



Free Interpreting Service

Helping real people every day

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Here is one day in a typical general practice in a suburb, the one where I work. The practice has eight doctors, two nurses, and around 9,000 patients. Although the identifying details have been altered, all of these are real cases.

10:30am Dr Hut Win, a junior doctor training to be a General Practitioner (GP), calls me into his room. He stares glumly at his elderly patient Sara who has booked to see him because she thought he spoke Karen, her language. “My parents are from Myanmar, but I can only speak kitchen Karen”. He and Sara make small talk about food for four minutes, while I ring the Translating and Interpreting Service (TIS National) and get a Karen interpreter.

Every day Australian doctors see sick patients whose spoken English is insufficient to communicate their symptoms or to understand their treatment. Sometimes the person’s lack of English proficiency is obvious to everyone. Sometimes the person can communicate in English but does not have the right technical language. Sometimes the person’s command of English has deteriorated due to age or illness.

20% of Australians speak a language other than English, and by their own estimate, 16% of them speak English poorly¹. Australia is one of the world’s most multilingual countries, and one of the most monolingual of countries. Over 200 languages are spoken in this country, and yet 80% of us can only speak English. The linguistic diversity of the population is so great that no matter how multilingual the doctor is, the languages of doctor and patient rarely match. Most doctors will need to make a decision about whether or not to use an interpreter every day.

The interpreter comes on line and Dr Win is able to work out that Sara has gastritis. He explains how to test for a bacteria in her stomach. Four minutes doesn’t sound like much, but that’s more than a quarter of the allocated consultation time. Time is one of the major reasons cited by doctors for not using interpreters.² Good functional practices delegate contacting interpreters to the front-office administrative staff. Dr Win has learned the hard way to clarify before the consultation begins that he needs an interpreter, ask the patient to wait while reception contacts the interpreter, and use that four minutes to read the patient notes and prepare himself.



12:30pm I'm called by the nurse in to see Amina, who has

presented with a sore belly after having her first baby six weeks ago by caesarean section. Her young husband hovers in the background. If they had been in their home country, an extended family of aunts and sisters would now be helping her to recover from surgery and care for her baby son. The nurse shows me the problem: Amina's wound still has the staples used to close it. I stare aghast at the angry wound with its ridges of infected skin, trying to bury the metal staples. These should have come out five weeks ago. When she was discharged, the staff had explained using Google Translate that she had to get the staples removed in ten days. Amina had not understood, and had been too embarrassed to say so.

2:00pm I have a regular appointment with Bruno, who has started psychiatric treatment for depression, and wishes to speak about his experiences in the war in his country ten years ago. We have booked an on-site interpreter who speaks his language. The interpreter crosses her arms, bows her head, and becomes Bruno's words as he speaks of massacres. I wonder about the impact on the interpreter of living through Bruno's war vicariously, and we debrief for a few minutes afterwards.

4:00 pm The receptionist calls. Hana, who has been in the country for five months, stands crying at the front desk with a three year old child in her arms. Her daughter has 'eaten an electric'. We have a huddled consultation with a phone interpreter in the treatment room. The child has swallowed the lithium battery from a toy. It will need to be removed by an endoscope under general anaesthetic. Hana wants to wait till her husband, who speaks better English, comes home from work. But there's no time to waste. The practice pays for a taxi, and through the interpreter the nurse explains the urgency of the situation. I ring the hospital to say they will need to get an interpreter on the phone for the consultation.



Not every consultation where the person has limited English proficiency will need a professional interpreter. Sometimes the situation is of low acuity and the patient can make themselves understood. In Amina's case, for example, I had rarely used interpreters as her general English was sufficient to manage a cough or a Centrelink certificate. There is no doubt however, that interpreters are underused in Australian medical practice. For every 100 consultations of a patient who speaks poor English, in only one will a professional interpreter be used.³

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There are four circumstances where doctors treating patients with low English language proficiency, must consider using a professional interpreter, and have a defensible reason for not using one. These situations are *consent*, *complexity*, *crisis* and to assess the *competence* of the patient to make decisions on their own behalf.



Consent
Complexity
Crisis
Competence

The doctors who perform the endoscopy and general anaesthetic on Hana's daughter who swallowed the battery will need to use an interpreter to ensure that Hana consents to the procedure.

Performing a procedure without informed consent is an assault. Yet all too often people with limited English proficiency are asked to sign a paper thrust in front of them, or have it explained by a family member whose technical English may be very limited.

A recent investigation of refugees' accounts of surgical treatments uncovered accounts of patients who had operations including a tubal ligation, a gall bladder removal, and dental extractions with no understanding of the procedure they had "consented" to.⁴

Amina's discharge instructions are an example of a complex message that warranted an interpreter. Even though Amina spoke some English, her understanding was compromised because she was recovering from a major procedure, and she had no prior experience of wound staples. Denied the opportunity to clarify, Amina left hospital believing that staples could be left in permanently. Complexity is also the reason that pharmacists can access TIS National. Mistakes in medication dosage can have major impacts on the patient, as in a case in our study of a patient who took regularly a medication that was prescribed to be taken intermittently, resulting in major neurological side-effects.

In a crisis, professional interpreters are often overlooked in favour of any available person. In a famous case in the United States of America, a nine-year-old child who suffered a severe reaction to a medication was herself used as interpreter in the emergency department. Her sixteen-year-old brother was subsequently co-opted into interpreting to their parents when she died.⁵ Failure to use an interpreter in a crisis is an indefensible approach when there is a 24-hour priority phone line to access interpreters.⁶ Without an interpreter, we would not have understood what had happened to Hana's child, nor would we have been able to convey the urgency of treatment.

On the way home from work, I called into a nursing home to see Wilf, an octogenarian whose ability to speak English, his third language, had declined as he aged. 42% of non-English speakers over the age of 75 have poor facility in English. The absolute numbers have increased by two thirds over the last ten years to at least 100,000 people.¹ Wilf was ignoring staff, and refusing meals, and the staff were worried about his mental competence. As I walked down the corridor to his room, I called the telephone interpreter. Wilf sat up, clutching the phone to his ear, and wept as we talked in his language. "I cannot speak to anyone," he said, over and over. No staff member, and no other resident in the nursing home spoke Wilf's language. Wilf was perfectly competent, but starved of conversation.

In a huge, linguistically-diverse country like Australia, the majority of interpreted consultations by doctors will always be by telephone. Rather than being a secondary, fall-back option, doctors should think of telephone interpreting as their best option. Using a telephone interpreter requires some practice, good administrative processes that empower reception staff to access interpreters, and telephones with speaker facility. Once mastered telephone interpreting helps doctors to be safer, more efficient and most importantly, to provide better service to their patients.

¹ Australian Bureau of Statistics. Proficiency in Spoken English. Australian Census, 2011

² Huang Y, Phillips, C. Telephone interpreters in general practice: bridging the barriers to their use', *Australian Family Physician* 2009; 38 (6): 443-446

³ Phillips CB, Travaglia J. Low levels of uptake of free interpreters by Australian doctors in private practice: secondary analysis of national data. *Australian Health Review* 2011; 35 (4): 475-479.

⁴ Anderson KA, Rowse J, Phillips C. Critical case analysis of adverse events associated with failure to use interpreters for non-English speaking patients of refugee background. Presentation to North American Refugee Conference, 2016.

⁵ Quan, K. *The high costs of language barriers in medical malpractice* University of California, Berkeley, 2010.

⁶ Bird S. Failure to use interpreter. *Australian Family Physician* 2010; 39 (4): 241-242.