

How to use interpreters in general practice: the development of a New Zealand toolkit

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ABSTRACT

BACKGROUND AND CONTEXT: New Zealand is becoming more ethnically diverse, with more limited English proficiency (LEP) people. Consequently there are more primary care consultations where patients have insufficient English to communicate adequately. Because effective communication is essential for good care, interpreters are needed in such cases.

ASSESSMENT OF PROBLEM: The literature on the use of interpreters in health care includes the benefits of using both trained interpreters (accuracy, confidentiality, ethical behaviour) and untrained interpreters (continuity, trust, patient resistance to interpreter). There is little research on the actual pattern of use of interpreters.

RESULTS: Our research documented a low use of trained interpreters, despite knowledge of the risks of untrained interpreters and a significant use of untrained interpreters where clinicians felt that the communication was acceptable. A review of currently available guidelines and toolkits showed that most insist on always using a trained interpreter, without addressing the cost or availability. None were suitable for direct use in New Zealand general practice.

STRATEGIES FOR IMPROVEMENT: We produced a toolkit consisting of flowcharts, scenarios and information boxes to guide New Zealand practices through the structure, processes and outcomes of their practice to improve communication with LEP patients. This paper describes this toolkit and the links to the evidence, and argues that every consultation with LEP patients requires clinical judgement as to the type of interpreting needed.

LESSONS: Primary care practitioners need understanding about when trained interpreters are required.

KEYWORDS: Communication barriers; primary health care; New Zealand; quality of health care; professional–patient relations; cultural competency

Background and context

New Zealand is becoming more ethnically diverse,¹ with increasing numbers of permanent residents born overseas. The number of people with limited English proficiency (LEP) is also growing. While comprehensive statistics are not collected, census data shows that there are increasing numbers of recent immigrants from Asia, with people of Chinese origin now the second largest group of migrants.² Clinical consultations in which the patient does not have adequate English to get optimal care are therefore increasingly common.

Effective communication is essential for good medical care.^{3–6} Communication problems occur

more frequently in consultations with LEP patients,^{7–8} with an increased risk of adverse outcome when professional interpreters are not used.^{9–10} Despite this, interpreters are often not used in the United States,¹¹ Australia,¹² or New Zealand.¹³

Under the NZ Code of Health and Disability Services Consumers' Rights¹⁴ patients have a right to effective communication, including the right to a competent interpreter. Lack of funding, especially in primary care, is an acknowledged obstacle to interpreter use.^{15–16}

The use of trained interpreters for all medical encounters with LEP patients is generally presented

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as best practice. This does not take into account the financial constraints and complexity of clinical interactions.

Interpreter services in New Zealand

The availability and quality of interpreting services in New Zealand has improved in recent years. Language Line, the telephone interpreting service offered by the Office of Ethnic Affairs since 2003 (available during business hours) has now registered nine (of 20) DHBs for use in hospitals, and 23 (of 33) Primary Health Organisations.¹⁷ Interpreting New Zealand (which offers 24-hour telephone and on-site interpreting) serves mainly Wellington and Christchurch.

Auckland, the most ethnically diverse area of the country,¹⁸ is now well served, with free interpreter services for primary care in the three Auckland DHBs.¹⁹

Assessment of the problem

International literature on communicating with LEP patients

There is an extensive international literature on health care interpreting, covering the use of both trained and untrained interpreters in hospitals and primary care. We use the term 'trained' rather than 'professional' because some interpreters may be paid for their services (and thus could be termed 'professional') but may not be formally trained. 'Untrained interpreters' encompasses all interpreters who lack specific training in interpreting, be they medical or other staff members, members of an ethnic community, medical students or family or friends of the patient. The main themes identified in our literature review were the benefits of interpreters in general; the relative benefits of trained vs untrained interpreters and different modes of trained interpreters (telephone vs in-person); the pros and cons of using family members; informed consent; the roles of interpreters; the importance of trust and continuity; advice on how to conduct interpreted consultations; the need for staff training in interpreter use; the under-use of interpreters; and barriers to interpreter use. One shortcoming of the literature is that it mostly depends on

WHAT GAP THIS FILLS

What we already know: Despite increasing numbers of limited English proficiency patients there is little use of interpreters in New Zealand. There is no evidence-based New Zealand primary care-specific guidance on how to communicate well with these patients.

What this study adds: This study reviews the evidence on the use of interpreters and critiques existing guidelines from New Zealand, Australia and the United States and describes an evidence-based toolkit for New Zealand general practice for using interpreters with limited English proficiency patients. The toolkit addresses practice structure, processes and outcomes to improve patient quality of care.

self-report data, rather than examining actual recorded consultations.

Much of the academic literature advocates the use of trained interpreters whenever there is limited English proficiency,²⁰⁻²⁶ and the many risks of using untrained interpreters are clearly delineated.^{11,27-31} These risks include linguistic problems (e.g. inaccuracies and omissions) as well as ethical problems such as role conflict and privacy.

There is also a literature describing the benefits of using family members as interpreters,^{30,32-37} the importance of trust³⁸⁻³⁹ and continuity⁴⁰ in interpreter use, and the occasional problems that can be caused by insistence on a trained interpreter.⁴¹

The contradictory nature of this evidence suggests that the choice of the most appropriate interpreter for a given situation is complex and context-dependent. Any interpreting (trained or untrained) can cause problems, and the cost and logistics involved in using trained interpreters means that they will never be used in all situations.^{42,43}

New Zealand literature on communicating with LEP patients

Until recently, there has been very little academic literature on the use of interpreters in New Zealand, with only peripheral reference to interpreters in a few papers.^{15,44-45} One recent study found the use of trained interpreters among Auckland pharmacies to be infrequent, despite regular LEP encounters.⁴⁶ Our own research investigated the use of medical students as interpreters,⁴⁷ and the

use of interpreters in general practice⁴³ and in hospitals¹³ in the Wellington region. The evaluation of the Primary Health Interpreter Pilot in Auckland studied the roll-out of fully funded interpreter services to all primary care services between 2008 and 2010, obtaining feedback from service providers, consumers and interpreters.⁴⁸

Our first study found that bilingual medical students were fairly often used as ad hoc interpreters without due consideration of the risks, but that there were some benefits.⁴⁷ It concluded with a set of guidelines for clinicians to consider when using medical students as interpreters. After publication, some local interpreters came out in strong opposition to the proposed guidelines, arguing the risks of such untrained interpreters are too great.⁴⁹ Our next study—in a general practice that sees a large number of immigrants and refugees⁴³—found that although family members were used 50% of the time, their use was mostly deemed satisfactory by the clinicians (patient

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satisfaction was not investigated). In Auckland, a similar rate of use of family members was found, even after the introduction of the free interpreter service.⁴⁸ Their small survey of consumers found a preference for trained interpreters over family members, but did not study actual consultations.

Suggested explanations for the low rates of use have been a “lack of awareness... of both the availability of interpreters, and of the potential risks”.⁴⁹ Our study of hospital staff confirmed anecdotal evidence that interpreters are under-utilised in this setting, but it also showed that the reasons for this were much more complex than suggested above, since there was a good level of awareness among clinicians of policies, risks and the accessibility of interpreters.¹³ There

were similar findings in Auckland where nurses in particular were aware of clinical issues but remained very low users of interpreters.⁴⁸

The key finding from our studies relates to the use of untrained interpreters. All three studies showed that they are still widely used, contrary to many DHB policies (see below). Two of the studies showed that there can be situations in which untrained interpreters such as medical students or family members are appropriate and adequate when particular conditions are met. The Auckland study, while adhering to the view that best practice is to use trained interpreters whenever possible, also found that clinicians saw benefit in family members providing ongoing support outside the consultation.⁴⁸

Guidelines and toolkits on interpreters

International

The use of trained interpreters for all medical encounters with LEP patients is generally presented as best practice in medical textbooks⁵⁰⁻⁵¹ and in all the United States’ and Australian guidelines and toolkits examined.⁵²⁻⁵⁷ The American Medical Association’s guide⁵² acknowledges that untrained interpreters can have some benefits, but without referencing supporting literature.

While there are documents which are comprehensive and well thought out, much of the content is country-specific (the United States⁵⁸ or Australia⁵⁹), or is designed for specific contexts: within hospitals,⁶⁰ or in mental health.⁵⁵ Their length and lack of relevance to the local context make them unsuitable for use within New Zealand general practice.

New Zealand

Many DHBs now have policies on interpreter use, but these are far from consistent.⁶¹⁻⁷² Whilst most advise against the use of untrained interpreters, some in quite categorical terms,⁷³ others give advice about specific situations when such interpreters might be used.⁷² Some DHBs, on the other hand, recommend using family members or community interpreters in the first instance and only obtaining a trained interpreter if none are available.⁶³ Some

recommend the use of telephone interpreters in preference to face-to-face interpreters.⁶¹⁻⁶²

In the Auckland region, DHBs have produced resources that give guidance on the use of interpreters. Auckland DHB's substantial document reflects a great deal of the complexity of the situation and contains information for health service providers, interpreters, and patients.⁷⁴ Waitemata DHB's resources address some of the complexity, but at times are contradictory, with the suggestion, for instance, to use a trained interpreter when the client is not accompanied by a family member, coupled with a recommendation not to use untrained interpreters.^{72,75} Other DHB resources in the Auckland region are aimed specifically at Auckland clinicians who see LEP patients frequently and are now able to access free interpreter services.

Results of assessment

Although most guidelines/toolkits promote trained interpreters as best practice, our review suggests that this recommendation is not soundly based on evidence. We agree that clinicians do need to be aware of the risks of using untrained interpreters. However, our research suggests that many clinicians still underuse interpreters despite such awareness. Moreover, the judgment of when to use trained versus untrained interpreters is a complex decision that needs careful consideration and weighing up of all the issues involved (clinical, ethical, practical, social and financial). Therefore, instead of giving advice which is unlikely to be followed (i.e. to always use trained interpreters), we argue that a better approach is to use a tool that guides clinicians through an evidence-based process to assess the actual risk in a given situation and make the best choice for that case.

Strategies for quality improvement

We have developed a toolkit for use of interpreters in New Zealand general practice. This toolkit aims to provide a systematic process to improve care of LEP patients in primary care. There is currently no concise general resource aimed at primary care practitioners in New Zealand that takes into account the financial constraints, that is firmly grounded in research evidence, and that

acknowledges the complexity of the decision and the possibility that sometimes an untrained interpreter may be the best option. It is suitable for general use throughout New Zealand, regardless of the level of ethnic diversity in the community. It is equally relevant to practices with large numbers of LEP patients and for those who deal less frequently with such patients. It is a concise document written from the viewpoint of the clinician.

The toolkit aligns closely with the quality framework⁷⁶⁻⁷⁷ in The Royal New Zealand College of General Practitioners' (RNZCGP's) document *Aiming for Excellence*.⁷⁸ This emphasises that quality improvements relate to the interaction of structure, processes and outcomes and that effective quality improvement requires attention to all these elements.

We use flowcharts to highlight where the decision points lie and the issues that need to be considered at each point. Several clinical scenarios and boxes detailing individual issues are included to provide different ways in to illustrate the same ideas.

Practice requirements

Figure 1 focuses on the aspect of structure in the 'Voyage to Quality Framework'.⁷⁶ For clinicians to be able to perform well, good systems have to be in place to support them. This chart focuses, at the practice level, on basic requirements for patient records, and on policy issues to be addressed if a practice decides that its population of LEP patients is significant. Seven action areas are described, including budget, where to source interpreters, staff training, and patient information systems. Some of the actions are simple (such as adding fields to patient records).

Is an interpreter needed when a patient is from a non-English speaking background?

Figure 2 encourages clinicians to consider the actual English abilities of any patient from a non-English speaking background (NESB). The term NESB is used here instead of LEP because the flowchart aims to help staff work out whether an individual patient should be classified as LEP (and thus requires an interpreter). There is a

Figure 1.

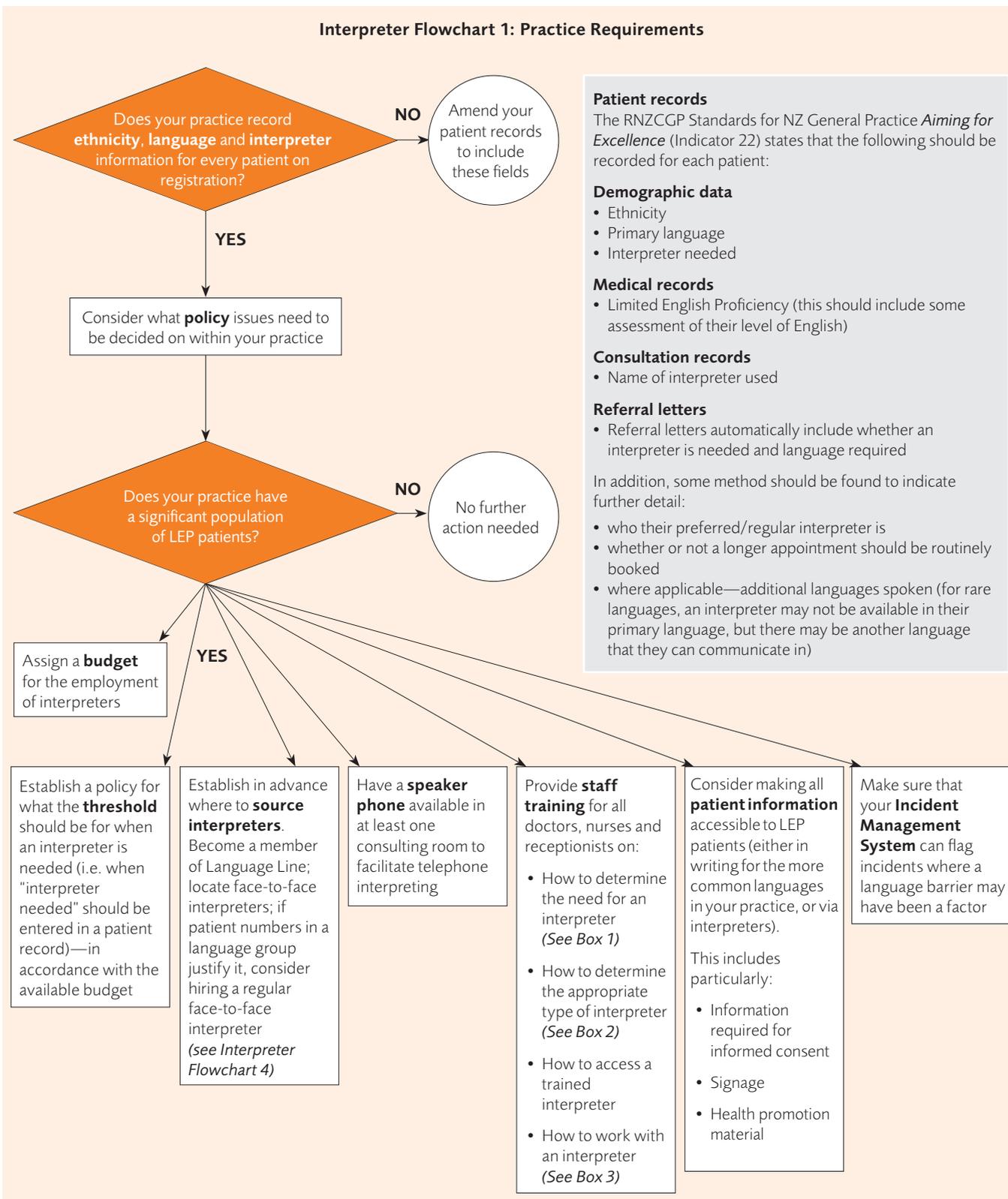


Figure 2.

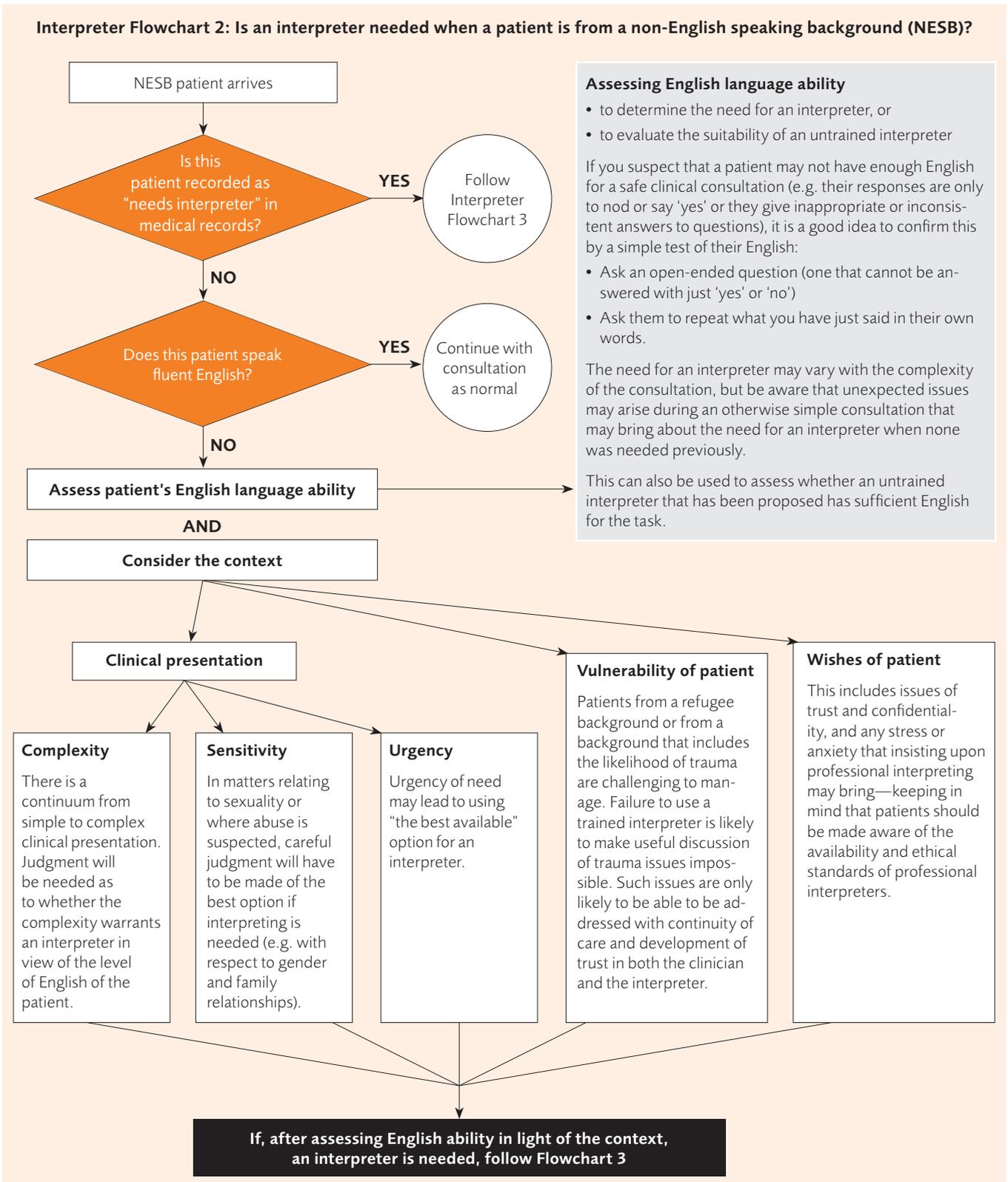
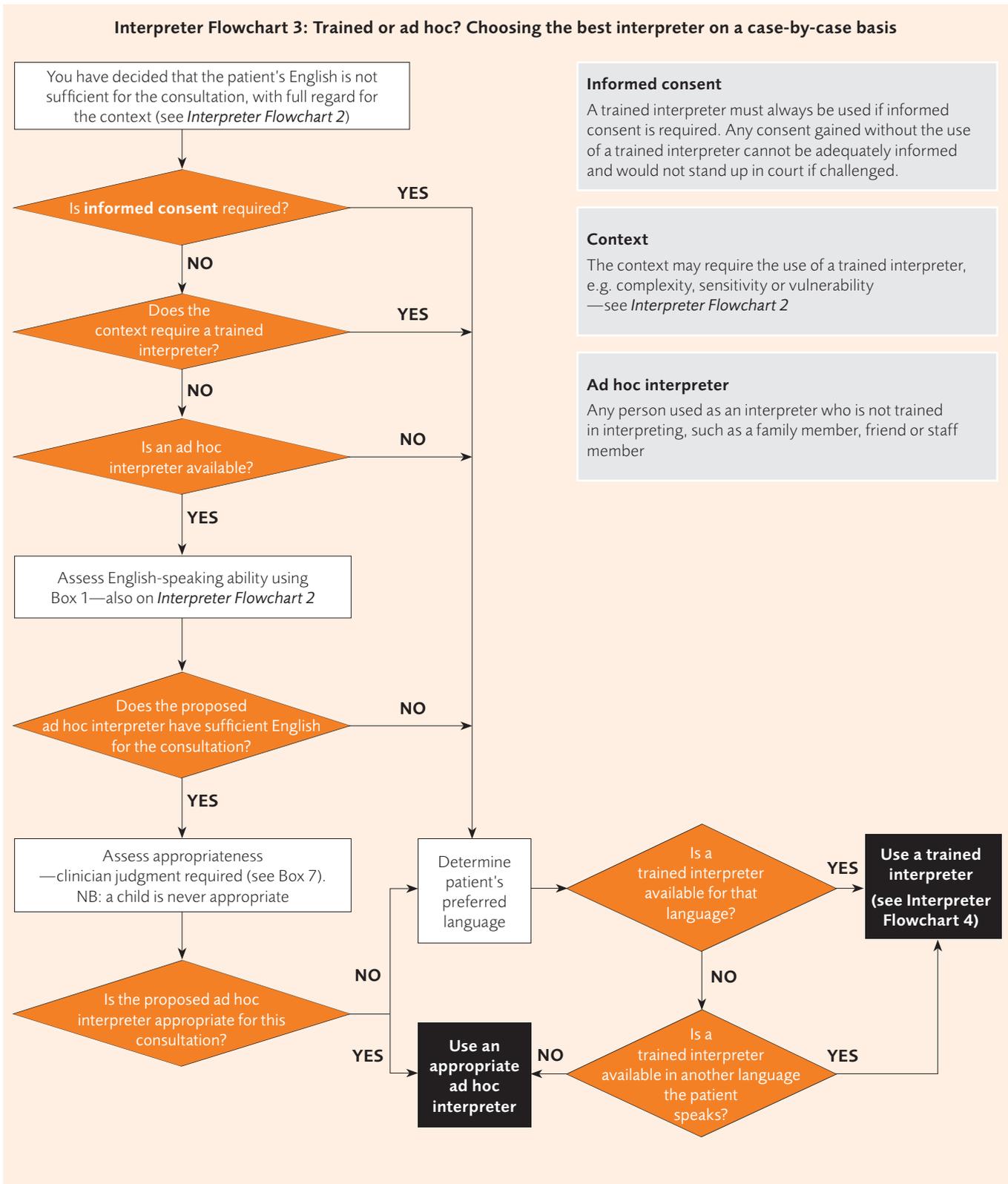


Figure 3.



continuum from 'fluent English' to 'no English at all', and it is the points in between where decisions on interpreter use are difficult. The flowchart emphasises that the level of English fluency needs to be considered in conjunction with issues like the nature of the clinical presentation, (complexity, sensitivity and urgency), the vulnerability of the patient (a particular concern with refugees) and the wishes of the patient. There is a continuum from minor to major for each of these issues, and weighing up the most appropriate action is a matter for clinical judgement.

Trained or ad hoc? Choosing the best interpreter on a case-by-case basis

The flowchart in Figure 3 asks about informed consent because it is essential that trained interpreters be used for this to ensure the consent is valid.⁷⁹ It then guides clinicians through the decision of whether a trained interpreter is required by considering the context (see Flowchart 2), the availability, and the English ability and appropriateness of any potential untrained interpreter. This aspect of the toolkit is where it most differs from other policies and guidelines in that it is more neutral on what best practice is. This flowchart reflects our findings^{43,47} that in some circumstances (particularly in primary care) there may be benefits to using untrained interpreters, and that careful consideration must be given to the decision, rather than simply following predetermined policy. As an example, the use of trained interpreters for retinal screening services in Auckland was not perceived to be any better than using family members due to the straightforward instructional nature of the communication.⁴⁸

If it is decided that a trained interpreter should be used, the final flowchart (see the appendix in the web version of this paper) guides clinicians through a process to determine the best type for the situation.

Scenarios and boxes

The toolkit also includes four scenarios, from the most straightforward (a booked appointment for a regular patient who regularly uses a particular interpreter where this has been recorded in their record and the interpreter arranged) to more com-

plex ad hoc situations (an LEP patient arriving either with no interpreter of any kind, or with a family member or friend as an interpreter). These four scenarios are available in the appendix in the web version of this paper.

Nine boxes give more discursive guidance on topics relating to interpreter use, including 'Assessing English language ability', 'How to work with an interpreter', 'Ethical issues in interpreting situations', 'Potential benefits of using an untrained interpreter', 'Assessing the appropriateness of an untrained interpreter', 'Finding the right trained interpreter', and a 'Chart of different interpreter options' which includes benefits and risks and other comments for each option. For the complete list and content of the boxes and scenarios, see the appendix in the web version of this paper.

Lessons and messages

Our survey of the NZ situation has established a lack of clear, consistent guidance at a national level on interpreter use in primary care. A review of the literature and our own research has shown the complexity of the decisions that need to be made. Our toolkit (developed for the RNZCGP) is firmly based in the current evidence on interpreter use and has been designed for use across NZ. It fits neatly within the CORNERSTONE® General Practice Accreditation Programme of quality improvement, and is designed from a clinician perspective to be a concise but nuanced, easily accessible resource.

The next stage of development will be to evaluate the efficacy and acceptability of the toolkit by trialling it in a number of practices and auditing patterns of interpreter use. Its impact on clinicians' awareness of issues will also be evaluated through surveys or focus groups as well as patient and clinician satisfaction with interpreter usage (both trained and untrained).

We believe that this issue is of sufficient importance to quality clinical care for LEP patients that this toolkit should be brought to the attention of primary health care practitioners at this early stage of development. Greater use of trained interpreters is necessary, but clinicians must be aware of the issues in order to make good decisions within the constraints they face.

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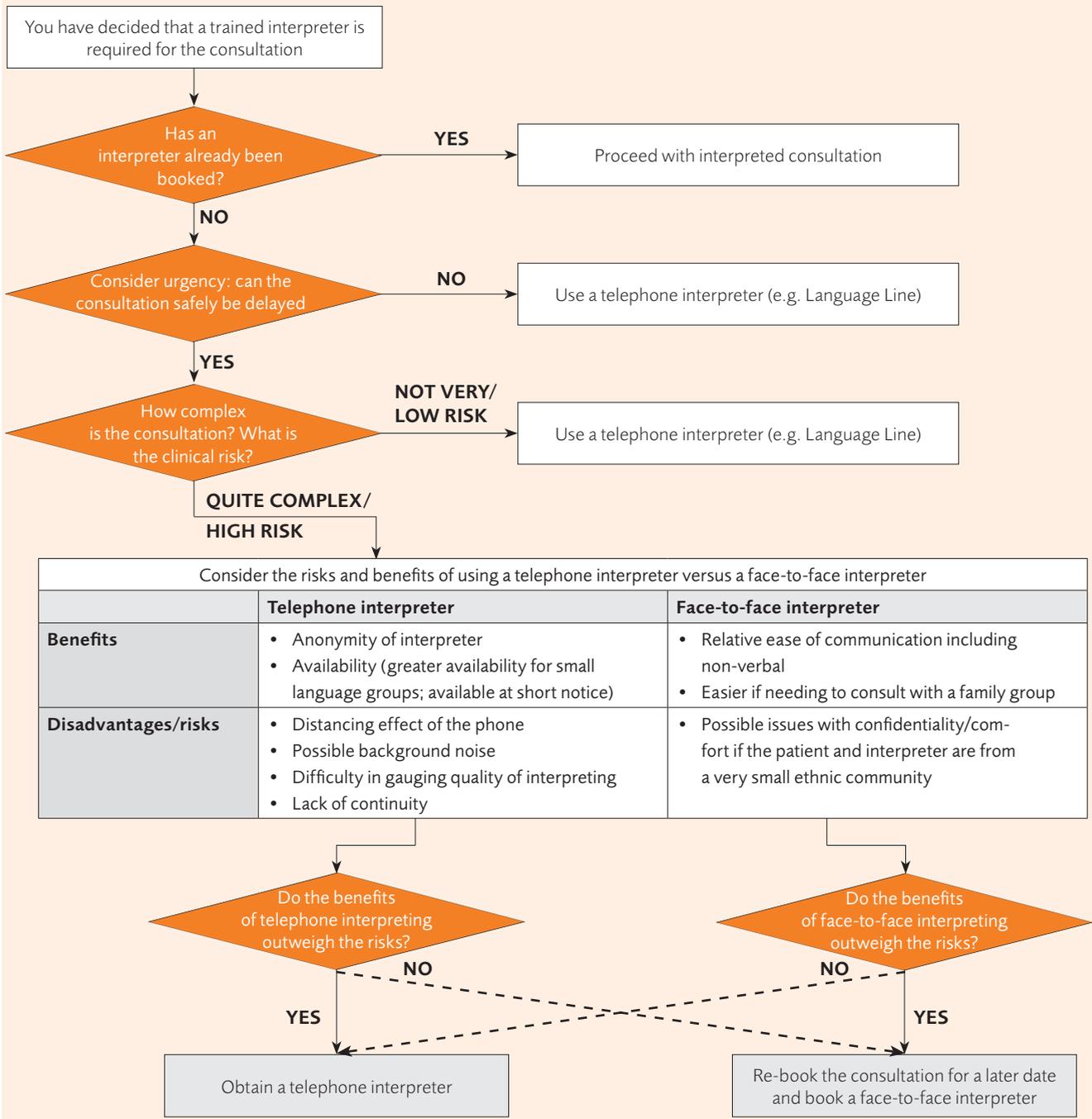
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COMPETING INTERESTS
None declared.

APPENDIX: Flowchart 4 of 'Toolkit for Using Interpreters in General Practice'

Interpreter Flowchart 4: Choosing the best TRAINED interpreter for the situation

A face-to-face interpreter is usually preferred (if possible) so that non-verbal communication and visual cues can also be interpreted and to avoid the distancing effect of the telephone



Clinical scenarios with LEP (Limited English Proficiency) patients:**1. Booked Appointment**

If a patient is coded as needing an interpreter, at the time of coding the notes should include who or what type the usual interpreter should be: face-to-face, telephone or ad hoc (and updated if further information comes to light). If such a patient books an appointment, their usual interpreter should be arranged in advance by practice staff.

2. LEP patient arrives without interpreter

- Assess English ability (see Box 1)
- How well do you know the patient? Have they previously been assessed as needing an interpreter?
- How easy is it to get an interpreter; how urgent is it to complete the consultation?
- Consider likely complexity of consultation
- Consider likely clinical risk of consultation.

Action:

If a face-to-face interpreter is required and appointment can be safely delayed, do so and book a face-to-face interpreter.

If a face-to-face interpreter is not considered necessary for the consultation at hand or if it is urgent, contact and use a phone interpreter (if available) on the spot.

3. LEP patient arrives with friend/family member (ad hoc) to interpret

Before you decide whether to go ahead with this interpreter or obtain a trained interpreter instead, consider the following:

- How well do you know the patient and the ad hoc interpreter? Has this combination worked for previous consultations?
- How easy is it to get an interpreter; how urgent is it to complete the consultation?
- Assess English ability (see Box 1) of patient and of proposed interpreter
- Consider likely complexity of consultation.
- Consider likely clinical risk of consultation
- Consider ethical issues that apply to this particular situation (see Box 4)
- Consider the benefits of using the chosen ad hoc interpreter (see Box 6)
- Is the patient aware of the interpreter options available?
- What is the health literacy status of the patient?
- How confident/competent do you feel with this ethnic group?
- Will using a professional interpreter instead cause interpersonal problems with the family, or undue stress or anxiety to the patient?

4. Problems arise during the consultation**i.e. status quo (no interpreter/ad hoc interpreter) is not working**

- Employ telephone interpreter on the spot, OR
- Reschedule for a later appointment with trained interpreter, on site or telephone.

Box 1: Assessing English Language ability

- **to determine the need for an interpreter, or**
- **to evaluate the suitability of an untrained interpreter**

If you suspect that a patient may not have enough English for a safe clinical consultation (e.g. their responses are only to nod or say 'yes' or they give inappropriate or inconsistent answers to questions), it is a good idea to confirm this by a simple test of their English:

- Ask an open-ended question (one that cannot be answered with just 'yes' or 'no')
- Ask them to repeat what you have just said in their own words.

The need for an interpreter may vary with the complexity of the consultation, but be aware that unexpected issues may arise during an otherwise simple consultation that may bring about the need for an interpreter when none was needed previously.

This can also be used to assess whether an untrained interpreter that has been proposed has sufficient English for the task.

(Based on guidelines from the American Medical Association, Auckland DHB and Waitemata DHB)

Box 2: How to choose an appropriate interpreter for your situation

The best interpreting option needs to be decided on a case-by-case basis. The following issues need to be considered:

Interpreter availability

Telephone interpreting is by far the best option because of ease of availability, but this does need to be weighed against the costs (in New Zealand) and the disadvantages of telephone interpreting: lack of continuity and personal relationship, need for interpreting of body language, patient intolerance of phone use and possible problems with background noise. Face-to-face interpreters are more expensive and likely to be more limited in availability.

Characteristics of the interpreter

Depending on the situation, you may need to consider the gender of the interpreter and their ethnicity (a common language does not always mean common ethnicity, a potential problem especially where patients are from countries at war).

Language ability

English proficiency of the patient (and of the proposed interpreter if an untrained interpreter is considered) must be assessed. In addition, the language to be used for interpreting is a consideration—does the proposed interpreter (trained or untrained) speak the patient's native language, or their second language? Do they share the same dialect? This may affect the quality of the interpreting.

Familiarity with patient and family interpreter

A clinician can judge the English ability of an LEP patient (or family interpreter) over a number of consultations and determine with some accuracy what their language competence is (and their appropriateness as an interpreter, if relevant).

Vulnerability of the patient

Patients from a refugee background or from a background that includes the likelihood of trauma are challenging to manage. Failure to use a trained interpreter is likely to make useful discussion of trauma issues impossible. Such issues are only likely to be able to be addressed with continuity of care and development of trust in both the clinician and the interpreter.

Clinical presentation

This is important for several reasons—the complexity may affect how much language is needed, and the nature of the issue may make it necessary to consider the gender of the interpreter and the relationship to the patient, factors which may rule out any consideration of use of family members for some sensitive discussions. Urgency of need may lead to using 'the best available'.

The wishes of the patient

This includes issues of trust and confidentiality, and any stress or anxiety that insisting upon professional interpreting may bring—keeping in mind that patients should be made aware of the availability and ethical standards of professional interpreters.

The patient's need for advocacy and/or ongoing support

This may make the use of a family member better if a suitable one is available, although there is nothing precluding using a trained interpreter and having the family member present also.

Seeking informed consent

Any consent gained without the use of a trained interpreter cannot be adequately informed and would not stand up in court if challenged. A trained interpreter must always be used if informed consent is required.

Use of children

Non-adult children should not be used as interpreters due to the high risk of both linguistic and ethical issues, i.e. with the quality of the interpreting (due to their limited medical vocabulary and health literacy) and the ethical issue of requiring a child to take on such a potentially stressful role.

Other issues that may influence the decision include the level of health literacy of the patient and the confidence and competence of the clinician with the cultural group concerned.

Box 3: How to work with an interpreter**What to do when using any kind of interpreter (trained or not)**

- Introduce all the participants to each other (if necessary) and state the purpose of the consultation
- If using a trained interpreter, inform the patient that the interpreter will maintain confidentiality
- Talk directly to your patient as if you speak the same language (i.e. use 'I' and 'you')
- Speak clearly, with frequent breaks
- Don't interrupt or talk over others
- Don't ask the interpreter to step out of role, e.g. to give an opinion
- Provide written information in the patient's language where possible (much is available on the internet).

Face-to-face

- Sit opposite the patient
- Position the interpreter at an equal distance from you both (e.g. a triangle)
- Maintain normal eye contact with the patient.

Telephone

- Use a speaker phone if possible
- Wait while the interpreter is connected to the call.

Cultural misunderstandings

- Be aware that cultural misunderstandings may impede communication, but that the interpreter and patient may not necessarily share the same cultural understandings
- Ask the interpreter for comment if you suspect a cultural misunderstanding, but ask them to repeat all cultural information that they give you to the patient as well to check they agree
- Allow the interpreter to volunteer cultural information if they think it is helpful.

After the consultation—with trained interpreters

- Offer the opportunity for a debrief if the consultation was emotionally taxing
- Plan follow-up appointments so as to arrange continuity of interpreting if possible.

Using untrained interpreters

- Ask them to interpret everything that you and the patient says, even if it doesn't seem important
- Be alert to any difficulties arising and switch to a trained interpreter if possible (at another appointment or immediately on the phone if urgent)
- Err on the side of very short turns at talk and interrupt and seek more information if a long turn at talk in the foreign language is followed by a short interpretation.

Box 4: Ethical issues in interpreting situations

Use of children—children should not be used due to problems with conflicting family roles and the emotional and maturity levels to cope with difficult situations.

Confidentiality/openness—in some situations problems may arise from the interpreter being privy to the medical consultation. This is less likely with trained interpreters due to their training and ethical code of conduct, but may still arise in very small ethnic communities where patients may not wish the interpreter to know their problems. It is more of an issue with untrained interpreters, where the relationship may make open discussion of certain matters difficult.

Gender issues—some matters will be best discussed with an interpreter of the same gender, especially but not only in the case of untrained interpreters.

Torture or trauma—for patients from a refugee or other background where there is the possibility of torture and trauma in their history, it is even more important to use a trained interpreter.

Box 5: When can a family member/friend be considered as an acceptable interpreting option?

A family member or friend may be a good option as an interpreter when specific conditions are met, i.e. when the untrained interpreter:

- Has enough English to effectively interpret
- Is not a child (under 18)
- Is known to the clinician to be reliable and in a good relationship with the patient.

And, when the consultation is:

- A fairly straightforward, non-sensitive one.

Box 6: Potential benefits of using an untrained interpreter

IF the untrained/ad hoc interpreter has adequate English ability, is over 18 and has a good and appropriate relationship to the patient, the following benefits **may** apply:

- High degree of trust and comfort for the patient
- Continuity of interpreting
- Advocacy for the patient
- Ongoing support for the patient within and outside the consultation
- Lack of financial cost.

**Box 7: Assessing the appropriateness of an untrained interpreter
(clinician judgement required)**

Consider:

- **Relationship** to the patient/clinician (Is there a good relationship?)
- **Clinical presentation** (ad hoc interpreters are more suitable for simple matters)
- **Wishes of the patient** (this includes issues of trust and confidentiality, and any stress or anxiety that insisting upon professional interpreting may bring—keeping in mind that patients should be made aware of the availability and ethical standards of professional interpreters)
- Patient's need for **advocacy or ongoing support** (this may make the use of a family member better if a suitable one is available, although there is nothing precluding using a trained interpreter and having the family member present also)
- **Familiarity** of clinician with the patient and ad hoc interpreter (a clinician can judge the English ability of an LEP patient (or family interpreter) over a number of consultations and determine with some accuracy what their language competence is (and their appropriateness as an interpreter, if relevant))
- **Gender** (is the gender of the proposed interpreter suitable for the nature of the consultation)
- **Health literacy** of the patient/proposed ad hoc interpreter (a trained interpreter may be helpful in cases of low health literacy)
- Clinician familiarity with the **ethnic group** (if you feel confident and competent in dealing with this group, this may lessen the need for a trained interpreter).

NOTE: Children should not be used. In exceptional circumstances (e.g. when there is no other option in an urgent situation) or for a very simple matter, a child might be considered as a last resort.

Box 8: Finding the right trained interpreter

1. Find out the preferred language of the patient (Language Line have posters that can help with this)
2. Find out whether a trained interpreter is available for this language
3. If options exist, decide whether a face-to-face or telephone interpreter is the best option (see Box 9 for benefits and risks of each)
4. Where options exist, consider the suitability of the interpreter for the patient and the situation. This may include (where appropriate) gender, ethnicity (sharing a language may not mean sharing ethnicity and may be an issue where there has been ethnic conflict), and relationships within the ethnic community
5. If the language is rare and no trained interpreter is available for it, find out whether the patient speaks another language
6. Find out whether a trained interpreter is available for this second language
7. If interpreting is provided in a patient's less preferred language, communication may be impaired even with the interpreter, so take extra care
8. If no trained interpreter is available, seek help from whatever ad hoc interpreter can be found as a last resort.

Box 9: Chart of different interpreter options

NOTE: patients should be informed of all the options available to them

Type of interpreter		Advantages/benefits	Disadvantages/risks	Caveats and comments
TRAINED	All	<ul style="list-style-type: none"> Trained in the skill of interpreting Excellent language skills Training in medical terminology Training in ethics 		
	In-house	<ul style="list-style-type: none"> Continuity/ability to develop a relationship of trust Face-to-face interaction 	<ul style="list-style-type: none"> If in a small ethnic community, patients may have issues with confidentiality and comfort 	<ul style="list-style-type: none"> Only possible if a large enough language group exists in a practice and there is a budget for it
	Face-to-face	<ul style="list-style-type: none"> Face-to-face interaction 	<ul style="list-style-type: none"> If in a small ethnic community, patients may have issues with confidentiality and comfort Lack of continuity 	<ul style="list-style-type: none"> Must be booked in advance
	Telephone	<ul style="list-style-type: none"> Anonymity of interpreter Greater availability when dealing with small language groups Available at short notice 	<ul style="list-style-type: none"> Distancing effect of phone Possible background noise Difficult to gauge quality of interpreting Lack of continuity 	<ul style="list-style-type: none"> Language Line only available during business hours Language Line: http://www.ethnicaffairs.govt.nz/oeaweb site.nsf/wpg_url/language-line-Index
UNTRAINED	Bilingual staff member/ medical student	<ul style="list-style-type: none"> Available at short notice Potential continuity 	<ul style="list-style-type: none"> Potential role confusion Uncertain language skill Lack of interpreter training Patient expectations of more than interpreting 	<ul style="list-style-type: none"> Need to be fully briefed about how to interpret Agreement to work in this role needs to be sought ahead of time
	Family/friend	<ul style="list-style-type: none"> Continuity Advocacy Ongoing support (outside the consultation) Trusted by patient Comfort to the patient <p><i>(Note: these are not necessarily present and clinicians need to assess if this is the case)</i></p>	<ul style="list-style-type: none"> Uncertain language skill Likely lack of medical terminology Potential for inaccuracy, omissions and additions Threat to confidentiality/ privacy Difficulty with sensitive discussions (depending on the relationship) Potential conflict with usual family roles and dynamics Own agenda of 'interpreter' 	<ul style="list-style-type: none"> Appropriate only for less complex clinical presentation Clinician will need to assess language ability and appropriateness