Editorials

Interpreters:

why should the NHS provide them?

In the UK, as in most other high-income countries in the 21st century, a significant proportion of the population does not have English as their first language, nor is adequately proficient in it. Any encounter with a doctor who does not speak their language (and some do) then depends on some sort of interpretation. Language competence becomes increasingly important as the degree of patient involvement increases, reaching its peak in encounters involving mental illness, matters of behaviour and motivation, and explaining somatic symptoms, where nuances of meaning and subtleties of expression make the difference between shared understanding and total communication failure. All these are the bread and butter of general practice.

Patients need to have their complaint understood, and need to understand the doctor's diagnosis, prognosis, and proffered treatment. Doctors need reciprocally to understand each patient's problems, including, in the patient-centred model, their ideas, concerns, and expectations, while seeking to ensure that their diagnosis and management plans are understood, are related to the patient's ideas and beliefs, and that there is agreement about ensuring that the best action follows, often called 'concordance'.[1] Given the huge effort over the past 50 years in research and teaching directed towards achieving such 'patient centredness' when there is a common language,[2] it is surprising that so little has been done to address the added barrier of not sharing a common language or culturally-related health beliefs.[3,4]

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RESEARCH IN DOCTOR–PATIENT–INTERPRETER ENCOUNTERS

In his exhaustive systematic review of 36 articles,[3] Flores concluded:

'... available evidence suggests that optimal communication, the highest patient satisfaction, the best outcomes, and the fewest errors of potential clinical consequence occur when LEP [limited English proficiency] *patients have access to trained professional interpreters or bilingual healthcare providers'.*

There has been a remarkable growth in studies of interpretation in medical encounters. Notable studies include those of Robb and Greehalgh,[5] which explored qualitatively, in relation to 'trust', the beliefs and attitudes of patients, doctors, and interpreters, and of Krystallidou and colleagues from Belgium,[6] a more quantitative study that looked at empathy in interpreted consultations and concluded that this largely depended on the interpreters. Both of these studies address the doctor–patient–interpreter triad which is so important in effective clinical practice.

It is well established that the patient–doctor relationship is key to effective management. In primary care the management of chronic disease is greatly enhanced due to the continuity of care,[7] however it is rare to have the same continuity of language support. Furthermore, the need for language support does not stop with the clinical interaction, with pressure to work 'smart' many previously doctor-facing tasks are being carried out by non-clinicians and remotely from the patient. This is leading to language support also being needed for many administrative tasks, such as booking for appointments, calling for results, managing prescriptions, medication reviews, and booking remotely for primary and secondary care appointments.

MANCHESTER'S CONTRIBUTION

The 2016 comprehensive report by the Central Manchester University Hospitals NHS Foundation Trust, with Multilingual Manchester, *Language Provisions in Access to Primary and Hospital Care in Central Manchester*,[8] evaluates their service. They found that clients with limited English proficiency often encounter difficulties with registering and booking appointments but generally have a high level of satisfaction with the interpreter provisions that are available to medical staff. The Report notes:

'It is widely accepted among practitioners that central Manchester is a "gold standard" in the Northwest region, and perhaps beyond, in providing language services, a product of many years of experience with migrant communities.'

However, they state that:

'General practitioners sometimes adopt a lax attitude toward relying on ad hoc, "casual" interpreting by patients' friends or family members without full awareness of the risks.'

And:

'There is no procedure in place for quality assurance of interpreter and translation provisions that are offered at GP surgeries, and no procedure to validate suppliers and contractors ...'

IMPLICATIONS FOR GENERAL PRACTICE

If the above is true for Greater Manchester, where the NHS makes extensive provision of interpreters, how much more is it likely to be the case across the UK?

We will consider the implications of this for general practice, and raise an alternative model. In primary care, clinical commissioning groups (CCGs) in England and Wales have taken differing approaches to the need for interpreters.

1. Commission external, commercial providers of both face-to-face and telephone interpreters (such as Language Line and The Big Word).
2. Develop 'not for profit' services and registered charities funded by local CCGs or federations, such as the Health Advocacy and Interpreting Service in Tower Hamlets, the Sussex Interpreting Services, and the now decommissioned Sheffield Community Access and Interpreting Service.
3. Support individual general practices with bilingual individuals, working in a number of different but overlapping roles

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(such as, bilingual receptionists, support workers, cultural brokers, and clinicians).

AN EXAMPLE

In one area of Sheffield, characterised by a high proportion of Urdu speakers, together with numbers of ethnic Roma people, Yemenis, and Somali speakers, one practice has, over 20 years, trained bilingual administrative staff to act as interpreters, and found there was only the occasional need for external interpreters. These bilingual colleagues acted as cultural brokers to the predominately white British medical staff, by helping to clarify not only linguistic issues, but also the cultural context and service expectations. Furthermore, these members of staff fulfilled the usual roles of reception and administration, but with the added language skills. This arrangement has been highly acceptable to patients, despite being contrary to current guidelines.

One ethnic group in Sheffield (and elsewhere) particularly disadvantaged by the traditional interpreter model is the ethnic Roma,[9] who, because of a shortage of Roma interpreters, often have interpreted consultations in a second language such as Slovak, Czech, or Romanian. Where Roma interpreters are available, as they are in this practice, it is our opinion that the consultations are more productive, as the patients implicitly trust the (culturally similar) Roma interpreter.[5]

By contrast, across the NHS the predominant model seems to be to use interpreters sourced through agencies, on an ad hoc basis. This ad hoc nature of the allocation of interpreters, whether face-to-face or telephone, leads to a disruption in the continuity of care, as both professionals and patients need to adjust to, and work with, many different interpreters. The use of professional telephone interpreters in particular is said to have a number of advantages including ease of access, anonymity, and costing by the minute instead of the hour. But these advantages do not always work in the GP's favour: interpreters are not always available, leading to long waiting times on the phone, loss of connection leading to restarting the call, and interpreters not based in the country and therefore unfamiliar with the NHS and its systems. Although it is hard to get figures for the whole of the NHS, this commercial model of language support is costing one local CCG in Sheffield more than £500 000 per annum, with the majority of the budget spent between six practices (C Thornton, personal communication, 2018).

OUR PROPOSED ACTION

Now, the time is right for NHS Commissioners across the UK to look at how best to supply language support in a culturally-appropriate and patient-centred fashion, but with flexibility of roles, working within a primary care team. Should practices or federations be encouraged to manage their own budgets, and look at supplying workers who can fill a number of roles that combine interpreting, advocacy, and admin roles, and recognise that interpreters need to be more than just translators of words? We think they should.

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