or political opinions or national enmity to interfere with the performance of their duties.

One physiotherapist was also worried about interpreters dominating the physiotherapist-client relationship.

Sometimes you have to be careful you don’t alienate the patient because the interpreter may be taking over. (Meg)

Meg’s reference to the interpreter ‘taking over’ seemed to imply that the interpreter undermined her role as a physiotherapist, or her authority. Pauwels (1995) suggested the perception of a loss of control may be due to the pauses and unnatural sequencing of interpreter-mediated conversation. Another explanation is the fear of encroachment on physiotherapists’ work autonomy. Autonomy is defined as ‘an individual’s ability to independently carry out their responsibilities of the position without close supervision’ (Blanchfield and Biordi 1990). Although interpreters do not directly encroach on physiotherapy practice, physiotherapists are often totally dependent upon interpreters to bridge the language barrier whenever they treat non-English speaking clients. Hence to some extent interpreters may be disliked because they decrease physiotherapists’ independence and autonomy in practice.

**Time constraints** The time required to organise interpreters for appointments was not an issue for the physiotherapists interviewed. This may be explained by the fact that receptionists, not physiotherapists, organised and co-ordinated physiotherapy appointments with interpreters. However, completing consultations on time when using interpreters was a constant source of stress for some physiotherapists.

One physiotherapist always allocated an extra fifteen minutes in outpatients for clients requiring interpreters. This practice was observed by the researcher during clinical placements in other hospitals. Most physiotherapists understood that in order to provide the same standard of physiotherapy care to clients requiring interpreters, extra treatment time was needed to compensate for the time spent in dialogue. Interestingly, there was concern that other clients were placed at a disadvantage:

The questions have to be asked twice and the answers given twice, so there’s an increase in time required. This is always a big problem especially in the health setting because we’re probably understaffed and servicing a large number of patients who we might not get to see. (Dean)

The majority of physiotherapists who were interviewed did not view punctuality of interpreters as a problem. Through personal experience, Meg showed understanding for interpreters who were sometimes late:

I can respect that [the interpreters being late] because I know that I’ve held them up for half an hour or so sometimes because I really don’t want to let them go.

The one exception was Kim, who believed 30% of interpreters were not punctual. She expressed strong feelings toward lateness saying it ‘really turns me off.’ It is important to some physiotherapists, such as Kim, that they maintain a routine throughout the day. Health care interpreters are seen as an interruption to the work schedule; hence negative attitudes are formed, resulting in reduced collaboration.

One physiotherapist complained of her experience with a particular interpreter who had been very ‘short’ and ‘sharp’ during consultations. Beryl said this interpreter’s attitude was:
Now this is a job, I’m only here for a set period of time, not longer; not a minute longer, you’ve got to get in everything you need to say.

Beryl did not rationalise the abruptness of the interpreter could have been due to time constraints which were out of the interpreter’s control. Instead, she saw it as follows:

They are paid for the half hour and they are not prepared to go beyond that.

Beryl’s negative perception of one interpreter was generalised to all health care interpreters, resulting in reduced collaboration with the service.

Cost of the interpreter service The perceived cost of the professional interpreter was a major issue for the physiotherapists who were interviewed. One physiotherapist said ‘It’s a waste of money’ while another physiotherapist believed interpreters were ‘a luxury’ that the health system could not afford. However, the Central Sydney Area Health Service reported that the health care interpreter service costs only $7 per head of ethnic population per year (Central Sydney Area Health Service 2004). Money allocated to the service was only 0.6% of the total area budget. The cost of providing the service is minimal. In addition, immigrants are also taxpayers and are entitled to such a service, especially since a goal of the public health system is to provide access and equity in terms of service.

Considering these statistics regarding the cost of the interpreter service, it would appear that physiotherapists who were critical of the service were possibly misinformed about the comparative costs of the health care interpreter service or were using cost as an excuse for not using professional interpreters. Although no physiotherapist was observed to deny a client an interpreter based on cost, they were wary and concerned about the issue.

Physiotherapists who commented on the cost of the interpreter service acknowledged that funding was a problem for the health care interpreter service. Despite their acknowledgement that the interpreter service could function better with more money, they still suggested that the health care budget should be ‘prioritised’ to other areas. Negative attitudes held by these physiotherapists may be caused by a perception that physiotherapy departments are competing with the health care interpreter service for funding.

With cost-cutting in mind, one physiotherapist suggested that a volunteer interpreter service should replace the current service.

Just as people become counsellors for doing Lifeline for suicidal people, volunteers go through very rigorous training and I see no reason why the same ethics couldn’t be employed. (Beryl)

The demand for the interpreter service in Central Sydney, with 99,909 occasions of service in 2003–2004 (Central Sydney Area Health Service 2004), far outweighs the capacity of a volunteer service. It is highly unlikely that volunteers would commit themselves to full time or regular part time work, or be on call 24 hours a day without any financial reward. Although volunteers may have good intentions, hospitals cannot use them because of legal and privacy concerns.

Only one physiotherapist considered the positive aspect in terms of interpreters saving the health system money. An interpreter who transmits the appropriate instructions from the health professional can ensure that clients understand their illnesses and their management regimens. This prevents further injury or sickness which would cost the health system more money. Meg gave an example where she used the telephone interpreter service and discovered that her client had been experiencing chest pain all day. She referred the client immediately to hospital through the telephone interpreter. Her action may have saved the cost of an emergency call as well as the emotional cost of family distress.

Further study This study addressed only one perspective in a three-way interaction between the physiotherapist, client, and interpreter. It would be interesting to compare the thoughts and feelings of clients toward the health care interpreter service, as well as the interpreters’ perspective toward the health care provider. Due to the small sample size of the study the results are not generalisable, however the study may be used as a basis for a future quantitative study with a large sample size. Qualitative research is generally a labour intensive method and accordingly sample sizes are often small. The strength of the method lies in validity and insight, rather than generalisability (Minichiello et al 2004).

Very few positive comments were made with regard to the health care interpreter service. It appeared most physiotherapists saw the interviews as an opportunity to express their concerns and perhaps verbalise their frustrations with the difficulties encountered when treating clients of non-English speaking backgrounds. A future study may purposely recruit physiotherapists who have had positive experiences with clients who required professional interpreters due to limited English proficiency, though this study indicates that such physiotherapists may not be easy to find.

Recommendations Previous research identified a positive correlation between training and the incidence of professional interpreters’ collaboration by medical practitioners (Karliner et al 2004). Similarly, the same results may be gained by educating physiotherapists about interpreter collaboration, the value of the professional interpreters, and the risks that result from using amateur forms of communication. Increasing physiotherapists’ exposure to the health care interpreter service, may in turn increase the frequency of collaboration, and lead to established links between the profession and the service, such that professional interpreters become the norm for consultations with any non-English speaking clients.

Understandably, professional face-to-face interpreter may not be readily available in all situations. However, every means should be taken to ensure effective communication. This may involve collaboration with the telephone interpreting service until a face-to-face professional interpreter can be organised for the client. Should a situation arise where interpreters are unavailable, physiotherapists and health professionals should be encouraged to record these as ‘adverse incidents’ so that they can be addressed within hospital quality improvement programs (Cioffi 2003).

It is stressed that education alone will not change some of the negative attitudes identified in this study. Physiotherapists need to undergo a change in their ideas, and to be aware of and undo some of their ingrained cultural bias (Meadows
To attain cultural competency, physiotherapists must learn to identify personal cultural biases, understand cultural differences, accept and respect cultural differences, and apply cultural understanding (Black and Purnell 2002). Health care professionals act as ‘gatekeepers’ to interpreting services (Gerrish et al 2004). Hence, it is essential that physiotherapists are aware of and value the importance of professional interpreters, so that effective communication can occur and quality care can be delivered.

Conclusion

This study found that the overall negative attitudes of physiotherapists toward health care interpreters were based on distrust, time constraints, and the perceived cost of the interpreter service. This results in reduced collaboration, increasing the risk of misunderstandings and frustration for both the client and the therapist. Physiotherapists need to be aware that interpreters are necessary in facilitating interaction with non-English speaking clients, and that it is a requirement under the New South Wales Health Standard Procedures and those of other Australian states.

Acknowledgement
The authors acknowledge the contribution of Angela Manson, Director of the Multicultural Health Unit at Central Sydney Area Health Service.

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