Communication study

Language barriers and the use of interpreters in the public health services. A questionnaire-based survey

Emine Kale a,*, Hammad Raza Syed b

a National Center for Minority Health Research (NAKMI), Oslo University Hospital, Ullevaal, Oslo, Norway
b Veum Hospital, Department of Psychiatry, Fredrikstad, Norway

ARTICLE INFO

Article history:
Received 9 April 2009
Received in revised form 14 February 2010
Accepted 1 May 2010

Keywords:
Communication
Intercultural communication
Language barriers
Use of interpreters
Minority health
Access to health services

ABSTRACT

Objective: This study aims to examine cross-cultural communication in health-care settings, which has implications for equal access to health services. We studied how often health-care workers experience a need for language assistance, what they do in such situations, what expectations they have of the interpreters and their evaluation of competency needs.

Methods: A quantitative cross-sectional design using a structured questionnaire was used. The participants were health-care providers in Oslo, and the survey was conducted 2004–2005.

Results: The response rate was 35.1%. The largest category of participants (51.1%) consisted of nurses, followed by the second largest category (26.6%) of 120 physicians. Our results suggested an underutilization of interpreter services in the public health-care system.

Conclusions: The use of interpreter services seems to be sporadic and dependent on the individual health-care practitioner’s own initiative and knowledge. Many survey participants expressed dissatisfaction with both their own methods of working with interpreters and with the interpreter’s qualifications.

Practice implications: A key area for further improvement is the process of raising awareness among health-care providers and institutions regarding the legal responsibility they have to ensure the sufficient level of communication with their patients/clients.

© 2010 Elsevier Ireland Ltd. All rights reserved.

1. Background

During the last few decades, Norway has become increasingly multicultural; almost half a million immigrants account for 10.6% of the total population. In Oslo, 26% of the population is immigrants, the highest proportion in Norway [1]. A consequence of these demographic changes is the challenge in integrating immigrant groups into existing health-care services; the language barrier is the primary challenge for meeting the health-care needs of the immigrant population.

The negative consequences of language barriers in intercultural communication in health care are well documented in the literature [1–16]. In Scandinavia, the consequences of poor communication between health-care professionals and minority patients have been extensively discussed [17–19]. In agreement with other studies, Essen [17] examined stillbirths among women from Somalia, Ethiopia and Eritrea and found a lower quality of care. Another study noted the negative consequences of poor communication between the Pakistani parents of disabled children and their Norwegian helpers [20].

A desirable way to overcome language barriers is to use a professional interpreter. Nevertheless, studies have found an underuse of professional interpreters in health-care settings [2–6,8,11–16]. The widespread practice of using non-professionals, family members or friends, as interpreters has been discouraged [21–23]. Emotional ties between the patients and their families and friends can interfere with the interpretation. Furthermore, non-professional interpreters cannot be expected to have the knowledge of medical terminology needed to impart correct information. Finally, the patients’ right of confidentiality and privacy may be breached if the patient feels forced to accept the presence of a family member as interpreter.

The rights of the Sami, indigenous people of Norway, are guaranteed by the constitution and The Sami Act of 1987. The Sami and Norwegian languages are equals, and the Sami people have an extended right to use their language in health-care and social-service sectors. Immigrants do not have the same rights, and their right to have professional interpreters is weakly anchored in


Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

ARTICLE IN PRESS

© 2010 Elsevier Ireland Ltd. All rights reserved.

0738-3991/$ – see front matter © 2010 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.pec.2010.05.002

Please cite this article in press as: Kale E, Syed HR. Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. Patient Educ Couns (2010), doi:10.1016/j.pec.2010.05.002
existing legislation. However, the increased emphasis on patient’s rights and the legal strengthening of these rights are important social developments in Norway that have implications for communication in health care. According to the Patient Rights Law [24], the patient has the right to choose from available examination and treatment methods. To facilitate the patient’s ability to make decisions, the law states that information should be adapted to the patient’s age, maturity, experience, cultural background and language, and that health-care workers should ensure, to the best of their ability, patient comprehension of the information.

Although communication and language barriers between health-care workers and patients has recently received attention in Norway, few studies document what health-care workers do when they encounter language obstacles. Therefore, this study focuses on health-care workers who have, according to the Patient Rights Law and the Health Personnel Law [24,25], a legal responsibility to ensure sufficient communication with patients and for consulting professional interpreters when necessary. Thus, the aim of this study is to document and describe common practices among health-care workers in terms of the following main research questions:

- What are the common practices among health-care workers in dealing with language barriers in communicating with immigrant patients with limited Norwegian proficiency?
- What are the expectations of health-care workers towards professional interpreters?
- How do health-care workers evaluate their existing competency and need for competency to work efficiently with interpreters?
- How do health-care workers evaluate the competency needs of interpreters?

2. Methods

The data were collected using a structured questionnaire, in a cross-sectional, descriptive study. The questionnaire, originally developed and applied by linguist Mette Rudvin and colleagues in Italy [26], was translated and adapted for use as a tool for collecting data in this cross-sectional, descriptive study conducted in Norway. Its 36 questions were organized under three sections: the first focused on the need for language assistance and the use of interpreters; Section 2 focused on the knowledge of how to cooperate with interpreters and the expectations of interpreters; and Section 3 focused on the competency needs of health professionals and their interpreters.

The survey was distributed to all general practitioners (GPs) at primary care clinics in the three city districts of Oslo that have the highest percentage of non-Western immigrants. In addition, we included health-care professionals (mainly physicians, nurses and other professionals, including social workers, physiotherapists and auxiliary nurses) in departments/wards of three hospitals that offer specialized health services to these city districts. Altogether, we covered somatic and psychiatric departments/wards, including medical, surgical, maternity/gynecological, and psychiatric wards and emergency rooms.

We distributed 1290 questionnaires and received responses from 453 participants from both primary and specialized health-care facilities. The response rate varied from 25 to 41% (mean 35.1%), depending on the facility. This rate was low but not unexpected for this type of survey. The largest category (51.1%) consisted of nurses, followed by the second largest category (26.6%) of physicians. As expected, the percentage of nurses and physicians participating was higher since these occupational groups represented the majority of our sample, and we focused on the responses from these two occupational groups.

2.1. Statistical analyses

In cooperation with a statistician, all analyses were carried out using SPSS (Statistical Package for Social Sciences). The Chi- squared test was used to estimate whether the results were statistically significant.

3. Results

Below, we present the results based on the thematic sections from the questionnaire.

3.1. The need for and the use of interpreters in the public health system

Thirty percent of the participants reported that they used interpreters quite often (from every day to a few times per month). This finding was expected, given the large immigrant patient population served by these providers. The survey indicated that physicians used interpreters more often than did nurses/midwives (p < 0.0001), which may reflect the different professional duties between the two occupations. Physicians, more often than nurses, are mainly responsible for diagnostic assessments and treatment plans and may require the precise and effective communication facilitated by an interpreter.

Furthermore, 60% of the participants responded that the need for an interpreter when communicating with a new patient was often assessed from the background information in the referral, i.e., when such a need was directly or indirectly mentioned. In addition, 25.3% of respondents indicated that they often conduct the initial consultation without knowing whether the patient’s Norwegian language skills were adequate. An interpreter may be arranged only after this initial consultation.

Health-care workers had difficulty judging the necessity of an interpreter when the patient spoke limited Norwegian; they questioned whether “some” Norwegian was “not enough” and whether language assistance was necessary to provide adequate and responsible care. To make this determination, we explored how often situations arose in which health-care workers did not use interpreters even if the patient’s comprehension of Norwegian was insufficient. “Insufficient” was defined as “You are unsure if the patient understands your questions, you have to repeat questions many times, you have problems with understanding what the patient says to you, the patient has difficulties in explaining herself/himself in Norwegian.” The results showed that this happened often/always with doctors and nurses in 28.8 and 41.5% of the cases, respectively. In addition, this happened sometimes with doctors in 43.2% of the cases and with nurses in 36.5% of the cases. Such situations arose significantly less often with the physicians than with the nurses/midwives (p = 0.001) (Fig. 1).

![Fig. 1. How often do situations arise in which you do not use an interpreter, even though the patient’s understanding of Norwegian is insufficient?](image-url)
The questionnaire explored how health workers justified not using an interpreter when the patient’s proficiency in Norwegian was insufficient. In our sample, 26% of all participants stated that summoning an interpreter was time consuming and impractical. Furthermore, 21% of all participants stated that poor access to interpreter services was the most common reason for not using an interpreter. A large percentage of respondents (24.9%) specified other reasons for not using an interpreter; examples included acute situations in which time was too critical to arrange for interpreter assistance or difficulty in securing interpreter services at all times of the day. Other responses included poor planning and use of relatives/family as interpreters as the most common reasons for not using an interpreter. In our sample, only 4% of all participants stated financial reasons for not summoning an interpreter, referring to the fact that such expenses must be covered by hospital budgets. We noted that only 6.4% cited that the patient does not want an interpreter; however, the questionnaire did not include questions that elucidated the manner in which the option to have an interpreter was presented to patients.

In response to the question how often do you communicate with the patient through family member(s)/friends, 52.9% of physicians and 51.3% of nurses responded often. The response category often/always was most frequently given by GPs. The responses from psychiatric and somatic departments were significantly different (p = 0.0001); personnel in psychiatric departments infrequently communicated with patients through family members and friends (Fig. 2).

For the question what happens in acute situations when qualified language assistance was not available, results showed that 38% often used family members or acquaintances as interpreters, while the percentage of those who often try to communicate with the patient as well as I can without an interpreter was also quite high (33%). In our sample, 12.1% answered that they often attempted to find an employee in my institution who can speak the patient’s language.

### 3.2. Health-care workers’ expectations of the interpreter’s role

Successful collaboration with the interpreter is essential and depends substantially on the health-care worker’s knowledge of the interpreter’s role, and we found that professionals varied in their understanding of the interpreter’s role and areas of responsibility. For example, linguistic competence of the interpreter alone will not ensure satisfactory results; an interpreter is also expected to master a number of technical as well as ethical principles such as impartiality and confidentiality.

In the survey, 92% of respondents considered it very important that the interpreter shows respect for the patient, 89% that the interpreter had the ability to express themselves clearly, 86.5% that the interpreter acted impartially, 79% that the interpreter could interpret accurately and 76% that the interpreter had good routines for informing the user about his/her professional confidentiality, role and working methods. These answers suggested that most respondents in our study had expectations coinciding with the existing guidelines for professional interpreters.

However, expectations regarding different aspects of the interpreter’s role seemed to vary among respondents. When questioned about what interpreters should do if they noticed that the patient lied about important issues, nearly 37% of respondents answered that they should report the lies to the health-care provider. These expectations conflict with the expectation of interpreters to be impartial, a responsibility which 86.5% of our participants considered to be very important.

Several questions in the survey focused on health-care professionals’ attitudes towards a wider definition of the interpreter’s role. One question asked whether interpreters should take a more active role as cultural mediators in consultations, e.g., inform health-care providers about relevant cultural factors. Approximately half of both physicians and nurses wanted the interpreter to be a “cultural mediator.” Additionally, nearly 50% agreed that the interpreter should speak with the patient after the consultation to further explain the discussion and/or give information about relevant services (Fig. 3).

### 3.3. Increased competency needed among interpreters and health-care workers

On average, 50% of the physicians and nurses expressed a need for increased professional competency among the interpreters. Approximately 55% of the physicians rated the competency need as to the highest degree (15.3%) and to a certain extent (39%), while most physicians (73%) stated that they were either very satisfied (12.2%) or fairly satisfied (60.9%) with the interpreter services. In general, about a quarter of the physicians and nurses experienced a certain amount of dissatisfaction with the interpreter services they had used.

In response To what extent are you satisfied with your own methods of working with an interpreter, 74.1% of the physicians were very or fairly satisfied (6.9 and 67.2%, respectively), while 59% of nurses were very or fairly satisfied. Perhaps reflecting the need for more knowledge regarding how to work with interpreters, 25% of the physicians and 40% of the nurses rated their satisfaction as somewhat not satisfied and 1.9% rated not satisfied at all.

In response to whether they were satisfied with the institution-provided opportunities for increasing their interpreter-use competency, 40.4% of the physicians reported that they were either very satisfied (8.5%) or fairly satisfied (31.9%). The corresponding figures for the nurses’ group were 4.5 and 22.5%, respectively, 41.5% of the physicians and 50% of the nurses were somewhat not satisfied. The largest dissatisfaction came from the nurses; 22%...
were not satisfied at all, in contrast to 18.1% of physicians. Almost three-quarters of the nurses and three-fifths of the physicians expressed at least some dissatisfaction with the opportunities provided by their institutions (Fig. 4).

4. Discussion and conclusion

4.1. Discussion

This study aimed to develop a general picture of how health-care workers deal with language barriers, common practices in using interpreter services, knowledge about and expectations of interpreters and evaluation of their own competency needs as well as the competency of the interpreters. In agreement with earlier studies [2–6,8,11–16], this study indicates that professional language assistance remains underutilized in the health-care sector. The use of interpreters is not a method that is sufficiently embedded in health care as a standardized and quality-assured procedure; such use is incidental and dependent on the health provider’s own knowledge and initiative.

Limitations exist for this study. First, due to the low response rate, the results highlight pertinent issues rather than provide definitive conclusions. Second, compared to qualitative methods, this study cannot provide nuances that could elaborate our understanding and knowledge base. Third, we did not include the patient’s or the interpreter’s perspective on language barriers. Future research should focus on these important issues.

Responses to the first part of the questionnaire indicated that health-care workers often do not use interpreters when the patient’s Norwegian language skills were insufficient (28.8% of cases with doctors and 41.5% with nurses). Furthermore, 25.3% indicated that they had often conducted the first conversation with a patient without knowing the sufficiency of the patient’s Norwegian language skills, possibly due to the lack of a standardized procedure to arrange for an interpreter on short notice. Although not examined in this study, hospital and primary health-care services seldom have clear procedures ensuring that an interpreter is invited to subsequent consultations if the communication in the first consultation was inadequate.

How does the first conversation take place when there is a language barrier, and how does this affect the subsequent interactions? Our survey did not provide answers to these questions. Facing language barriers, patients and health-care providers may feel defeated, vulnerable and helpless. Clinical experience has shown that patients often blame themselves for not speaking the majority language more proficiently and often feel ashamed. Sometimes, they do not concede having language difficulties; instead, they pretend to understand.

Similarly, in acute situations that might involve life-threatening conditions, many respondents often tried to communicate with the patient without an interpreter (33%). This is a thought-provoking finding, considering that such situations might involve life-threatening conditions. There were strikingly few who mentioned telephone interpreter services as an alternative when, in fact, a community crisis telephone service has existed for several years (and is also available on evenings and weekends and on short notice). One possible explanation for this is that health-care providers may not be aware of this service. We did not, however, ask health-care providers whether interpreter services were available during non-regular business hours and in different settings. Thus, we could not rule out the possibility that health-care providers underutilize this crisis telephone service or other interpreter services for reasons other than not knowing about them.

This study shows that health-care workers tend to resort to solutions that are most easily available, for example, using family or friends as interpreters or trying to communicate with the patient using inadequate language resources. More than half of the physicians and nurses responded that they often communicated with the patient through family member(s) or friends. Health-care personnel at psychiatric departments, compared to providers at somatic departments, use family members or friends less often. While this pattern may reflect a preference for using professional interpreters, it might also reflect a failure to recognize language problems.

Health-care workers most frequently cited poor access to interpreter services as a barrier and that arranging for an interpreter can be impractical and time consuming. Since administrators were not included in this study, it is difficult to determine whether some of the underutilization may reflect a policy of discouraging “overuse” to avoid straining hospital budgets.

Interestingly, our results indicated that there might be some conflicting expectations regarding interpreters. Most respondents reported that they very highly valued the impartiality and neutrality of interpreters. At the same time, a considerable proportion of respondents (37%) reported that interpreters should tell the physicians about any discrepancy if the patient is hiding information. This may imply that many health professionals think of impartiality only in terms of their own needs and perspectives. In this survey, we did not ask about the expected role of interpreters who notice the opposite situation in which the physician, rather than the patient, requests that the interpreter withholds information.

The results indicated that a considerable number of our respondents wish for the interpreters to have an additional role as a cultural mediator. These responses may imply that there is a need for expanding or redefining the interpreter’s role to include cultural mediation. Currently, this role does not exist in the interpreter’s professional guidelines. We may also interpret the results as a need for providers to feel more competent in various cultural issues pertaining to health, such as varying explanatory models about health, illness and treatment. A comprehensive approach to improving the quality and outcomes of encounters in health-care settings should include cultural competency [27–29].

Many physicians and nurses were dissatisfied with the interpreters’ competence, their own competence in working with interpreters and the opportunities to increase their competence in this field. It is encouraging that health-care professionals, given the language barriers, want to receive training in how to best work with interpreters and want to learn which strategies they should use to obtain optimal results.

4.2. Conclusion

The findings indicate that health-care providers are often influenced by hectic working conditions when making the decision of whether professional language assistance is needed. As a result,
providers resort to solutions that are most easily available but not optimal. For patients with limited majority language proficiency, these practices can have negative consequences. The Patient Rights Law in Norway unequivocally places the responsibility on health-care workers and health-care institutions to guarantee the patient’s right to information and input by providing optimal communication with patients. Having little to no training in how to evaluate patients’ language abilities and often no clear procedures for overcoming language barriers, health-care providers have limited resources in making important decisions. Therefore, there is an important and urgent need to increase awareness among health-care administrators and health-care policy makers to secure the knowledge base that is necessary to fulfill the intent of the laws.

4.3. Practice implications

When addressing future challenges, health-care providers noted the need for increased competence among health-care workers and interpreters as well as administrators and interpreter services. Suggestions include better routines and procedures in the workplace to ensure effective cooperation with interpreters and an increased awareness at the organizational level about appropriate measures taken to adapt health-care services to patients with limited majority language proficiency.

Conflict of interest

The authors declare that they have no competing interests.

Acknowledgements

We want to thank all the health-care providers for their participation in the survey. We would like to thank Prof. Nora Ahlberg, former director of NAKMI, and psychiatrist Carl Ivar Dahl for their generous support and encouragement; Mette Rudvin, Karin Harsløf Hjelde, and Thor Indseth for their valuable comments on an earlier draft of the manuscript; Claire Mock-Munoz de Luna and Jennifer Gerwing for helping with the language; and Cathrine Brunborg for the statistical analysis.

Contributors: EK conducted the research and wrote the manuscript. HRS contributed to the initial planning of the study and the content of the manuscript.

References


[20] Lov 1999-07-02 nr.64: Lov om helsepersonell m.v. [Act relating to health personnel, etc.]


