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The use of interpreters by South Auckland GPs

Iris Chan
Trevor Lloyd MBChB, Dip Obst, FRNZCGP
Kenneth Tong BMedSc, MBBS, Dip Paed, FRNZCGP

Iris Chan is a sixth year medical student at Auckland School of Medicine.

Trevor Lloyd is a Senior Lecturer in General Practice at Auckland School of Medicine.

Kenneth Tong is a GP in Auckland.

ABSTRACT

Aim: To investigate the extent of communication problems between South Auckland GPs and their non-English speaking patients and the strategies used to cope with this problem, particularly the use of competent interpreters.

Method: A questionnaire was administered to a random sample of South Auckland GPs.

Results: Most of the GPs surveyed were regularly seeing patients with whom they were having difficulty communicating in English. A variety of strategies were used to cope with this problem. The use of qualified interpreters was uncommon and reasons for this were identified.

Key points

- Twelve per cent of people in the South Auckland area do not list English as a language they are able to speak
- Most GPs surveyed were regularly seeing patients with whom they were having difficulty communicating in English
- The use of interpreters other than family members was uncommon
- Cost and availability were the main barriers to using qualified interpreters

Conclusion: There is likely to be a communication problem between South Auckland GPs and their non-English speaking patients. The use of qualified interpreters is not seen by GPs as a practical solution to this problem. Further research needs to include the patient's perspective.

INTRODUCTION

New Zealand is an ethnically diverse society with a large proportion of the population speaking a first language other than English. Over the past few years, the number of immigrants has risen continuously, with 44,360 permanent and long term arrivals in 1987 to 80,288 in 1996.[1] A high percentage of these immigrants arrive speaking English as a second language, with various degrees of proficiency.

In the *1996 Census*,1 88,443 (35 per cent) of the people residing in the South

Auckland area had been born outside of New Zealand. With such a high proportion of immigrants, doctors practising in this area regularly see patients from non-English speaking backgrounds. Of those people in the *1996 Census* who spoke some language (excluding mainly infants), 37,263 in South Auckland (12 per cent) did not list English among the languages they were able to speak.

Adapting to New Zealand life and accessing medical services could be a stressful experience for many immigrants. A major barrier in receiving good health care for immigrants is having communication problems with their doctors.[2]

The Health Interpreting and Translating Service, based at Middlemore Hospital, is available to South Auckland GPs at a cost of $150 per hour, with a minimum one-hour charge. A telephone interpreting service, based in Wellington, has been set up since the time of the study.

In Australia a questionnaire study was conducted to investigate the communication between GPs in Melbourne and their non-English speaking patients.[3] The authors found a frequent mismatch between the languages spoken by GPs and their patients. The use of interpreters was uncommon, except where family members were used. The main reasons for this were cost and lack of availability of interpreters.

With the introduction of the Code of Health and Disability Services Consumers' Rights on 1 July 1996 and the increasing awareness of providing quality medical services, the use of interpreters is potentially an important issue, for both the patients and the GPs. Right 5(1) of the code states that: "Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter."

The Health and Disability Commissioner has commented that the fact a person knows two languages does not necessarily make that person a competent interpreter for the purposes of the Code of Rights. Competent interpreting encompasses elements of training and knowledge (including knowledge of ethics, the role of the interpreter and the cultural understandings of illness). Furthermore, in the area of health, a medical background would assist an interpreter to give proper explanations to patients (Health and Disability Commissioner, personal communication, 19 December 1996).

Table 1: Languages Encountered at least once per week by GPs

Language Group	**Languages mentioned (and frequency)**
Austronesian (language of South Pacific origin)	Samoan (20), Tongan (14), Niuean (6), Maori (5), Cook Island (4), Pacific Island (4), Fijian (1)
Chinese	Cantonese (7), Chinese (6), Mandarin (4)
Other Asian	Vietnamese (8), Cambodian (6), Indian (4), Hindi (3),

	Korean (3), Gujarati (1), Thai (1)
European	Dutch (3), German (1), Russian (1)

All providers of medical services are required by the Code of Rights to take reasonable steps to facilitate the best possible interpreter services available in the circumstances. The code acknowledges there will be circumstances where an interpreter is needed but it is not reasonably practicable to provide one, eg, in an emergency, or where the provider is a sole GP in a rural situation and is consulted by the occasional tourist.

It is also acknowledged there may be times when a patient's family or friends are a more practicable choice of interpreter rather than "professional" interpreters. Accordingly, while in the case of the rural GP the most reasonable step may be to rely on the patient's fellow tourists, friends or family, it would probably be "reasonably practicable" for a GP in Auckland to arrange for an interpreter.

The aims of our study were to investigate: (1) the extent of the communication problem between GPs and their non-English speaking patients; (2) the strategies they use to communicate with those patients; (3) the extent to which GPs make use of interpreters; (4) GPs' views on the section about the use of interpreters in the code; and (5) the practical problems arising from the compliance with the code, including the cost of interpreters.

METHOD

All GPs working in private practices and accident and medical clinics within the Middlemore catchment area, which includes most of the southern and eastern suburbs of Auckland, were identified. A random sample of 50 GPs was chosen from a list of 290 GPs supplied by South Auckland Health. Only one GP was included from each practice.

Table 2: Languages Spoken by GPs

Language Group	Number of GPs	Languages mentioned (and frequency)
Austronesian	4	Samoan (2), Maori (2)
Chinese	4	Cantonese (3), Mandarin (1)
Other Asian	9	Sinhalese (4), Indian (2), Hindi (2), Tamil (1)
European	7	French (3), Dutch (2), German (2)
Others	1	Afrikaans (1)

A letter was sent to each of the GPs explaining this study. An appointment was then made over the phone for those who agreed to take part. Replacements were chosen for those who were unavailable. The questionnaire used in the Australian study was modified, with the help of members of the Department of General Practice at the University of Auckland, to adapt this for the New Zealand situation and to emphasise the use of interpreters as a communication strategy.

The questionnaire was administered face to face at each GP's surgery. The data were recorded and entered onto Microsoft Excel for analysis.

RESULTS

Of the 50 GPs initially selected, 11 were unavailable. Of these, five were on holiday, one on parental leave, four had left the practice and one did not consider him/herself to be a GP.

Eight of the 50 finally selected refused to take part. Of these, five were too busy, one turned out to be unavailable for a face to face interview, one was unable to get permission from his/her employer and one did not feel he/she understood the aims of the study.

Of the 42 GPs who took part in the study, seven (17 per cent) reported seeing non English-speaking patients at least once per day, 17 (40 per cent) reported this at least once per week, while for eight (19 per cent) it was at least once per month. Ten (24 per cent) GPs rarely saw patients from non-English speaking backgrounds.

There were 30 languages, excluding English, that the GPs indicated were spoken by patients in their practices. The commonest language was Samoan, mentioned by 29 GPs (Table 1).

There were 25 languages, excluding English, spoken by the GPs (Table 2).

Although 25 of the GPs (60 per cent) could speak other languages, only 14 (33 per cent) had less than average difficulty communicating clinical information in that language. Bilingual doctors were more likely than other doctors to encounter patients with whom they shared a common language. However, this went only a small way towards addressing the communication problems.

When dealing with non-English speaking patients, GPs used a number of strategies to improve their communication with these patients (Table 3).

Some 23 GPs (55 per cent) said they were aware of interpreting services available in their local area. Twenty mentioned Middlemore Hospital, one mentioned a private trust providing Cantonese and Mandarin interpreting services, and one GP mentioned another patient being a qualified interpreter.

Thirty-four GPs had heard of the Health Interpreting and Translating Services available at Middlemore Hospital. This included 11 of the 19 who could not name an interpreting service available in their local area. Only four out of the total sample (10 per cent) had used the service before and they had only used it once.

Thirty-seven GPs (88 per cent) had seen or heard of the Code of Health and Disability Services Consumers' Rights. Twenty-five (60 per cent) knew about the right regarding the use of interpreters. Nineteen out of the 25 GPs believed they were complying with the code. Some others indicated they were complying to their best ability. Nine of the GPs who did not know about the section believed they were complying after reading the relevant section of the code.

A typical GP's comment on the code was "very well in principle but impractical". Organising an interpreter was a problem because patients were often late or did not turn up. Access to qualified interpreters was identified as an issue. "Patients just turn up and you cannot organise an interpreter immediately." One GP also suggested that a list of interpreters should be available to all GPs, with both voluntary and qualified interpreters.

Cost was an issue in complying with the code. "In South Auckland a lot of the patients cannot even afford the consultation fees and how can they pay for an interpreter?" was a frequent comment.

Responding to the question on what would be a fair payment to a qualified interpreter in a GP consultation, four indicated $15, seven $20, nine $30, four each for $40 and $50, and one each for $70, $90 and $100. Eleven refused to answer.

Generally, GPs felt they should not be paying for an interpreting service (Table 4). They saw it as the responsibility of the patient. They believed that non-English speaking patients should bring along a friend or relative to interpret.

Of the 10 who opted for the patient and the RHA paying jointly, four said it should be an equal contribution, three indicated the patient should pay 20 per cent, one indicated the patient should pay 30 per cent, and the remaining two said the patient should pay 60 per cent.

Only one out of 42 GPs indicated he would be willing to pay the full cost, as long as only a small proportion of his patients required such a service. Another GP was willing to share 40 per cent of the cost with his patients. Two GPs refused to comment on the issue of cost.

Eight of the 42 GPs indicated the RHA should cover the entire cost of the interpreter. Among these GPs, and those who indicated the RHA should contribute part of the cost, there was a general feeling that "if the Government requires us to provide such a service by law, then the Government should be paying".

DISCUSSION

The extent of the likely communication problem was highlighted by the frequent contact and the mismatch of languages spoken between South Auckland GPs and their patients.

The majority (24 or 57 per cent) came into contact at least once per week with patients with whom it was impossible or very difficult to communicate in English.

Table 3: Strategies used by GPs when dealing with non-English speaking patients

Strategies used	Frequency	%
Speak slowly and clearly or use gestures	27	64
Ask a friend or relative of the patient to interpret	41	98
Ask another staff member to interpret	9	21
Use qualified interpreters	4	10

Yet only 12 GPs (29 per cent) shared a common language with their non-English speaking patients. However, a relatively large proportion of GPs (10 or 24 per cent) rarely saw non-English speaking patients, and most GPs said they did not experience any major communication problem in their practices. Almost all of the non-English speaking patients brought along a friend or relative through whom the GP could communicate.

The majority of GPs were aware of the Code of Health and Disability Services Consumers' Rights. On the whole GPs agreed with the principle of patients having a right to an interpreter. However, they indicated there were practical problems. Even though the majority (34 or 81 per cent) knew of interpreting services available in the community, only four GPs out of the 42 had ever used a qualified interpreter, once.

Cost was the main barrier to using a qualified interpreter. The average fair payment to a qualified interpreter for a consultation, as suggested by the GPs, was $35. This was about the same as the GP's consultation fees. Most GPs were not prepared to cover the cost themselves but saw it as the responsibility of the patients. However, GPs indicated that the patients who needed the service most were the ones who could least afford to pay.

Although the term "competent interpreter" is not defined in the Code of Rights, and does not necessarily mean a qualified interpreter, GPs should remember that the obligation placed upon them by the code is to take "reasonable actions in the circumstances to give effect to the rights, and comply with the duties" in the code.

The "circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the GP's resource constraints. The Health and Disability Commissioner encourages GPs to create systems or take practical steps that would reduce the costs to themselves and consumers where interpreter services are commonly required. For example, a GP with a number of patients who require a Samoan interpreter could organise that interpreter to be at the surgery for two hours a week, and schedule non-urgent patients for that time.

Table 4: GPs views on who should pay for an interpeter

Who should pay?	Number
Patient	19
Patient and RHA	10
Doctor	1
Doctor and patient	1
RHA	8

Another option, for those with a number of patients speaking a particular language other than English, would be to hire a support staff member with dual language skills, although only a minority of GPs in this study had staff or other patients who could act as interpreters.

The choice of interpreter should also take into account the cultural needs of the patient, eg, it may be culturally inappropriate for a young boy to interpret his mother's gynaecological condition.

The most useful strategy for promoting the use of competent interpreters "where necessary and reasonably practicable" would appear to be the setting up of an interpreting service available to all GPs at an affordable charge. As travel is a significant component of the cost of interpreter services, and time may be of the essence, an 0800 or 0900 line where interpreters can be accessed by all health and disability service providers should be promoted.

The Health and Disability Commissioner has been encouraging the Health Funding Authority to review this and other practical solutions which allow compliance with the code to the best extent possible in the circumstances. Such steps should ultimately be of benefit to the GP.

We have investigated GPs' views on this important issue in this study. However, the patients' views have not been considered. Future research should be done including the view of the patients to further establish the need for interpreters in a medical setting, and to develop practical solutions, in conjunction with consumers, to

respond to this need.

Correspondence to: Dr Trevor Lloyd, Trust Health Care, PO Box 240, Manu-rewa, Auckland.

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