



Guide for Clinicians Working with Interpreters in Healthcare Settings

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GLOSSARY

In this Guide,

Auslan means the language of the Australian Deaf community. It is the preferred language of the majority of Deaf Australians. It is a highly visual language using signs, enhanced facial expressions and body language to communicate.

Chuchotage means simultaneous interpreting in a whisper for the benefit of a person or small number of people listening to speech in a language in which they are not fluent. Chuchotage is also known as 'whispering' or 'whispered interpreting'.¹

Consecutive interpreting means a mode of interpreting where the interpreter waits for the speaker to finish an utterance of reasonable length (given the interpreter's memory and/or note-taking skills) before interpreting it.¹

Deaf interpreter, also known as a Deaf Relay Interpreter, means an individual who provides interpreting for those individuals who do not use standard Auslan. A Deaf interpreter is usually deaf, fluent in Auslan and written English, and may have additional familiarity with a foreign sign language or pidgin. They may work in tandem with Auslan/English interpreters and can provide a unique language or communication bridge for Deaf individuals whose communication mode cannot be adequately accessed by a standard Auslan/English interpreter.²

Health literacy means the skills, knowledge, motivation and capacity of an individual to access, understand, appraise and apply health-related information to make effective decisions about health and health care and take appropriate action.³

Interpreter means a practitioner, conveying spoken or signed information from one language into another language, who has obtained certification issued by the National Accreditation Authority for Translators and Interpreters (NAATI)⁴—the national body responsible for setting, maintaining and promoting standards for the translation and interpreting industry through its certification system for translators and interpreters—at one of the following levels:

- Certified Conference Interpreter
- Certified Specialist Interpreter (Health or Legal)
- Certified Interpreter
- Certified Provisional Interpreter
- Recognised Practising Interpreter (for some languages, in which NAATI certification is not available).

All NAATI credentialed interpreters are bound by the Australian Institute of Interpreters and Translators (AUSIT) code of ethics⁵ or by the Australian Sign Language Interpreters' Association (ASLIA) code of ethics,⁶ respectively, obliging them to maintain impartiality, objectivity and confidentiality.

Language includes Auslan and other sign languages.

Person or people from migrant backgrounds means person or people who are permanent migrants, including first generation (born overseas) and second generation (at least one parent born overseas) Australians, as well as temporary migrants. People from migrant backgrounds include people from culturally, linguistically and religiously diverse backgrounds.

Person or people from refugee backgrounds means person or people with refugee-like experiences, including people who are humanitarian migrants granted permanent or temporary protection, asylum seekers, and permanent or temporary migrants. People from refugee backgrounds include people from culturally, linguistically and religiously diverse backgrounds.

Preferred language means a language most preferred by a person for communication. Preferred language may not be related to country of birth, and may be a language other than English, even where the person can speak fluent English.

Professional with bicultural skills means a professional employed in a range of positions within an organisation, and able and willing to use their cultural skills and knowledge to facilitate communication between the organisation and communities with whom they share similar cultural experiences and understandings. Some professionals with bicultural skills are employed specifically for their cultural skills.

Professional with bilingual skills means a professional who is employed in a range of positions within an organisation, and is not an interpreter, but able and willing to utilise their proficiency in a language other than English as an additional skill. Some professionals with bilingual skills are employed specifically for their proficiency in a language other than English.

Sight translation means the process whereby an interpreter or translator presents a spoken translation of a written text.

Simultaneous interpreting means a mode of interpreting where speech is interpreted while it is being spoken (usually with a delay of no more than a few seconds).

Teach-back method means a way for a clinician to confirm that the clinician explained to the person what they need to know in a manner that the person understands by asking them to teach back directions.⁷

Translator means a practitioner who conveys written information from one language into another language in the written form.¹



ABOUT THE GUIDE

This Guide is intended to be a complementary resource to the Competency Standards Framework for Clinicians (the Framework)—*Culturally responsive clinical practice: Working with people from migrant and refugee backgrounds*—developed by the Migrant and Refugee Women’s Health Partnership (the Partnership).

While the Framework establishes recommended and optimal cultural responsiveness competency standards for clinicians in healthcare settings, this Guide focuses specifically on effective communication and working with interpreters and seeks to provide relevant recommended approaches and evidence-based good practice points.

The Guide is divided in five sections:

- 1 – Why engage an interpreter
- 2 – Determining interpreter need and requirements
- 3 – Engaging an interpreter
- 4 – Interpreter’s role and scope of practice
- 5 – Practice points for clinicians working with interpreters in healthcare settings

Each section of this Guide sets out key recommended approaches for clinicians, which refer to the standards within the Framework (see Attachment B for the list of the Competency standards).

SECTION 1 – WHY ENGAGE AN INTERPRETER

Clinicians should:

- respond sensitively and without assumptions to the diversity of individual characteristics—including linguistic considerations—and modify their approach as appropriate
- acknowledge and address barriers to facilitating informed decision-making, and obtaining informed consent, as well as to quality use of medicines
- understand the medico-legal risks and implications of failing to engage an interpreter, if necessary, especially when: assessing the decision-making capacity of the person; obtaining consent for a procedure; and starting or adjusting complex medications
- understand the impact of linguistic differences on participation of people in their care, including when verifying understanding and gathering feedback.

Competency standards 1.1, 2.1, 2.2, 3.1, 3.2, 5.1, 5.3*

More than one-fifth (21 per cent) of Australians speak a language other than English at home, and overall 3.5 per cent of Australians say they speak English poorly or not at all.⁸ Proficiency in English is worse among older populations, with one in eighteen adults aged over 65 years saying they have limited or no proficiency in English. People with limited English proficiency are recognised to have poorer health outcomes⁹ and substandard contacts with healthcare providers. They tend to have limited access to care and preventative services,^{10,11} and are at risk of severe adverse outcomes during or after hospital admission.¹²

Clear and effective communication underpins every aspect of good clinical practice. Good clinician-person communication is linked to the person's satisfaction, adherence to clinical instructions, and health outcomes.^{13–16} Ineffective communication between the person and the clinician can result in limited, delayed, inefficient care,^{17–20} leading to more costly

treatment and intervention, as well as negatively impacting the person's understanding of, and trust in, the healthcare system at large.

People with limited or no English proficiency benefit from the engagement of interpreters to assist in communication. Engaging interpreters has been found to:

- decrease communication errors²¹
- increase the person's comprehension²¹
- reduce unnecessary tests and treatments²⁰
- improve clinical outcomes²¹
- raise the quality of care to the same level as that for people without language barriers²¹
- improve the person's satisfaction associated with improved understanding of self-care and follow-up plans, reduced errors and better treatment adherence.^{21,22}
- improve the healthcare provider's satisfaction.²²

As a matter of good practice, clinicians should ensure the person understands the discussion that takes place and the proposed care plan, engaging an interpreter if necessary.²³ Failure to determine the need for, and engage, an interpreter in consultations with people with limited English proficiency or Deaf people may be considered to be a breach in duty of care.^{17,24–26} From a medico-legal perspective, engaging interpreters helps clinicians to ensure that they have adequately assured informed consent, and that a person understands complex instructions and is competent to make decisions.²⁷ These all underpin informed decision-making.

In addition to considering the person's linguistic background and the need to engage an interpreter to check that the person understands everything they have been told, linguistic considerations should be factored in to support people's right to provide feedback or complain. This may require documentation and resources to be translated, or for interpreters to be involved to discuss this information.

* See Attachment B for the list of the Competency standards.

Informed consent

Consent for any procedure requires the person to be:

- fully informed about the underlying illness or disease, the nature of the procedure, the consequences of not having the procedure, the degree of certainty about the outcome, the time for recovery and the cost
- able to raise any concerns about risks of particular relevance to them.²⁸

The clinician's duty of care includes clearly explaining the benefits and potential harm of specific clinical treatments and the consequences of not following a recommended management plan.^{29,30}

Engaging an interpreter is essential for obtaining informed consent from individuals with limited English proficiency or Deaf people from migrant and refugee backgrounds.

At a minimum, clinicians should:

- assess the person's understanding of the information provided to consent to treatment, taking into consideration both the complexity of the issues and the individual's English language proficiency
- engage an interpreter for people with limited English language proficiency.³¹

Consent may not be valid if it is obtained through third parties, including the person's family members, or professionals with bilingual skills facilitating interpretation.³² These individuals' lack of interpreting competence and the possible breach of confidentiality or conflict of interest may render them inappropriate facilitators of interpretation.³³ There is particular risk of misleading information and miscommunication occurring when engaging family members or friends as facilitators of interpretation. Minors should never be engaged to obtain consent from their parents for procedures.³⁴

Assessing competence

Assessing decision-making competence involves assessing a person's capacity to understand, retain and believe the information about the treatment options; and their ability to weigh the information to reach a decision and to communicate that decision.³⁵ A person's competence may vary through the course of their condition, so competence may need to be reassessed at different points if there is concern.

Complexity and the safe use of medicines

A good example of complex instructions for which an interpreter may be necessary is medication instructions. People with limited English proficiency, including those from migrant and refugee backgrounds, are at greater risk of medication-related harm, due in part to language and communication barriers.^{36,37}

At minimum, clinicians should ensure an interpreter is engaged when:

- Starting or changing the dose of high-risk medicines (e.g. anticoagulants, insulin, opioids, chemotherapy, digoxin and other medications with a narrow therapeutic range³⁸)
- Starting a medication that requires the use of therapeutic devices (e.g. spacers or injecting devices) that need to be explained by the clinician
- In situations where people are taking multiple medications or multiple daily doses, or their doses have been changed by other clinicians, or in another health service organisation.

SECTION 2 – DETERMINING INTERPRETER NEED AND REQUIREMENTS

Clinicians should:

- understand the medico-legal risks of failing to determine the need for an interpreter, and failing to respond appropriately if the person refuses an interpreter
- not engage minors and not rely on family members, intimate partners, friends, and web-based translation applications to facilitate interpretation.

Competency standards 3.1, 3.3

Clinicians should err on the side of caution when assessing whether an interpreter is needed. A person's ability to engage in a general conversation in English is not a measure of their capacity to discuss and understand health related matters. People may appear to have sufficient English proficiency for every-day social engagement but insufficient English to understand technical terms, medical terminology and procedures, or pharmaceutical information.^{39,40} Even when complex terminology is not used, health concepts require a sophisticated understanding of language, to ensure the person has the opportunity to interrogate the information adequately and understand the impact of the health condition on their life. Further, people may have gaps in confidence and competence between receptive English (understanding what a clinician says) and expressive English (being able to ask questions in English). Deaf people from migrant and refugee backgrounds require an Auslan/English interpreter (if they use Auslan) or a Deaf and Auslan/English interpreter (if they use another sign language).

When assessing the need for an interpreter, it is important to be aware of possible changes in the person's circumstances. That is, while an interpreter may not be deemed necessary at the onset of a consultation or procedure, clinicians should be prepared to engage an interpreter should circumstances change during the course of the consultation or procedure.²⁶

In practice, a legitimate assessment for an interpreter may be made by the clinician and/or by the person, and either assessment should be actioned. The fact

that a person, or their family member, does not request an interpreter does not mean one is not required to assist with communication.⁴¹ The fact that a clinician does not deem the interpreter to be necessary, does not mean that the person may not independently assess that they do need one.

If the person refuses an interpreter, the clinician should:

- address the person's concerns (e.g. confidentiality, gender-concordance or cost considerations)
- discuss the risks associated with misunderstandings or miscommunication
- inform the person that engaging an interpreter is of benefit to the clinician as much as to the person, and that family members can still be involved as support persons.

If the person still refuses an interpreter, or a particular interpreter, the clinician must document the discussions and outcome in the person's medical record.⁴²

If the clinician is unable to engage an interpreter if requested, the clinician should document the attempt used to engage an interpreter, and document the language support provided for the person.

Responsibility not to engage minors as facilitators of interpretation

Engaging minors to facilitate interpretation poses a number of ethical dilemmas: it undermines the parent's authority, may affect family dynamics, and imposes potentially dangerous emotional responsibilities upon minors.³⁴ Some cultures have topics that are considered out of bounds for discussion by minors. Parental privacy and confidentiality may be breached if their children are co-opted into facilitating interpretation. Enormous emotional burden is placed on minors when facilitating interpretation for a parent about a serious or terminal illness, or histories and impacts of violence. In some situations, this may traumatise the minor, impacting on their emotional and psychological well-being.^{43,44}

Importantly, minors from migrant and refugee backgrounds may be fluent in English but not necessarily in their parents' first language or languages. Their knowledge of clinical terminology in English, let alone in another language, may be very limited or non-existent. The risks are therefore high and range from omitting to interpret to misinterpreting the diagnosis or proposed treatment, or to telling a parent to sign a consent form without interpreting the information about the procedure and its risks. This may lead to an erroneous procedure, unnecessary tests, extended length of stay, or possible fatal outcomes.²⁵

Risks of relying on family members, intimate partners, friends, and web-based translation applications as facilitators of interpretation

Clinicians must consider the potential ethical, professional and legal consequences and significant adverse outcomes of permitting personally involved individuals, including family members and intimate partners, to facilitate interpretation. Risks which could lead to inappropriate clinical decisions being made include:

- inaccurate and inadequate interpretation due to lack of interpreting skills, subject matter knowledge and specialised medical terminology
- inappropriate behaviour due to lack of professional ethics
- possibility of information being withheld or distorted because of family relationships; in view of potential family, domestic or intimate partner violence situations; or due to the emotional and sensitive nature of the health issues
- undermining the clinician's confidence that the necessary information is being communicated appropriately
- compromising confidentiality
- causing potential trauma to family members.

Therefore, failure to engage interpreters and, conversely, inappropriate engagement of family members to facilitate interpretation poses a risk of harm^{12,24} due to communication errors.²⁰

While web-based translation applications are becoming more prevalent and continuously improving, clinicians should assess the risks of using such applications as inaccuracies could lead to clinical error, confusion, embarrassment, or cultural improprieties that affect the person's trust in their clinician. Web-based translation applications have not yet been proven to provide safe and accurate translation in complex health settings.⁴⁵ Noting the risks, consideration may be given to using such applications in limited instances and in low-risk situations (e.g. in triage areas) as a short-term measure until an interpreter is engaged.

SECTION 3 – ENGAGING AN INTERPRETER

Clinicians should:

- understand the medico-legal risks of failing to engage an interpreter, if assessed as necessary, even if the person does not request an interpreter
- ensure that an interpreter, appropriate to the person's language and gender-concordance preferences, is engaged when assessed as necessary or requested by the person
- undertake effective handover of care, including information about relevant individual linguistic considerations, needs and preferences
- promote a whole-of-organisation use of interpreting services by informing persons about their right to access interpreting services, and by ensuring that their clinical and non-clinical colleagues have information about: when an interpreter may be required; how to arrange for an appropriate interpreter; and the importance of documenting the need for an interpreter in the patient management system once the need is identified.

Competency standards 3.1, 4.1, 6.1, 8.2

Once the need for an interpreter has been established, it is the clinician's responsibility to ensure that steps are taken to engage an interpreter. It is important to have necessary arrangements in place with an appropriate language service provider. Interpreters can be engaged either in person or via telephone, depending on circumstances. Engaging interpreters over telephone is particularly appropriate in regional and remote areas.

In requesting an interpreter, clinicians should consider the person's ethnicity, religion, language or dialect, and preference for gender of the interpreter.⁴⁶ The interpreter's ethnicity and religion may be important to some people, in view of a perceived bias if the interpreter is from an ethnic group which is or has been in conflict with the person's ethnic group.⁴⁶ Some people may request the same interpreter throughout their care or have preference for an interpreter of the same gender. This is particularly

likely to occur in consultations related to sexual and reproductive health or, in some cases, mental health, and may be a high priority in people from some cultural backgrounds. In gender-discordant consultations, where the clinician and the person are not of the same gender, engaging a gender-concordant interpreter can improve the person's satisfaction with the consultation.⁴⁷ When the available interpreter is of a different gender than the person's preference, the person should be informed and telephone interpreting should be offered instead.

People from migrant and refugee communities may prefer interpreting services over the telephone, even when an interpreter is available in person, due to their confidentiality concerns if it is likely that the interpreter is from the same small and tight-knit community.⁴⁸ Telephone interpreting may also be preferred if the consultation involves a sensitive topic, such as mental or sexual health, and particularly if the available on-site interpreter is of the opposite gender.⁴⁹

It may not be possible to accommodate all individual preferences with regard to interpreter requirements (e.g. ethnicity or religion), in view of language service provider policies. However, understanding people's concerns and informing them of available options, while clarifying the role of interpreters as facilitators of communication who are bound by confidentiality and impartiality, helps build trust and effective partnerships.

In the event that an interpreter is not available, clinicians are responsible for assessing the risks of proceeding with the consultation without an interpreter as opposed to the risk of rescheduling the appointment to allow time to engage an interpreter.

In case of an emergency and when an interpreter is not available, this must be noted in the patient record and an interpreter should be engaged as soon as possible to ensure accurate information is communicated.⁵⁰

Use of interpreting services

Clinicians should ensure that people are informed of the interpreting services that are available to them when accessing health care, as well as collecting medications from a pharmacist, and that services are:

- provided by certified interpreters
- free for the person
- confidential.

The requirement to engage an interpreter may need to be determined outside of the person's encounter with the clinician, including when communicating with the clinician's clinical and non-clinical colleagues or making an appointment. Clinicians must ensure that their colleagues have guidance on how to assess when a person is likely to need an interpreter (i.e. when the person is unable to communicate effectively in healthcare settings due to having limited English proficiency or being Deaf) to enable an interpreter to be arranged in a timely fashion.

Clinicians should work with their colleagues to ensure that the need for an interpreter is clearly and visibly documented in the patient management system.

Information should include:

- whether an interpreter was provided when requested or identified as needed
- the person's preferred language
- the person's preferred gender of interpreter.

This information should be used to alert the clinician and colleagues of the need to request an interpreter for all future consultations.

SECTION 4 – INTERPRETER’S ROLE AND SCOPE OF PRACTICE

Clinicians should:

- collaborate with interpreters as non-clinical members of a healthcare team
- recognise the role of interpreters in healthcare settings, including their skills, responsibilities and scope of practice.

Competency standard 7.1

Interpreters relay the messages uttered by all parties as accurately as possible, without adding or omitting content or attempting to correct the person’s style or grammar. This includes maintaining the person’s tone of voice, style and manner of speech when interpreting into English (e.g. for people with mental illness who speak in incoherent ways), as well as maintaining the register of all parties’ utterances.

Clinicians should not request or expect interpreters to:

- assess any of the person’s functional abilities, except for their linguistic abilities
- make a judgment as to the competence of the person or establish the person’s understanding
- act as a chaperone for clinical examinations
- act as a professional with bicultural or bilingual skills, a carer or a health advocate for the person.

Interpreters maintain and observe professional boundaries, and do not overstep their role to explain or to establish understanding.⁵ This implies that, while the interpreter removes the communication barrier, the responsibility for establishing understanding rests with the clinician. By using the teach-back method through the interpreter – whereby the clinician asks the person to explain in their own words what they’ve been told – clinicians can make sure that they are understood.⁷

If the interpreter recognises cross-cultural misunderstanding, or comprehension or cognitive difficulties on the part of the person, the interpreter may raise it with the clinician to allow the clinician to take appropriate steps with the person, such as rephrasing, clarifying, or asking further questions.⁵¹

While there are circumstances where it may be useful to engage a chaperone when working with a person, interpreters are not trained for this purpose, and acting as a chaperone would conflict with their impartial role.

An interpreter works within the consultation. It is not their function to act as a professional with bicultural or bilingual skills or a health advocate (e.g. an interpreter should not be expected to accompany a person beyond the consultation to assist at the local pharmacy). Similarly, clinicians should avoid engaging a professional with bicultural or bilingual skills or a health advocate to act as an interpreter as they are not qualified for such a role.

Written translations by translators vs sight translations by interpreters

Non-English speaking or Deaf people from migrant and refugee backgrounds may also be unable to read or write in English, and some may be illiterate in their own language. This makes filling out healthcare forms or questionnaires challenging. However, on-site interpreters should not be asked to provide written translations of material or fill out forms or questionnaires on behalf of the person. They are not always certified as translators and thus, cannot provide written translations of documents. Clinicians should request that such material be translated, if possible in advance, by a certified translator through a relevant translating service.

If it is necessary for a person to fill out a written document, or for a clinician to inform a person of the contents of a document (e.g. information about a procedure), the clinician should read the questions to the person through the interpreter. Clinicians, or their clinical and non-clinical colleagues, may then complete the form according to the person’s answers as conveyed by the interpreter.

Alternatively, when necessary, an on-site interpreter may be asked to provide sight translation of written information (e.g. clinical instructions or letters related to the person's clinical history), thereby transferring a message written in one language into a message delivered orally in another language.⁵² Sight translations must take place in the presence of the clinician, or their clinical and non-clinical colleagues.

Sight translation should be used sparingly and for brief documents only (200–300 words). Interpreters should not be required to sight translate consent forms, complex medical reports or documents with extensive information on conditions, procedures, options of treatment and risks.⁵¹ Long, complex or technical documents—including documents associated with a person's participation in a clinical trial—are not suitable for sight translation and warrant written translation.

SECTION 5 – PRACTICE POINTS FOR CLINICIANS WORKING WITH INTERPRETERS IN HEALTHCARE SETTINGS

Practice point 1: Clinicians inform interpreters on the nature of the consultation prior to its commencement, where possible, recognising the need to assist the interpreter to prepare for the information that may need to be interpreted

Where possible and relevant, clinicians should provide brief information to interpreters describing the context of the consultation immediately before it occurs. This is to ensure quality and effective communication, and achieve best possible outcomes for the person in the consultation.

Interpreters will be in a better position to accurately interpret if they have a clear understanding of the purpose of the consultation and have an overview of the session including, as appropriate, a description of the activities that will take place and whether the consultation may be distressing.⁴⁶ If it is anticipated that the consultation will include counselling, or other complex matters, the clinician should inform the interpreter before the consultation.

Informing the interpreter is particularly relevant for highly specialised consultations (e.g. if the person has a speech defect⁵¹), sensitive or difficult consultations (e.g. a mental health consultation, palliative and end-of-life consultations, delivering bad news), or in situations where additional occupational risks for the interpreter may be anticipated (e.g. consultations with regard to abuse or violence⁴³).

Interpreters may also take a proactive approach and request the clinician to brief them if this is possible, in accordance with the AUSIT Code of Ethics, which encourages interpreters to “request [a] briefing and access to reference material and background information before their work commences.”⁵

Opportunities to inform an interpreter may be limited in a consultation interpreted via telephone, or a consultation interpreted via video for a Deaf person, and may only include flagging the nature of the consultation with the interpreter, if it is known.

A process of iterative briefing may also be needed, if the consultation moves to cover issues for which the interpreter was not prepared (e.g. sexual and reproductive health matters when the telephone interpreter is of a different gender to the person).

Practice point 2: Clinicians introduce the interpreter to the person and explain the role of the interpreter as a non-clinical member of the healthcare team, who is tasked with facilitating effective communication in the clinical consultation through accurate interpretation, is bound by confidentiality and maintains impartiality

Clinicians should begin the consultation by introducing the interpreter and explaining their role as a non-clinical member of the healthcare team who is:

- tasked with accurate interpretation
- bound to confidentiality
- bound to impartiality.

Alternatively, the clinician can ask the interpreter to introduce themselves and state their role to the person.

It is good practice for clinicians to ensure that:

- conversations with other clinicians in the person’s presence are always interpreted, and that the person’s linguistic presence is maintained

- interpreters are never directed not to interpret particular segments of what is being said, as it would be a breach of the interpreter's ethical duty of accuracy
- whenever they engage in discussions with the interpreter, the interpreter is given an opportunity to inform the person of what is being discussed.

When the clinician leaves the room, the interpreter should not remain alone with the person but should also leave to ensure the role of the interpreter as a communication facilitator between the person and the clinician is enforced. Interpreters prefer not to stay alone with the person, so as not to engage in a private conversation, noting that anything discussed in the absence of the clinician remains confidential unless disclosure is mandated by law.

Practice point 3: When possible and appropriate, clinicians and interpreters may debrief and exchange feedback following a consultation

Clinicians and interpreters should be sensitive to situations when mutual debriefing and exchange of feedback between clinician and interpreter may be required (e.g. difficult and traumatic consultations, particular language observations).

Debriefing and feedback may be necessary to discuss the person's lexical, grammatical or speech errors, or other linguistic characteristics, particularly in speech pathology, neuropsychology or mental health settings. The clinician may also need to clarify the person's body language and gestures throughout the consultation if they appear to be confusing or framed by culture.

Both clinicians and interpreters in healthcare settings may participate in distressing encounters, deliver bad news, and experience emotional impacts from some consultations. In particularly distressing or disturbing situations, there may be a need for both the interpreter and the clinician to debrief together about their experience. Debriefing is of particular importance in situations where individuals may experience vicarious trauma as a result of the engagement (e.g. counselling, domestic and family violence).^{45,50,53} Mutual debriefing may be short, simply acknowledging the complexity and potential stressfulness of the consultation.

In the event of telephone interpreting, clinicians may choose to ask the interpreter to stay on the line following the consultation to clarify any elements of the consultation, or to acknowledge the potential impact of the consultation.

Vicarious trauma presents an occupational health and safety issue, and organisations commissioning interpreting services and interpreting service providers are encouraged to provide formal avenues to address instances of work-related trauma among interpreters, including through counselling services.⁵³

Practice point 4: When working with an onsite interpreter, clinicians interact directly with the person, using direct speech, and maintaining appropriate body language and facial expressions

When assisted by an interpreter, either on-site or via telephone, clinicians should use direct speech and first-person pronouns with a non-English speaking person, to establish rapport and facilitate accuracy of interpreting.

Direct speech means speaking directly to the listener rather than asking the interpreter to relay questions, information, or instructions. For example:

- "I'd like to carry out some tests" rather than "Tell her I'd like to carry out some tests"
- "Is this area painful?" (by telephone: "Is the area I am examining now painful?") rather than "Ask him whether that area is painful"
- "Please raise your left arm" rather than "Ask her to raise her left arm".

It is equally important and reassuring to the person to maintain eye contact (if culturally appropriate), use facial expressions, gestures and congruent body language (e.g. nodding while the person is speaking or the interpreter is conveying the message). In addition, the interpreter should be acknowledged every now and then, as this includes them in the team.

When working with an on-site interpreter, it is recommended that the participants position themselves in a way to allow the clinician and the person to see each other, and that the interpreter be seated within the clinician's visual field.⁴⁵

This can take a form of a triangle arrangement: Clinician-Interpreter-Person.⁵²

Practice point 5: When working with a telephone interpreter, clinicians use a speakerphone or a hands-free telephone

When working with a telephone interpreter, using a speakerphone or a hands-free telephone or portable video equipment makes the communication more efficient for all participants. All healthcare settings where interpreters are or may be engaged should be equipped with speakerphones or hands-free telephones. For Deaf people, video telephony equipment should be available and tested. If the clinician is obliged to use a telephone without a speaker function in hand-passing mode, they should indicate to the interpreter when the telephone is handed over to the person, and to the person that the telephone should be handed back.

Practice point 6: When working with a telephone or video interpreter, clinicians interact directly with the person, ensure they manage turn-taking, and use adequate descriptive language

When working with a telephone or video interpreter, clinicians should continue to address the person directly and face the person during the interpreting session.

Telephone interpreting deprives interpreters of visual cues that give context and meaning to language. Clinicians can make up for this by using visual language to describe what is happening throughout the consultation or by indicating who is speaking if more than one clinician is present. The clinician should verbally comment on visual surroundings, movements, acts and intentions (e.g. when pointing to the X-ray that they are holding in front of the person).

While on-site interpreters can readily identify, by gestures and eye direction, if the clinician is breaking the consultation to address them directly, telephone interpreters need to be verbally notified that they are being addressed, rather than the person. If the clinician needs to directly talk to the interpreter (e.g. if they are explaining that the person has left the room and the interpreter should stay on the line), they should address them directly as 'Interpreter'.

Practice point 7: Clinicians speak clearly, use plain English and explain complex concepts and terminology to enhance the person's understanding

Speaking clearly, using simple language and avoiding colloquialisms, idioms, technical language and acronyms is important when working with interpreters,²⁷ as technical clinical terms and abbreviations, in particular, may complicate the interpretation. Interpreters may ask for clarifications or repetitions if needed. If technical terms are unavoidable, they should be explained in plain English so the interpreter can convey those explanations to the person. Clinicians should take responsibility for explaining complex concepts and terminology to the person, and not expect the interpreter to simplify or explain those.

While the interpreter can assist in bridging the language gap, the cultural meaning embedded within language adds further complexity to cross-cultural consultations. Languages are not equal in terms of available vocabulary, and some English clinical terms do not have a direct equivalent in other languages, resulting in the interpretation being a paraphrase of the information. This may take longer and does not indicate that the interpreter is adding an opinion or comment.

Where the clinician assesses the person on intimate or sexual and reproductive health matters, they may have to address the person using a certain descriptive vocabulary, employing terms and descriptions of intimate body parts or acts. In these situations, it is important to warn the person about the sensitive nature of the questions about to be asked. If there is gender discordance between the person and the clinician or the person and the interpreter, it is important to ensure that the person is comfortable enough to have the conversation about sensitive issues.

Practice point 8: Clinicians speak at a reasonable speed, with appropriate pauses and avoiding overlapping speech, so as to enable the interpreter to interpret

While Auslan/English interpreters mostly work in the simultaneous mode, spoken language interpreters work primarily in the consecutive mode (i.e. they start conveying the message from one language to the other after each speaker finishes their utterance). Speaking with reasonable pauses or breaks facilitates accurate interpretation. While some interpreters may use various strategies to manage long speech segments (e.g. taking notes, cutting in to interpret while speakers are talking, asking for repetitions, or interpreting simultaneously), it is best for the clinician to speak in manageable segments to avoid omissions in the delivery of the messages.

Practice point 9: In a multidisciplinary team consultation, clinicians ensure adequate speech rate, pauses and turn taking for all parties to facilitate good quality and accurate conveyance of messages to the person

If interlocutors do not observe turn taking, this will result in overlapping speech and content loss, damaging the accuracy of interpretation.

Clinicians do not need to give the interpreter a turn to talk if they are talking amongst each other or with a family member. In these situations, interpreters keep the person informed by interpreting simultaneously in the chuchotage (i.e. whispering) mode. Interpreters have to keep people 'linguistically present' even when clinicians are having a discussion among themselves or with family members.

Should the interpreter experience difficulty interpreting in the consultation that involves a number of family members as well as a multidisciplinary team, they will indicate this by raising their hand, or interrupting if they are interpreting by phone, and asking participants to speak one at a time.

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ATTACHMENT A: RESOURCES

Access to interpreting services

Free Interpreting Service for private medical practitioners

www.dss.gov.au/settlement-services/programs-policy/settle-in-australia/language-services/free-interpreting-service/free-interpreting-service-for-private-medical-practitioners-0

- Doctors Priority Line, through TIS National, for private medical practitioners 1300 575 847 (further information at www.tisnational.gov.au)

Free interpreting services for pharmacists

www.dss.gov.au/settlement-services/programs-policy/settle-in-australia/language-services/free-interpreting-service/free-interpreting-service-for-pharmacies

National Auslan Interpreter Booking and Payment Service

www.nabs.org.au

- Free for private health care appointments for Deaf people who are not eligible for the National Disability Insurance Scheme

Working with interpreters

Using Interpreters – a Guide for GPs (C. Phillips, Australian family physician, 2010)

<https://www.racgp.org.au/afp/201004/36589>

Medical interpreting: Improving Communication with Your Patients (H. Tebble, 1998)

<https://eric.ed.gov/?id=ED426614>

Translated health resources

Health Translations is an initiative of the Victorian Government, managed by Centre for Culture, Ethnicity and Health. The platform provides access to reliable, accurate, and up to date health information in many languages.

www.healthtranslations.vic.gov.au

Resource collections

Subject Portal: Resources in Refugee and Migrant Health, Royal Australian College of General Practitioners

www.racgp.org.au/support/library/subject-portals/refugee/

Curated Collection: Refugee and Immigrant Health, Royal Australian College of Physicians

www.racp.edu.au/fellows/resources/curated-collections/refugee-and-immigrant-health

Resources, Refugee Health Network Queensland

www.refugeehealthnetworkqld.org.au/resources/

Resources for practices

Appointment reminder translation tool, NSW Refugee Health Service

<https://www.swslhd.health.nsw.gov.au/refugee/appointment/>

Find your language tool, Health Translations Directory

http://healthtranslations.vic.gov.au/bhcv2/bhcht.nsf/pages/find_your_language

ATTACHMENT B: COMPETENCY STANDARDS FOR CLINICIANS

Domain 1: Clinical Expert

Competency standard 1 – Clinicians understand, and respond to, the individual, cultural and social considerations in the provision of quality and safe care to people from migrant and refugee backgrounds

- 1.1 Clinicians respond sensitively and without assumptions to the diversity of individual characteristics and social determinants of health—including cultural, religious or spiritual and linguistic considerations, health beliefs, individual abilities, choices and preferences—and modify their approach as appropriate.
- 1.2 Clinicians recognise the impact of refugee-like experiences, including experiences of traumatic events and post-traumatic stress disorder, and take these experiences into account during the assessment, diagnosis, treatment and ongoing care to modify their approach as appropriate and to provide trauma-informed care.
- 1.3 Clinicians recognise ethno-specific variations and health disparities of people from migrant and refugee backgrounds.
- 1.4 Clinicians recognise the family and community context of people from migrant and refugee backgrounds and its impact on consent, treatment and follow up.

Competency standard 2 – Clinicians understand, and respond to, barriers to quality and safe care experienced by people from migrant and refugee backgrounds

- 2.1 Clinicians acknowledge and address barriers to discussing the risks and benefits of a proposed procedure, and obtaining informed consent.
- 2.2 Clinicians acknowledge and address barriers to quality use of medicines and ensure education about medication safety.

Competency standard 3 – Clinicians are aware of medico-legal responsibility in ensuring effective communication when working with people with limited English proficiency and deaf people from migrant and refugee backgrounds

- 3.1 Clinicians understand the medico-legal risks of:
 - failing to determine the need for an interpreter;
 - failing to engage an interpreter, if assessed as necessary, even if the person does not request an interpreter; and
 - failing to respond appropriately if the person refuses an interpreter.
- 3.2 Clinicians understand the medico-legal implications of failing to engage an interpreter especially when:
 - assessing the decision-making capacity of the person;
 - obtaining consent for a procedure; and
 - starting or adjusting complex medications.
- 3.3 Clinicians do not engage minors and do not rely on family members, intimate partners, friends, and web-based translation applications to facilitate interpretation.

Domain 2: Communicator

Competency standard 4 – Clinicians understand the impact of linguistic differences on communication and respond to communication needs of people from migrant and refugee backgrounds

- 4.1 Clinicians respect people's right to communication assistance and ensure that an interpreter, appropriate to the person's language and gender-concordance preferences (including a Auslan/English or a Deaf interpreter), is engaged when assessed as necessary or requested by the person.

Competency standard 5 – Clinicians understand the impact of cultural and linguistic differences on participation of people from migrant and refugee backgrounds in their care and support their informed decision-making

- 5.1 Clinicians provide clear, accurate, culturally appropriate and timely information in appropriate formats to enable people to understand the health issues being discussed, including the diagnosis, management and recommended follow up.
- 5.2 Clinicians recognise that people may require involvement of their families in managing their health issues and provide adequate information to those whom the person wishes to include in their care.
- 5.3 Clinicians gather feedback from people in an appropriate manner and recognise the impact of language, literacy and cultural considerations on the person's participation in their care.

Domain 3: Collaborator

Competency standard 6 – Clinicians collaborate with other healthcare professionals within the health service organisation and across networks

- 6.1 Clinicians undertake effective handover of care, through both verbal and written communication, including information about relevant individual cultural and linguistic considerations, needs and preferences.
- 6.2 Clinicians build and use referrals—across community health and allied health sectors—to support the provision of quality and safe health care.

Competency standard 7 – Clinicians collaborate with interpreters as non-clinical members of a healthcare team and within the scope of the interpreter's practice

- 7.1 Clinicians recognise the role of interpreters in healthcare settings, including their skills, responsibilities and scope of practice.
- 7.2 Clinicians work effectively with interpreters, following *Practice points for clinicians working with interpreters in healthcare settings*.

Domain 4: Leader

Competency standard 8 –
Clinicians contribute to
whole-of-organisation
cultural responsiveness

- 8.1 Clinicians lead the creation of culturally responsive and accessible environments by informing whole-of-organisation practices that:
- recognise and respond to cultural differences in the provision of care;
 - enable community input; and
 - collect relevant data.
- 8.2 Clinicians promote a whole-of-organisation use of interpreting services by informing persons about their right to access interpreting services, and by ensuring that their clinical and non-clinical colleagues have information about:
- when an interpreter may be required;
 - how to arrange for an appropriate interpreter; and
 - the importance of documenting the need for an interpreter in the patient management system once the need is identified.

Domain 5: Health Advocate

Competency standard 9 –
Clinicians contribute to
enhancing health literacy
and health system literacy
of people from migrant
and refugee backgrounds

- 9.1 Clinicians incorporate health literacy, preventative health education, and health system literacy in their work, taking into account relevant individual cultural, linguistic and literacy considerations, as well as pre-migration experiences.
- 9.2 Clinicians support migrant and refugee communities to facilitate community-led health literacy and preventive health activities by actively seeking community insights on their needs and by contributing to appropriate responses, including education and resource development.

Domain 6: Scholar

Competency standard 10 –
Clinicians are committed to
incorporating education about
meeting the healthcare needs
of people from migrant and
refugee backgrounds in the
provision of care and in their
continuing learning activities

- 10.1 Clinicians continually learn and develop cultural responsiveness, including learning how to work effectively with interpreters, by attending courses, in-service programs and reading journals, and by demonstrating awareness of practical, informed and quality data and research regarding cultural diversity demographics and population health.
- 10.2 Clinicians maintain ongoing practice innovation through the use of resources, including technology, to facilitate the provision of culturally responsive care to people from migrant and refugee backgrounds.

Competency standard 11 –
Clinicians are committed
to teaching others about
the provision of culturally
responsive care

- 11.1 Clinicians contribute to improving the cultural responsiveness of the profession, both within their own discipline and interprofessionally, through modelling appropriate conduct, teaching students, peer learning, review and practice support.

Domain 7: Professional

Competency standard 12 –
Clinicians are committed
to cultural responsiveness,
reflexivity and self-awareness
in all aspects of practice

- 12.1 Clinicians develop and maintain an awareness of their own culture, beliefs, values and biases, and their impact on the clinician's interactions in healthcare settings.
- 12.2 Clinicians recognise the presence, and understand the impact, of systemic biases in institutional policies, resource allocation, and laws.
- 12.3 Clinicians adhere to high ethical standards and are committed to the principles of:
- person-centred and family-focused care;
 - access and equity;
 - quality and safety;
 - dignity and respect; and
 - effective communication

when providing culturally responsive care to people from migrant and refugee backgrounds.

