

Bilingual health communicators: role delineation issues

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Abstract

Managers of health care services are seeking new opportunities to improve communication with clients who have limited English proficiency. An increase in bilingual health staff and the frequent use of their language skills in patient encounters provides opportunities but also brings with it confusion surrounding the role of interpreters and bilingual health staff.

Secondary analysis of transcripts from 18 focus groups with monolingual and bilingual health staff has provided a method of distinguishing the roles of these complementary communicators. This paper clarifies the roles of interpreters and bilingual communication facilitators using seven key features: scope of language, language proficiency, nature of communication/interaction, nature of the contact and relationship, client responsibilities, and relationship with other health care providers. We discuss differences in how bilingual health staff use language when providing care, and alternative types of interactions interpreters could adopt to extend their current role. A collaborative group of communicators located within a health team is proposed, that is able to identify need and select the best communicator for the task.

Introduction

Managers in health care services throughout Australia are confronted daily with the realities of meeting the needs of clients from culturally diverse backgrounds. Whilst this poses challenges for staff and managers, it is not a modern problem. Australia, from the early days of European settlement, has been a country that has experienced difficulties in communication related to language. The need for a language broker or 'interpreter' was first noted in the 1850s, where Chinese immigrants required assistance with language within Australian law courts (Jupp (p31) 1990). In 1996, 13.9 percent of Australians over 5 years of age spoke a language other than English at home (Australian Bureau of Statistics, 1996), suggesting a continuing need to negotiate language diversity.

Difficulties with communication, and the need for language brokers, are also evident within the health care setting. The languages spoken by health care clients are diverse. The Bureau of Immigration Research (1999) reported there were 282 major languages spoken in Australia. There is a limited number of health staff who can respond to these communication needs. The response of the health system to managing multiple languages within health care has been to initiate the Health Care Interpreter service, the Ethnic Health worker program, and other specialised programs for specific language groups or immigrant health issues.

With increases in the languages spoken by contemporary health care providers, the potential for additional communicator roles has emerged (Johnson, Noble, Matthews & Aguilar 1998; Minas, Stuart & Klimidis

1994). An audit of language skills of all health staff working in an Area Health Service in Sydney found that 31 percent of these health care workers spoke a language other than English (Johnson et al. 1998). Whilst the staff spoke a diversity of languages, these did not always match the main languages spoken by clients using the health system, confirming the need for additional services.

Bilingual health professionals make a major contribution to enhancing communication within the health setting through their use of language in both social and more complex technical contexts (Johnson, Noble, Matthews & Aguilar 1999). However, it became apparent from this study that tension existed between the defined role of the interpreter and the use of languages other than English (LOTE) by health staff. The aim of this paper is to develop a typology derived from characteristics of bilingual communicators and aspects of their communication. This typology is proposed as a basis for differentiating the roles of interpreters and other bilingual health staff.

Health professionals usually communicate with patients within a dyadic communication encounter - two persons in direct interaction, such as a doctor and patient. The technical nature of the language, and at times distressing information that has to be conveyed within the health care setting, create a further layer of complexity. For effective communication to occur, health staff must be able to understand this context, in order to facilitate communication and assess when effective communication is not occurring (McLeod 1996). The ability of health staff to translate complex technical language into language accessible to non-technical or lay persons is vital to successful communication (Bourhis, Roth & MacQueen 1989; Scott & Weiner 1984; Swenson 1984). When language is not shared, interpreters may assist, creating a communication encounter involving three people or a triadic interaction - a provider, a client and an interpreter.

The Bilingual Health Communication Model proposed by Johnson et al (1999) provided a conceptual framework for understanding how language and communication was negotiated when patients spoke a LOTE. This simple model proposed that there were two main components involved in the process: language proficiency and the context within which the language assistance is required. The proficiency and context axes intersected, providing an opportunity for multiple communication roles for bilingual health staff.

Numerous roles have been broadly described for bilingual health staff within Australian and North American literature, including direct caregiver, co-worker, cultural advocate or broker (Barbee 1987; Fong & Gibbs 1995; Fuller 1993; Jezewski 1990; Johnson et al. 1999; Mitchell, Malak & Small 1998). Various descriptions of these roles included a direct caregiver being a bilingual staff who uses their language in their 'normal' role; a co-worker being a bilingual staff member who provides communication support to colleagues who are monolingual. Similarly, being a cultural and linguistic advocate or broker involved staff in activities that enhanced health program development and testing within different cultural groups (Johnson et al. 1999). These are all important roles within a health care organisation.

The role of the interpreter within health care in Australia has developed over the past twenty years with the establishment of a Health Care Interpreter Service in NSW in 1977. Health care interpreters usually possess complex language proficiency, accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) in a particular community language. Interpreters are skilled in interpreting the sense and intent of what is being said by the health care professional, while at the same time preserving the content of the interview (Phelan & Parkman 1999). Intrinsic to the interpreting process is the 'dexterity to decipher two linguistic codes, each with its own geographical, cultural, and sociopolitical characteristics' (Vasquez & Javier 1991, p.164). There are three types of interactions described by Hatton and Webb (1993) as occurring within triadic communication encounters. First, the interpreter can work as a '*voice box*', translating information word for word. Second, the interpreter acts as an '*excluder*', where the interpreter takes over the conversation and leaves the professional out. Finally, the interpreter acts as a '*collaborator*', allowing exchange of control of the conversation between the interpreter and the practitioner.

Interpreters are also proficient in English, trained in medical terminology, have interpreting skills and operate under a code of professional ethics placing health care interpreters within the 'voice box' type, where health staff have the biomedical content knowledge and control the exchange of information. Interpreters focus on delivering the message rather than the meaning of the message, leaving the outcome of effective communication to rest with the health professional and not the interpreter (Hale & Luzardo 1997).

One of the key features in workforce planning and strategic human resource management is the delineation of roles (Nankervis, Compton & McCarthy 1993). Delineation is often defined in terms of professional qualifications as well as the actual roles and functions performed. In health services, this is even more important because of the high level of occupational specialisation with distinct occupational socialisation as well as potential medico-legal implications (Birnbaum & Somers 1998; Southon & Braithwaite 1998). Similar concerns about role delineation apply when considering the use of LOTE with patients in the health care setting (Riddick 1998; Zulueta 1995).

Recent research by Johnson et al (1999) suggested that bilingual staff perceived difficulties with the nature of interpretation, but also misunderstood the process of interpreting. Bilingual staff often perceived themselves to be 'interpreting' although the situations they described did not support their claims to be interpreters, rather they were facilitating communication (Johnson et al.1999). The need to clarify roles and reduce this conflict prompted further exploration of the roles and functions of interpreters and bilingual communicators and their communication, in order to differentiate these indicators more precisely.

Method

Qualitative data derived from eighteen focus groups of monolingual and bilingual staff were analysed using secondary data analysis techniques. Staff who participated came from diverse staff categories and language groups. The sample characteristics, and questions and prompts for the focus groups are described elsewhere (Johnson et al.1999).

Content analysis was undertaken using Non-Numerical Unstructured Data Indexing and Searching Theorising (NUD*IST). The original coding of data described by Johnson et al (1999) was the basis for subsequent coding. Further codes and exemplars were added to highlight the similarities and differences in the roles and functions of interpreters and bilingual health staff using a number of key features.

Results

Seven features based on language proficiency and contexts of interaction were developed from these data. They were the scope of language use, language proficiency, the nature of the communication or the interaction, the nature of the contact and relationship to the client, patient/client responsibilities, and the relationship with other health care providers (Table 1). Each feature contains a number of key characteristics that differentiate the role of interpreters and bilingual health staff.

The scope of language use could vary from social language proficiency in a social context from calming or reassuring a patient, to more complex interactions such as counselling and use of medical terminology that require social/technical or technical language proficiency. Bilingual health staff could have language proficiency at any point on this continuum, whereas interpreters are required to have NAATI accreditation at a defined level of proficiency.

Interpreters spoke of a formal interpretation (triadic) that bilingual health professionals did not convey. Bilingual health professionals did conduct dyadic interactions with the client, where the client was not their patient, but the patient of a health professional who did not speak the shared language. This was not seen to be formal interpreting. Rather that the bilingual health professional acted as a consultant, with the patient becoming the shared responsibility of both health service providers. For example, they referred to '*... helping a colleague or actually undertaking a clinical examination. They like it because they can consult [on] their problem as well.*'

Bilingual health professionals described their use of language within their direct care role as part of their everyday work, reflecting the nature of the communication or interaction. They perceived their language as assisting in providing health care through direct communication between themselves as the caregiver, and the client. For example, they talked about '*... everything that a nurse might do. If you've got someone who can't speak English you have to communicate everything. So whether you're doing a test for them or you're teaching them something or getting them out of bed or telling them that they're not allowed to walk or anything that you do. We need to communicate a lot of information.*'

Table 1: Characteristics of bilingual communicators and their communication

Characteristic	Interpreter	Bilingual or multilingual communication facilitator
Scope of language use	<ul style="list-style-type: none"> • Formal interpretation (includes written and verbal consent) 	<ul style="list-style-type: none"> • Social • Social/Technical • Written and verbal consent • Qualifications from overseas
Language proficiency	* NAATI-accredited ¹	Or <ul style="list-style-type: none"> • NAATI accredited¹ Or <ul style="list-style-type: none"> • Social language proficiency (self-assessed)² • Complex language proficiency (formally tested)²
Nature of communication		
/Interaction	<ul style="list-style-type: none"> • Triadic communication³ 	<ul style="list-style-type: none"> • Direct communication between care giver and client • Dyadic⁴
Nature of the contact	<ul style="list-style-type: none"> • Intermittent 	<ul style="list-style-type: none"> • Intermittent and continuous • Expected to be of short duration • Expected to be of long duration
Nature of the relationship to the client	<ul style="list-style-type: none"> • Limited 	<ul style="list-style-type: none"> • Limited • Developing throughout the course of care • Beyond the current episode of care
Patient/client responsibilities	<ul style="list-style-type: none"> • No direct/indirect client health care responsibilities 	<ul style="list-style-type: none"> • Direct care provider • Case Manager • Advocate
Relationship with other health care providers	<ul style="list-style-type: none"> • Health care provider is client 	<ul style="list-style-type: none"> • Consultant⁵ • Shared responsibility for clients • Assists in health care provision through communication

¹ Paraprofessional or Professional Level.² Specific instruments to test social and complex health language are currently being developed by these and other investigators.³ Triadic three way communication, where the facilitator assists two other parties to communicate; the direct lines of communication are between persons other than the facilitator.⁴ Dyadic meaning two persons involved and direct face-to-face communication. There may also be another person present but not directly involved in the communication.⁵ Consultant gives advice to other health care staff.

Bilingual health staff work within settings that pre-determine some of the differences in the nature of their contact and their relationship, patient responsibilities, and the relationship with other health care providers. The contact was described in four main ways: intermittent, continuous, or anticipated to be of short or long duration. This was related to the type of service used by the client. The nature of contact that is likely to occur in an Early Childhood Centre is different from that in a general surgical ward, which differs again from a rehabilitation or

recovery unit. Variations in length of stay are inherent in particular services and types of disease and complications that may occur during the hospital stay. This will affect the types of interactions that take place.

For interpreters, however, not only the setting predetermined the nature of the contact, but also the health professional. Health professionals are the client of the interpreter, and request assistance from interpreters based on their perception of the patient's 'need'. The interpreter assisted communication, within a triadic interaction, between the health professional, and the client of the health professional. The interpreter did not take on any direct responsibility (indirect) for the care of the health professional's clients. The interaction between the health professional's client and the interpreter was therefore, often intermittent and limited the nature of the relationship. Interpreters were used to provide information that health professionals wanted to convey to clients (indirectly), whereas the bilingual health professional could use the shared language whenever the need arose to directly deliver information. *'You were able to come in day one and you'd be able to constantly, every time you walk in that room, be able to use your language skill and help the patient rather than say right I've got to book an interpreter for an hour and try and cram everything you can in that hour to educate the patient.'*

The setting can therefore affect the nature of the relationship with the client. This was described as being limited, or developing throughout the course of episodes of care, or going beyond the current episode of care.

Health staff spoke about limiting their relationship with the client. A limited relationship was characterised by minimal assistance to the client, enough to get the work done without becoming overly engaged in the care of the patient. This usually occurred when the bilingual health professionals consciously chose to limit care. Limiting the relationship played a protective role in preventing interruptions to getting work done, as well as reducing increases to workload. *'I think that... people are very demanding ... I'm not here for you 100% of the time. I also have my work in here for this time and this day and that's it. So I think you should set your limits before ... the family tend to go to you all the time and tell you please help me I need a tissue or something.'*

Limited relationships could also occur when bilingual health staff assisted another staff member and the patient was not in their direct care or their ward. This assistance was limited to providing information in another language. *'One sister the other day ... had a situation where I had to explain something to a gentleman [who] didn't speak English ... she said can you please come and tell this gentleman because he couldn't pass water in the twelve hours after the operation so I have to explain to him a catheter has to be put in.'*

Bilingual health staff also deliberately limited interactions when they felt the patient was, in their words, "expecting too much", "using them", or "putting them down" by requesting to be moved to another part of the ward or reverting to English, no longer using the shared language to prevent further stress. *'There are situations ... sometimes I find if someone is trying to push me into a situation where I might be taken advantage of for undue reasons ... then I like to stick to the official [English] language.'*

More frequently though, staff spoke about being there for the patient as determined by patient need. The relationship developed throughout the course of the episode of care. Additional care was taken to answer or encourage questioning, using the understanding of cultural nuances and switching between English and the other language as appropriate. It was most frequently talked about as a calming or reassuring role. *'To provide comfort it is important that you create a very comfortable situation for them ... quite often they are quite stressed and frightened.'*

Putting patients, rather than tasks first, often led to a continuous relationship with the client which was beyond their current episode of care. For bilingual health staff working 'beyond their current episode of care' had the capacity to greatly increase their workload. It differs from developing throughout the course of the episode of care as it takes that extra step to provide a better outcome for the patient. *'We've had quite a few patients who have come back and who have benefited from coming to us and they've come back to thank us because ... they've come under stress. They haven't been explained what is going to be done to them and they suddenly have been told they've got cancer and no counselling, no nothing and we just sit and talk to them. You know we spend time with them. We don't rush them in and out of the place as long as they want to talk ... a lot of patients come back.'*

Bilingual health staff working within this relationship also took the opportunity to teach skills that empower clients within the health setting. They explained that they 'give them words to use in English; give them confidence', and '... encourage them to develop survival skills for instance to make a phone call to call an ambulance or a taxi ... encourage a client to use English to access a service.'

Bilingual health staff talked about letting the client know they could call on them, they also talked about being actively sought out by the patients and monolingual staff. *'Because if you're the only one who can understand the patient then you have to prepare a bit more time for interruption because people will ask you ... to see the patient and see what the patient is asking for.'*

Sometimes this seeking out by patients was simply to have someone to talk to, providing a comforting interaction in an otherwise isolating environment. *'When there's no one who can speak Vietnamese... they like ... to talk to you. Coming from clients it's okay sometimes and sometimes it's not really okay ... they [patients] tend to call you a lot of times when in fact they just want to talk with you. When they [the client] know they can talk to you ... they tend to talk to you a lot more ... they think to call you.'*

At other times it provided vital information for decision making around treatment and hence the outcome of care. *'They ask you questions outside of your area, which sometimes you might have to deal with or refer to another person. Because they bring out a lot more issues because you're the only one who they can ask.'*

An additional dimension of this role was seen as community support. This work occurred outside of normal duties, incurred additional responsibilities and was generally conducted in staff's own time. It did not normally relate to the care of specific individuals as clients of the health system, but was a community role taken on to provide information in another language to the community at large. It included work in a community pharmacy, designing questionnaires, translating documents, producing newsletters and community radio work; in essence, the role of a consultant and advocate. *'I have some experience with the radio. The community based radio here in Sydney. I used to do broadcasts on health issues. I used to invite doctors and speak to them in Polish. Obviously for the audience it's outside the hospital setting so I'd done it for years ... I could express myself in my own language over the radio maybe for 2000 of them.'*

Discussion

Bilingual health staff and interpreters play central roles in effectively communicating with patients with limited English language proficiency. Tension between these workers, in relation to their roles in supporting communication for patients who speak a LOTE, was the impetus to undertake further examination of existing qualitative data. Several writers have identified that interpreters and other bilingual health staff can, and do, fulfil a range of roles from formal interpreters where the client is the health care provider, to roles where health care providers are direct carers, case managers, advocates, and consultants (Johnson et al. 1999; Kaufert & Putsch 1997; Meleis 1992; Riddick 1999). The potential for confusion in these roles from the worker's and manager's perspective is evident (Johnson et al. 1999). Similarly, the increasing demand for Health Care Interpreter Services also suggests the need for other support services. This study goes beyond the labelling of roles, to defining the form of communication and the qualifications of the communicators, within a Bilingual Health Communication Model. A simple tool (Table 1) has been developed to assist health staff and their managers to match the most appropriate bilingual staff member (whether a bilingual health professional or interpreter) with the required communication task.

Seven key features identified in this study differentiate the role of the interpreter and the bilingual health staff. Interpreters work within a triadic relationship within the health care setting with the health care provider as the client. The interpreter, who is usually NAATI accredited, provides formal interpretation between the health care provider and their client. Contact with the client is intermittent, leading to a limited relationship with no direct or indirect health care responsibilities. Bilingual health staff, referred to in Table 1 as bilingual communication facilitators, share some of these features. However, there are selected key features that differ. Bilingual communication facilitators engage in direct dyadic interactions rather than triadic encounters. Language proficiency and the scope of language use vary along the continuum from social to complex. The nature of the relationship and the communication context has a greater capacity to move from being limited and intermittent to a more long-term one. Bilingual communication facilitators also have different relationships with their colleagues, being called upon to act as consultants, share responsibility for clients and assist in health care provision through their communication skills.

The scope of language differs with the type of communicator and this has major implications for health services and health consumers. Bilingual health staff, particularly nurses who are constantly present in the ward, have greater opportunities for communication, and often more social communication, simply because of their physical presence. The value of social language proficiency is in changing what could be isolating, alienating experiences into more satisfying and successful health care encounters. The important role that bilingual health staff play within the limited contexts of social interaction such as providing comfort and reassurance, meeting simple needs, checking food requirements, and giving instructions, should not be underestimated.

Bilingual health staff working in a direct care role or within their area of expertise such as, medicine, paediatric nursing, ophthalmology have the added advantage of the content knowledge of their field. This knowledge, coupled with an understanding of language and culture, makes them the most effective persons to see a client of the same background. Knowing when information is not being understood or indeed, won't be complied with, and having the flexibility to negotiate treatment within clients' cultural paradigms and the monoculturally dominant approach of western medicine, may lead to better outcomes and a more satisfied client (Fuller 1997; Pittman & Rogers 1990; Smart & Smart 1995; Tebble 1999). As Bourhis et al (1989) suggest, it is the ability to transform complex technical language into terms understood by laypersons, that is most critical to successful communication.

On the other hand, interpreters are 'called in' by health professionals when a need has been identified. Health professionals (bilingual or monolingual) are therefore the initiators of an interpreter service. Interpreters also work outside of the clinic, ward or treatment area, resulting in less opportunity for interpreters to see clients and take up that everyday social and comforting role. Indeed, for interpreters this may not be the best use of a limited resource, nor are interpreters trained to give psychosocial support or to have in-depth knowledge of every specific health field. However, once the interpreter is present and part of a triadic relationship, the interpreter plays a central role in ensuring effective communication occurs.

For interpreters to be responsible for effective communication and contribute to better outcomes requires movement out of the current 'voice box' type into the 'excluder' and 'collaborator' interaction types previously described (Hatton & Webb 1993). To make this change requires additional skills. To work as a 'collaborator' the interpreter needs to recognise subtle cues and then feel empowered to pass this information onto health staff. To work as an 'excluder' requires extensive experience in the health care setting. The interpreter needs to know the information being imparted and how the health professional adjusts or transfers technical information into lay terms so that the client can improve their understanding. This change also requires a giving up of the current accepted roles by health professionals and a willingness to allow interpreters to move into these alternative interaction types.

This study is limited to findings based on health staff's recall of interactions. This may or may not be supported in an observational study of patient communication encounters. These investigators, to observe interactions in the work place and confirm the differentiation of these roles, are conducting further research.

The aim of better health outcomes for clients with limited English language proficiency can be best served by a complementary relationship between interpreters and bilingual staff. These authors would propose that interpreter services might be improved by the location of an interpreter within close proximity to client populations that represent the interpreter's normal caseload. In essence, interpreters need to form part of the health team within a cluster of inpatient units. This can be achieved through physical placement of the interpreter near the units or through a collaborative team relationship. Although this is a much more intensive service that requires additional training and resources, it may provide opportunities for interpreters to engage in extended roles of collaboration and selective exclusion. This would enhance the interpreters' ability to understand the transition of complex technical language into language for laypersons, and thus engage in assessment of the message being delivered, and negotiating treatment that is culturally acceptable. Similarly, this may also provide an opportunity for relationships to be established with clients and health staff. The potential for self-referral by clients to interpreters may evolve, enhancing the interpreters' and clients' sense of autonomy, increasing clients' participation in decision making on all aspects of their care.

Bilingual health staff are a valuable asset to the health system at all levels of language proficiency. Social language proficiency can be used to help clients feel better, to provide information, to increase dialogue with the client to meet their needs more effectively. More complex proficiency can be used to assess, diagnose and treat clients,

thus resulting in improved care. Managers will need to have processes in place to ensure bilingual staff are requested only to work within appropriate boundaries acknowledging staff language proficiency and their professional role. Gaps between the languages spoken by clients and health professionals will continue to exist, requiring alternative communication strategies within the health care system. Managers, bilingual health staff, and interpreters need to recognise when an interpreter or a bilingual communication facilitator should negotiate communication. The best possible outcome for the patient will be obtained from a collaborative group of communicators in unit health teams, able to identify need and select the most suitable communicator for the task.

Acknowledgements

The authors wish to acknowledge the assistance of the staff of the South Western Sydney Area Health Service. This research was funded by the Multicultural Service Enhancement Program, NSW Health, Australia.

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