An Evaluation of Uptake and Experience of a Pilot Interpreting Service in General Practice in the HSE Eastern Region

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PREFACE

Migration brings a diversity of cultures and languages to host countries. This poses specific challenges for host healthcare systems. The fact that healthcare providers and migrant service users often struggle with a language barrier is a specific challenge that can interfere with information sharing and processes of care. Responding to this, international contemporary health policies recommend the use of professional, paid interpreting to address language barriers rather than informal interpreting involving bilingual health workers or people from service users’ social networks, for instance family members or friends (Department of Health and Human Services Office of Minority Health, 2001; Department of Health, 2004).

Ireland has experienced unprecedented inward migration and with this comes an unprecedented cultural and linguistic diversity\(^1\). The context around social integration is ever-changing in terms of political approaches and responses and, also, in terms of the pattern and scale of migration. The current recession, for example, is likely to have an impact on inward migration. However, many migrants will remain and migration experts emphasise that issues of interculturalism and integration will continue to be important ones for the Irish context (MacEinri, 2008).

Estimates suggest 200 spoken languages are currently in use here (National Consultative Committee on Racism and Interculturalism (NCCRI), 2008). In the healthcare sector, negative effects of language barriers have been documented and we know that the lack of a national interpreting service, staffed by trained interpreters and subject to ongoing monitoring and evaluation, is a problem for service providers and service users. In line with current international policy in this area, the National Intercultural Health Strategy 2007-2012 (Health Service Executive, 2008), a focussed health strategy for addressing health and social care needs of ethnic minority communities, prioritises the development of appropriate interpreting services to respond to the challenges of linguistic diversity in the healthcare setting.

In September 2005, the Health Service Executive initiated a free pilot interpreting service in the former Eastern Regional Health Authority area, now known as the HSE Eastern Region\(^2\). However, an initial assessment of use after six months showed that uptake of the service by general practitioners was very low. Therefore, the Health Service Executive, as part of its implementation priorities

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1 These new languages add to the already bilingual context in Ireland of English and Gaelic speakers.

2 This service is still in place at this time.
for the National Intercultural Health Strategy, commissioned this combined methods evaluation of the pilot interpreting service to explore the ‘gap’ between the demand from general practitioners for an interpreting service and the evidence of their low uptake of that service when made available free of charge.

The primary remit of this project was to focus on general practitioners’ experiences and uptake of the service. The project did not have a remit to evaluate the nature or quality of interpreting being provided. In order to contextualise the experiences of general practitioners, we also explored as much as possible key issues with general practice administrative staff, ethnic minority community representatives and representatives of the interpreting sector. The outcome of this process of engagement and dialogue far exceeded our expectations: it provided a depth and breadth to the research for which we, as researchers, are deeply grateful. It also strongly and persuasively confirms the value of a multi-stakeholder approach to research. Such research is capable of generating negotiated solutions to commonly shared healthcare problems. To this end, as suggested in our recommendations at the end of the report, we urge the use of participatory approaches to create partnerships, support dialogue and generate solutions. This will lead to further learning to inform models of interpreting services and the identification of sustainable, workable and effective strategies for improving the management of language barriers in Irish (multicultural) general practice.

Acknowledgements

We begin our acknowledgements by sincerely thanking all our participants who gave their time, energy and considerable expertise to the research. Particular thanks to non-governmental organisations Access Ireland, Cairde and SPIRASI for facilitating access to members of ethnic minority communities in the research area.

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Finally, we acknowledge the contribution of our research steering group: Sherif Gayed, Lionbridge International, Dublin; Austin O’ Carroll, Mountjoy Street Family Practice, Dublin; Mary Phelan, Dublin City University; Philip Watt, National
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Responsibility for any errors lies with the authors.

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EXECUTIVE SUMMARY

1. Overview of the Present Study

1.1. Background
In September 2005, the Health Service Executive initiated a free pilot interpreting service in the former HSE Eastern Region. The functional area of this health authority was the county borough of Dublin and the administrative counties South Dublin, Fingal, Dún Laoghaire-Rathdown, Kildare and Wicklow (see Map page 20). The service, provided by a commercial interpreting company, was available to all general practitioners in the area.

It is important to emphasise that the impetus for the project came from the general practice community. General practitioners had reported that language barriers were a major problem for them in their work with service users with limited English and they called for resources for interpreting services (Crowley, 2003). In response, the Department of Health and Children provided funding for a pilot interpreting service for general practitioners. For the Health Service Executive, the development of the pilot interpreting service linked positively with the recommendations of the Eastern Regional Health Authority Strategy for Ethnic Minority Service Users (2004). The HSE Social Inclusion Unit and Primary, Community and Continuing Care (PCCC) directorate, in collaboration with the Irish College of General Practitioners, undertook extensive preparations for the development and initiation of the service (see Chapter 1 page 17-21 for full details of the impetus and development of the pilot interpreting service).

However, an initial assessment of use after six months showed that uptake of the service by general practitioners was very low. Therefore, the Health Service Executive, as part of its implementation priorities for the National Intercultural Health Strategy, commissioned this combined methods evaluation of the pilot interpreting service to explore the ‘gap’ between the demand from general practitioners for an interpreting service and the evidence of their low uptake of that service when made available free of charge.

In terms of exploring this phenomenon, current perspectives in the international literature suggest that it is valuable to adopt an organisational perspective to understand why service provision does not guarantee service uptake. More specifically, we need to explore levers and barriers to uptake and the wider context in which these occur (see Chapter 2 pages 22-23 for further details of the rationale for an organisational perspective for this issue). These facts and
perspectives inform the present study in terms of focus, identification of key aims and objectives, research context, approach, and methodology.

1.2 Key Aims and Objectives of the Study

The primary aim of the present research is to evaluate general practitioners’ uptake and experiences of paid interpreters available through the free pilot interpreting service in the Eastern Region. The specific objectives of the research are to:

1. evaluate general practitioners’ uptake and experiences of paid interpreting to identify levers and barriers to its use in routine general practice
2. engage in a two-way educative dialogue with general practitioners and related key stakeholders about language barriers and interpreting
3. identify strategies likely to improve general practitioners’ uptake of paid interpreters in routine general practice.

1.3 Research Context and Approach

Our research is informed and supported by a whole systems analysis. This means we view the general practice as an organisation in and of itself. It has established structures and systems, policies and cultural norms which operate across macro and micro levels of the organisation. These shape behaviours which are acted out by people in time and space. Generally, the stability of an organisation depends on routine ways of working that are ‘taken for granted’ by people in their daily activity.

When a complex intervention, such as interpreted consultations, is introduced, it places a whole series of new demands on the organisation and its workers. The organisation and its workers have to stretch their boundaries to try and incorporate new ways of working into daily activity. Sometimes, organisational structures, systems, policies and cultural norms are modified and adapted, and behaviours are re-examined and re-shaped so that the intervention can be implemented across the organisation. When this occurs, the complex intervention is accepted as being ‘workable’ and becomes ‘normalised’. However, it is very difficult for complex interventions to be normalised. They are frequently rejected as unworkable, are rarely accessed or used, and are not normalised.
In this study, the *interpreted consultation* is viewed as a complex intervention which is introduced into the organisational system, the practice. Intended to ameliorate the problem of language barriers in healthcare consultations, ideally it needs to be implemented and, over time, become a routine event in the day-to-day activity of a surgery. However, the initial low uptake by general practitioners of the free pilot interpreting service reflects the difficulties associated with normalisation of complex interventions and begs many questions. What factors contributed to that? Were they macro level factors, like organisational policy? Were they micro level factors, such as a lack of confidence between the two professionals involved with a service user in an interpreted consultation? What experiences promoted uptake of the interpreting service? What experiences detracted from it? What are the key levers and barriers to implementation of this complex intervention? In what conditions does an interpreted medical consultation become normalised, that is, embedded as a routine and ‘taken for granted’ element of clinical practice? This study set out to address these key questions.

1.4 Summary of Key Methods

The key methods used during this study are summarised below. Full details of our methodology are provided in Chapter 2.

This is a combined methods study comprising a quantitative and a qualitative component.

*Quantitative Research*

The quantitative research is an analysis of uptake of the available pilot interpreting service by general practices in the study region, identifying patterns of use, the range of languages for which interpreting was requested, the modes of interpreting (telephonic or on-site) and the costs of service provision for the evaluation period. The quantitative analysis covers the period from February 2006 to the end of October 2007.

*Qualitative Research*

The qualitative analysis draws from the fields of sociology and anthropology. We adopt a Participatory Learning and Action (PLA) mode of engagement with research participants where possible and appropriate (Chambers, 1994).
We also draw heavily on a recently developed sociological model, the Normalisation Process Model (NPM) (May, 2006). The NPM encourages ‘whole system’ analyses and has been developed to explain and predict the implementation of complex interventions in healthcare settings.

The model comprises four domains that attend to macro and micro level issues:

1. the organisational context and setting
2. skills for implementing interpreted consultations
3. relationships among the network of actors
4. interactions between healthcare providers and service users.

We use these domains to shape our thinking, analysis and presentation of results, discussion and recommendations throughout the report.

**Quantitative Research – Sampling**

Our principal target group for the quantitative component of the study was general practitioners within the study region. Records provided by the Health Service Executive, coupled with records of logged requests from the interpreting company mandated to provide the pilot interpreting service, enabled us to identify the full cohort of 160 general practitioners who signed up for the service in 2005. This cohort comprised our ‘universe’ for this component of the study.

**Qualitative Research – Sampling**

Our principal target group for the qualitative component of the study was general practitioners within the study region; we also accessed representatives of general practice administrative staff, ethnic minority service users and representatives of the interpreting sector.

We followed the principles of non-probability purposeful sampling and critical case sampling (Patton, 1990; Kane and O’Reilly-de Brún, 2001) to identify a research participant group comprising a balance of ‘highest frequency’, ‘infrequent’ and ‘non-users’ of the pilot interpreting service from the cohort of 160 general practitioners.
We identified questions for the research process in an ongoing iterative manner informed by a PLA mode of engagement, and the four domains of the NPM. We engaged in face-to-face interviews, focus groups and telephone interviews to generate data.

Fieldwork for the qualitative component took place between February and July 2008 (Round 1) and again during September and October 2008 (Round 2). Each category of service user was well represented across both rounds of data generation. The total number of participants in the research was 41. The total number of data generation encounters was 43.

Data analysis followed the principles of thematic analysis using the constant comparative method (Silverman, 1993). Results of the thematic analysis were ‘mapped’ against the Normalisation Process Model (May, 2006) to generate ‘higher order’ categories.

2. Key Findings

We set out the study findings in extensive detail in Chapter 3 (pages 36-112). Here, we present key findings from the quantitative and qualitative components of the study.

Quantitative Component

The quantitative analysis presents findings across the extended 21 month period of the pilot service from February 2006 to October 2007 and provides a contextual backdrop for the qualitative component of the study.

We see an upward trend in levels of uptake from the initial HSE review, both in terms of the number of practices requesting the service and the number of interpreting sessions requested per practice. There is a rise from 19 to 39 practices requesting the service. However, this demand represents just a quarter of the entire cohort of 160 practices that first signed up for the service in 2005. One hundred and twenty one practices who also signed up have never accessed the service to request an interpreter.

Furthermore, while there is a general upward trend, there are ‘highest frequency’ and ‘infrequent’ users of the interpreting service and this means that a pattern of a relatively small number of dedicated users emerges. Assessed in terms of the
overall uptake of 293 sessions, the top six service users account for 58% of all uptake.

Interpreting was provided in 37 separate languages. Romanian, Polish, French, Arabic and Russian were the five most frequently required, together making up 191 of the total 293 interpreted consultations (65%). These languages are reflective of frequently spoken languages in modern Ireland, for example Polish, French and Arabic are among the top ten languages spoken (see Pieper et al., 2008).

Finally, in relation to cost, the analysis shows a relatively even spread of costs for 2006 and 2007; the breakdown is €3,673.50 in 2006 (11 months) and €3,084.04 in 2007 (10 months). While the overall upward trend in uptake levels might suggest substantially higher costs would be incurred, we must remember that interpreting sessions can be of varying lengths and are costed accordingly; a higher number of sessions in a given period does not necessarily mean higher costs.

Qualitative Component

The qualitative analysis is based on data generated during face-to-face and telephone interviews with general practitioners, and either focus group sessions or face-to-face interviews with representatives of ethnic minority communities and the interpreting sector. ‘Pilot company interpreter’ is the term we use to refer to a representative of the commercial company providing the pilot interpreting service. The company manager explained that the company provides one full day’s intensive in-house training to their new interpreters. The new interpreters also participate in a ‘buddy’ system, accompanying a company interpreter to the courts for one day and they receive training from the United Nations High Commission for Refugees on interpreting in a refugee context. 3

We also refer to paid ‘independent interpreters’. ‘Independent interpreter’ is a term we use to refer to two interpreters who participated in the research and who are not working for the company providing the pilot interpreting service. During the course of the research we established that these independent interpreters were trained in-house with an NGO that works with ethnic minority communities.

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3 UNHCR training is for half a day and is presented by a member of the UNHCR team in Dublin. This training targets interpreters who provide interpreting services in the different stages of the asylum process. Although it is not focused on medical settings, it addresses many similar issues: the focus is on interpreting for people who have been through trauma, people with high levels of anxiety, and in situations that are life-changing where accuracy of the interpreting and independence of the interpreter are of paramount importance.
They received three intensive days training. This included details of the NGO’s own ‘Code of Practice’ which they are required to follow in their work. On completion of their training, they received a Certificate from the NGO. They then worked in-house with six health professionals (medical, legal, psychotherapeutic, psychological, psychosocial and complementary therapy) and completed six successful hours of interpreting across these fields before being considered ready to work as in-house interpreters. One independent interpreter also had Graduate Certificate in Community Interpreting from Dublin City University.

‘Service user representatives’ is the term we use to refer to those participants who were representing ethnic minority service users in ‘new communities’ in the study region.

Our qualitative analysis is layered and presented as seen through the lens of the Normalisation Process Model. Through this, we have identified 4 levers and 12 barriers to uptake of the pilot interpreting service from the particular perspectives and context of general practitioners who had access to the service. The tables below show a synthesis of the key levers and barriers within each domain of the NPM. In column 1 of each table, we show the themes that emerged for each domain. Levers and barriers are shown in columns 2 and 3 respectively. The final column describes the relevance of these levers and barriers to normalisation of interpreted consultations in this setting. A lever suggests a positive influence and a barrier a negative influence. Assessing these vis-à-vis each other, we can assign a ‘weighting’ regarding the likelihood of normalisation (high, medium, low). For instance, the first row relates to policy and its relevance for normalisation. Reading across the table, we see that there is a lever around policy at practice level. This has a modest influence on uptake but is ‘countered’ by a barrier relating to policies at national level. We conclude that in relation to the theme ‘policy’, the likelihood of normalisation of interpreted consultations is LOW.

Each theme can be read across the Tables in the manner we have described here for ‘policy’.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Levers to uptake</th>
<th>Barriers to uptake</th>
<th>Likelihood of normalisation of IC*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POLICY</strong></td>
<td><strong>L1.</strong> Some practices have policies of inclusive access for all service users: ‘policy of inclusion’</td>
<td><strong>B1.</strong> No knowledge of national policy about intercultural health.</td>
<td>The lever around policy at practice level has modest influence on uptake and is ‘countered’ by the barriers relating to policies at national level. <strong>LOW</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>B2.</strong> Scepticism about availability of resources to implement national policies generally</td>
<td></td>
</tr>
<tr>
<td><strong>KNOWLEDGE</strong></td>
<td><strong>L2.</strong> During educative dialogue, researcher provided information about the available pilot service to GPs.</td>
<td><strong>B3.</strong> GP and ethnic minority service users’ knowledge of the available pilot service is limited.</td>
<td>The impact of information provided by researcher to GPs was modest (for practical reasons, given the scale of the research). Overall, the knowledge base of the pilot service was very low. <strong>LOW</strong></td>
</tr>
<tr>
<td><strong>ABLE WORKFORCE</strong></td>
<td>None documented</td>
<td><strong>B4.</strong> No training was planned or provided to general practice staff re implementation of interpreted consultations.</td>
<td>Training was absent and there are no documented levers around this. <strong>LOW</strong></td>
</tr>
<tr>
<td><strong>TIME PRESSURE &amp; FINANCIAL PRESSURE</strong></td>
<td>None documented</td>
<td><strong>B5.</strong> Uptake of available service was associated with serious time pressures by general practice staff.</td>
<td>The time pressure is a major issue for GPs across the board. The financial pressure is problematic for some GPs. There are no levers around either of these. <strong>VERY LOW</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>B6.</strong> Uptake of service was associated with loss in earning power for some general practice staff.</td>
<td></td>
</tr>
</tbody>
</table>

*IC = Interpreted Consultation
**Skills among General Practice Staff for Implementation of Interpreted Consultations**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Levers to uptake</th>
<th>Barriers to uptake</th>
<th>Likelihood of normalisation of IC*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TASKS &amp; DUTIES</strong></td>
<td>L3. Many new tasks and duties are compatible with existing administrative staff roles and identities.</td>
<td>B7. New skills for assessing need for interpreting and choosing appropriate interpreting mode occur 'on-the-job' – without formal training or support.</td>
<td>The lever relating to skills compatibility is 'countered' by a barrier relating to a gap in skills base for implementation work. MEDIUM</td>
</tr>
<tr>
<td><strong>TRAINING</strong></td>
<td>None documented</td>
<td>B8. Training for implementation of interpreted consultations was not emphasised by many GPs.</td>
<td>The need for training was not initially emphasised by many GPs; following educative dialogue, there was a favourable response to suggestions around training for GPs. MEDIUM</td>
</tr>
</tbody>
</table>

**Professional Relationships and Confidence between GPs, interpreters and service users**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Levers to uptake</th>
<th>Barriers to uptake</th>
<th>Likelihood of normalisation of IC*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERPRETERS FROM CURRENT SERVICE</strong></td>
<td>None documented</td>
<td>B9. GPs and service users have mixed confidence re knowledge and expertise of interpreters from current service.</td>
<td>Taken together, these barriers undermine confidence between the parties involved in an interpreted consultation. VERY LOW</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B10. GPs and service users have limited understanding about roles, responsibilities and professional needs of interpreters.</td>
<td></td>
</tr>
<tr>
<td><strong>ALTERNATIVE STRATEGIES</strong></td>
<td>None documented</td>
<td>B11. GPs and service users expressed some confidence in informal strategies (friend/family member as interpreter) used along with, or in preference to, the available service.</td>
<td>Confidence in alternative strategies circumvents use of interpreted consultations available through the pilot service. VERY LOW</td>
</tr>
</tbody>
</table>


*IC = Interpreted Consultation
Interactions in the Interpreted Consultation

<table>
<thead>
<tr>
<th>Levers to uptake</th>
<th>Barriers to uptake</th>
<th>Likelihood of normalisation of IC*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONSULTATION GOALS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L4. Some GPs consider that the use of a formal interpreter enables ‘better’ consultations.</td>
<td>B12. Use of interpreter can be a challenging communication event for the GP which frustrates the work of the consultation.</td>
<td>The lever is ‘countered’ by a barrier: the use of interpreters may enable or deflect the work of the consultation. MEDIUM</td>
</tr>
</tbody>
</table>

*IC = Interpreted Consultation

Finally, the table below describes the overall likelihood of normalisation per domain. Here, we consider the weighting for normalisation per theme in each domain and provide an overall weighting for the domain. For instance, the weightings for normalisation in the table on organizational setting for policy (LOW), knowledge (LOW), able workforce (LOW), time pressures and financial pressure (VERY LOW) are given an accumulative weighting of VERY LOW.

**Overall Assessment of Likelihood of Normalisation**

<table>
<thead>
<tr>
<th>1. Organisational setting</th>
<th>2. Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VERY LOW</strong></td>
<td><strong>MEDIUM/LOW</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Relationships and confidence</th>
<th>4. Interactions in the interpreted consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VERY LOW</strong></td>
<td><strong>MEDIUM/LOW</strong></td>
</tr>
</tbody>
</table>
3. Recommendations

This whole system analysis shows there is no single strong component in the entire system. There are two very weak components. We conclude that the likelihood of normalisation of interpreted consultations in these general practices is very low. There are a range of actions required to address the weaknesses documented. We set out seven recommendations drawn from our learning across participant groups. These are explained in full in Chapter 4 (pages 113-127) and are presented in summary form here. A key point about these recommendations is that most of them require effective inter-agency collaboration between all key stakeholder groups:

- NGOs working with ethnic minority communities
- The commercial interpreting companies providing interpreting in medical settings
- Academics with expertise in interpreting in medical settings
- The Irish Translators’ and Interpreters’ Association (ITIA)
- General practitioners using the commercial interpreting companies
- The Irish College of General Practitioners and
- Relevant offices in the HSE.

This means that all stakeholder groups can shape the various ideas and activities featured in these recommendations.

There are two fundamental issues running through these recommendations. First, the likelihood of normalisation will improve if Irish general practices have more commitment to (see L1 above), and capacity for (see B5 and B6), incorporating interpreted consultations into their routine work. To date, there is a ‘gap’ between commitment and allocation of resources to enhance practice capacity. Second, there is a need for more attention to the issue of training for the professional groups involved. Given the limited knowledge and skills of general practitioners about interpreting (see B7, B8, B10 and B11), general practitioners would benefit from training about language barriers, interculturalism, good practice in interpreting, and skills for working in interpreted consultations. Given the accounts of variable quality in interpreting practice reported here (see B9 and B12), all interpreters working in medical settings should be fully trained and professionally accredited. This view is supported by recent research by the NCCRI.

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4 Academics at Dublin City University’s School of Applied Language and Intercultural Studies offer a Graduate Certificate in Community Interpreting and would be important experts to include in the recommended inter-agency activities

5 Interculturalism is a large area of study. The training mentioned here would need to be based on selected material appropriate to issues of language barriers and the use of interpreters.
(2008) which recommended improvements in training and accreditation across the interpreting sector. Following implementation of these recommendations around training for general practitioners and interpreters, multiperspectival monitoring and evaluation of service provision and service use should be undertaken.

**Domain 1: Organisational Setting**

**Recommendation 1**
General practices, as ‘local level’ organisations, should develop clear written policies of inclusion that reflect HSE core values and national equality legislation. There is an important role for the Irish College of General Practitioners in this area.

**Recommendation 2**
The HSE Social Inclusion Unit, under the auspices of the 2008 HSE National Strategy on User Involvement and following on from the HSE National Intercultural Health Strategy, should continue their work on the development of congruent policy about language barriers with the involvement of service users, the Irish College of General Practitioners, the interpreting sector and national policy makers with a remit for general practice. We recommend the use of a participatory dialogue approach to this process.

**Recommendation 3**
Advertising and dissemination processes need to be reviewed. This should be done with direct input from key stakeholder representatives who have ideas about how this can be achieved. This review could be part of the HSE led participatory dialogue outlined in Recommendation 2 and should be seen as a shared and supported task across stakeholder groups. It should be complemented by other approaches and resources: use of peer to peer networks and, also with reference to national equality legislation.

**Recommendation 4**
The reviewed advertising and dissemination process should take place as part of a broader, HSE initiated project designed to guide and support the implementation of interpreted consultations in routine general practice.

**Recommendation 5**
Irish general practice should examine its organisational culture and the extent to which that culture does or does not support equal access and equal treatment for

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*http://www.hse.ie/eng/Your_Service_Your_Say/Service_User_Involvement_in_the_Health_Services/
service users with limited English proficiency, with particular reference to international policies and recommendations about people's right to have access to primary health care. The ICGP and the Irish Medical Council would have a central role in this in terms of supportive education and training initiatives.

**Domain 2: Skills**

**Recommendation 6**

A training package about the implementation of interpreted consultations should be designed and monitored in a participatory manner with input from all key stakeholder groups and made available to general practice staff. Key content for the training package would be general information on interculturalism, the impact of language barriers for service users, good practice in interpreting, and skills development for working in interpreted consultations. This participatory design would ensure that the training package is, and remains, responsive to all stakeholder needs and developing principles of best practice. The package could be designed as, or include, a practice based demonstration at the practice itself or at ICGP Continuing Medical Education meetings. This action could be part of the HSE initiated participatory forum outlined in recommendation 2.

**Domain 3: Relationships and Confidence**

**Recommendation 7**

Together with implementation of recommendations around training for general practitioners and interpreters, formative monitoring and evaluation of service provision and service use of interpreted consultations in general practice should take place, be independent, and take into account all stakeholders’ perspectives.

**Domain 4: Interactions in the Consultation**

The NPM analysis suggests that if recommendations 1-7 are put in place, this would positively affect the immediate interaction of the consultation. For example, the general practice organisation would modify its policy and culture to support a long consultation if deemed necessary for the service user. The general practitioner and interpreter would have necessary training and skills for participating in the triad and ought to feel confident and comfortable in their respective roles. The knowledge being shared and mediated between these

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7 The UK General Medical Council sets the standards for knowledge, skills, attitudes and behaviours that medical students should learn at UK medical schools. These standards are set out in Tomorrow’s Doctors (2003), which is available at http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/tomorrows_doctors.asp
people should be authentic for each of them. This would all feed into the experiences of the immediate face-to-face interaction for everyone involved. This is important because if the time is made available, and if the interplay of roles is experienced positively by those involved, this should enable the positive flow of communication, and engender a feeling of authenticity and a sense of confirmation for all parties about who they are and what they are doing in this face-to-face interaction.

Finally, as explicated in all recommendations, we urge the use of participatory approaches to create partnerships, support dialogue and generate solutions. This will lead to the identification of sustainable, workable and effective strategies for improving the management of language barriers in Irish (multicultural) general practice.
CHAPTER 1 INTRODUCTION

In this chapter, we set out the broad context in relation to migration and linguistic diversity and clarify terminology in the field and in this report. We then focus on the Irish context and its evolving response to new linguistic diversity. We review international and national literature about experiences and management of language barriers in health care, leading to a discussion about the benefits of looking at the issue from an organisational perspective. Finally, we set out the aims and objectives of the present research.

1.1 Migration and Linguistic Diversity

Migration brings a diversity of cultures and languages to host countries. This poses specific challenges for host healthcare systems because the well acknowledged power imbalance and knowledge differential between ‘lay’ and ‘professional’ is layered with a cross cultural element (see Stacey, 1988; Helman, 2007; Ferguson and Candib, 2002). The fact that healthcare providers and migrant service users may not have a shared language is a specific challenge. This challenge warrants attention because language barriers:

- produce significant detrimental effects on the quality of care
- lead to difficulties for service users’ understanding of medications
- reduce service user satisfaction.

There is also an associative relationship between language barriers and health status and health outcomes (Timmins, 2002).

For these reasons, and to ensure quality and safety for migrant service users, appropriate support to address language barriers is seen as the cornerstone of a culturally competent healthcare system. International contemporary health policies recommend the use of professional, paid interpreting rather than informal interpreting involving bilingual health workers or people from service users’ social networks, for instance family members or friends (Department of Health and Human Services Office of Minority Health, 2001; Department of Health, 2004).

1.1.1 Clarifying and Defining Terms

For the purposes of accuracy, we wish to elucidate the meanings of some of the terms mentioned above that are commonly used in this field, in order to
distinguish between different types of interpreters and different types of responses to the challenge of the language barrier.

Policies do set out a preference for ‘professional paid interpreters’. However, in practice, not all paid interpreters are professional: they are not necessarily trained or certified by accredited bodies, nor do they have membership of relevant professional bodies (e.g. in Ireland) and it can be difficult to decipher whether paid interpreters are regulated by professional bodies (e.g. in England) (MacFarlane, Singleton and Green, 2009). Because of this, the term ‘professional interpreter’ can imply a quality of interpreting and professional practice which may not always be the case.

A bilingual health worker may be a clinician (e.g. nurse, doctor) or ancillary staff member (e.g. cleaner, administrator) who happens to speak the language of a host country and also the language of a migrant service user, but who does not have formal training for the interpreting role.

Cohen et al. (1999:165) characterise interpreting by family members or friends as a situation when someone is brought to the consultation by the patient “having some skills (although they may be quite limited) in translation [sic] between two relevant languages but not having any formal or professional training in the task of interpreting”.

In this report, we follow a recent comparative cross-national analysis of responses to language barriers in health and social care settings (MacFarlane, Singleton and Green, 2009). We categorise strategies used in response to language barriers as ‘formal’ or ‘informal’. Formal strategies include the use of available, paid interpreters who may or may not be trained, certified or accredited. Informal strategies do not involve the use of a paid interpreter. They involve the use of a family member or friend as interpreter, a bilingual health worker as interpreter or other verbal and non-verbal strategies (e.g. the use of mimes or gestures, ‘getting by’ with broken English, using phrase books and dictionaries).

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8 It would be more accurate to use the term ‘interpreting’ here in preference to the term ‘translation’ but we have presented the original quote as is.
1.2 Irish Context: An Evolving Response

*Migration and Integration*

Inward migration is a new phenomenon for Ireland (MacEinri, 2007a). Figures from Census 2006 confirmed that 10.4% of the population was foreign born with this percentage expected to increase to 18% by 2030. The changing socio-economic profile of Ireland over the last 20 years has resulted in it becoming a ‘pulling’ destination for immigrants. However, despite these changes, MacEinri (2007b) highlights that there is no comprehensive, long term integration strategy for Ireland.

Positive initiatives that have taken place, for example the establishment of the post of Minister for Integration (established 2007) and the launch of a Migration Nation Statement (see [http://www.justice.ie/en/JELR/Pages/Migration%20Nation%20Launch](http://www.justice.ie/en/JELR/Pages/Migration%20Nation%20Launch)) are now under threat in terms of their ability to develop and implement integration policy because of the national economic downturn and associated budgetary constraints. The recent government decision to abolish the National Consultative Committee on Racism and Interculturalism[^9] is a prime example of serious cutbacks in the field of integration. These cutbacks may reflect a perception that the current economic downturn will reverse patterns of inward migration or that, at least, the scale of inward migration will be reduced. However, as mentioned in the Preface, while the current recession is likely to have an impact on inward migration, many people remain and migration experts emphasise that issues of interculturalism and integration remain important ones for the Irish context (MacEinri, 2008).

**Intercultural Health Services**

It is imperative that Ireland develops a coherent and comprehensive response to the needs of its migrant communities. The Health Service Executive launched its first ever National Intercultural Health Strategy (2007-2012) early in 2008. This strategy provides a comprehensive framework within which the health and social care needs of people from diverse ethnic and cultural backgrounds may be addressed. The strategy is strongly underpinned by the HSE’s stated vision of “easy access, public confidence and staff pride” and the associated ethos of person centredness, which is a critical component of the HSE Transformation programme. It builds on principles and objectives of the National Health Strategy:

Quality and Fairness (2001) and the Primary Care Health Strategy (2001) and is strongly aligned with other key policies, including the National Strategy for Service User Involvement in the Irish Health Service 2008-2013. The strategy is further underpinned by equality legislation.

The National Intercultural Health Strategy (NIHS) contains a number of recommendations, primarily around improving access to services, enhancement of data to facilitate evidence based planning, and building of staff capacity to enable delivery of responsive, culturally competent services.

Key actions of the NIHS relevant to this study include:

- Identification of information, language and communication as priority areas for attention for service users from migrant communities with limited English proficiency
- Prioritisation of the development of a national interpreting service in Ireland with some evaluation of existing systems of facilitating interpreting to inform the nature and design of that service.

The identification and prioritisation of information, language and communication as issues for the HSE is essential because new patterns of inward migration, described above, bring a new cultural and linguistic diversity to Ireland. It is difficult to ascertain the precise number of languages spoken in Ireland at this time, but present estimates are that there are 200 languages in use (NCCRI, 2008). We know that language is a barrier to communication between service providers and service users. An inter-agency conference about ethnic minority health care held in Galway in January 2007 highlighted this as a major problem around the country and across healthcare settings (see MacFarlane, 2007), indicating clearly that a national interpreting service, staffed by trained interpreters and subject to ongoing monitoring and evaluation, should be in place.

There are some positive developments; for instance, the Health Service Executive has developed an Emergency Multilingual Aid (2009) which is available in 20 languages. This resource for secondary care was rolled out nationally across hospitals from the end of July (see http://www.hse.ie/eng/Publications/services/SocialInclusion/EMA.html). This is designed to assist staff when patients present in acute or emergency situations – it is not intended to replace the services of an interpreter. Also, under the European Refugee Fund, the Health Service Executive are now supporting a project led by Dublin based NGO, Spirasi, one strand of which is the development of a training package for clinicians working with interpreters. However, in broad terms the situation is poor in that there is just one accredited training course for
interpreting (i.e. Dublin City University, School of Applied Language and Intercultural Studies, Graduate Certificate in Community Interpreting) and a small number of unregulated commercial interpreting agencies operating with interpreters who usually do not have accredited training (Phelan, 2006).

In acknowledgment of the importance of working towards provision of professional, accurate, high quality interpreting and translating services for people with low proficiency in English, an extensive research study was led by the National Consultative Committee on Racism and Interculturalism in Ireland (NCCRI)\(^\text{10}\).

A key recommendation of the report of this research, “Developing Quality Cost Effective Interpreting and Translating Services for Government Service Providers in Ireland”, included development of a national policy framework for the provision of interpreting and translating services, to be developed in conjunction with government service providers and other stakeholders. The report also recommended development of a code of practice\(^\text{11}\) and accredited training and standards, together with some arrangements around establishment of a register of accredited translators and interpreters, which could be used by government service providers as a means of sourcing practitioners.

**Intercultural Services in General Practice: Problems and Context**

Irish general practitioners cited the lack of interpreters as the single biggest barrier to offering quality medical care to asylum seekers and refugees (Crowley, 2003) and sought resources for interpreting services.

In response, the Department of Health and Children provided funding in 2005 towards addressing communication needs of general practitioners. In the former HSE Eastern region, this funding was used towards establishment of a free pilot interpreting service for the general practice sector (see map page 20). Development of this service was coordinated by the Director of Social Inclusion of the then South Western Area Health Board in that region in his role as Chair of the Interpretation Subgroup. It was established on foot of recommendations contained in the innovative regional health strategy for ethnic minority communities (2003). Extensive preparation for implementation of the pilot took place in collaboration with the ICGP and with key partners in the National Social Inclusion Unit and in

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\(^\text{10}\) This study was funded by the Reception and Integration Agency of the Department of Justice, Equality and Law Reform; the main functions of this agency were absorbed into the then newly established Office of the Minister for Integration, which continued to support the study.

primary and community areas. Development and implementation of the pilot service continued, uninterrupted, with the establishment of the HSE.

The launch of the NIHS and associated identification of interpreting as a priority issue in intercultural health provision offered a timely opportunity for evaluation of a number of aspects of interpreting, of which this study is a key element.
EASTERN REGIONAL HEALTH AUTHORITY AREA
It is worth highlighting the nature of the relationship between general practitioners and the HSE. In the United Kingdom, general practitioners are part of the National Health Service (NHS); they work for the NHS and have an identity as NHS practitioners. In contrast, Irish general practitioners are independent professionals who have individual contracts with the HSE to provide services. The outcome of this is a different tone to the relationship between the HSE as the administrative body for general practice and Irish general practitioners as self-employed service providers. Within this relationship, for example, the HSE can make services and resources available to general practitioners but the general practitioners are not obliged to use them.

Planning and Roll-Out of Pilot Interpreting Service for General Practice

Following tendering for a commercial interpreting company to deliver a region wide service, four separate notifications were sent to all general practitioners in the region (two via the SWAHB and two via the ICGP). Notifications included concrete materials such as stickers with the contact details of the interpreting agency, and relevant forms around invoicing the HSE. General practitioners were also invited to indicate their interest in participating in a training workshop on multicultural health.

This correspondence was sent out on a planned, phased basis so that general practitioners in the area would be well informed about the project. The final correspondence sent to all general practitioners was an A3 size laminated poster for their waiting rooms. This informed service users in 20 languages that they could ask their general practitioner for an interpreter.

At the same time, regular routine meetings were held by the HSE with the NGOs in the area around general social inclusion issues. Roll-out of the pilot interpreting service was an ongoing agenda item for these meetings.

After this intensive inter-agency advertising campaign, 160 general practices out of 628 ‘signed up’ to participate.

A review after six months indicated that uptake of the service was low. There were only 34 instances of uptake and half of these came from a single practice. The Health Service Executive judged that no discernible pattern had emerged and decided to retain the service.
This formal evaluation was commissioned by the HSE in October 2007. The present research is designed to inform appropriate policy and service developments. It is informed by a review of international and national literature about language barriers in health care which is summarised in the following section.

1.2.1 Language Barriers in Health Care

There are three key themes in the literature in this field. First, international research indicates that the use of informal strategies, specifically unpaid interpreters such as family members, friends or bilingual healthcare workers, can be inadequate and lead to inaccuracies and clinical error (Rhodes, Nocon and Wright, 2003; Elderkin-Thompson et al., 2001; Pochhacker and Kadric, 1999). This practice can have negative cost implications (Flores et al., 2003) and cause disruptions to normative social and familial relations (Ngo-Metzger et al., 2003; Cohen et al., 1999; Burnett and Peel, 2001). For instance, the use of children as interpreters for their parents can put a strain on the dynamics of the parent/child relationship and can also limit the scope of consultations because parents may be reluctant to discuss certain kinds of health issues in front of their children.

Second, despite this evidence of significant problems and risks associated with the use of unpaid informal interpreters and the policy rhetoric outlined above (i.e. health policies advocate the use of professional, paid interpreters), the use of paid interpreters in routine practice is low. In the United Kingdom for instance, provision of qualified, paid interpreters is patchy (Jones, 2007) and use is ad hoc. There is, in fact, a heavy reliance on informal strategies including the use of service users’ family members and friends, and attempts to ‘get by’ with gestures or broken English in health and social care consultations (Greenhalgh et al., 2006 & 2007; Moss et al., 2005; Mirza and Sheridan, 2003; Cohen, Moran Ellis and Smaje, 1999). These findings resonate with studies from other jurisdictions as well, for instance in Europe (Pochhacker and Kadric, 1999; Bischoff et al., 2003) and the United States of America (Lee et al., 2002; Sarver and Baker, 2000; Woloshin et al., 1995).

In Ireland, a telephone survey of general practitioners’ responses to language barriers in consultations with refugees and asylum seekers with limited English found that the need for interpreting was high: 77% of respondents had experience of a consultation in which language assistance was required. Respondents reported very low knowledge of the available paid interpreters and relied, predominately, on informal strategies. Interestingly, when given a choice, general
practitioners in this survey would more often choose informal over formal methods of interpreting, despite the fact that confidentiality was a significant concern (MacFarlane, Glynn, Mosinkie and Murphy, 2008). A qualitative interview study with general practitioners in the same region indicated that general practitioners were broadly satisfied with the use of informal strategies in their day-to-day practice (MacFarlane, Singleton and Green, 2009).

However, in stark contrast, while service users concurred that general practitioners rely heavily on informal strategies (e.g. the use of informal interpreters, dictionaries, phrase books, and mimes/gestures) they reported significant dissatisfaction with this situation, emphasising the burden of work and responsibility placed on them to manage the language barrier. Participants emphasised that, for them, the use of informal interpreters can be inadequate and problematic and can leave them worried, frustrated and with experiences of error and misdiagnosis (MacFarlane, Dzebisova et al., 2009).

Third, language is not the only barrier to consider. There are several studies which elucidate the power relations and the important influences of gender, ethnicity and class in these cross-cultural consultations and the ways in which these become barriers to relationship development and rapport/trust (Green et al., 2003; Greenhalgh et al., 2007; Mirza and Sheridan 2003; Bowler, 1993).

From this perspective, spoken language is not the only barrier for service users with limited/no English. Other socio-cultural elements are also at play. These relate to more subtle and intangible language(s), for instance the ‘tone’ of the encounter and the way in which this is linked to perceived gendered racialisation (Bowes and Domokos, 1995; Mirza and Sheridan, 2003; Green et al., 2003). This has been reported in the Irish context in terms of Eastern European service users’ expectations of the consultation style and delivery which is grounded in their contact with and ‘formation’ as patients in a different cultural context (MacFarlane and de Brún, in press). An example of this is that participants were more used to and comfortable with the more ‘authoritarian’ style of Eastern European doctors compared with the ‘consultative’ style of western-trained general practitioners.

1.2.2 Summary of Literature

To summarise, we know that a formal strategy (the use of a paid, ideally qualified, interpreter) provides the most accurate interpreting and, most likely, the safest consultation. Ideally, it would be completely routine for general practitioners to employ this strategy in their day-to-day practice with service users from ethnic
minority communities who have limited English. In practice, in Ireland and abroad, this is not the case. There is a reliance on informal strategies, particularly the use of family members or friends as interpreters. There is some evidence that this may be explained by the fact that service providers have low knowledge of available services but, even where there is knowledge of an available service, this will not guarantee its use (see for example MacFarlane, Singleton and Green, 2009). This moves our attention away from the issue of knowledge at an individual level about an available service toward the issue of uptake and, also, barriers and levers to uptake of an available service and the wider context in which uptake occurs. Greenhalgh et al. (2007) have argued that to advance knowledge we need to adopt an organisational perspective on the issue. They frame the interpreted consultation as an organisational routine and explore how this new routine is embedded into practice alongside or instead of existing routines. A recent sociological model, the Normalisation Process Model (May, 2006) is designed to explain and predict ways in which new organisational practices become routine and normalised (i.e. taken for granted) in healthcare work. This model encourages a ‘whole system’ analysis of implementation processes surrounding these practices. Our research study adopts the Normalisation Process Model (NPM) as its theoretical framework, and this is outlined in more detail in the Methods section.

1.3 Research Aim and Objectives

The aim of this research is to evaluate general practitioners’ uptake and experiences of paid interpreters available through a pilot interpreting service in the Eastern Region. Specific objectives are to:

1. evaluate general practitioners’ uptake and experiences of paid interpreting to identify levers and barriers to its use in routine general practice
2. engage in a two-way educative dialogue with general practitioners and related key stakeholders about language barriers and interpreting
3. identify strategies likely to improve general practitioners’ uptake of paid interpreters in routine general practice.

The HSE Social Inclusion Unit, who commissioned this research, placed an emphasis on general practitioners because they were considered key ‘decision makers’ with regard to uptake of the available pilot interpreting service in the Eastern Region. The inclusion of other stakeholders in the research is an attempt to locate general practitioners’ experiences in a wider context and, also, to
identify material for the educative dialogue about language barriers and interpreting. The research is not designed as a comprehensive evaluation of the other stakeholders’ experiences. Finally, it is not designed as an evaluation of the company providing the pilot interpreting service. Full details of study design and its development are provided in Chapter 2.
CHAPTER 2 CONTEXT AND METHODS

In this chapter, we describe the area under study and the study design as well as details of sampling, recruitment, data generation and analysis.

2.1 Area under Study

The geographical area under study was the former Health Service Executive Eastern Region, comprising North and South Dublin (City & County), Dublin West, Mid-Leinster, Co. Wicklow and Co. Kildare. This area has a mixed urban and rural population and has 628 General Medical Services (GMS) registered general practitioners. Figures from the Central Statistics Office (CSO, 2006) indicate that over the previous decade more than 750,000 people from 211 countries migrated to Ireland. About 10% of the current Irish population have a nationality other than Irish. The Dublin region has one of the highest concentrations of migrants in the country (CSO, 2008).

2.2 Study Design and Methodological Approach

The study design comprises a quantitative and qualitative component. The Irish College of General Practitioners granted ethical approval for the study. Below, we present details of the quantitative methodology first, followed by details of the qualitative methodology.

2.2.1 Quantitative Research

The quantitative analysis is based on information provided by the HSE, and records from the interpreting company which detail logged requests made by general practitioners within the geographical study area. The timeframe for this analysis was February 2006 to October 2007 inclusive, the 21-month period directly following the initial assessment conducted by the HSE. The quantitative analysis of service uptake, patterns of use and associated costs provides a backdrop for the qualitative component of the study.

2.2.2 Qualitative Research

This study is predominantly qualitative and draws from the fields of sociology and anthropology. Qualitative research allows us to attend to the persistent requirement in social policy to understand complex behaviours, needs, systems

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12 Source: GMS lists provided by HSE
and cultures (Ritchie and Spencer, 1994). We adopt a Participatory Learning and Action (PLA) mode of engagement with research participants where possible and appropriate (Chambers, 1994). We also draw heavily on a recently developed sociological model, the Normalisation Process Model (May, 2006) to inform both our process and analysis. These combined sociological and anthropological resources are described in some detail below.

2.2.3 Participatory Learning and Action (PLA): Mode of Engagement

Participatory Learning and Action (PLA) is an approach and method that engages participants in an adaptive, learning process which enables them to share, enhance and analyse knowledge across stakeholder groups, with a view to identifying solutions to commonly-shared problems and issues (Chambers, 1994). The specific participatory research elements in this study included:

- an educative dialogue which was ongoing throughout the qualitative study: emerging research findings were shared across stakeholder groups during research encounters – the researchers acted as ‘brokers’, bringing the respective knowledge, insights and experiences of one group to the next for comment and development

- a commitment to eliciting solutions across the stakeholder groups to any identified problems associated with the use of paid interpreters

- the use of data generation techniques typical of participatory approaches, for example ‘card sorts’ and ‘preference ranking’ exercises.

2.2.4 Normalisation Process Model (NPM) – A Sociological Model

The qualitative component of the study was also informed by a recently developed sociological model called the Normalisation Process Model (NPM) which has been developed to explain and predict the implementation of innovation in organisational settings. This model is employed here because it encourages a ‘whole system’ analysis of interpreted consultations. For our ‘whole system’ analysis, we frame the interpreted consultation as a complex intervention and our attention is then given in this study to the extent to which the interpreted consultation as a complex intervention may be described as normalised or not in routine general practice. These terms are explained in more detail below.
2.2.5 The Interpreted Consultation as a Complex Intervention

The term ‘complex intervention’ refers to modified or new technologies, techniques or organisational forms which are introduced by healthcare providers or policy makers as a means of improving the efficiency and clinical and cost effectiveness of health care and health service delivery. The UK Medical Research Council defines a complex intervention as something which has:

- several different components at once
- a range of different people or actors
- ‘new tasks’ introduced to people’s work (see Campbell et al., 2000).

Following this definition, an interpreted medical consultation can be considered a complex intervention because it

- incorporates a number of different components at once, e.g. policy developments, resource allocation, administrative actions, a triadic rather than dyadic medical consultation and a cross-cultural medical consultation
- involves actions by, and interactions between general practitioners, administrative staff, interpreting company, interpreters and service users with limited English
- introduces ‘new’ tasks to the work of the general practitioners and administrative staff, among others.

Complex interventions are often difficult to implement and sustain in routine practice. The concept of ‘normalisation’ is helpful here. It refers to the embedding of a technique, technology or organisational change as a routine and taken-for-granted element of clinical practice (see May, 2006). Given the evidence reviewed in the literature section (e.g. evidence of a disjunction between policy recommendations and practice on the ground and evidence that trained interpreters provide superior interpreting in the communication event), we know it is important to be able the answer the following question: in what conditions does an interpreted medical consultation become embedded as a routine and ‘taken-for-granted’ element of clinical practice?
The Normalisation Process Model (May, 2006) has been developed to have practical value because it can heighten understanding about how new ways of thinking, acting and organising become routine in practice. It also offers a conceptual map to guide analysis and to process evaluation of complex interventions (May, 2006). In this study, the NPM has practical value because it heightens understanding of accounts of interpreted consultations from the range of stakeholders involved in the pilot interpreting service. It has conceptual value because it can add a theoretical layer to sampling, data generation and analysis. In this way, the NPM sensitised the researchers to a range of issues and encouraged a whole systems analysis of the interpreted consultation as a complex intervention.

The Normalisation Process Model has four domains which draw our attention to key questions that are apposite for this particular study. The first two domains relate to the institutional structures and organisational contexts in which consultations take place:

1. **the organisational context and setting** (in the NPM, this is called contextual integration): this focuses on the wide health service context in terms of policy around language barriers, use of interpreters, and also the general practice as an organisational setting in which the interpreted consultation is to be implemented. Key questions for this study: What are the formal and informal policies that might influence implementation? What is the capacity and will of general practices to do the implementation work?

2. **skills** (in the NPM, this is called skill set workability): focuses on institutional divisions of labour and skill-sets to do the work involved in implementing interpreted consultations in routine practice. Key questions for this study: Who needs to do what in order to streamline the interpreted consultation into routine practice and, importantly, are these implementation tasks compatible with their existing workload, skills and professional identity?

The second set of domains relates more to the dynamics of individual consultations:

3. **relationships among the network of actors** (in the NPM, this is called relational integration): this focuses on the wide network of people that are
involved in the implementation work. This includes general practitioners, service users, administrators and interpreters. Key questions for our study: Do they trust each other and the work that they are there to do as individuals or groups? Do they trust the interpreted consultation as an authentic medical consultation?

4. **interactions between healthcare providers and service users** (in the NPM, this is called interactional workability): This focuses on what goes on between doctors, service users and interpreters in the immediate interpreted consultation. Key questions we ask in this study include: Is there clarity about appropriate roles and behaviour in the triad? Do all parties feel that the work of the consultation is achievable/achieved? Is the overall impact of the consultation congruent and is there a sense of meaningfulness about the immediate interaction for all parties involved?

We identified initial questions for the research process that generated data in response to all four domains of the NPM. We also developed new questions based on early analysis of our initial interviews. In addition, the NPM suggested additional areas for exploration as key themes emerged from the iterative analytical process over time. This iterative process is consistent with good practice in qualitative research (Huberman and Miles, 1998).

**2.3 Sampling and Recruitment**

In qualitative research, the emphasis is on identifying ‘information rich’ cases, participants who are known to have knowledge and experiences relevant to the phenomenon under investigation (Patton, 1990). For the purposes of this study the key target groups were general practitioners, representatives of ethnic minority service users and representatives of the interpreting sector.

**2.3.1 General Practitioners**

We combined non-probability purposeful sampling and critical case sampling (Patton 1990; Kane and O’Reilly-de Brún, 2001) procedures here because we wanted to recruit general practitioners with very different patterns of use of the interpreting service:

- General practitioners who accessed the pilot interpreting service frequently
• General practitioners who accessed the pilot interpreting service infrequently
• General practitioners who never accessed the pilot interpreting service.

The findings from the quantitative analysis (completed in December 2007) provided our sampling frame for the identification of general practitioners from each of the three categories above. The researchers made initial contact by telephone, outlining the research focus and inviting the general practitioner to take part in the research. General practitioners who expressed an interest received a letter providing details about the project and clarifying participant rights; follow up calls were then made to confirm participation and arrange interviews at a time and place convenient for the general practitioner. Overall, 26 were contacted, 18 participated and 8 declined. The reasons given for non-participation were: lack of time; the practice did not have ethnic minority service users judged to be in need of interpreting services; the practice staff did not see the relevance of the study to their practice. All 18 general practitioners had GMS lists and they came from a spread of geographical areas in the study region (see Table 2.1).

Table 2.1 Geographical Area of Participating General Practitioners

<table>
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<tr>
<th>Geographical Area</th>
<th>GP No.s:</th>
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<tbody>
<tr>
<td>Dublin 2</td>
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<td>Dublin 6</td>
<td>1</td>
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<td>Dublin 9</td>
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<td>Dublin 15</td>
<td>1</td>
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<tr>
<td>Co. Dublin</td>
<td>2</td>
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<tr>
<td>Co. Wicklow</td>
<td>6</td>
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<td></td>
<td>18</td>
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</table>

Given our original remit, we did not expect to be generating data with practice managers. However, valuable, informal, unsolicited discussions with practice managers occurred during fieldwork in four of the above practices (frequent user practice n=3; infrequent user practice n=1).

When these valuable discussions occurred we decided to (a) advise our funders to broaden the remit of the study to include this group and (b) sought and received ethical approval from the ICGP to do so. Fieldnotes, made immediately after the
discussions with practice managers, were checked with these four administrators for their accuracy and permission to include as data for our analysis.

2.3.2 Representatives of Ethnic Minority Service Users

We engaged with other relevant key stakeholders, primarily representatives from ethnic minority communities. Contact and recruitment was facilitated via existing networks between HSE Social Inclusion Unit and three Dublin based organisations who hold a remit covering healthcare issues and advocacy for ethnic minority communities. We successfully liaised with senior personnel for their participation and the participation of community representatives in either focus groups or interviews.

We use the term ‘service user representative’ throughout this report to identify data that were generated by and with individuals from this group of participants, most of whom are members of ethnic minority new communities in Dublin and are constantly in touch with the experiences of people at community level.
2.3.3 Representatives of the Interpreting Sector

We intended to recruit interpreters from the company currently providing the pilot interpreting service. The manager was approached by telephone and available for interview. However, access to interpreters employed by the company was not granted. We recognised the need to have some representation from the perspective of ‘formal’ paid interpreters (see page 17) and explored other options. Therefore, as an alternative, we recruited via a participating NGO two independent interpreter representatives, who were experienced in medical interpreting.

We therefore draw a careful distinction throughout our report with regard to paid interpreters: we refer to paid interpreters from the commercial company currently providing the pilot service as ‘pilot company interpreters’. This term clarifies when general practitioners or others are speaking directly about their experiences involving these paid interpreters. The company manager explained that the company provides one full day’s intensive in-house training to their new interpreters. The new interpreters also participate in a ‘buddy’ system, accompanying a company interpreter to the courts for one day, and receive training from the United Nations High Commission for Refugees on interpreting in a refugee context.

We also refer to paid ‘independent interpreters’. ‘Independent interpreter’ is a term we use to refer to two interpreters who participated in the research and who are not working for the company providing the pilot interpreting service. During the course of the research we established that these independent interpreters were trained in-house with an NGO that works with ethnic minority communities. They received three intensive days' training. This included details of the NGO’s own ‘Code of Practice’ which they are required to follow in their work. On completion of their training, they received a Certificate from the NGO. They then worked in-house with six health professionals (medical, legal, psychotherapeutic, psychological, psychosocial and complementary therapy) and completed six successful hours of interpreting across these fields before being considered ready to work as in-house interpreters. One independent interpreter also had a Graduate Certificate in Community Interpreting from Dublin City University.
Finally, we must remember that, not having been granted access to any pilot company interpreters, we were unable to include their voices in the educative dialogue which became a central feature of this study.  

2.4 Generation of Data

Social science research often talks about data ‘collection’. In this study, because of our focus on participatory approaches and educative dialogue, the term ‘data generation’ is more appropriate and descriptive of the work undertaken.

The specific objectives of data generation with general practitioners were:

1. To evaluate general practitioners’ experiences and uptake of the pilot interpreting service to identify levers and barriers to its use in routine general practice

2. Following research engagement with other key stakeholder representatives, to engage in dialogue with general practitioners about language barriers and interpreting

3. To identify strategies for improvement of service uptake among general practitioners.

Details of tools and techniques used for data generation are provided below.

2.4.1 Research Tools and Techniques

The guiding questions for the face-to-face interviews with general practitioners constituted an intrinsic element of the research process itself and, to some extent, was iterative and organic in nature, in line with good practice in qualitative research (Douglas, 1985; Fontana and Frey, 1998; Spradley, 1979; Reinharz, 1992). These interviews with general practitioners and other key stakeholder individuals were initially conceived as semi-structured interviews (Kvale, 1996) with openness to the development of material as the interviews progressed. In our first fieldwork trip, we noticed that many categories of meaning and analysis which correlated generically and strongly with the NPM domains also served to elucidate these domains with respect to our specific study focus; this

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13 It transpired during the focus group discussion with one of the community representative organisations that three of the participants were in fact former interpreters with the company currently providing the pilot service. In this way, there was some representation of company interpreters although, clearly, the sample is limited.
provided us with new and more focussed areas for exploration in subsequent fieldwork trips.

### 2.4.2 Fieldwork

The main body of data generation took place between February and July 2008. In Round One, 18 general practitioners participated in one-to-one interviews; 10 were face-to-face and the remaining 8 by telephone. Of these, 7 general practitioners were from the ‘highest frequency’ service user category identified in the quantitative component of the study; 7 were from the ‘infrequent’ service user category and 4 were ‘non-users’ of the pilot interpreting service.

Also in Round One, we engaged in data generation with 16 service user representatives and 2 interpreter representatives and this took the form of either face-to-face in-depth interviews or focus groups (Kvale, 1996; Krueger and Casey, 2000). PLA Card Sort techniques were also introduced into some of these encounters. A total of 36 participants were involved in this round of research.

A second round of data generation took place during September and October 2008. The rationale for this second round of data generation is in keeping with the iterative process at the centre of qualitative research. Going back ‘into the field’ allowed us to check understanding of generated data and our interpretation of them and, also, to expand our understanding and interpretation. The second round of data generation was also crucial for promoting dialogue across stakeholder groups which was an objective of the study.

In keeping with the primary remit of the research, our main focus for the second round of data generation was on general practitioners. Of the 18 who participated in Round One, 15 participated in Round Two. Of these, 6 were ‘highest frequency’ service users; 5 were from the ‘infrequent’ user category and all 4 ‘non-users’ of the pilot service participated. We note that each category of service user is well represented across both rounds of research.

Table 2.2 provides an overview of the total number of participants in the research and shows that there were 41 participants and 43 data generation encounters. It is important to note that 15 of our 18 general practitioners participated in two interviews which explains the greater number of one to one interviews (n=33) than general practitioner participants (n=18).
Table 2.2. Overview of Number of Participants and Data Generation Encounters

<table>
<thead>
<tr>
<th>No. of Participants (n=41)</th>
<th>Data Generation Encounters (n=43)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 x General practitioners</td>
<td>33 x one-to-one interviews</td>
</tr>
<tr>
<td>4 x General practice administrators</td>
<td>4 x One-to-one informal interviews</td>
</tr>
<tr>
<td>2 x Independent interpreters</td>
<td>1 x Focus group</td>
</tr>
<tr>
<td>2 x Service user representatives</td>
<td>2 x One-to-one interviews</td>
</tr>
<tr>
<td>14 x Service user representatives</td>
<td>2 x Focus groups</td>
</tr>
<tr>
<td>1 x Company manager interview</td>
<td>1 x One-to-one interview/consultative meeting</td>
</tr>
</tbody>
</table>

We assigned codes to all participants to protect their anonymity (see Appendix A).

Sample sizes in qualitative research are determined by theoretical saturation, that is, the stage when knowledge and understanding of the topic under investigation is considered complete and comprehensive (Patton, 1990). In this study, we combined this intention with the practical time frame available for the research. We are confident that the data generation and analysis continued to a point where themes were comprehensively identified, explored and verified by us as researchers along with the research participants.

2.5 Data Analysis

Interviews and meetings were tape recorded with participants’ consent and were transcribed verbatim. Analysis followed the principles of thematic analysis using the constant comparative method (Silverman, 1993). Results of the thematic analysis were ‘mapped’ against the Normalisation Process Model (May, 2006) to generate ‘higher order’ categories.

2.6 Ethics

Standard ethical requirements in terms of confidentiality and anonymity were adhered to (Creswell, 1998). Interviews took place at surgeries/health centres or other agreed venue(s) to minimise the time required of general practitioners participating in the study. Meetings with relevant stakeholder representatives took place in suitable agreed venues. We sought consent from all participants to
use digital tape recorders to facilitate accurate recording of interviews and meetings. All participants signed and returned consent forms to the research team. At all times, we aimed to be aware of any sensitive issues and checked with participants if they felt their anonymity was adequately guarded. All participants had the opportunity to see a draft of this report, to consider if the information they had shared was accurately represented and suitably placed in context in the text.

2.7 Reflexivity

Throughout the qualitative and participatory mode of engagement, our reflection as researchers on what we were doing (‘reflexivity’, Seale, 1998), encouraged us to choose inclusive language for the report, to privilege participants’ voices in the results and not to interfere or amend their language. In this way, we present their perspectives faithfully to the reader.
CHAPTER 3 RESULTS

In this chapter, we provide results of the quantitative component of the study. We then provide results of the qualitative component under the four headings of the NPM.

3.1 Quantitative Component

The quantitative analysis is based on the logged requests made by general practitioners to the interpreting company providing the pilot service (see Chapter 2). The objectives of the quantitative analysis are to collate data on levels of uptake and on patterns of use and associated costs. Results are presented here on

1. levels of uptake
2. patterns of use
3. interpreting mode
4. languages requested and language frequency
5. patterns of use and associated costs.

3.1.1. Levels of Uptake across 2006, 2007

The total number of interpreted sessions requested from health clinics, medical centres and practices (for ease, hereafter referred to collectively as practices) over the period of the analysis was 293. The lowest rate of use was six sessions in June 2006 and the highest rate of use was in October 2007 with 24 sessions recorded.

From February to December 2006 inclusive, the number of sessions requested was 129, averaging 10.75 per month (calculated over 11 months). From January to October 2007, the number of sessions requested was 164, showing a clear upward trend and a rise in the average monthly figure to 16.4 sessions (calculated over 10 months). Chart A shows these comparative uptake levels and the upward trend across the entire 21 month period.
3.1.2. Patterns of Use across 2006, 2007

While there is an upward trend in the use of the pilot service, with the rate of growth increasing more strongly in 2007 than in 2006, the number of practices regularly using the service remains limited. In all, 39 out of a possible 160 practices requested the 293 sessions logged by the interpreting company – which means that just one-quarter (24.37\%) of the 160 ‘signed-up’ practices actually requested the extended pilot service.

Chart A
Extended HSE Pilot Interpreting Service: Comparative Uptake

Levels by

Number of Interpreting Sessions

Chart B
Extended HSE Pilot Interpreting Service Breakdown of Uptake Levels by Infrequent Users
n=26 practices
For the purpose of the analysis, practices have been categorised as **infrequent** and **highest frequency users**. Infrequent users are those who requested less than five sessions and highest frequency users are those who requested five or more sessions across the entire 21 month period. For purposes of anonymity, practices were assigned an alphabetical code and the key to the code was held securely by the researchers. (This allowed practices to be selected for sampling in the qualitative element of this evaluation). The 26 infrequent users are coded from A-Z and the 13 highest frequency users are coded from AA-MM.

Chart B shows **26 practices that can be categorised as infrequent users** of the service. Nine of these only used the service once, six used the service twice, four used the service three times and seven used the service four times. Together, they account for 61 of the total 293 interpreting sessions (20.8%).

Chart C shows the remaining **13 practices which can be categorised as highest frequency users** of the service. Seven practices requested between 5 and 14 sessions and the top six practices requested 20 or more sessions.

The highest uptake by any one practice is 52 sessions. The two next-highest rates of uptake by single practices were 27 and 26. In fact, the top six frequent service users account for 170 of the 232 sessions in this ‘highest frequency user’ category (73.2%).
Assessed in terms of the overall uptake of 293 sessions, the top six service-users account for 58% of all uptake.
3.1.3. Modes of Interpreting

There are two interpreting modes available to users of the extended HSE pilot service: face-to-face (on-site) or telephonic. Both types can be booked in advance but it is obviously easier to arrange an unscheduled telephonic session.

Chart D shows that, of the 129 sessions requested between February and December 2006, on-site interpreting sessions numbered 26 and telephonic interpreting sessions numbered 103. Of the 164 sessions requested from January to October 2007, on-site interpreting sessions numbered 52 and telephonic interpreting sessions numbered 112.

The rise in both modes of interpreting mirrors the general increase in uptake levels we have previously noted. What is striking is that the ratio of on-site to telephonic sessions changes across the analysis period, with on-site sessions doubling while telephonic sessions increase by approximately 9%.
3.1.4. Languages Requested and Language Frequency

Interpreting is available across a wide range of languages, and in the case of ‘rare’ languages (for example, Uighur, which is spoken in a border area between China and Russia) when an interpreter is not available in Ireland, the interpreting company is able to utilise its international cadre of interpreters to facilitate a health consultation via a telephonic link-up. Records show that there are few instances in which an interpreter was not available, but whether this relates only to languages involved, or occurs for other reasons, needs to be established.

Chart E shows the range of languages for which interpreting was requested, the number of requests and their relative frequencies. These languages are reflective of frequently spoken languages in modern Ireland: Polish, French, Arabic, Latvian, Chinese (Mandarin) and Lithuanian are among the top ten languages spoken (see Pieper et al., 2008).

Interpreting was provided in 37 separate languages. Romanian, Polish, French, Arabic and Russian were the five most frequently required, together making up 191 of the total 293 interpreted consultations (65%). The remaining 32 languages were required less frequently but were necessary to make it possible for ethnic minority patients and their doctors to communicate in 102 separate healthcare consultations (35% of all consultations).
3.1.5. Patterns of Use and Associated Costs

The total cost of providing 293 interpreted sessions for the analysis period is \textbf{€6,757.54}. The breakdown is €3,673.50 in 2006 (11 months) and €3,084.04 in 2007 (10 months). Chart F shows this cost analysis:

\begin{center}
\includegraphics[width=0.5\textwidth]{chart_f.png}
\end{center}

3.1.6 Summary of Quantitative Results

In the first five months of the pilot service (September 2005 to January 2006) the total number of interpreted consultations was 34, an average rate of just seven sessions per month. We know that 16 of these 34 sessions were requested by one large practice; even if we assume that the remaining 18 interpreted sessions were from individual practices, the total possible number of practices involved in requesting interpreters in 2005 can have been, at best, 19.

The extended pilot service displays an upward trend, both in terms of the number of practices requesting the service and the numbers of interpreting sessions requested. During 2006, the average number of sessions per month rose to 10.75 and this rate increased to an average of 16.4 sessions per month during 2007. We also see a rise from 19 to 39 practices requesting the service over the entire period of its availability.

It is notable that while the demand for the interpreting service is increasing, this demand is still concentrated in just a quarter of the practices that first signed up
for the pilot interpreting service. It is not known why the remaining 121 practices have never requested an interpreter.

Related to this point is that, while there is a general upward trend, there are ‘highest frequency’ and ‘infrequent’ users of the interpreting service so, once again, the pattern of a relatively small number of dedicated users emerges. Assessed in terms of the overall uptake of 293 sessions, the top six service-users account for 58% of all uptake. These findings must be assessed against the broad research backdrop, which clearly indicates a demand and need for interpreting services, voiced by general practitioners themselves (Crowley, 2003) as well as ethnic minority service users with limited English skills (MacFarlane, 2007). The consistently low uptake levels seen in this analysis appear dissonant with the 2003 call from general practitioners for an interpreting service and this remains an important area for further exploration in the present evaluation. At the same time, demand from general practitioners for the interpreting service is increasing and it will be very important to try and establish the factors that explain the documented upward trend in use.

Interpreting was provided in 37 separate languages. Romanian, Polish, French, Arabic and Russian were the five most frequently required, together making up 191 of the total 293 interpreted consultations (65%). It would be valuable to set these findings against documented demography of migrant communities in the region.

Finally, in relation to cost, this analysis shows a relatively even spread of costs for 2006 and 2007; the breakdown is €3,673.50 in 2006 (11 months) and €3,084.04 in 2007 (10 months). Given the increase in the number of interpreted consultations in 2007 compared with 2006, the cost analysis might, at first glance, seem to confound this fact. However, interpreted sessions are of varying lengths and are costed accordingly, and on-site sessions are consistently longer and therefore more costly than unscheduled telephonic sessions. Therefore, a higher number of sessions does not necessarily mean higher costs.

The quantitative data currently available have provided us with clear information about uptake levels, patterns of use, languages used and costs. By their nature, quantitative data do not provide insight into motivation and behaviour or details of the contexts in which these are shaped and enacted. The qualitative component is designed to address these issues and the next section provides results of the analysis of qualitative data.
3.2 Qualitative Component

The qualitative analysis is based on data from face-to-face and telephone interviews with general practitioners, and either focus group sessions or face-to-face interviews with representatives of ethnic minority communities and the interpreting sector (see Chapter 2).

We have analysed the data using the NPM and present our results here according to the four domains of this sociological model. They are:

1. Organisational context: commitment, capacity, value accrued
2. Skills: Making it work
3. Relationships among the network of actors
4. Interactions between healthcare providers and service users.

We then synthesise data from across the four domains of the model to identify levers and barriers to uptake. To conclude, we describe the influence of these on the likelihood of normalisation of interpreted consultations in this setting.

3.2.1. Organisational Context: Commitment, Capacity, Value Accrued

This set of findings focuses on the ‘big picture’ and relates, in general terms, to the organisational context in which a complex intervention is introduced, and, at the level of the organisation, the subsequent work that needs to be done to implement the intervention and ensure its integration into the existing system. (NPM: Contextual Integration).

In this specific project, we are focussing on the general practice as the organisation into which the complex intervention, an interpreted consultation, is introduced. Interpreted consultations involve the use of an interpreting service and therefore differ significantly from standard or typical consultations with which general practices are familiar. Our focus here is on what the organisation needs to understand and agree at the practice level in order to ‘manage the unfamiliar’ and integrate the use of interpreted consultations into day-to-day practice activity.

Key questions are: does the practice (organisation) have the will, or commitment, to use the interpreting service? If commitment is present, does the practice have the capacity to use the interpreting service? If commitment and capacity are present, does the practice have a sense that positive value accrues to the
organisation as a result of using the service, thus strengthening the chances of consistent and ongoing use of the interpreting service over time, resulting in ‘normalisation’?

Here we describe:

- the **commitment** of general practices to use the interpreting service
- the **capacity** of general practices to use the interpreting service
- the **sense of the value** that general practices expect to accrue from using the interpreting service.

### 3.2.1.1 Commitment: The Influence of Policy

The commitment of a general practice surgery to the use of the interpreting service could be influenced by a number of different mandates or policies. Some of these are ‘from on high’ (national policies from the Health Service Executive) and others are ‘local policies’ (generated within the practice itself).

We asked general practitioners if they were aware of national level policies – most were not. A small number were aware that such policies existed but either knew little about them, or were sceptical about them, seeing them as ‘yet another policy’ unsupported by sufficient resources to put them into practice:

**#22 Q:** Ok. Are you familiar with the national policy in this area, like the recent launch of the National Intercultural Health Strategy [or] any of the work that the ICGP is doing, or...?

**#22 A:** Well [regarding the] work that the ICGP are doing, they probably launched some cultural strategy or other and they probably sent us some powerful booklet and I probably said I would read it sometime... so quite possibly they have launched a strategy but there are so many strategies that don’t amount to being so (inaudible).

**#22 Q:** Another GP was saying that they were getting incoming messages from the HSE about diabetes, asthma, intercultural health and that influx of information...

**#22 A:** Yeah, yeah, I don’t remember seeing too much on intercultural health, I have to say.

**#22 Q:** No. Well, would you like to?

**#22 A:** I’m not massively overawed one way or another... but, I mean, we are feeling under-resourced already and they seem to launch all these strategies without any resources, which is... [silence]. (M; INFREQ)
While we can assert that national level policies have little or no driving impact on general practitioners in relation to the implementation of interpreted consultations, the data clearly indicate that this is not necessarily specific to this issue or patient group. We have learned from general practitioners in this study that they are inundated with recommendations about a wide range of healthcare issues and for a wide range of patient groups. They say that it is generally very difficult to respond to these recommendations because of the demands and burdens of busy and stressful surgeries. Therefore, the minimal impact of national level policies about intercultural health has to be considered in that context.

The data indicate that commitment of general practices to implement interpreted consultations was more likely to be influenced by their local policies, that is, policies generated within the general practices. We know of one practice that had developed a policy explicitly orientated toward implementation of interpreted consultations, even before the pilot service was established:

#6 A: ...and it happened that one of the other principals saw them [service user] on a particular day, and she just said “What is going on? I couldn't possibly stand over that consultation....because she was saying that she had pain, and I couldn't say where, you know... and at that point she had been the sort of doctor who would be extremely straight down the line in terms of ‘this is not good medicine’. And they [general practitioners] took a decision, I mean, we'll pay for a translation service and we'll see if we can get some [money] back from the Health Board afterward, I think they did subsequently, because they made a case for it. (M; FREQ)

Other practices had ‘policies of inclusion’, meaning that they had a commitment to open access for disadvantaged communities, including ethnic minority service users:

#24 Q: Are your ethnic minority service-users – are they migrant workers, refugees, asylum seekers?

#24 A: It would be a mixture I suppose, most of them are working, I don’t think we have many asylum seekers here... we have an open policy here, we don’t stop anybody coming through, so we have a fairly mixed crew of people. (M; INFREQ)

Ethnic minority community representatives whose focus of work is the health care of ethnic minority groups emphasise that this kind of ‘open access’ policy is rare. They state that their clients experience tremendous difficulty finding a general
practitioner in the Dublin city area. This is, currently, their most pressing concern in relation to Irish general practice:

**NGO C:** The issue we’re coming up against in terms of GPs isn’t at this point [of getting an interpreter] – it’s getting access – getting clients access to GPs, GPs actually taking them on their books. (FG a-h)

Other ethnic minority community representatives confirmed that, even when some service users do get into a practice, they may experience difficulty being ‘seen’ in both the obvious and subtle sense; they may sometimes find it difficult to even get appointments because, with little or broken English, they need special attention from administrative staff around the provision of interpreting:

**Q:** And where does that information come from? Is that from people that you work with? Service users who have been to doctors who actually reacted to them [like that] and they are picking that up and they come back to you?

**NGO B:** Yes, because sometimes when you are discussing where the GP fits in, some people are shaking their head already before they respond, and they are saying the GP has no time for them. I’ll give you a practical example of a family [with just a few words of English] who have just come out of crisis, they’ve got their refugee status now and they are fine, but their experience around a particular issue with the GP was very blank, you know, they have gone several times and sat in the surgery and the surgery closes and they are told to come back the next day because [the surgery] is busy. Now they never had a telephone interpreter, they both speak very poor English and that’s how they’ve communicated around their own health issues and their children.

**Q:** How have they communicated at all with the GP?

**NGO B:** Just, just the words they have, a few words, and you know pointing and body language. So they’ve been in the system quite a while and I think it’s quite shocking when you hear something like that.

**Q:** Is that a Dublin based practice, just for the geography of it?

**NGO B:** Yes, it is. In the region of the HSE, and they have a free telephone interpretation service available.

During our educative dialogue, one general practitioner who has extensive experience working with ethnic minority service users had no hesitation in stating that, to his knowledge, service-provider bias exists:

**#16 A:** It would be difficult to get over service provider bias. There are GPs that don’t want to deal with language problems and they’ll say the list is full, bottom line. (M; FREQ)

In startling contrast, only one practice had a formal written policy of inclusion:
A: Well, I mean, we took a policy decision early on, I mean we have an actual [written] practice policy statement which says that our practice tries to produce the best quality health care and... ‘we seek to address the issues of health inequalities within a vulnerable population’, and that includes ethnic minorities. We’ve discussed the issue of how we manage minorities in practice, and so we’ve, we don’t discriminate - you will find, being honest with you, practices that will not take certain groups of patients - we’ve said we’ll take anybody, and when we close our list we close our list to both private and public, so we try and keep it as non-discriminatory as possible.

Q: Okay. So there’s a very specific policy there.

A: Oh, there definitely is, yeah. (M; INFREQ)

General practitioners who are highest frequency users of the interpreting service seem to be more likely to come from such committed practices. But it is interesting that even within these practices:

- use of the service is not actually very frequent¹⁴ and is rarely/never exclusive¹⁵
- some individual doctors do not use the interpreting service
- within a practice some colleagues are unclear as to whether others are using it or not.

This suggests that while practice policy has some influence on implementation of interpreted consultations, this is variable, with a lot of scope for individual discretion.

Data also clearly indicate that even practices which accessed the interpreting service relatively frequently had not developed any formal policy around its use. This was not because they were unaware of the potential value of a formal policy, but was, again, because they have very demanding workloads and need to ‘keep everything afloat’:

Q: And is there a policy in the practice, you know, an actual policy – for example, this is what we do, we

¹⁴ 13 practices were designated ‘highest frequency users’ of the service – 7 of these requested between 5 and 14 sessions over 21 months; the top six user practices requested 20 or more sessions over the same period.

¹⁵ ‘Not exclusive’ means alternative informal strategies are regularly employed, e.g. using family members and friends as informal interpreters, using internet translation services, mimes and gestures, etc.
believe in this, this is important to us – anything like that? In a formal way or an informal way?

#4 A: You mean a policy in relation to what, interpretation services, or dealing with ethnic minorities, or...?

#4 Q: Dealing with ethnic minority patients, using interpreting services in order to facilitate consultations...

#4 A: There isn’t a formal policy, I mean, you know, we sit and say we should have a formal policy about everything, but we never get around to it, just because we’re keeping everything afloat, em, no there isn’t, but I think we’re of similar minds. (M; FREQ)
One general practitioner pointed out that service users requiring interpreting could arrive at the surgery but she might not even know they were there awaiting her attention; this is another way in which service users can be rendered ‘invisible’:

#13A: Secretarial staff at the front desk who are busy, they definitely perceive [the arrival of a service user who needs the interpreting service] as, Oh my god, you know, I’m under pressure now...

#13 Q: Yeah...
#13 A: And it has to be really important that the system changes, and that that doesn’t turn into, you know, a prejudice against the patient - does that make sense?

#13 Q: Absolutely makes sense, yes...
#13 A: And so, as a doctor then, you might not know if that is or isn’t going on.

#13 Q: Okay...
#13 A: Like you might never know that seven patients didn’t come in to you, you know. (M; FREQ)

Given these insights, it seems crucial that a clear and unambiguous policy is active for all members of a general practice who deal with service users who require interpreting services. In the educative dialogue during the second round of data-checking and data generation, general practitioners who participated in the study responded strongly to this issue:

#17 A: I don’t think I have informed my reception staff enough on that [policy of inclusion]. First, that they would be informed about it, and second, that they would know who to ring and where to ring so they would have a clear instruction as to what to do. (F; NON-USER)

#4A: Policy of inclusion, that’s the strongest one. If there’s a mindset in the place that we’re going to take these [service users] on board, and you call the interpreters, and you incorporate them in. Now, that said, I don’t have a written policy but I have an unwritten policy, so there’s a sense that we’re going for this and I would suggest that would be the strongest lever. (M; FREQ)

#14 A: I think a practice policy is the most important thing – for the first point of contact, if there was a practice policy, let’s say if my secretary had it at her fingertips that yes, you are from such a place and you have no or poor English – it automatically would set it in motion to get an interpreter... the way we’re operating down here, we have no policy, so that would probably be the most important [lever]. (M; NON-USER)
### 3.2.1.2 Capacity: Knowledge, Able workforce, Issues of Time and Money

Given that commitment is the first hurdle to overcome, the next challenge a general practice faces is capacity. Capacity, in this case, incorporates ‘knowledge’ as an underlying resource, the workforce as a resource, and issues of time, money and motivation.

**Knowledge**

Knowledge of the available interpreting service is an underlying resource. There is a strong indication in these data that knowledge is very varied across the participating general practitioners. Here we present data that show this variation in knowledge.

Some general practitioners have clear knowledge of the availability of the service and details of how to access it:

**#13 Q:** Is [company name] the only company that you are using - or are there other companies maybe also being accessed for interpreting services - would you know that?

**#13 A:** Yes, there are, I think there are other ones being used, but the GPs would have to pay for them themselves. [Company name] is the only one that I know.

**#13 Q:** Yeah.

**#13 A:** It’s the only one that was funded in the pilot by the HSE. (M; FREQ)

**#5 A:** It’s [company name] interpretation that we use and they would supply both, don’t they?

**#5 Q:** There was an advertisement poster that [company name] sent out in 2006, I think, and stickers for the phone. And stuff like that...

**#5 A:** Yeah, we have it there, look. We have it there too. I think we have it on most phones. We have a lot of refugees and asylum seekers.

**#5 Q:** Oh, you have, wow, I think you are the first one that has it on the phone.

**#5 A:** Yeah, we do, and we do use them. (M; FREQ)

However, many general practitioners have ‘fragmented knowledge’ – they are not aware of nor in possession of any relevant advertising material which would enable them to encourage access and are unclear about the details of the services available (i.e. f interpreting modes).
#14 A: I can’t remember what details they had on, on methods of contact with them… if you asked me now where the [interpreting service] telephone number is, I wouldn’t have a clue! (M; NON-USER)

#19 Q: Would you be aware of the name of the company that provides this free interpreting service…?

#19 A: Well, it was ______…but I think they were taken over, I don’t know…

#19 Q: Yes, they are now called [company name]…

#19 A: Oh, right! Well, I didn’t know that!

#19 Q: It seems some surgeries have never seen that information and others may have, so would you have any idea if your frontline staff or if any of your colleagues or yourself have ever seen this information…

#19 A: I don’t think we did get that advertisement - I don’t remember it.

#19 Q: I’ll show you what it looks like actually – this is the interesting thing – there’s this language card here and the idea is that the frontline staff would have this handy and, you know, if somebody comes in the question that’s asked here is ‘Do you speak this language?’ and it’s asked in all these different languages, so at least they can identify what interpreting language is required…

#19 A: No, I have never seen that...

#19 Q: The other thing that was sent out was this poster here…

#19 A: I have the old one here, under there (GP indicates old poster on wall with previous name of company, obscured by other more recent posters) so that’s the one we’ve got…we usually use that number.

#19 Q: Yes, it’s still the same number. And these are the stickers for the phone…

#19A: No, I haven’t seen those. (F;INFREQ)

#3 Q: You do use the interpreting service regularly for this but… you don’t use an on-site interpreter…?

#3A: I didn’t actually realise that was available until I was talking to a lady [from the interpreting company] the other day who thought I was asking her to come out and she said ‘Oh, I’ll never make it out to G_______ by that time’ and I said: ‘Oh no, I just need you on the phone’, so then I thought, hmmm, maybe I could actually get somebody out.

#3 Q: So you’ve never experienced an on-site [interpreter]?

#3 A: I didn’t even realise that you could have somebody on-site and again, I suppose you just need some advance warning. But I presume they come out from Dublin, eh, mostly, so I
don’t know if they would come out this far or anything, but I could look into it. (F; FREQ)

Other general practitioners know that they signed up for an interpreting service of some kind, but have forgotten about it, while others have no knowledge about who pays for the service:

**#21 Q:** Can I ask, are you aware of the company that provides the service for the HSE?

**#21 A:** No...I didn’t know you even had it before you rang there a couple of weeks ago.

**#21 Q:** Sorry, I missed that?

**#21 A:** I had forgotten that we had an interpretation service.

**#21 Q:** Right.

**#21 A:** ....and the [inaudible] is, no doubt, at the bottom of a pile of stuff somewhere...

**#21 Q:** Yeah.

**#21 A:** But I wouldn’t know how to access it now. (M; NON-USER)

**#23 A:** I was aware that if I needed an interpreter it would be available to me in some shape or form, but I wasn't sure if I would be paying for it or not, so. (M: INFREQ)

Several general practitioners did not know that a HSE-funded pilot interpreting service existed:

**#23 Q:** So first of all, had you ever actually heard of the pilot interpreting service?

**#23 A:** No.

**#23 Q:** No, grand. Did you know that the HSE had actually contracted a company called [company name] to provide this service to GPs in the region?

**#23 A:** I hadn’t heard of [company name]. (M: INFREQ)

These data highlight that, while the costs of the service are covered by the HSE, the underlying capacity of general practices to use the service is diminished because their knowledge of it is low or minimal and, in several cases, that capacity remains completely untapped because practices have no knowledge whatsoever of the service. Without knowledge, practices cannot utilise other resources they may well possess, such as an able workforce capable of integrating interpreted consultations into the work of the practice.
In the educative dialogue, it became clear that this dearth of knowledge on the part of practices means that the opportunity for service users to become aware of the service or to be proactive in requesting it when they attend a general practitioner is virtually eliminated, as these representatives of ethnic minority communities confirmed during a focus group session:

**Q:** Given that some GPs weren’t aware, that other GPs have vague, very vague memory of signing up for something... my question is, from your perspectives, how at all would ethnic minority service users know that this interpreting service is available?

**NGO A:** By mistake only!

**Q:** (Researcher addressing another participant) ...and would that be the case from your experience as well?

**NGO A:** Yes, it’s the same experience.

**Q:** Okay... another NGO has mentioned to us that there was no attempt to look at how that information could be disseminated through any of their fora, and they’re obviously, as you are, connected so well with the ethnic minority communities...

**NGO A:** This is the first time I am hearing that such service is available. And from GPs!

**Q:** And it’s free...

**NGO A:** GPs did not know about it! There were GPs asked by clients [service users]: ‘Look, we know we can avail of an interpreting service?’ Nah, nah, nah, we don’t know anything about that, we don’t want to pay for interpreters, it’s very expensive...

(FG a-f)

Focus Group participants from another NGO concur:

**NGO C:** I was asking people have they been aware of the service; all of them replied: No, they didn’t know of the service. And there’s another thing – usually, if you’re trying to access services, you are in better position if you know this service exists! (FG a-h)

In dialogue with general practitioners, we highlighted this lack of knowledge on the part of service users and asked them if they had ever witnessed or heard of an ethnic minority service user ‘knowing about the service’ – walking into a surgery and requesting an interpreter, or specifically asking about the pilot interpreting service. None had, and several seemed to find the notion astonishing or intriguing in itself. We must remember that this shared lack of knowledge on the part of ethnic community members with limited English and general practitioners means they are simply mirroring each other’s common coping strategies – they ‘muddle by’ with minimal language skills or supports, they
attempt to communicate in stressful circumstances, and in the end, service users may judge the Irish primary care system accordingly:

**NGO C:** We have clients saying: ‘I told my doctor I had this and that [symptom], and [I gave] this explanation… I ask these clients ‘What did you say [to the doctor]?’ and they explain it to me and it’s very difficult [for me] to understand what they’re saying. And they got incorrect treatment, and they are saying ‘All GPs are very bad in Ireland’, and ‘I’m not doing well’, and ‘I’m going to my doctor and nothing is improving’ - so it’s like a circle… (FG a-h)

Ethnic minority community representatives suggest that the burden of knowledge about the interpreting service should not be placed entirely at the feet of general practitioners, and that community-based approaches to knowledge dissemination are key to raising awareness and improving uptake:

**NGO A:** Service providers might not know there is a language difficulty – if the person is making reasonable attempt to speak English, they might think it’s ok, but the person needs to know [that they can avail of interpreting service]. (FG a-f)

**NGO C:** In terms of the right of entitlement to access the right information and accessing services, the GPs, they have no inclination to inform the public or (inaudible) to facilitate that process, so people are not aware whether the service exists or not. So there’s no adequate methodology or strategies that target these procedures or this process. So they need to open up communication channels with different organisations like ourselves… (FG a-h)

Confirming this, in consultative meetings and focus groups with ethnic minority community representatives, the need for community-based engagement for successful dissemination of knowledge was emphasised, and practical suggestions about how to advertise the service came thick and fast:

**NGO C:** They could have launched this interpretation service with a genuine engagement with ethnic minority community leaders – [explaining] this is what’s happening, this is a leaflet on it in different languages, get out to your communities and explain, it’s only a pilot, it’s only in the following GPs, but we want you in those areas to know what’s happening - if there was some community ownership of the service, I guarantee you that there would’ve been a lot more than 25% take-up. (FG a-h)

**NGO A:** There should be openness about the way [advertising material] should be displayed. From census or other sources you can find out where pockets of particular nationalities are so you have more info in those languages disseminated in
that [geographical] area... now don’t laugh, but in the men’s toilet is the best place to advertise it. Community groups have their networks, newspapers, websites, shops, ethnic shops, mosque, so everything - people are going to churches, public places, airports, social welfare office. When you go the first time to the social welfare office you could receive it in your own language... (FG a-f)

An interesting ‘matching’ feature of the data is that some general practitioners who fell into the ‘unaware of/have forgotten about the service’ group, once they were informed or reminded via the research process, clearly expressed a willingness to consider using it:

#17 A: Who pays them, the health board will pay these interpreters?
#17 Q: Yes the health board pays all the bills from the pilot interpreting service company that come through logged requests from the GPs on the system.
#17 A: We should be using it more really.
#17 Q: Certainly it’s free, it’s accessible, it’s available and it makes no difference where you are geographically in the region, obviously, if you are using the telephonic interpreting service.
#17 A: Send me on the details. (F; NON-USER)

#14 A: I mean I’m glad you rang because in a way you’re reminding me that [the interpreting service] is there (laughs)...
#14 Q: Yes...
#14 A: ...and that is, and that it is a service that is also available on the phone, it doesn’t mean that we have to get somebody down from Dublin to sit in with us. (M; NON-USER)

The willingness on the part of general practitioners to consider using the service is likely to be matched by a desire on the part of service users to avail of it, once they know it exists and is free of charge. Essentially, lack of knowledge can be overcome and does not need to remain an impediment to service uptake.

Able Workforce

Aligned with the underlying resource of ‘knowledge’ about the interpreting service, an able workforce is required to negotiate the use of the service within the organisation and integrate it into existing patterns of activity. General practitioners, practice nurses, practice managers, and receptionists—the entire workforce that interacts with a service user who needs interpreting services—must understand and agree together, either tacitly or overtly, on the allocation of
control and infrastructure resources required to successfully achieve normalisation of the intervention.

The ‘allocation of control’ could mean, for example, the understanding within the organisation about how additional tasks associated with interpreted consultations are to be handled – this ought to be clear and unambiguous.

The ‘allocation of infrastructure resources’ might refer, for example, to arranging separate waiting spaces for interpreters and service users prior to their entering the general practice consultation room.

Moving on to other capacity issues, ‘time’, ‘money’ and ‘will’ emerged as other resources that are also crucial to the integration of the interpreted consultation into daily patterns of activity.

**Time Pressures**

The key question here is does the workforce have the capacity in terms of time to figure out ways of integrating interpreted consultations into the everyday activity of a busy surgery? The data indicate that this is, in fact, extremely challenging. This is primarily because normative constructions of ‘time’ in general practice dictate that, on average, standard consultations should be completed in ten-to-fifteen minutes, and practice administrators typically plan appointments on that basis. The general practitioner, in turn, can expect to see service users at ten-to-fifteen minute intervals. However, this norm is radically interrupted when a service user needs an interpreter, and the workforce must navigate this new situation.

It is clear from the data that when a service user with limited English proficiency arrives at the reception desk, a number of choices must immediately be made and a time pressure is created. It takes time for administrative staff to assess the need for an interpreter, the language required, contact the company, wait for a response, and find a ‘window of opportunity’ to match the interpreter’s availability to that of the general practitioner.

On occasion, administrative staff assess a service user’s need and judge that an interpreter is not necessary but, within the first few moments of the medical consultation, the general practitioner may realise that the service user actually has insufficient English for the developing complexity of the complaint; in these
cases, the general practitioner judges that the language barrier is insurmountable and will utterly frustrate the work of the medical consultation. At this point, the general practitioner or practice staff makes contact with the interpreting company. Typically, the service user is returned to the waiting area and all parties now await the arrival of an interpreter (on site or on the other end of the phone) and, again, have to find a ‘window of opportunity’ through which to continue the consultation. The general practitioner takes the next-in-line service user, knowing that the ethnic minority service user awaits her/his attention and the tension in the building is rising.

In addition, interpreted consultations are described by general practitioners as ‘long’ – sometimes taking ‘up to half an hour’ and in some cases, even longer. This is supported by quantitative data from the interpreting company showing practices in the ‘highest frequency’ category with a significant number of telephonic interpreting sessions going beyond the basic 15 minutes charged, with some lasting 40 minutes. Even more telling, among these ‘highest frequency’ practices, on-site interpreted consultations are, on average, one hour in duration. This is the precise case for this general practitioner:

#4 Q: So interpreted consultations take longer?
#4 A: You’re right, damn they do, yes.
#4 Q: So that really is quite a...
#4 A: Oh yeah, it’s a huge issue, it slows down the whole process... (M; FREQ)

The more we engaged in educative dialogue with general practitioners, the more we learned about time pressures and related stresses:

#3 Q: You’ve mentioned time, and effort. And that’s one of the things we’re very conscious of – that most interpreted sessions take longer than a regular session. Now that must put a strain on the whole system, on you, on the practice, everything – what’s that like?
#3 A: It does. It is, yeah, it does put a strain, em, you know, it does put a strain on the system and usually puts you behind because we’ve all fifteen minute appointments whereas their, sometimes their consultations would be quick but in general they’re longer than the normal, they’re twenty minutes or maybe twenty five or thirty minutes, so, em, it does put, put a strain on, you know, on you – because we’re nearly always fully booked here all of the time anyway – and then... there’s all this add-ons on top of that, em... and always phone calls with extra problems that need to be sorted out, so there isn’t the time there. (F; FREQ)

16 An aberrant case which may be an error in the company records has been deleted from this calculation – if included, it would escalate the average time for an on-site interpreted consultation to almost 2 hours.
People say, you know, it’s time consuming initially but you save time in the long term. I don’t know that you do save time in the long term, I don’t think that there’s any saving time by using interpreters. I think it always takes more time.

Yeah…

And if anything the patient is more likely to return to you, so you’re more likely to continue to have longer consultations. So using an interpreter is a better consultation, but that’s where the advantage begins and ends to some extent. It doesn’t save time, I don’t think – it will always take up more time, and that’s the problem, because you’re always feeling really under pressure for time. (M; FREQ)

These ‘extra problems’ that occur outside the consultation take time to resolve – time that is never included in the timesheets of the interpreting company, but is certainly experienced as additional pressure by general practitioners and administrative staff. These lengthier interpreted consultations also have to be integrated into a busy surgery:

Most days… I would see between 20 and 25 people in the morning and between 15 and 20 in the afternoon, 45, 50 a day so like… obviously there will be people [coming] in that might take 45 or 50 minutes already you know, because I always give extra time to people who have problems, but adding an extra layer on top of this, sort of interpreters, can be problematic. (M; INFREQ)

And I have a huge practice, trying to service them all, and literally we are closing our practice in two weeks time, our list is being closed for the next four or five months because we just can’t cope any more. It’s [time] pressure like. You see we, our practice works on not just appointments, we do an open surgery...

So personally, it’s someone like this who’s sick, is going to come into the open surgery, open surgery means they come in and wait… but on a Monday morning, I could have fifteen sitting outside waiting...

So what do I do, put this person sitting outside and wait for an interpreter? Probably that’s what I should do. (F; INFREQ)

We work by appointment but I don’t know from when I come in in the day who’s going to need an interpreter at the beginning of the day, and when they present in here, to
In non-emergency situations, service users can be asked to return for a planned interpreted consultation. This is the arrangement that is most easily incorporated into the daily activity of a surgery and, to some extent, alleviates the time pressure on the practice and its workforce. However, this is suitable for non-emergency conditions only and where an open surgery operates, service users may arrive who immediately require an interpreter. In cases like this, the time problem and the pressures it places on the practice are exacerbated.

Ideally, general practitioners need the impossible: an on-the-spot interpreter. As GP#14 said, interpreters are needed “at the flick of a switch”. But the time delay involved in arranging interpreting, whether telephonic or on-site, is unavoidable.
Several general practitioners linked the fundamental time pressures associated with interpreted consultations to a *loss in earning power*. There is some evidence that non-users and infrequent users of the service fear this will be the outcome if they use the interpreting service regularly.

Other general practitioners reflected on the influence of practice type (whether predominately *private* or *medical card* service users) on this issue. This general practitioner, who works in a practice with mostly medical card service users, explains that they are more relaxed than a private practice might be about giving extra time to interpreted consultations, although this impacts on appointment times:

#2 A:  
*Em, I suppose it’s just a matter of how you, how you view your business basically. Em, you know, and that’s different in different places... we are, the vast majority, a medical card practice, so, we probably are a bit more lax with our appointment times than somewhere that’s private and is run as a more efficient business, you know. And I think that influences it, so we don’t mind [the time pressures]. (F; FREQ)*

Representatives of ethnic minority communities asked an important question in relation to the capacities of general practices to absorb this economic burden:

NGO C:  
*Well, maybe you’d know more about the medical card system and GPs than I would, but are there GPs who have such a burden of medical card holders that they don’t balance that out with sufficient private clients or fee-paying clients and that’s why, that’s where the breakdown is? (FG a-h)*

In response to this question, we could see that time pressures and impact on earning power do present problems for certain medical card practices because

- They already take a ‘loss’ in earning compared to their colleagues in ‘private practices’
- They are often located in areas with disadvantaged communities and are already stretched because of the complex health and social care needs of their service users
- They have the highest numbers of ethnic minority service users and therefore the highest need for the interpreting service.

Among these general practitioners, there is a sense of concern for the health care of ethnic minority service users, but this is coupled with a real fatigue and
frustration that the capacity of their organisation is being stretched beyond its limit:

#24 A:  I’m constantly sort of, you know, surprised that people are falling off our radars when they should have had their vaccines and didn’t get them or didn’t follow up with the results of a bad blood test or something, yeah…..The point is that, yeah, I don’t believe for a moment that the non-nationals are getting the best deal that they can get or the best treatment they can get, I mean, but I would have to use the same argument, they don’t give the diabetics or the hypertensives or the arthritics or some of the other people, the lung people… the best deal they can get. So, in general practices it is just very, very busy. (M; INFREQ)

#22A: If you feel that you are being paid the bare minimum for the whole lot of them [medical card patients] and there are this particular bunch that take extra time [ethnic minority service users with limited English] you say, well that is the job, and live with it - but eventually you get to the stage where you are saying stuff the whole lot.

#22Q: Do you feel like that sometimes...?
#22A: Obviously yeah, I mean there are worse jobs etc. but, you know... (M; INFREQ)

GP#2, quoted below, and a limited number of other general practitioners were the only ones who considered that acceding to the time pressure could be considered an investment in the long term. This was described as an investment made for better clinical outcomes, not a financially rewarding one:

#2 A:  ….you might spend a longer period of time initially, but it’s worth it in the long run because you know, it’s easier to get to the issues and solve the problems as much as you can, deal with whatever needs to be dealt with. So I think, I think clinically it’s very worth it, you know, putting in the investment in the time to begin with and yeah, it does create time pressures, but you know, that’s, that’s, so do lots of other conditions and you just have to deal with those as they crop up, you know, we don’t find we have to do it terribly often, so. (F; FREQ)

#13 A: Any time I’ve used it, it’s taken me ages. It does take longer but it’s far better in the long term.

#13 Q: Yes...
#13 A: You know, and you just have to factor in the fact that it takes longer. (M; FREQ)

A senior trauma therapist working in the field of ethnic minority health care responds from her perspective to the tension general practitioners describe
between ‘not financially rewarding’ and ‘better clinical outcomes’ and is clearly in favour of thorough initial consultations:

**Q:** You were going to make a comment...?

**NGO B:** (Picking out card from bundle) - 'Not financially rewarding’ – well, my argument would be that if clients were seen for a longer period in the initial consultation, the patients would have to return to the GP far less often than when they are actually not totally being heard and not really having the problem addressed in the first place.

**Q:** Okay.

**NGO B:** I’d say that particularly for asylum seekers, refugees, torture survivors, trauma survivors - a lot of the literature would recommend that in working with that client group, the best practice would be that, in the very beginning, whoever is the first point of contact, which often is the GP, a full assessment is really important, and using an interpreter in that consultation. And I’ve yet to see that really being best practice in our country unfortunately.

**Financial Incentives**

There was general consensus among our sample of general practitioners that incentives from the HSE for general practitioners to use interpreters would be a valuable way of addressing time pressure and associated economic consequences:

**#16 A:** The odd numbers [Dublin city postal codes] where you’ll have more GMS, more elderly, more immigration - I suppose you could start targeting those areas in a more positive way. That’s another way of looking at it. They are trying to work out where the needs are and then maybe have quick access or an emergency interpretive service you know. So there’s... plans for needs, rather than global provision. (M; FREQ)

**#4 Q:** Regarding improvements to the pilot service?

**#4 A:** If I wanted to improve [the interpreting service], I mean, yes, I suppose I have to say there are issues around finance around it as well, I mean, I think we do put a lot into our ethnic minority patients and if it was equitable as it’s deemed, in terms of - I look at colleagues in other practices, I mean I think we don’t get the remuneration for looking after them in bulk... I think we have worked an arrangement with Hatch Hall which is satisfactory, I suppose, to our needs, but I’m not sure the - you know, we can talk medical politics and IMO contracts and what’s arranged - and there was something, an allowance for looking after ethnic minorities, and I don’t know where that is at the moment, I don’t know if it’s being honoured by the health board or what’s happening with regard to it, but em,
we certainly put a lot of time into our ethnic minority people. (M; FREQ)

#3Q: Would you have any kind of thoughts or suggestions about how that could be supported more? You know, in the broader system, because this is one of the things we need to look at, what supports are needed?

#3 A: Yeah, well I suppose if there was a financial incentive it might help practices, em, but that's probably something that, that would all go back to the GMS, eh, contract which is actually due for renegotiation in the next few years, so that may well be one of the... one of the issues brought up at that stage, you know, that there might be, you know... extra payments for dealing with, em, you know, patients like that who require extra time, interpretation and all of that, you know. Because we do get, you do get extra payments for certain things that you would do with your medical card patients that require extra time or, if you see them out of hours and all that sort of thing, but whereas seeing them during normal routine hours, you wouldn't get any extra payments for any of that, so you, you are losing out that way, you know, financially. (F; FREQ)

Will

Time pressures can also diminish motivation or the ‘will’ to arrange an interpreted consultation. Under time pressure, several general practitioners judge that it is not worth calling on the interpreting service because access and ‘delivery’ is rarely easy or quick; time delays cause disruption to the flow of work in the surgery; interpreted consultations put pressure on the system and create tension in the practice. Stark choices may be made – general practitioners often elect to ‘muddle along’, either without any interpreter, or with an informal interpreter or alternative strategy:

#1 A: I should mention this, because it’s true, if I was really under time pressure I wouldn’t call an interpreter.

#1 Q: If you were really under time pressure you wouldn’t call an interpreter at all?

#1 A: I wouldn’t call an interpreter, at all. (M; INFREQ)

#19 A: I suppose from our point of view it’s the time it takes, the disruption to consultations and stuff, and if there is somebody with them at all it’ll do grand, and just keep going - if you’ve twenty people sitting outside just to try and keep the whole thing moving, and that’s just what we’re getting away with. (F;INFREQ)

#16 A: But in the cold light of day, it’s easier for me to have a friend of the patient there who speaks English, if I had to have an interpreter that was insured and rubber stamped by
central office it would slow my day up. Because there are emergency walk-ins every day who have limited English. The idea of that person coming in as an emergency and me having to ring up [the pilot interpreting service] and the response time is an hour to get somebody out, or two hours, when I'd prefer to be doing house calls. (M; FREQ)

#6A: I think a lot of the more Eastern European kinds (of service users) would have reasonable English, or if not, they bring someone with them.

#6 Q: Mmm...
#6 A: There seems to be more of a culture of that.

#6 Q: Yeah, ok, so if an Eastern European person arrives here and they have someone with them, I think you were saying this at the very outset, that [if that] person is prepared to act as an informal interpreter, if, you know, it's their friend, or a family member, whatever... you'll roll with that?

#6 A: We'll roll with that.

#6 Q: That would be the policy almost?

#6 A: It's quicker, more time efficient, easier...Em... you'd probably say to them, you know, “Is that ok?”, because you'd probably have to ask some personal questions and, you know, so... (M; FREQ)

However, from the perspective of NGOs representing the ethnic minority communities, ‘rolling with it’ may mean best practice is being compromised and general practitioners and service users need to be appraised of this:

Q: But what do you say to the service user who clearly indicates to their doctor ‘I'm really comfortable with my friend here... I’ve asked her to come with me as my interpreter’, what do you say to the choice of that service user in that situation to bring that person in as their informal interpreter and say I don’t choose a formal interpreter, I'd like my friend to do this, please?

NGO B: Yes, well, we have that constantly here... I explained to a Muslim woman recently who had her daughter interpreting (and she had being doing it for a lot of others) and I explained to her that I don’t know anything about her, but there may be stuff [in later consultations] for example around sexuality, intimacy, relationship, whatever - and would this be ok with your daughter interpreting? And immediately she got that message. Immediately. But if you haven’t had that explained to you, how do you know it’s not going to [work], and she was very appreciative and then she wanted an older woman as an interpreter and that’s how we [proceeded]. We have a responsibility, I believe, as professionals to offer that [guidance].

Q: So you have to almost, in a sense, offer that bit of insight and education?
Another consideration is the will of a general practice to increase its capacity to respond to the challenges associated with the work of integration. The data indicate that there was little proactive response to the challenges experienced. For example, to our knowledge, a very small minority of practices have attempted to initiate double appointment slots for interpreted consultations but this happens on an ad hoc basis and is not a formal practice policy.

We did observe, however, that some practices were proactive in other ways. In this quote, a general practitioner describes his experience of reviving his French language skills, his motivation to learn other languages and his willingness to provide French language classes for practice staff:

#1A: I revived my Leaving Cert French and started to practice it, and that actually was a huge help because a lot of them [service users] were say, Rwandans, Congolese...

#1 Q: Yeah, former French colony...

#1 A: Former French colonies, yeah. So, that actually took a huge swathe of people, in fact a lot of French people came to the practice as a result of that. Now, that was the best experience of all, because obviously people appreciated when you spoke the language....

#1 A: I was talking to A ______ [colleague in practice] I was talking about the idea of going off and doing Russian or Polish to see if that would help, because I sort of found the French experience so good, I was wondering about the possibility of learning that [Polish]. I think there’s, there is something about developing the language skills and getting the language skills amongst the, em, amongst the doctors....

The other idea was to get a Polish doctor, I’ve heard of one, but in fact I can’t find one at the moment.

#1 A: We hired in a French teacher for the practice staff, to give them basic French, and we did a course - it didn’t go beyond the course, though, because they found it very hard to cope with French and even though they could speak small, minimal bits of French, they didn’t develop huge proficiency. They still try it every now and then but they’re not particularly good at it, so we did attempt to try and train them in French. (M; INFREQ)

His colleague mentions her own training in cultural diversity and notes the value of cultural diversity training:

#13 A: I did a wee course with the NCCRI, they do anti racism and inter-cultural awareness training, but they call it ‘training for trainers’ so they teach people to teach it, if that makes sense.
There were other examples of practices which utilised bilingual reception staff (e.g. secretaries from Poland, Slovakia) to provide interpreting in an attempt to augment their organisational capacity. While positive in some respects in the sense that it indicates a desire to address language barriers in the practice, these strategies serve to circumvent the use of the available interpreting service.

On the whole, the practice of employing informal strategies as alternatives to the pilot interpreting service, or to circumvent it, is clearly perceived in a negative light by representatives of ethnic minority communities. They outline many reasons for eschewing such practices. There is the issue of less-than-holistic care, false economies, underlying psychological conditions going unresolved leading service users to return again and again to surgeries, and the dangers inherent in service users with limited English trying (and failing) to communicate with general practitioners:

NGO B: We are missing the point, if we say people’s English is fine - what is fine? How is fine? And also if we say ‘fine’ do we miss out on good holistic care? I would say in the longer term it’s an economic issue, if people keep going from one centre to another and accessing lots of people when their issues should have been dealt with in the very beginning with a good holistic assessment with an interpreter from their country of origin, whether they speak English or not. We are not adhering to best practice around this. What we are doing is we are just losing out in terms of time, economics and energy...

Q: It’s a false economy?

NGO B: It’s a false economy. [You need to] get the full history, social, medical, psychological, legal and otherwise. So, very thorough at the beginning. That’s where you save the time.

Q: If the [service users] you mentioned aren’t getting that kind of first experience, what are the consequences, would you see?

NGO B: Em... poor communication around some of the underlying issues to the medical problems. You know, the client maybe presenting with quite a number of psychosomatic illnesses, for example... For this client group, it’s much more of an advantage to look at the person as a whole person at the beginning. Because if they are exiled for any reason, whether it’s torture or trauma, you know, or political oppression - it doesn’t matter, the impact is much more
than on a physical [level] because the physical issue very often can be addressed quite easily. But that’s the very nature of a lot of the reasons why people are continually accessing GPs is around some of the unresolved psychological issues which are presenting as physical.

Q: Okay, and [because of absence of interpreter] sometimes that isn’t delved down into enough?

NGO B: No.

NGO C: Yes, the experience we have here is that they are going in - they are presenting their difficulties in their own damaged English and the communication is breaking down at that point, treatment doesn’t resolve the difficulties for them, and so the relationship tends to go backwards… (FG a-h)

NGC C: There is a serious undercurrent here that there is a growing disenchantment between ethnic minority communities and the GP service, you know, their faith in it - and it’s not all an accurate interpretation of the medical system in Ireland - some of it is maybe misperceived. (FG a-h)

In contrast to this experience of diminished confidence in Irish general practitioners, there is a clear appreciation of the positive difference that knowledge about, access to and uptake of formal interpreting services might make to ethnic minority service users, and how this could ameliorate possible misperceptions about Irish primary care:

NGO C: So, the difference between a client from an ethnic environment going in knowing that they have an entitlement to ask for the interpreting service is that they might go in with a sense that, you know, something might come out of this if I ask the GP for the interpreting service… (FG a-h)

As part of our educative dialogue, we asked one general practitioner to imagine herself in the service user’s shoes:

#19 Q: This is a question I actually haven’t asked anybody else up until now: Have you ever imagined what it would be like to be a service user coming into a GP surgery, possibly for the first time even, not speaking more than five or six words of English, vulnerable in that you’re unwell, and just not knowing what to do next?

#19 A: Not really, it’s not really something I’ve really thought about - putting myself in their shoes – scary thought!

#19 Q: Why is it scary?

#19 A: Ahm, because I suppose they’re at a HUGE disadvantage. You know, I mean, even Irish people are at some disadvantage coming in, because you’re trying to - it’s not as bad as it might have been ten years ago – but you’re trying to explain yourself, something you’re worried about, concerned about and upset about, but I suppose if you
3.2.1.3 Value Accrued

Value accrued to the organisation refers to a sense of benefit the organisation expects to get by delivering a particular service. The data indicate that many general practitioners place a value on equitable access to communicability for their ethnic minority service users and on delivering the kind of holistic health care that representatives of ethnic minority communities have referred to.

However, it is challenging to deliver on these values because of the various time pressures and financial consequences outlined earlier. Some general practitioners reflected on the fact that they would often like to have more time for ethnic minority service users (and other service user groups) but they must also attend to the organisational context and pressures. Put simply, general practitioners cannot always do things as they would like to. In this case, general practitioners may wish to use the interpreting service but the organisational challenges of time and money act as major barriers to its uptake.

#23 A: There’s time constraints as well, I suppose, you know, where we want to provide the best service, a lot of the time we don’t realise that an interpreter’s needed until they turn up, it’s, you know, you try your best to deal with whatever problem the patient is bringing to the table. You know, in an ideological world and perfect primary care, you’d be inviting them back and having a set time when an interpreter would be there. (M: INFREQ)

This would explain why even highest frequency users of the interpreting services are not exclusive users and why practices with open policies of inclusion are not necessarily users or frequent users of the service. For most general practitioners, the organisational losses seem to outweigh the organisational gains.

3.2.2. Skills: Making it Work

Having begun with the big picture – the contextual framework of a general practice within which policy, knowledge, resources and abilities coalesce (or fail to coalesce) to support the implementation of interpreted consultations – our focus turns now to the mechanisms by which knowledge and skills about the implementation of interpreted consultations are distributed across the workforce. For example, implementation of an innovation typically generates new tasks and
duties and it is important to examine who takes these on (NPM Skill Set Workability).

In this project, this refers to additional tasks and duties associated with the implementation of interpreted consultations. Who could, or should undertake these tasks and duties? Do additional tasks ‘fit’ existing skills and roles of the workforce – the general practitioner, administrator, and interpreter? Is training required to provide skills to execute these new tasks and duties?

Here we describe:

- a range of **new tasks and duties** that are associated with interpreted consultations
- the issue of **training for new tasks and duties**
- **educative dialogues about training**.
3.2.2.1. New Tasks

As described in the first part of the results, administrators and general practitioners have to spend time assessing the need for interpreting for an ethnic minority service user. Earlier, we focussed on the organisational context and pressures associated with this work. Here, we focus on the way in which this work ‘fits’ the existing skill sets of administrators or general practitioners.

Assessing the Need for an Interpreted Consultation

The task of assessing the need for interpreting is a significant one. The bulk of the data from general practitioner and administrative staff show that this task is undertaken by administrative staff at the reception desk. Sometimes, this task is undertaken by general practitioners because of the nature of the unfolding consultation. It seems that general practitioners and administrative staff develop this skill over time and use subjective criteria to assess whether or not a service user has ‘good enough’ English to manage without an interpreter.

A related task required of administrators and general practitioners is to decide which type of interpreter to call. Data from both groups indicate that telephonic interpreters are considered suitable for acute conditions because these need immediate attention. Generally, on-site interpreting is organised for less acute conditions because there is scope to arrange an appointment for a later date. Again, this skill seems to be developed over time based on experience. In some practices, the interpreting mode chosen relates to general practitioner’s individual preferences for one form of interpreting over another; this is described in more detail in section 4.

Organisation of an Interpreted Consultation

There is also a set of tasks involved in actually organising an interpreted consultation (create/use IT systems to check the need for interpreted consultation, telephone the interpreting service, identify suitable appointment slots, negotiate mutually suitable times between the interpreter, service user and general practice, find a window of opportunity to match the interpreter’s availability to that of the general practitioner). The majority of this work is carried out by administrators at the reception desk.
Administrators emphasise that the tasks involved are challenging and it is often stressful organising an interpreted consultation. However, overall the data from general practitioners and administrators indicate that administrators accept these tasks as being part of their duties. We infer that they see the new tasks and duties as being compatible with their professional role and identity. There is some evidence that there is a domino effect at play in that individual general practitioners, as key decision-makers in the practice, influence administrative staff towards acceptance of these tasks as part and parcel of their jobs/identity - they are expected to complete the tasks necessary to facilitate ethnic minority service users with limited English. This is an example of the way in which informal practice policy (described in the first set of findings) can influence professional roles.

It is interesting to look at examples of ‘successful’ divisions of labour in the practice whereby this work is hidden from general practitioners because the organisation of interpreted consultations is ‘streamlined’:

#2 Q:  
So we’re kind of interested in just how that is actually working out through the whole system, you know?

#2 A:  
…..what we do, often we have like on our computer files, the first page of it, if you like, is all their personal information, you know, and usually on that is written if somebody needs an interpreter, so whenever they come to book an appointment it comes up saying ‘needs interpreter’ and the girls just automatically organise that then. (F; FREQ)

#4 A:  
I’m thankful I’m removed from that [organising the interpreter]…. because I’ve a good team and they, they set someone up with me, I just, it’s someone walking in the door with an interpreter with them, and that just happens, fait accompli! (M; FREQ)

#24 Q:  
So what would your sense or experience have been of trying to get in contact with [the interpreting company], you know, the times that you did need them, the time issue and setting it all up, what would your…?

#24 A:  
I haven’t done, what I have done is I have simply asked the girls at the front desk to get a Polish interpreter and within a few moments they would have an interpreter here. (M; INFREQ)

These quotes illustrate that often the division of labour is so successful that general practitioners have little idea of how challenging it is to organise interpreted consultations.
3.2.2.2 Training for New Tasks and Duties

We know from our first set of findings (organisational context) that, despite the offer from the ICGP for training about intercultural issues, no general practice received training relevant to the implementation the complex intervention. Some of the new tasks and duties associated with implementation and described above do not require training (e.g. making telephone calls to arrange interpreters) but others do (e.g. skills to assess the need for an interpreter, to identify the most appropriate kind of interpreting). There are further skills required to participate effectively in an interpreted consultation. As one general practitioner simply stated:

#18A: Our training never involved having a third person in the room.

Our understanding from general practitioners is that both administrative and communication skills mentioned here tend to develop over time and ‘on the job’.

#2 Q: Patients coming through with no English at all, and in a sense there are arrangements that need to be made, what’s that like for the practice itself? How is that handled?

#2 A: I think it works very well now, I think it used to be extremely difficult when we didn’t have this option and, em, it used to be fraught, you know, I suppose down at the reception desk, they were trying to figure out what do you want, who do you want to see, where, you know, and they used to find it very difficult. Whereas, eh, now they know straight away, to book somebody in for a longer appointment and to book, to have a translator at the same time. And they do that pretty much automatically now, they try to communicate that to the patient, that there will be a translator there, which they seem to manage to do, and I think that helps, I think that just makes it easier for everyone. (F; FREQ)

#5 Q. What would you say to any other GP who hasn’t ever tried the telephonic service that you are familiar with and yet they do have patients coming along who might benefit from it...?

#5 A. Well, I will tell you what I would say actually – it’s like a skill for any sort of job. I think there is skill to it. And there is a skill to learning to use a telephonic service properly. And what it teaches you to do is to what I call have high value questions. You don’t ask questions - you have to ask very direct questions first of all that you want a specific piece of information from. And you need to also ask questions that you know are relevant to the patient’s complaint. I think in someone sitting down in front of you, both of you speak English, you can kind of go on a fishing trip and ask
questions that aren’t directly relevant to the main complaint, but you get there in the end, you get the right information. But in this, because it’s so much slower to go through the phone to the client and the client back to you, you really have to make every question count because otherwise you are wasting time. So it teaches you to be more selective in what you ask and perhaps to phrase your questions a bit more clearly. And that’s a good skill, in a way, because I think you can transfer that skill back to ‘normal’ consultations, if you can call them that. So that would be the main thing. (M; FREQ)

Few general practitioners raised the issue of training or training needs during the first round of interviews. If asked explicitly or directly about training, some did acknowledge its relevance:

**#22Q:** Do you think training would be valuable?

**#22A:** I suppose I think we are muddling along fine, but if you went to training you’d probably discover nuances that you hadn’t realised, or you’ll always learn if you are properly trained, you know, you never know everything! (M; INFREQ)

Of those general practitioners who did consider that training would be valuable, some mentioned the potential role of the

- Irish College of General Practitioners (e.g. ICGP Continuing Medical Education Groups)
- Postgraduate General Practice Training.

This lack of training for general practitioners can be problematic – the independent interpreters who participated are clear about the challenges they face when working with general practitioners who are unskilled and unfamiliar with the roles and responsibilities of interpreters:

**Q:** Okay, yes, and do you ever experience difficulties?

**FG #11a** I did experience – well, this is from the doctor’s side, because the doctors are not used to working with the interpreters - sometimes they talk to me directly as if the user was not there.

**Q:** Ah, okay.

**FG #11a** So that breaks the link, the communication link between them, and it creates a link between [interpreter] and the doctor or the other way round as well. The user tries [to get the interpreter] to mediate for them, so if the doctor has gone to get some papers outside or something, they start saying ‘Oh, could you please tell the doctor and make sure that he knows...’ It’s not our role to be there gathering information when the doctor is away. So that’s one of the difficulties I think. I think it’s... it’s important.

**Q:** What would you do in that kind of scenario?
FG #11a  What I usually do is... I'd refer back to the doctor and say: 'Listen, wait a minute, the doctor will be here in a minute and then we will talk about that. You repeat that [to] the doctor', that’s how we kind of wrap it up so it’s brought up later on.

Q: There is a sense among some GPs themselves that they are not trained, they recognise it’s quite a skill, in fact, to manage that triad...

FG #11a  Yes, some of the doctors, like, they wouldn't know that the interpreter speaks in the first person, like, you know. And they would be confused when [the interpreter] says 'I am sick'. Oh, you are interpreter and you are sick!? So some of the doctors they are not trained, they don’t know how the interpreter acts in the interpreting session, like.

One service user representative pointed out that, because interpreted consultations are complex, training for interpreters will take us only so far; training for the other key professional in the triad is critical in several respects. She suggested that many general practitioners might benefit, not only from support around the practicalities of operating in an interpreted consultation, but also from a thorough awareness and understanding of the impact of culture and ethnicity on the interpreted consultation.

Q: These are complex interactions...?

NGO B:  It really is very complex and unless, as I say, the interpreter and the clinician are equally understanding of the complexity of it, and when it works well and when it doesn’t work well, that’s when it breaks down. You could have a very good interpreter who is with a clinician who as I said is just not experienced, or has no training working with him, and it’s as bad as having a bad interpreter. So I have come to believe that all this training stuff about interpreters and translating and all that - unless we move into the work with the clinicians as a whole we are missing out hugely.

Q: When you say move into work with the clinicians...?

NGO B:  Training, creating awareness around cultural differences, communication barriers, and how to do it. How to do it - practice around how to do it.

As asked by a different service user representative if general practitioners had suggested they needed cultural or ethnicity awareness training, the researcher acknowledges that this was not an overt feature of the research encounters to date.

NGO A:  I suppose another question that it brings up is the training of GPs and [other] users of interpreters – and the training, obviously the cultural training – is so important. I mean some of them obviously have it but, you know, that is so important... I mean, did that come up at all?
Q: People haven’t directly said that. I mean, I haven’t heard GPs say directly to me out of the blue, if you like, well what we GPs really need is training in cultural understanding, you know, training in ethnicity awareness.

One general practitioner felt that training of this nature should be seen as mandatory in general practice work:

GP#13: Rather, I think it should become statutory, you know. It’s a bit like health and safety and all of that you know, it should just be something that has to be done. (F; FREQ)
3.2.2.3 Educative Dialogues about Training

It is critical for the normalisation of most innovations that training is provided; training that is designed to support implementation, to generate confidence in new or changed roles and relationships, and to enhance the skills of all the key actors in the network. In our second round of interviews, prompted by the questions raised about training by service user representatives, and as part of our ongoing iterative educative dialogue, we asked general practitioners directly about three areas of training:

1. Training/guidelines for general practitioners and relevant practice staff around organising interpreted consultations in the daily life of the surgery; assessing the need for interpreting; choosing between interpreting modes.

2. Training for general practitioners and relevant practice staff about language barriers and working effectively with interpreters and service users with limited English; information regarding skills general practitioners need; also information regarding the nature of respective roles, responsibilities and needs of general practitioners, interpreters and service users interacting in interpreted medical consultations.

3. Training/guidelines for general practitioners and trainee general practitioners about the limitations of informal interpreting strategies.

Asked if any or all three areas were potentially useful and if so, why, the vast majority of general practitioners responded affirmatively. Interestingly, general practitioners who are highest frequency users of the pilot service expressed high levels of interest. Several made suggestions as to the potential nature of the training, how to deal with related time/energy issues around attendance or completion of training, and how delivery mechanisms would need to be flexible and carefully designed to suit various needs and tastes, ranging from interactive internet modules to written guidelines or on-site workshop-style training:

#2A: I think something that would encourage me to use [the interpreting service] more would actually be further training – particularly even at this stage in relation to something we discussed earlier about, you know, the role of the interpreter, and those kinds of things, they're still areas you could learn more about and improve on. And that would definitely give you more confidence and make those interpreted consultations more effective, you know. All of the [suggested areas of training] would certainly be valuable – I think the first one certainly because it mentions the other practice staff and the organisation of consultations, and that's the first contact and that needs to be handled well and practice staff need to know what they're doing and how to do it and why they're doing it. And the second one about language barriers - it ties
in really because, you know, having the understanding of language barriers and how to work around them is part and parcel of using the service appropriately and effectively. The third one is also important, especially for trainee GPs coming through… (F; FREQ)

#6A: Yeah, all types of training would be good. Another way of doing it would be sessions through the CME [Continuing Medical Education] system. Just looking at issues of language and interpretation, that would be possibly even more effective, sometimes workshop type things can be better, you know, very short, concise, you go away with ideas of how to do it and you take that into your own practice. Something thought-provoking, not too laborious. (M; FREQ)

#1A: I think [training] would be valuable but I do think what’s key is – it’s not so much the training as the time issue and delivery mechanism – that’s the key element for me, how you fit it in with time. (M; INFREQ)

Other general practitioners point out what might deflect interest in training and what mechanisms might enable it:

#4A: Ok, I think, an overall response to that - training is always good and important but the nature of the training is a thing I’d be very careful to highlight - I’m not going to realistically take a day off to go to a training thing in this regard, I’m just not, with the way things are backing up around me, and most other GPs will be the same. So how you organise training nationally – I’m not sure at that level. I’m a big believer in education, in getting something online rather than something arriving in a book to me. The book arrives in the post to me, where do I put it, which file? And it goes with all the other reports that I get in during the week. I’m a big believer in having something online where I can go and retrieve it, so if guidelines are put up on an easily identifiable website - it can be printed off for GPs who are not computer literate or for members of staff - there is a repository of the information there online. The learning modules in that regard can be highlighted as well, if someone is interested enough to look it up they will be directed to go and look at the training module on-site and they can sign off on that somehow. (M; FREQ)

Concentrating specifically on telephonic interpreting, this general practitioner adds:

#16A: What I would say is best is [to do it] just like a drug rep – somebody comes around to the practice and does one model example – just says: just imagine that I speak Russian and sits in front of the [general practitioner] and gives them a number and the GP rings the number and there’s a guy at the far end, that’s what I would do. What’s very important is to deal with the perceived hassle, to explain – I think a visit [like that] to assuage perceived concerns, that’s all. (M; FREQ)
The non-users of the pilot service had interesting and open attitudes towards training for interpreted consultations:

**#17Q:** Research shows that admin staff and general practitioners have had to learn on-the-job; they have had minimal assistance - would the first type of training be valuable?

**#17 A:** Yes, because we don’t know what would happen if we do ring, how long would it take, so we’re kind of daunted before we begin...

**#17Q:** So do you think that first type of training would be useful?

**#17 A:** Yes, yes.

**#17Q:** The second type of training is about language barriers...

**#17 A:** My big problem is getting hold of an interpreter, and the procedure that would lead to doing it. If I’d done that a few times, I might know what problems would arise... but we’re naïve because we haven’t used it, so we really don’t know.

**#17 Q:** The third type of training would highlight the limitations of informal interpreting strategies...

**#17A:** Yes, it may be more circuitous [to use the service] but it would be better in the end. (F; NON-USER)

A small number of general practitioners seemed reluctant or reserved about the value of training but mainly on the basis that they had very few interpreted consultations and saw little need for it. The problem with this is that it is a circular argument – many general practitioners have few formally interpreted consultations because they utilise informal strategies, attempt to get by without, or circumvent the system; this reduces their uptake of the service and therefore they may not see themselves or their practice staff as a focus for training in this respect. However, what we must keep firmly in view is the fact that training for general practitioners and practice staff is ultimately oriented towards enabling them to engage beneficially with ethnic minority service users with limited English proficiency, and thereby provide this service user group with the best possible holistic health care.

### 3.2.3. Relationships Among the Network of Actors

The third set of data moves our focus from the organisational level to the more immediate conditions around the clinical encounter. The emphasis is on the network of people involved and the relationships between key ‘actors’, particularly their sense of trust and confidence in each other’s work, knowledge and expertise (NPM: Relational Integration).
In this project, this refers primarily to the relationships between general practitioner, administrative staff, service users and interpreters from the company currently providing the pilot service. Do they relate well to each other and trust each other’s knowledge and expertise? For example, do general practitioners have confidence in the knowledge and expertise that they obtain via the medium of these interpreters? Are there issues around general practitioners’ knowledge of how to operate appropriately in an interpreted consultation? Also, given how crucial trust is to the cohesion of the network, how do general practitioners assess the professionalism and credibility of pilot company interpreters?

All of these questions relate to formal interpreting experiences. In order to complete the complex picture of relationships in the network, we also needed to explore experiences of informal interpreting (consistently referred to by all the actors in the network) and seek understanding about confidence/lack of confidence in the knowledge and expertise of informal interpreters from various actors’ perspectives. Closely linked to this, we noted concerns raised from all perspectives about the potential impact and dangers of relying on informal interpreters.

Here we describe:

- a mixed sense of confidence among general practitioners, service user representatives and independent interpreters regarding the knowledge and expertise of pilot company interpreters
- concerns raised by independent interpreters about how well general practitioners understand an interpreter’s role
- the criteria used by general practitioners to assess the credibility of pilot company interpreters
- issues of confidence regarding informal interpreters from the perspectives of general practitioners and service user representatives
- service users: issues of trust with general practitioners.

### 3.2.3.1 Mixed Confidence in Pilot Company Interpreters

Several general practitioners judged that the pilot company interpreters were ‘good’ and ‘fine at their job’. They expressed confidence that interpreters can
function to maintain confidentiality in interpreted consultations and facilitate trust between the general practitioner and service user:

#3 A. Then, you know, we could get the interpreter in, especially if you didn’t want them [service user] to be interpreting through a colleague or friend... you know, in terms of confidentiality.  (F; FREQ)

#4 A: I think trying to establish that relationship that you might have easily with, you know, an Irish person or an English speaker as well, is important, and there are cultural things as well to get through. So, if you’ve a good interpreter maybe they might facilitate that, so you can, so that you get a sense that it’s working... So again, the point I was just making - that initial trusting relationship, I think is the biggest challenge and, you know, a good interpreter can facilitate that. (M; FREQ)

#2 A: From what I’ve experienced of the, of, em, the translators we’ve had here, they’ve been very professional and I think, you know, that always creates a sense of trust as well. (F; FREQ)

The perception among some general practitioners that service users were ‘comfortable’ and willing to ‘open up’ and share details of personal and medical history in the presence of pilot company interpreters further supported this sense of confidence:

#2A: Patients do often open up then and talk about things that are probably extremely difficult for them to talk about to a stranger, but you know, so they seem comfortable in doing that, so, yeah.

#2 Q: That kind of does say a lot all right, about the relationship that’s building in some way, doesn’t it?

#2A: Yeah, yeah.

#2Q: So they do come forward with stuff that might be quite difficult, and they’re already stressed, you say...?

#2 A: Yeah, and you know, they’re faced with two strangers now as opposed to one, so, yeah. (F; FREQ)

These experiences of trust, openness and confidence are all central to the development of positive relationships in the network. This general practitioner reflected on the feeling of safety in his work when pilot company interpreters are involved:

#6 A: We were probably, I suppose, flying by the seat of our pants a little bit before that. Now, we were getting by, and I don’t think that we were being terribly unsafe, but there was the potential for something to go wrong...

#6 Q: Yeah...
#6 A: And then, you know, it's people's lives and their welfare and their health that we are talking about.

#6 Q: Yeah, so this service really does then help to ensure the safety for the patient, and accurate diagnoses, all of those things?

#6 A: Absolutely. Yes, I think so. (M; FREQ)

Early in the research process, the interpreting company had confirmed that ‘the interpreters are freelancers... they are not all based in the office here, readily available to take calls’. Given that they were not working from a central base, we asked what constituted the right type of environment for freelance interpreters to operate in, and were told:

Comp#8: It has to be quiet, quiet, and where there is no noise and no distraction. It has to be an environment which is confidential, so you have to be on your own. So you can’t be in a room like this, because there are two of us here and I can’t really do any interpretation, because you would hear what you shouldn’t hear. That is all highly confidential information. So it’s a quiet place where you are on your own – to protect the confidentiality and to ensure that you will not be disturbed. So we can’t have the kids coming from the kitchen and screaming and running and so on. And then if you are on a mobile phone then you have to make sure that you have a good signal. So you are not somewhere you have a poor signal. So you wouldn’t be interrupted or cause disruption to the customers. That is it in a nutshell.

However, in contrast to this account, some general practitioners raised questions about experiences with individual pilot company interpreters which related to issues of credibility, reliability, professionalism and best practice. They mentioned concerns they and their service users had about interpreters working from a public place (e.g. on the Dart, in a supermarket) or while doing other duties (e.g. at home minding children). These general practitioners felt that this compromised the quality of communication in the interpreted consultation:

#5 A. What tends to happen is that [the interpreting company] gets people on mobile phones. And I know they can’t have them sitting in booths waiting for me to phone, and that’s fine, I understand. But sometimes I am on the phone and they are either in the middle of Grafton Street or O’Connell Street and there are buses and trucks going by and I can’t hear them. And sometimes the patients - there are crying babies in the background or just the line is just very bad. And that does affect sometimes the communication and I have, on one or two occasions, said: Look, this isn’t working - get me someone else. (M; FREQ)

#13 A: I have had noises in the background like children, you know... so you get the impression - you know, it was a female at the time and you could hear her family, so - so
you know she’s part time and she was, you know, busy
child minding at the time. (M; FREQ)

These experiences on the part of general practitioners were consolidated by information that arose unsolicited in focus group discussions with service user representatives, some of whom, it emerged, had previously been employed as freelance interpreters by the company currently providing the pilot service. They, too, were concerned about what they knew from first-hand experience and what they have learned from service users about the perceived level of knowledge and expertise of some pilot company interpreters:

NGO A: From some information I have from talking to some GPs, visiting them, several of whom have a number of refugees and asylum seekers coming to their offices...there is a concern about confidentiality. A doctor will call [the interpreting company] - we need an interpreter for French - [the company] will call somebody who will be in a market, in Dunnes Stores, in Tesco’s, so he will be discussing somebody’s health issues in a shop, in a party, or somewhere in the street. Because interpreters are not sat there [in the company offices], they don’t sit to wait for calls, they are not paid - they are paid only for time - they could be anywhere. So clients, they won’t accept it, when once they hear noise behind, it won’t be confidential to use it. So I think one GP in Dublin has tried four times, once somebody was drunk, the interpreter was drunk in a party, ok, this is in Dublin 7... so he is saying we’ll never use an interpreter – because at least we can use sign language instead of getting it from someone who is not responsible.

Q: You are very sure about this?

NGO A: (A different participant responds:) Yeah, I am, because unless it was booked previously, [in which case] they ask you to stay at home, and you will be called on your landline at this time – that’s a different way. Otherwise they get you on your mobile phone... I was driving once, and I had to stop my car and park somewhere quietly and take the call.

Q: So this is very real, the fact that people are hearing the DART in the background, the noise of the DART, and they know that their medical condition is now being discussed on the DART by an interpreter, in a public place...?

NGO A: This is not a regulated profession - ask them how do they choose their interpreters? Ask them if they provide ongoing training? They will say, yes we do it! Ask the interpreters - they will say: what training? What training? (FG a-f)

Clearly, there is some considerable distance between stated company policy and the practice and behaviours of individual pilot company interpreters on the ground. As the company would not allow us to interview of their interpreters, it was not possible to explore these particular issues from their perspectives. However, former interpreters with the company (who now work with a non-
governmental organisation providing support to ethnic minority service users) provided particular insights around this issue and also the factors that may drive freelance interpreters to accept an interpreting assignment from the company in less-than-ideal circumstances:

**NGO A:** The doctor will just call [name of the company currently providing pilot service] – we need an interpreter in Swahili – then [company name] will call me, ask if I am available, of course I need money, if I am, I say yes, I stop my car or I go in the corner in the shop, I give your number to the service provider or what they do is they [the company] put you on hold and they connect you to the GP and they can record because they can hear what you are saying, so it is through the mobile phone... interpreters, they don't have an office, they don't have a landline...

**NGO A:** The interpreters, they don't have any contracts with the company (inaudible), so they [the company] can only contact them on the mobile...

**Q:** Does the interpreter stay on the line with [company] and then wait until [the company] connects the GP who is on hold with the interpreter who is on the mobile phone?

**NGO A:** That is what happens.

**Q:** Are you saying that, to your knowledge, this is happening right now? Or is this something that happened six months ago...?

**NGO A:** I know almost all of the interpreters; they won't have landlines so no other way to reach them and again no-one is sitting at home waiting on their landline, so they can be anywhere - so the only way to reach them is on mobile phone so this is the current practice.

Earlier, service user representatives questioned the extent and adequacy of the company training provided to freelance interpreters. This, coupled with the financial pressure that may drive some pilot company interpreters towards behaviours that cannot be described as best practice, alerts us to the dangers inherent in a service provision system that is not independently monitored and evaluated.

These are not the only problematic issues. One general practitioner also reflected on the limited language skills of a company interpreter and the concerns this raised for her about her confidence in the interpreting and, therefore, her clinical decisions:

**#13 A:** I have had one experience where I wasn’t confident that the interpreter would have been interpreting correctly. Only because it was medical language and you know, you could tell that they had difficulty coming up with the interpretation. And I just thought, I don’t think they have the breadth of medical language to be able to interpret and
they just did a very simple thing like called fingers toes so, you just, you know – it really made you go: Oh God, I’m just not sure – again it was far better than me not having someone, but, you know, it just brings into clarity that whole notion of you have to trust the interpretation.

#13 Q: Yes...
#13 A: But the buck stops with you if there’s any mistake. (M; FREQ)

The issue about ‘where the buck stops’ is confirmed and reinforced by service user representatives who express concern about the quality and reliability of pilot company interpreters:

NGO A: One thing maybe not mentioned is the quality of the interpreter service – most GPs, they prefer to hear information from their client himself instead of the interpreter, who just makes up whatever he wants; because it turns out in some cases that the patient has much more English than an interpreter.

Q: So this is what you’re hearing from the ground, from GPs themselves?
NGO A: Yes, from some GPs themselves. I won’t mention them but they told me: if you want us to use interpreters, they need to be accountable in case they give wrong information and there is a wrong diagnosis – and something happens, who will be responsible? At least if it is the individual [service user] who say it, that is fine, but where there is a third person [the interpreter] - they need to be reliable. (FG a-f)

A senior trauma therapist, with extensive experience of working with qualified trained interpreters, points out how important it is that interpreters have a good working knowledge of medical terms, are clear about their responsibilities and follow best practice principles:

NGO B: And the other good thing would be that [interpreters] actually have a good knowledge, a really good working knowledge of the jargon, so when the doctor or the service user uses a particular jargon of their professional work that actually it translates quite easily. Or that even when it doesn’t translate so easily that there’s the ability for the clinician to check with the interpreter - how did this translate into your language? But it’s done professionally. And therefore you know that the message isn’t getting mis comunicated. So I’d say they are examples of good practice.

Positive relationships cannot develop in an atmosphere of concern and constraint – this general practitioner describes how her uncertainty about interpreter’s skills affects her confidence and constricts her clinical decisions and actions:
#13 Q:  So just going back to this experience of you know, being unsure that the interpreter is adequately able to do the task if you like, what kind of impact does that have on you, first of all... when you’re trying to manage a consultation?

#13 A:  Just in terms of your confidence, you know, you’ve more concerns, you’re less confident. The only way I can describe it is a kind of narrowing down to, first, ‘do no harm’ then ‘do good’ so ‘first do no harm’ is up higher than ‘do good’ so you’re going to do the minimum because it’s safer to do less and do it safely than to do more and maybe make a mistake, you know?

#13 Q:  Yes.

#13 A:  You’re more likely to just cover the basics in that sort of situation.

#13 Q:  You could be forced to [do that]...

#13 A:  Yeah...

#13 Q:  And what does that feel like?

#13 A:  Em, I suppose that type of experience - you have that type of feeling - it’s always about juggling possibilities and probabilities in consultation, so it’s just unsatisfying, is the only way I can put it, it’s just – ‘I could do better’ is the feeling you have at the end of that consultation.

#13 Q:  Yeah, sure...

#13 A:  You know, it could have gone better, I could do better. And also, I need to see this patient again is often how you end those consultations, you know, there’s more needs to be done here.

#13 Q:  It’s kind of like you really need to follow up and it’s...

#13 A:  Yeah.

#13 Q:  You’re not going to be able to leave it there and rest easy,

#13 A:  No, no. (M; FREQ)

The independent interpreters also share these same concerns about professionalism. They make important distinctions between ‘qualified interpreters’ and ‘native speakers’, alerting us to the fact that a native speaker may have facility with a language but not necessarily sufficient training as an interpreter to operate in a fully professional manner:

*FG#11a* Many of the interpreters who are working out there are not qualified interpreters, only native speakers and they don’t have the training as interpreters to weigh up all these codes of conduct and issues.

Q:  Yes.

*FG#11a: That’s a big issue, that’s why I’m saying this is all theory, because in practice most of the interpreters working out there are not qualified.*
FG#11b Yes, and I agree with my colleague - there’s so many of our colleagues not qualified and they are working as interpreters for other services, you know. The [services] are just using them, you know, but they never give them proper training or no training in it at all. They just send them to the site, you know, to do the job.

FG#11a There’s a lack of proper training in Ireland as well and that’s the major, that’s the whole point, there’s not a proper training for interpreters in Ireland.

Q: **And there’s no way of assessing or monitoring or evaluating the quality of what’s happening out there on the ground at all?**

FG#11a: No.

Q: **What would your biggest concern be around this?**

FG#11b It’s a fact that many qualified interpreters pass on to other jobs because they didn’t have the working conditions that they deserve, basically. So the agencies are constantly looking for native speakers instead of looking for qualified interpreters because they are not ready to give the working conditions that proper interpreters would need. So it’s as basic as that.

This high turnover of native speakers who are not qualified interpreters relates to concerns some general practitioners have expressed about a lack of consistency in the quality and ability of part-time interpreters, the complexity of cultural dynamics that can occur in the triad, and the general practitioner’s awareness of how important a positive relationship between doctors and interpreters is:

GP#4: **If you have consistent translators as well, who, you know, who are doing it all the time, rather than a student who’s doing it for a few months, they understand the nature of the dynamic between a doctor and patient and em, that’s an interesting thing because [service users] have cultural differences in how they relate to a doctor. So if you’ve got interpreters coming in, who are bringing their cultural experience to the agenda as well, then that affects the consultation also. Whereas if you’ve got a person who is used to sitting in on Irish doctors, then that helps. Certainly we’ve had interpreters in the past who knew us and knew our style, and you know, there was even a relationship with the interpreters we were establishing and that’s good as well. But that’s maybe a hard thing to create.** (M; FREQ)

Service user representatives in a focus group commented further on the need for gender-sensitivity when interpreters are being assigned to a triad:

NGO C: **Another thing that happens to so many women that I know, is that when a woman goes to the GP and they are asked if they need an interpreter and she says yes, and they bring [her] a man and sometimes when the issue is very private - she just ends up not saying what she’s really there for...so at least they should ask them if they want a female or a male...** (FG a-h)
Coupled with gender compatibility, the issue of political compatibility/incompatibility between service user and pilot company interpreters came up for discussion across the groups participating in the research. Throughout the educative dialogues it became clear that several general practitioners were quite aware of this issue, although attitudes towards it differed greatly:

**#13 Q:** A couple of GPs have mentioned things like their awareness that it’s important that the interpreter and the patient are culturally and politically compatible. Not just language...

**#13 A:** Oh, well, that happens over the phone as well.

**#13 Q:** Does it?

**#13 A:** We were using an interpreter and [the service user] was an Iranian guy, and I just, I wouldn’t be able to tell you the political situation in Iran but anyway the guy was seeking asylum on political grounds. He was in university and he was in some slightly left wing group and the interpreter was conservative, you know, opposing politics anyway, and he [service user] just wasn’t happy.

**#13 Q:** Yeah yeah.

**#13 A:** But I had a good relationship with the guy [service-user] so we, you know, just agreed that we would try again the next time. (M; FREQ)

**#16 A:** I don’t tend to worry about what the patient’s fears are, you know? Like sometimes you’ll have a fear of some political agenda that you are not aware of, you know, the two people - you’ve got a Ghanaian interpreter and a Ghanaian refugee, you know, you could spend an endless amount of time worrying as to whether they know each other from the past, or from different political parties, or whether one is worried that the other will siphon back information and this kind of thing, you know, you just can’t build that into your consultation. You can’t, so I just deal with the presenting complaint and try and deal with that.

**#16 Q:** Who do you think should be responsible for those things, because they could be very real in some situations?

**#16 A:** I think if the client brings it up, if they are showing concern or fretting or they want another interpreter, then that’s reasonable to request. (M; FREQ)

Finally, this comment from a service user representative sums up the current situation and its ‘lottery’ nature:

**NGO A:** I mean the fundamental problem with interpreting as we know is that there are no set standards, there is no quality control, so the interpreter you get is very random. You may get somebody who has been trained but that’s fairly unlikely...
Participants in the research have highlighted that the company interpreter involved in the triad might, or might not, be qualified; may be well or poorly trained; could be highly experienced, or a ‘native language’ student providing the service for a few weeks or months; may be well versed in how to handle the cultural, political and gendered layers of communication or ill-equipped to do so and could be aware or ignorant of relevant codes of conduct and principles of best practice. The lack of ‘quality control’ for interpreting services essentially does a disservice to all actors in the triad and makes the work of the interpreted consultation very difficult to achieve.

3.2.3.2 How well do General Practitioners Understand the Interpreter’s Role?

We know it is important for the implementation of interpreted consultations that all key actors involved in the network develop and maintain trust in each other’s work, knowledge and expertise. Above, we have seen how a lack of confidence among some general practitioners and service user representatives in the knowledge and expertise of interpreters from the pilot service can impact negatively on the network. Here, we move to another issue: general practitioners’ understanding of the interpreting role in general and how this can influence the level of trust in the network. One key experience, ‘off centre conversations’, emerged unsolicited as a concern for every participant group in the research. Initially raised by general practitioners, we found that during our educative dialogues, the independent interpreters responded strongly to this issue and service user representatives had views on it as well.

We begin with general practitioners describing what they perceive as ‘off centre’ conversations occurring between interpreters and service users during interpreted consultations. This creates a sense of discomfort and confusion for the general practitioner and reduces his/her trust in the interpreter’s skills, compromising confidence in the network:

#5 A: In some ways I would maybe prefer for someone to just do the translation. You do sometimes get people where they are clearly having a conversation, which is off centre - it’s not necessarily part of what you have asked about. And that can delay things. I remember seeing a comedy show onetime where somebody was translating and they go blah, blah, blah for 5 minutes and then they turn around and say: ‘Yes.’ You know that can sometimes happen. And then you say well, what the hell else was he saying for the other 5 minutes? So sometimes it’s social chat and sometimes when they get on the line and they find out what part of Botswana they came from, and, you know, do
they know so and so from the town or whatever. That sometimes gets in the way, not very often, but it can.

#5 Q. And does that even happen on the telephone?
#5 A. Yeah.

#5 Q. Ok, so not just on-site then?
#5 A. No - that has happened on the telephone. (M; FREQ)

The discomfort general practitioners experience is related to not knowing how to interpret seemingly off centre ‘conversational digressions’. They do not know if they are necessary or if they are obstructing the work of the consultation. They end up feeling out of control, with diminished confidence in the work of the interpreter.

The independent interpreters and service user representatives suggested that general practitioners were having this kind of experience because pilot company interpreters may not have received adequate training. The independent interpreters pointed out that the key function of an interpreter is to ‘be a voice’ – their task is to interpret the words uttered during the consultation, to add nothing, to omit nothing and to remain relatively impassive regardless of the content that may pass between the service user and the general practitioner. Most importantly, the interpreter attempts to maintain an unbroken communication link between general practitioner and service user:

Int#10: Yes, as the professional interpreter we are a voice; we are not allowed to add or omit anything that’s being said, only what has been said during the session - nothing more than that. We can’t offer our opinion, judging the service user or the doctor. You just give each person a voice - so when the user is talking in their native language you interpret that to the doctor, and then interpret what the doctor has to say to the user. So basically you are just establishing the link for communication purposes.

There are very specific circumstances, however, when the link must be temporarily broken and the flow of communication interrupted. If an interpreter needs to clarify the nuanced meaning of an ambiguous or culture-specific term, and this is likely to take a few moments, the interpreter ought to explain the need for ‘time out’, and this enables the general practitioner to understand the nature of the ‘digression’. Otherwise, s/he is left sitting, observing a long and seemingly meaningless conversation between interpreter and service user. For the general practitioner who is unaccustomed to ‘three people in the room’, this can lead to a sense of ‘being outside’ the consultation and even ‘out of control’.
A service user representative who has worked extensively with professional interpreters explains:

**NGO B:** If [the consultation] is not facilitated well or there’s breaches in that, that’s when the [general practitioner] gets frustrated, doesn’t know where it’s going and finds it difficult. It’s so important that [the interaction] is free flowing and not obstructed, or there isn’t little conversations going on between the two people in between and [the GP] is not quite sure what's happening. Because again some of the bad practice stuff that really changes maybe a whole context is where, you know, there might be a little conversation going on and the interpreter is not stopping [the service user], saying: I have to clarify this [with the GP]. So it looks as if they are having their own talks.

**Q:** That’s really interesting because, from the other side of the table if you like, the doctor actually describes feeling ‘on the outside’ of the consultation.

**NGO B:** Right, very out of control… Yes, if the GP feels it’s out of control because they are having a little chat, the skill is there – [a good interpreter will say] “Can we just stop here for a moment? I need to just clarify – this might take a few moments because you’ve used the term ‘depression’ but in Swahili there’s no word for depression.”

The bottom line is that most general practitioners have limited knowledge about the complexity of the interpreter’s role and relevant principles of best practice related to that role. This issue of a limited knowledge base among general practitioners about the interpreter’s role relates both to our opening section dealing with developing organisational level capacity and to our second section dealing with training. It points up again the crucial role of training and education. It is necessary that professional bodies and institutions negotiate, learn, and develop understanding about appropriate divisions of labour in the triad, and ensure that appropriate training is available for personnel to support actual practice on the ground. A limited knowledge base does not need to remain a serious impediment to increased uptake of interpreting services.

### 3.2.3.3 Criteria used by General Practitioners to Assess Credibility of Pilot Company Interpreters

Because general practitioners have not had training in this area and they are learning ‘on the job’, they tend to use subjective criteria to assess the professionalism of pilot company interpreters and the credibility and reliability of the knowledge they mediate during the interpreted consultation. In this quote, we see how the general practitioner draws on her expertise in communication skills
and reading non-verbal cues to assess the general professionalism of a company interpreter; interestingly, her subjective criteria match quite closely what the independent interpreters have described as typical of their role.

#2Q: You said you found the interpreters very professional. How do you have a sense of that... because it’s very interesting?

#2 A. It’s very difficult to define actually. I suppose it’s em, maybe reserved manner, formality with the patient and, em, good eye contact with the patient. Just their general appearance and their manner appears to me – obviously I don’t know actually what they’re saying, and I’ve no idea of the standard of the translation – but it appears to work, you know?

#2 Q. Yeah. Well, I suppose you’d pick up, would you pick up cues from the patient at some level perhaps, in some way?

#2 A. Absolutely, yeah, I mean the patients do tend to respond very well, you know.

#2 Q. Yeah, and as you said you’re observing body language, as well as the verbal language that’s passing between...?

#2 A. Yes, and you know, patients do often open up then and talk about things that are probably extremely difficult for them to talk about to a stranger, but you know, they seem comfortable in doing that...

#2 Q. That kind of does say a lot alright, about the relationship that’s building in some way, doesn’t it?

#2 A. Yeah, and you know, they’re faced with two strangers now as opposed to one. (F; FREQ)

Another general practitioner reflects on the different interpreting styles that he has experienced. He describes how he cannot, for good reason, readily establish the quality of interpreted consultations, and he is cautious about evaluating one style against another:

#4 A. I’ve a sense they [service users] leave with a basic understanding of what’s happened. As to the degree of quality of that, I couldn’t honestly comment on, because people will smile in front of the doctor when they’re leaving, they will thank the doctor and they’ll, they’ll put out their hand to me again – and it’s hard to interpret that as really a sense of satisfaction or just out of courtesy to me, em, I think it depends on the quality of the interpreter and that varies from people who take ownership of the patient sometimes and really mind them, to others who are quite diffident and removed, maybe, from them as well. And maybe that comes out in the, in the dialogue between them. So, I, I suppose I find it hard to answer that clearly. (M; FREQ)

#4 A: I could point to consultations... that I’ve been happy with, and maybe others where all of them I haven’t been happy
with... Interpreting my meaning as opposed to interpreting what I say, and some people go overboard and they start to reminisce with someone and of course, you suspect that he’s trying to explain the whole dynamic instead of translating my words and that can be frustrating sometimes. Maybe it can be useful sometimes as well. I’ve had interpreters in, maybe, em, very dry individuals who will crisply transfer, I suspect, the words I’ve said, with a very blank, em, inscrutable face and maybe that’s good sometimes because they just say what I want them to say, and that’s it. The others get into a dialogue and they get animated in the consultation as well and trying to work it out and there’s a lot of to-ing and fro-ing and eh, and maybe that’s good sometimes and it’s hard to evaluate that, really, I think, I’ve had good results I think from it, em, em....(M; FREQ)

These examples of the genuine attempts made by general practitioners to assess the professionalism of pilot company interpreters and the credibility of the knowledge mediated in the consultation show that, without professional confirmation/disconfirmation or guidance with regard to the validity of the subjective criteria they utilise, general practitioners are left unsupported in this respect, and cannot know what they ought to expect of interpreters in the triadic encounter. This lack of certainty echoes our earlier discussion in this section about general practitioners struggling to interpret ‘conversational digressions’. These grey areas of experience for general practitioners can only serve to diminish trust and confidence in the network of actors attempting to achieve the work of the interpreted consultation.

Given that general practitioners possess incomplete knowledge about how to assess the professionalism, credibility and appropriateness of an interpreter’s behaviour during a medical consultation, how can they be expected to evaluate or assess the difference between well or poorly trained interpreters? If this discernment is not possible, some general practitioners are using the pilot interpreting service without knowing whether or not it is ‘fit for purpose’. The interpreting company points out that while there is a ‘feedback system’ (an evaluation form that general practitioners can fill out following an interpreted consultation) they rarely receive responses. Given the time issues and pressures on general practices discussed at the outset, this comes as no surprise. Only one general practitioner in the study expressed awareness about the feedback system. Although one of the ‘highest frequency’ users of the pilot service, she stated she had never used it.

While there is a feedback system in place for general practitioners to use should they wish, it is notable that no feedback system was planned or put in place for
ethnic minority service users to evaluate their experiences of pilot company interpreters in particular, or the pilot interpreting service in general.

3.2.3.4 Issues of Confidence Regarding Informal Interpreters

At this point, we turn to the issue of confidence in informal interpreters, first from the perspective of general practitioners and administrators for whom this is the most typical ‘alternative strategy’ used in preference to the pilot service; and second from the perspective of service user representatives and the participating independent interpreters.

We note that general practitioners and administrators have a measure of confidence in alternative strategies, particularly informal interpreters, for managing language barriers. No general practitioner asserted confidence in the interpreting service to the point that they would never employ any other strategy. We know that they rely heavily on the use of service users’ family members and friends, and also use bilingual staff as interpreters for service users with limited English. This behaviour suggests that general practitioners and administrators trust, to an extent, the knowledge and expertise mediated by these informal interpreters (e.g. interpreting by the Polish cleaner is a ‘positive experience’; teenagers interpreting for service user parents are ‘switched on’ and are ‘quite good’). In the series of quotes below, it is also interesting to note that general practitioners highlight some additional advantages gained by using informal interpreters: they provide post-consultation clarification, support and comfort to service users, which is beyond the remit of formal interpreters.

#1 A: [I have had] a cleaner coming in interpreting for a patient, and usually it’s been a positive experience because they trust the cleaner for doing it... so it was nice, so it didn’t work so badly, obviously has its limitations and I recognise it and we avoided using it, but it didn’t work so badly from our perspective, it was quick and efficient. (M; INFREQ)

#4 A: But I would accept that [informal interpreter/friend/family member] rather than, I must say, rather than going for a phone translation – I think I would, because I’ve the person in the room and as we’re responding to one another, that adds a lot to it – dialogue is very much part of the consultation in a primary care setting. (M; FREQ)

#5 Q. And what does that give them, do you think, what do you sense bringing the friend in, who maybe has more English than they do, do they get a comfort level with that...?

#5 A. I think it’s support in one sense but also it’s somebody that – they can leave the consultation and ask again the questions. Because quite often the information being
transferred is a bit complicated. And quite often the people [informal interpreters] who come in are very bright people who have 3rd level qualifications or whatever and they are very good. I mean we rely on them heavily to be kind of, you know, they would hear the information and then be a sounding board for the person who has the illness then later on. I think that works quite well.

#5 A: The other method that maybe you have not seen happen before is that a lot of people come in and they have a mobile phone and they will have a friend who speaks English [ready to take the call] and they won’t want the interpreter, they will want their friend, so they have the mobile phone and the person is on the phone – and that’s ok as well.

#5 Q: So that works quite...
#5 A: Yeah, that works well – and also in terms of when the consultation is over – that person can be a resource for them in terms of reinforcing the information that you have given and explaining it to them. (M; FREQ)

#24 Q: Some GPs are saying that they are not inclined to use the pilot service because actually people arrive at the surgery with a family member, a friend or a child or whatever, and they can get by with that...

#24 A: Yes, we had some really switched on young fellas in this practice, who interpret for their parents and, like, the parents would be sort of middle-aged to elderly and the youngsters would be teenagers going through secondary school. [They] would be quite good and they would be able to give me the issue.

#24 Q: And you have explained that this is something you find happening here?
#24 A: Yes, we would use that [informal strategy] primarily, if that was the situation that presented itself, because sometimes the family member has the ability to communicate for you and sometimes you can learn that very quickly.

#24 Q: Yeah, how do you know?
#24 A: Well, you know that by the quality of the answer you get. When you ask a question and you get an answer, if it isn’t consistent with the question, you know that the interpreter has got a problem as well; there has to be a consistency to this, you know, so you would be asking different questions and if they don’t match together to make a meaningful whole, then there is a problem, obviously so. (M; INFREQ)

The practice of relying on informal interpreters and the measure of trust and confidence general practitioners express in this alternative strategy is, without doubt, a key factor in the low uptake of the free pilot interpreting service.

In contrast, several general practitioners signalled concerns about relying on informal interpreters, ranging from experiences that compromise the efficiency of
a consultation to experiences that raise very serious ethical issues for the general practitioner about confidentiality and the safety of the service user:

#22 A: Yeah... possibly [formal interpreting] would be more satisfactory generally because there is none of the baggage of having the family members there – you just ask the questions and get the answers, you know. (M; INFREQ)

#21 A: When you have an informal interpreter, they tend to engage in the whole process, you know, with glee, so to speak, so that you have the patient and the interpreter chatting away to each other, like trying to....rather that just answer the question...

#21 Q: Yeah.

#21 A: You know, this is the question, translate it exactly, and then tell me what the patient says...

#21 Q: Yeah.

#21 A: ...you know, they have a chat about what the symptom is, and then she delivers to me what she thinks the symptom is, which isn't the same thing at all...It's not my business to be trying to teach the person how to be an interpreter. (M; NON-USER)

#15 Q: Do you have any concerns around confidentiality for the service user when using a family member or friend as an informal interpreter?

#15 A: I had one experience – now I have never seen the couple again, it was a few years ago – of a husband and wife. And I would have had my doubts about what he was telling me - whether it was the truth or not...

#15 Q: Yes.

#15 A: And, oh, I had a major problem, I would have, you know, I would have wondered what he was doing to her and with her at home.

#15 Q: Right.

#15 A: And I could not, you know, ascertain that because he was doing all the translating. (F; INFREQ)

This highlights the gendered layer that may be ‘invisible’ but lies beneath the surface and can utterly confound the work of a consultation.

How do other actors in the network perceive and judge this reliance on informal interpreters? Some general practitioners had mentioned that service users with limited English ‘have their own strategies, too!’ often electing to bring along friends or family members to act as informal interpreters, and employed other strategies similar to those outlined and accepted by general practitioners above. This might suggest that service users consistently choose informal interpreters over formal ones, but we must view this practice on the part of service users
within its key context: the introduction of the pilot service did not include any process of dissemination of knowledge about its availability across ethnic minority communities. This is significant because in the absence of knowledge, service users cannot request, suggest or prompt use of the formal interpreting service. Without knowledge of the free available service, service users can only continue to draw from within their own networks and resources and use the alternative strategies they have typically employed. During educative dialogues, service user representatives acknowledged that these strategies were indeed commonly used, and gave good reasons for them, but they insisted that there were clear dangers inherent in such practices. The series of quotes below voice some of the perceived ‘positive’ reasons for relying on informal interpreters and then some reasons and contexts in which that reliance can become problematic:

Q: One GP told me that, to her knowledge, no-one had ever walked into her surgery and asked for interpreting...

NGO A: No, because when you come new to a country you use your network, you ask your friend to come along. If you use an interpreter the quality is different. You just don’t go to the GP. Because people fear looking stupid, they are ashamed to say I don’t speak English, they just don’t go to the doctor, they just ring home, send me some anti-biotics to sort out the problem, and the cultural differences are huge! (FG a-f)

NGO C: Then hospitals claim that whole families are turning up, but in fact the burden of interpretation is falling on people to get their friends and family members – people they feel they can have confidence in, who are going to respect their confidentiality outside [in the community], you know, when they leave the surgery. (FG a-h)

Q: Some GPs say: the decision is taken out of our hands because the person comes with a friend and presents and says my friend speaks English and she will help me and the GP response is: “That’s ok, now we’re sorted...” but I see you all shaking your heads, so it’s not a problem sorted...?

NGO A: How can it be? Even if I am fluent, as a friend, how can I express your feelings? (ALL FOCUS GROUP PARTICIPANTS VOCIFEROUSLY AGREE.) (FG a-f)

NGO C: If they are coming from their home country and they have an existing diagnosis – how do you [as informal interpreter] explain that without [fluent] English? You’ve been told you have a condition at home, how do you explain that without strong English? (FG a-h)

Similar issues were raised with another focus group representing ethnic minority service users:
Q: Some GPs said things like: It’s fine, we’re managing – if a family member comes along [to provide informal interpreting] we’re managing, so as a GP, you know, my need for a professional interpreter goes down. Would any of you have a response to GPs around that – is it ok for the [ethnic minority] community that GPs aren’t using professional interpreters?

NGO C: No, it’s not ok.

NGO C: No.

NGO C: No, it’s not good. (FG a-h)

Some of the key reasons why it is ‘not good’ add to the dangers inherent in informal interpreting and remind us of issues we have already seen emerge in the research: concerns about mis-communication and cultural ‘gaps’ between general practitioners and service users; how these gaps may jeopardise holistic health care and can easily be ‘read’ by service users as discriminatory and, finally, deep concern about the issue of differential treatment for ethnic minority service users:

NGO C: Maybe I speak English, but even so, there are certain things I cannot express for myself and I would want an interpreter for that. (FG a-h)

NGO C: There’s a basic communication gap between the GP and the client.

Q: Why, what is people’s sense of why that gap is happening? What do the community feel is happening in that gap?

NGO C: Sometimes as much as the language barrier – it’s all beyond that – it’s the communication barrier, between the client and the GP, it’s not clear, so there is a barrier there. The other thing is that people felt that they are not being listened to, they are given prescription and then go – that’s all. So they are not treating you, you know, it’s all medical aspect of treating people, so it’s not about social, you know, trying to listen to the people, trying to understand the problem…the fact that they are medical card holders, the fact that they have different accents, the fact that they are a different colour – that’s what they felt. (FG a-h)

NGO C: There is a fundamental right that everyone gets an equal treatment under human rights and every other law, so just because you’re an ethnic minority you shouldn’t be subject to an informal medical system, or an informal diagnosis, or an informal communication system – you have the same fundamental rights as the person who comes through the door with perfect English – so that’s a very dubious concept – that the health service would get away with providing a lesser service to somebody from an ethnic minority. In fact, it’s not dubious, there’s nothing dubious about it, it’s a complete and utter abuse of their rights that they could get away with an informal communication in one community and perfectly fluid communication with another community – it’s just not acceptable. (FG a-h)
Finally, there are strong ethical and legal implications around the continued use of informal and alternative strategies that cannot be ignored. Whether it is the acceptance of children as interpreters for parents, the use of internet translation systems, or reliance on gestures and phrase books, such strategies, irrespective of levels of trust that actors in the network may or may not have in any or all of them, run the risk of being challenged as ‘unsafe’. General practitioners and service user representatives mentioned this issue and highlight its seriousness:

#16A: I don’t know the legalities of it – if, for instance, some GP gets sued because there was misrepresentation by somebody who is not, say, a centrally appointed interpreter, that would knock out that informal system pretty quick... most of us are hoping it never happens, because then you are left with a decision as to whether to deal with interpreter services as they exist or get rid of anybody on your list who doesn’t speak English. (M; FREQ)

NGO A: One of our [interpreters] said to me that – in terms of support – he said: “What about, you know, they’re talking here about words, meanings and words and all of that, you know, and that has to do with medical diagnosis and medical information...what about interpreters who make mistakes, you know, they do need some kind of insurance cover also.”

This is echoed from the perspective of the interpreting company:

Q: So if I was to come back to that question...what would you be saying to GP’s who don’t avail of the service? To indicate to them why they might do so, or why they ought to do so...what would be the key things that you would say to them?

Comp#8: Well, there are a few factors to take into account. And the first one, which I think is the most important one, is for risk management... especially in the medical field, I think mainly in the medical and legal field...if you think about it, world wide, the main users of interpretation services world wide, no matter what country you look at, you find them in the medical field and the legal field. Because the risk is quite high...So I think the first one is risk management – it’s crucial. And needless to say, there are serious legal implications if anything goes wrong, and liability issues. Not to mention the humane and humanitarian element of caring for people and their well-being.

3.2.3.5 Service Users: Issues of Trust with General Practitioners

Finally, we consider the sense of trust that service users have in general practitioners. Service user representatives are very clear that many people in their communities are frustrated with their general practice consultations. Some of these frustrations relate to the ‘technical’ difficulties presented by language
Other frustrations relate to difficulties embedded within but, also, ‘beyond’ these technical difficulties. We have touched on these above but here we give further examples of the kind of problems the community perceive in relation to general practitioners as communicators as well as the efficiency of the Irish healthcare system in more general terms. We see that communication breakdowns can lead to assumptions of racism, diminished trust among ethnic minority service users in their general practitioners in Ireland and their preferences and tendencies to seek medical treatment from their home countries.

**NGO C:** I remember S_____ coming in to me one day and he was very frustrated he told me because the doctor gave the child Seven-Up but I said that’s probably because he had gastro and that’s quite an appropriate thing to do, but unless that’s communicated it sounds patronising and discriminating … (FG a-h)

**Q:** It’s like an act in a vacuum, it’s like something happening in the consultation and people don’t have a context – they’re not able to have a discussion about it?

**NGO A:** Yes, the knowledge of medical issues – the client is immediately in a disadvantaged place – the power difference is phenomenal. So unless the GP makes an effort to communicate why they’re making a certain diagnosis or interpretation of the person’s symptoms – it’s very important that’s communicated for confidence to be sustained in the system. (FG a-f)

**NGO A:** I tell you the experience of people in my community - they buy a flight ticket and they go home because they don’t trust the GPs in this country. My good friend – he has a baby boy – when the baby was a few months old he had a rash and he took him to the GP – it will take six months to get rid of it. Come on, people! He flew home, he made an appointment by phone, flew home today, tomorrow saw the GP at home, 3 days everything sorted… (FG a-f)
In this section, we have explored aspects of relational cohesion/dissonance in the network of actors who are involved in interpreted consultations. Our exploration has alerted us to a simple fact: a wide range of issues, practices, attitudes and behaviours serve either to develop or to erode the basic trust and confidence that is necessary for the network as a whole to achieve the agreed ‘work’.

3.2.4. Interactions between Healthcare Providers and Service Users

Our final set of data brings us into the consulting room and the focus is on the immediate interactions between healthcare providers and service users. The emphasis is on the work that needs to be done in the time and space of the consultation, the roles enacted by each party including ‘rules of engagement’ that govern their interaction, and the communication between parties. (NPM: Interactional Workability).

In this project, the ‘immediate’ is about the experience of being in an interpreted consultation. Interpreted consultations are complex in that they depart from the typical dyadic interactions between general practitioner and service user and become triadic interactions involving a third ‘actor’ – the interpreter. As these consultations are bilingual and multicultural, the challenge of the interaction deepens because the linguistic barrier may be exacerbated by cultural, gender and other layers present in the communication, and three people are now attempting to navigate this together. The work that needs to be done and the goals that need to be achieved in the medical consultation remain the same, but the additional need for interpreting impacts in various ways on the usual work done in a consultation.

Here we explore general practitioners’ experiences across a range of key elements of the immediate interaction that takes place in the consulting room; we expand this picture with additional insights from service user representatives and the independent interpreters. This gives us a more integrated sense of the complexity of the interaction.

The ideal immediate interaction between a general practitioner, interpreter and service user would exhibit certain ‘signs’ – and would be:

- **effective** – it must achieve the goals of the consultation: appropriate treatment of the service user (respect, rapport, trust, comfort,
engagement that is gender and culture-sensitive, etc) and appropriate treatment for the service user (medication, referral, etc.)

- **professional** – the roles of the general practitioner and interpreter should remain clear and unambiguous; formal and informal rules of engagement should be agreed, agreeable and adhered to; the interplay between the professional identities of these actors ought to be positive; professional boundaries should not be crossed

- **positive communication** – underpins effective and professional interactions and should be normative, i.e. accomplished with relative ease as it is key to achieving the work of the consultation

- **congruent** – the experience of the consultation should ‘hang together’ seamlessly – there should be no significant sense of missing the mark, of ‘unfinished business in the consultation, of frustration, disengagement or disempowerment on the part of any actor

- **timely** – the goals of the consultation should be achieved in the time and space available

- **meaningful** to all – the overall process (assessment and diagnosis of the service user’s medical condition) and outcome of the consultation (appropriate treatment for the service user) should be meaningful for all the actors concerned and confirm them in their roles and statuses vis-à-vis one another.

The experiences that general practitioners have around these key interrelated dimensions of the immediate interaction either **enable** them to achieve the work of the consultation, or **deflect** them from this goal.

Here we describe:

- Positive experiences that **enable** general practitioners working with interpreters to achieve the work of the consultation, to reach key goals and attain meaningful outcomes with and for service users
Mixed experiences that inhabit a ‘middle ground’ – some elements of the experience support the work of the consultation, but other elements frustrate it.

Negative experiences that deflect or frustrate general practitioners from the work of the consultation.

3.2.4.1 Enabling the Work of the Consultation

Positive Experiences

Clearly, language barriers between general practitioners and ethnic minority service users make the work of a consultation difficult, if not impossible, to achieve. The presence of an interpreter (on-site or on the other end of a telephone) alters this situation in various ways. These general practitioners described positive experiences of interpreted consultations that were effective in achieving the work of the consultation because they enabled positive communication, ensured that medical needs were progressed, and allowed the invisible cultural ‘layer’ of the interaction to be adequately attended to:

#2 Q: Could you describe the best experience that you’ve had? Just, you know, an illustration almost, a story of one particular encounter that you found really, really worked?

#2 A: Em, okay, trying to think, because it’s been quite a while since I’ve had somebody in here, but the last one that would’ve been very helpful would’ve been somebody who did have psychological issues, which is why he had come over here as an asylum seeker, and, em, his English was okay, but not good enough for him, to, to explain his symptoms, so I had seen him on his own, and felt I wasn’t getting far enough, and arranged then, em, for an interpreter, and I think he, he got probably more out of it than I did, because he really just seemed to appreciate the opportunity to be able to describe his symptoms in his own language, and that was very important to him, I think, to be able to do that. So, while I felt I gained some more information, I think it was more therapeutic for him, yeah. (F; FREQ)

#4 Q: What is the best kind of thing that’s been happening in that experience [using an interpreter]?

#4 A: Em, I think as a consequence of the translation service, we have been able to engage with individuals meaningfully, they have been able to understand us and we have been able to progress their medical care and needs, em, arising out of there being a translator there – and meaningful things can happen and referrals and understanding takes place. (M; FREQ)
I’m just sort of checking if there is anything else that springs to mind about positive consequences – like good things that come out of having an interpreter – or have you covered everything?

Definitely for me when you use an interpreter, I’ve learned an awful lot you know about different cultures, just over the years, from looking after patients. But if you have an interpreter, again, you also learn more because the patient is able to give you more information. So each consultation is a better learning experience for you as a doctor because you have the ability to learn more because there is better communication.

Right, okay, so it facilitates that kind of cultural aspect of the consultation as well?

Yeah, yeah.

Ok, because as we go through the research, we’re noticing that obviously, you know, it isn’t just a linguistic barrier...

No, I agree it definitely isn’t, but what happens as well is, if you don’t have access to an interpreter, it gets stuck at the language barrier – so you don’t even get on to cultural issues, do you know what I mean? (M; FREQ)

Other general practitioners described positive experiences where the interpreter’s presence and action enabled them to pay attention to the service user’s body language. These general practitioners felt that this enabled trust and rapport in the triad and provided reassurance for the service user who then felt ‘listened to’. This enables meaningful engagement. All of this contributes to empowerment of the service user and to the effective achievement of the work of the consultation.

I think if somebody is here [on-site interpreter] maybe the patients find it easier to have that contact, you know, because it’s more than just the words, there’s obviously the whole body language [experience]... and we can observe that as well, which is helpful while, you know, they’re interacting. So, I think we probably find that patients get more out of it, or find it easier to have somebody there at the time [an on-site interpreter]. (F; FREQ)

From your sense of working with your Uighur family, if you like, how do they find that phone interpreting experience? Have you any sense of that?

I think they found it reassuring.

Ok.

I think they found it reassuring listening to someone in their own language...and certainly in their case it was very important in that they didn't feel quite so alone.

Yes, yeah...
#6 A: So I think that they find that comforting....and helpful. Yeah...there seemed to be a genuine interaction, you know.

#6 Q: So some kind of interaction?

#6 A: Yeah, you definitely got a feeling that they were able to say what they wanted to say, and that they were listened to, so I suppose that’s very important.

#6 Q: Yeah, that’s pretty positive anyway. How much control do you think that allows them to have, or feeling of kind of positive power in the dynamic?

#6 A: Oh, I think it’s essential. Yeah, really important, because again in their circumstances, they would have felt completely out of control with the whole situation, things were happening and they had no power over anything, but this at least gave them some sense of....I mean when they come here now they probably feel that they get listened to, and that things can happen through here...

#6 Q: Ok, yes.

#6 A: So it reflects well on us, I mean they have a sense of trust here, I think, which I know they don't seem to have the same with the hospital. (M; FREQ)

#2 Q: And would you notice when you have an interpreter on-site, would you have a sense of whether rapport has built up between them and a patient?

#2 A: Yeah, you can usually see it, you know, em, you can see the patient respond with body language, with their voice or enthusiasm, you know... [some] really click with the interpreter and they open up more, you know. (F; FREQ)

Our educative dialogue with service user representatives provided further insight into the impact that good interpreting can have on the immediate interaction, particularly in relation to building the relationship ‘in the triangle’ and keeping the consultation on track and the communication ‘free-flowing’ and positive:

NGO B: I would say that perhaps the interpreter sometimes underestimates the importance of what they are doing in the process. And while I understand absolutely that they are only translating the actual words... that done in a good way can really, I think, enhance and build the relationship between the professional and the client. If [the consultation] is not facilitated well or there’s breaches in that, that’s when the professional gets frustrated, doesn’t know where it’s going and finds it difficult.

NGO B: It’s not two-way, it’s very much three-way, it’s the triangle and I really believe that’s very important because in best practice [terms] where you have it flowing... after a while you only hear the voice, but it’s so important that it is free flowing.
The independent interpreters themselves echoed this relational dimension of their role and emphasised the manner in which they close the linguistic gap and assist in raising the comfort level for the service user:

Q: Can you say a bit more about what you think that enables between the GP and the service user? When you make that link and you close the linguistic barrier, if you like, what do you think happens for them, what do you see in your experience?

Int#9: I think basically you see them communicating, even verbally you can see that they understand each other, so the doctor can work and the user can have a feeling that he’s being helped and he’s being listened to. And that his worries in terms of health are being taken care of, basically.

Int#10: Yeah, I would like to say that he [the general practitioner] must make it clear to the service user that we are there to help them to communicate. To make it easier, the communication between the doctor and the service user, so then the service user will be comfortable to speak to the doctor through the interpreter. That is one of our main roles as an interpreter, make them feel comfortable speaking to the doctor.

These examples of general practitioners’ positive experiences of the strengths of good interpreting give us some insight into what contributes to a congruent experience for all, and enables the work of the interpreted consultation to be achieved.

From these accounts, it is not difficult to see how general practitioners and interpreters who are fully trained to work in the triad that is the interpreted consultation, working from their respective strengths of role and relationship, can provide a service user with the key supports needed to promote healing and well-being. Overall, the impact of these positive experiences is likely to confirm the professional actors in their respective roles and statuses.

3.2.4.2 Mixed Experiences

We found that general practitioners gave many accounts of interpreted consultations that are ‘mixed’ in that the general practitioner can describe positive aspects of the consultation but always returns to some negative aspect which ‘dilutes’ the positive.

For instance, the dilution is sometimes caused by the effort required to get the work done. This general practitioner describes his use of telephonic interpreting and how he also has to manage a range of other tasks during the consultation. He
describes the experience as a positive one in that good communication is achieved but, at the same time, he admits that it is difficult and stressful:

#6 Q: *For example, on the practicalities, do you use a speaker phone? Or do you hand the phone back and forth?*

#6 A: Em... I hand the phone back and forth. Sometimes I will try and do some of the examination while I give a long explanation and he is explaining to the patient, I will check the blood pressure, the pulse....

#6 Q: *So it’s kind of like all hands on deck sort of process?*

#6 A: Yeah. A little bit. Otherwise you just won’t get through the consultation in any kind of time.

#6 Q: *It will take forever then?*

#6 A: It could do, and in particular this family has particular, there’s actually very difficult problems, there’s a multitude of physical and psychological problems...

#6 Q: *Em...people who have a speaker phone function still choose sometimes to hand the phone back and forth, I’m just curious about that...*

#6 A: Yeah I think, ... because then you can write a note...

#6 Q: *How do you mean write a note..?*

#6 A: You can write your notes maybe when they are giving an explanation...

#6 Q: *So you’re writing up your medical notes...sort of your consultation notes?*

#6 A: Yeah, but you might be doing that as well, you can do that as well, so you can do that while...

#6 Q: *Yeah. J______, the feeling I’m getting here is that there’s like ‘multi multi-tasking’ going on. You’re talking on the phone with the interpreter, the interpreter is then interpreting back to the patient who might then be holding the phone, while you’re possibly examining the patient, and then a little bit further down the line you’ll actually be writing up the notes on the consultation while the interpreting is still ongoing?*

#6 A: Yeah, you would, you would try and to generally get through [the consultation] like that.

#6 Q: *What’s that like to manage?*

#6 A: Ah, it can be a little bit, it can be difficult, it can be stressful. Yeah, it can be difficult and stressful, and you feel, you know, you sometimes feel am I really getting a quality service and stuff like that, but at least you feel you’re being understood, because it’s so much worse if you really don’t know what’s going on. (M; FREQ)

In other cases, the ‘dilution’ is caused by factors already discussed in earlier sections, for instance, time pressures associated with interpreted consultations or
the quality of the interpreting. In the accounts below, we can see how general practitioners ‘weigh up’ positive and negative aspects of using interpreters:

#1A: [Interpreting] is about being more effective and hearing the patient more clearly and the patient having a better experience – but it is also about managing time... the time issue is always there.

#1 Q: Yeah. We’ll come back to that.
#1 A: It’s always there. (M; INFREQ)

#13 Q: Is there anything else you want out of it [the interpreted consultation]?
#13 A: Anything else I want...hmm. As much as possible you know, improving just the quality of the interpreters – as I say without complaint, I’m delighted with what I have but just... have some kind of consistency with the quality of the interpreter.

#13 Q: So the quality of the interpreter is quite important...
#13 A: Yes, yeah. (M; FREQ)

These mixed experiences inhabit the middle ground, yet they make it quite difficult for general practitioners to effectively achieve the goals of the consultation with anything approaching ease, or within the time available for the consultation. Do general practitioners have other experiences that go beyond this and are, in fact, even more fraught?

3.2.4.3 Deflections and Frustrations to the Work of the Consultation

Negative Experiences

Beyond the middle ground, general practitioners have difficult and negative experiences during the immediate interaction in the consulting room which deflect them from their key goals and frustrate the work of the consultation. In these experiences, the ‘signs’ which indicate that an interaction is working well are absent, or significantly compromised.

Timeliness

The accounts below show that it can be difficult to achieve the work of the consultation in a timely manner. General practitioners have to utilise communication skills that differ considerably from those required for a monolingual interaction: information has to be exchanged in a specific way, using very focussed relevant questions, and smaller, clearer ‘bytes’:

#5 A: ....it’s so much slower to go through the phone to the client and the client back to you, you really have to make every
question count because otherwise you are wasting time (M; FREQ)

#3 A. Of course some of what you’re saying might be lost a little bit in translation as well, you know. You can’t give the interpreter too much information because you have to remember they’re not of a medical background... so you have to break things up into, instead of saying everything which I might say to an Irish person all in the one big long sentence, I’d have to break it up into several points and stop and start because otherwise it’ll probably get lost and not all of it will be translated properly...[you need to] be fairly specific and keep things fairly simple and straightforward with them, and break it down into smaller points, which does mean more to-ing and fro-ing with the phone, but that, I suppose would be the main thing, not to overload them with, eh, longwinded explanations and things, so I suppose that’s the main point to bear in mind, you know. (F; FREQ)

For general practitioners, working like this slows the consultation process down. The issue of time pressure once again raises its head and it becomes clear that the work of the consultation is difficult to achieve in the time available:

#5 Q: So is there a real difference, like, in time?
#5 A: Timewise, yes, there is, because you are having to - you know the way it works is - it slows you down completely and I have to say to them: interpreter, can you ask him how long he has had the pain and, you know, what makes it worse, and does he get vomiting with it - all those things - and then he has to ask the patient and you can see that, because there’s a third person, it does double the amount of time - it certainly slows down things – there’s no doubt about that. (M; FREQ)

#22 A: ... but I mean the workload that they generate in terms of time and explanations and that.

#22 Q: The community in general, or particular families that you have?

#22 A: Not particular... well, there is a difficulty involved in translation, I mean you have to be... doubly sure that they have got it correctly you know, it’s a lot of work for the return. (M; INFREQ)

The general practitioner speaking below describes the effects of this time pressure on his reactions to service users who need interpreters, and his concern about how this could lead to discrimination against ethnic minority communities. He notes how important it is to assign blame to the ‘communication difficulty’ and not to the service user.

#1 Q: Yeah, you mentioned [that phrase] before, I never heard that...
[‘Heartsink patient’] – it’s a terrible phrase, it’s used to describe patients that when they walk into your room, your heart sinks. Of course, it’s totally unfair because that’s labelling the patient with your reaction and it’s stigmatising… it’s also not reflective of the fact that there is a relationship issue, it’s not one person’s fault, but I suppose the phrase ‘heart sink’ is a good description… your heart sinks when you see [that] an interpreter is involved – and it’s nothing to do with the patients – it’s just to do with the loss of control – I think… that people feel certain patients are ‘heart sinks’ – it’s usually a sense of loss of control, disempowerment, out of control, lost the power to control what’s happening…

There is that danger of blaming patients for your own frustration, and so I think there is a danger with any time you feel out of control, that you can – the anger can be directed at them… and I think there is a potential there for discrimination against ethnic minorities, they’re [seen as] so much trouble, hassle and it’s not [them], it’s the communication difficulty is the trouble, not the patient.

Not the patient, yeah, it’s an important distinction, that one, isn’t it?

It is. I think there’s a danger that if that blurs, it can lead to discrimination – that’s the danger. (M; INFREQ)
Effectiveness

The work of the consultation must be effective; for example, as well as being provided with appropriate medical treatment, this means the service user deserves to be treated with respect and cultural awareness. Few general practitioners raised cultural issues, but during educative dialogues with service user representatives, key points were made about how hard it is to ‘see’ culture; how the interpreter herself or himself involved in the interaction might actually be culturally incompatible with the service user, compromising opportunities to build trust and rapport or to empower the service user:

NGO A: I meant to say that when you were talking about doctors, They don’t see - a lot of people, most of us - don’t see cultural differences, you know…

Q: Mmm...

NGO A: It’s hard to spot them really, or to be aware of them.

NGO: Interpreters obviously can come from any country where the language is spoken, so for instance, his country is Rwanda, so you could have an interpreter from France [selected for him] …

Q: Yes.

NGO A: So it’s not necessarily...

Q: So they could be linguistically compatible but culturally not?

NGO A: Yes. [Many interpreters] are not trained in the significance of cultural issues. And the key point is the empowering [of the service user], so that they’ve more confidence and it helps them in using the service again and again.

In educative dialogue with a focus group of user representatives, we learned that the effectiveness of the work of the consultation can be compromised entirely simply by failing to ask the service user respectfully what language they might be most comfortable with and leaving it to the roll of the dice in the selection of an interpreter:

NGO A: The first question the interpreter should ask the service user is what language are you most comfortable in – is this language ok for you? For example, I am from Romania, there are people in Romania who are from a Hungarian background and they speak Hungarian… there’s no point someone speaking a broken language when he could speak in a language he’s comfortable in… (FG a-f)
Another service user representative described the hesitation service users may feel about interacting with a telephonic interpreter whom they cannot see, because the interaction is likely to be somewhat ‘culture-blind’:

NGO A: Well, I think it’s important... I mean, we would see [telephonic interpreting] as a deficit. I mean, obviously it’s of benefit in an emergency type situation but I suppose a deficit or a negative feature is that it is not culture-visible...

Q: Mmm...

NGO A: ...and no attention can be paid to that, unless the telephone interpreter is particularly skilled.

Q: Yes, right.

NGO A: Which would be, you know, unusual, well, not unusual that the people would be skilled – but it’s a heavy expectation to have, isn’t it?

Q: Yes, so again it might bring us back to the issue of training and awareness and again, that kind of skill level – to be aware that if I’m the telephone interpreter it’s very hard to help the doctor have those kind of ‘culture cues’ you know...?

NGO A: Exactly.

Professionalism: Roles and Rules of Engagement Concerning Communication

General practitioners spoke extensively about their experiences of the professional dimension of communicating in the immediate interaction, and roles and rules of engagement concerning this. Good communication underpins professional interactions and should be normative, i.e. accomplished with relative ease in order that it contributes to achieving the work of the consultation.

We know that, ideally, the respective roles of the general practitioner and interpreter should remain clear and unambiguous; formal and informal rules of engagement should be mutually agreeable and adhered to; the interplay between the two professional identities ought to be positive, and professional boundaries should not be crossed. What happens in real terms?

In real terms, the presence of the interpreter brings an entirely new dimension to the dynamics of the interaction: communication becomes frustrated when the general practitioner’s role is challenged or upended either by the presence of the interpreter or by the engagement between interpreter and service user. This is particularly the case when the role of the interpreter is perceived to undermine or impinge on the general practitioner’s role, specifically his/her normative role as ‘lead’ and ‘communicator’. This relates to the issue of divisions of labour in
interpreted consultations in terms of people’s knowledge and agreement about who should do what in the encounter. This is an organisational level issue in terms of negotiating appropriate boundaries but these data are relevant here because they emphasise the issue of role boundaries within the immediate clinical encounter.

General practitioners gave examples of interpreters ‘interviewing patients’, initiating questions or spontaneously providing information to service users about other health and social care services.

#1A: I started to realise that the interpreters would be actually interviewing the patient and finding out what was important, em, so that’s...

#1 Q: How do you feel about that? What’s your sense of that?

#1 A: I haven’t a difficulty with that, but it means that I’m out of the consultation... I can understand why they would do it, I can see pros for it because they’re teasing out what they think I need to know [but] they don’t know what I need to know, they’re interpreting what I want to know and then relaying it to them, so it’s two-way communication and it’s not effective communication. (M; INFREQ)

#5 Q. Ok yeah - what is the feeling for you being the one who is not part of that conversation?

#5 A. Well it’s a little bit annoying I have to say, because you kind of get the feeling that the person on the phone doesn’t get the reason why they are there.....I had one chap and very helpful I am sure, [but] the interpreter was telling the other person about SPIRASI (non-statutory service for survivors of torture), the service which I was going to tell him about. But he started telling him about it already before we really got into it very much more and the guy who was the client was writing down the information. And, you know, in fairness that is ok in one way, but it wasn’t what I had wanted the interpreter to do. (M; FREQ)

These examples of ‘crossing boundaries’, where interpreters fail to respect discrete professional identities, leaves general practitioners feeling discomfited and annoyed. They have a sense of being ‘left out’ of an interaction in which they are, usually, very much in control. Several general practitioners found this loss of control problematic, although GP#22 had a different, lighter view on the matter:

#22Q: ... and the other thing that [general practitioners] said is that when you are in that triad that they can sometimes feel as if they are out of control of the consultation, or that they are kind of outside it, and that that is not normally what it feels like.

#22A: Get a grip!
However, we cannot ignore that this is one area of experience where emotions genuinely run high, and it is also worth noting that feelings of ‘being outside’ and loss of control and power become enmeshed with the stress emotions caused by time pressures and are part of an ‘engaged’ experience, because the general practitioner cares about the communication experience:

**#1 A:** Yes, I suppose what I would just say is that, even though emotionally there was frustration, you just had to do it, because that’s what you had to do to communicate with patients, that’s why I did it.

**#1 Q:** This is getting the interpretation?

**#1 A:** Getting the interpretation. But it’s definitely the big disincentive, is that element of, this is the emotional feelings that are related to the time pressures and the feeling of being on the outside, out of control.

**#1 Q:** Yeah. So they’re not kind of, these are not disengaged experiences, they all feed into one another, the time issue, the emotional issue, the distance issue, feeling disempowered, like that’s kind of a ‘whole’. So it’s all happening inside you, right there in that room at that time...

**#1 A:** It’s all happening at the one time, it’s a here and now experience.

**#1 Q:** Yeah, absolutely, it’s very immediate, isn’t it?

**#1 A:** Absolutely immediate, yeah. And a strong feeling, you feel right here, you’re angry, you’re frustrated – fuck!

**#1 Q:** There’s so much goes on in this, it’s really...

**#1 A:** And you see, it’s interesting, because I worked as a counsellor, I like communication, I trained in communication skills, so I love it, and I just feel so on the outside of that one [the immediate interaction]. (M; INFREQ)

Speaking in a focus group, the independent interpreters described, from their perspectives, how important it is to be clear about their role and the ‘rules of engagement’ that govern their interactions in the immediate medical encounter:

**Q:** I’ve one other question - you are very clear about your role and the boundaries around that, you’ve explained that sometimes a patient might cross over the boundary by giving you information when the doctor is out of the room, or that the doctor might draw you over the boundary by leaving you alone with the patient...

**Int#9:** Yeah, yeah.
Q: ...and I do understand [that] you are there as a voice... but can you think of any other examples or incidents where you feel perhaps you draw yourself over the boundary a bit because of something you are seeing, or something you want to fix or mend in a consultation? Say maybe where you are relying on the doctor to pick up on the [service-user's] level of anxiety and you can only interpret the words, but say a doctor isn't [picking up the anxiety] and you are left interpreting - presumably that could get quite frustrating?

Int#9: Well, I think, I know this is going to sound very cold but it’s not my responsibility if a doctor is not doing their job well. And if a doctor is not getting the anxiety from their patient it’s not my responsibility, you know. So I think in a way I cannot add anything because I have to think, as an interpreter, ‘the doctor knows best’. Because that’s the only way the system is going to work. So even if I feel the doctor doesn’t know this, I have to hold over and say no, the doctor is doing their job and if they are not picking this up, well, there’s nothing I can do.

Q: In some way, however subtly, would you agree that you need to somehow build trust and rapport?

Int#10: Yeah, I would agree that we need to build up the trust, you know.

Q: But you are still only allowed to be the voice.

Int#10: Yes.

Q: How do you do that?

Int#10: Just I think we should be introduced to the patient as the interpreter and speak maybe for 2 or 3 minutes not be left with the patient for half an hour waiting in the same waiting area.

Q: So just a few minutes to relax together and chat a little?

Int#10:: Yes, that’s right.

Q: Okay.

Int#10: That would be the correct way.

Int#9: You were asking how can we build trust? I just wanted to say that a doctor hasn’t seen the patient until that moment either. How does the doctor build trust? It’s the same way that we build trust. So it’s up to the doctor basically to build trust with his or her patient, it’s not up to us. If the doctor welcomes the patient then we are welcoming the patient, as a voice. It depends entirely on the doctor.

Q: So if the doctor was very short, very clipped and said, ‘Okay, let’s get going’ – you have to say: ‘Okay, let’s get going.’

Int#9: Yes, exactly. You introduce yourself and after that it’s up to the doctor, so if the doctor wants to talk about the weather, that’s fine, but, you know, it’s up to them.
Q: **So the control is the doctor, the doctor controls to some extent?**

Int#9: Yes.

Q: **So when you are in a consultation and you are the voice and you sense that, let's say, for example, a service user is upset and concerned or even has strong emotion, how do you work with that?**

Int#10: I think it’s a body language issue. If you have a good doctor they can sense themselves that body language, if a person is worried about something you wouldn't be sitting the same way that if a person was not worried at all. So that’s up to the doctor to pick it up, and then you only need to send a message, if the person is worried he will be using a lot of worrying words, if you know what I mean. So you just pass them over.

Q: **So you are hoping the language will get that across as well as the doctor being able to see the body language?**

Int#9: Yeah, yes.

Int#10: And it’s the doctor’s job to pick up the service user’s body language, emotional signs.

Clearly, the independent interpreters perceive the general practitioner as the key ‘lead’ in the immediate interaction. They understand and describe their own role with respect to this primary boundary. This clarity about the formal and informal rules of engagement is crucial to effective communication in the immediate interaction. An interaction where this clarity is absent is likely to ‘miss the mark’ and perhaps leave unfinished business, and a trauma therapist representing service users explains how she would deal with this situation:

**NGO B:** No, if [the service user] is not comfortable I would let the interpreter go... But I then have the responsibility and I feel I have to book another session with the service user – to follow up with an appropriate interpreter, so therefore I wouldn't make any recommendations, I wouldn't make any interventions based on this ‘poor interaction’, I'd call it.

**Congruence and Meaningfulness**

These ‘gaps’ in the interaction mean they lack congruence and do not ‘hang together’ seamlessly for the actors involved. Frustration, disengagement and disempowerment are the marks of problematic interactions and, understandably, the work of the consultation will suffer. The impact of these negative experiences is likely to erode a sense of the professional roles and status of both general practitioner and interpreter.
We have limited data on a sense of meaningfulness for the service user. During the course of the research, we asked general practitioners to consider if they can know whether a service user feels the work of the consultation has been achieved. Many responded that they do not always know this and reflected that it would be valuable to be much clearer about that in the future:

**#4 Q:** Can you get a sense of how that experience of interpreting has been for the service user?

**#4 A.** Em, I think... I’ve a sense they leave with, with a basic understanding of what’s happened. As to the degree of quality of that, I couldn’t honestly comment on, because people will smile in front of the doctor when they’re leaving, they will thank the doctor and they’ll, they’ll put out their hand to me again and it’s hard to interpret that as really a sense of satisfaction, or just out of courtesy to me. (M; FREQ)
3.2.5 Levers, Barriers and their Influences on Normalisation

In this chapter, we have described general practitioners’ uptake and experiences of a pilot interpreting service across the four domains of the NPM. We have also described the perspectives of other key stakeholders to contextualise these data. Interestingly, the perspectives of other key stakeholders have significantly augmented understanding of issues across the four domains. To close the chapter, we return our focus to the general practitioners’ experiences in order to carefully consider the key levers and barriers to uptake of the pilot interpreting service from their particular perspectives and context. This focus is appropriate because it is the remit of the research (see Chapter 1). It is also appropriate given the findings we have presented in this chapter concerning the lack of dissemination of knowledge about the pilot interpreting service to ethnic minority service user communities. In the absence of this dissemination, all of the decision making power to uptake the service or not lay with general practitioners at local practice level.

Tables 3.1-3.4 show a synthesis of the key levers and barriers within each domain of the NPM. The themes that emerged for each domain are shown as column 1, levers and barriers are shown as columns 2 and 3 respectively. The final column describes the relevance of these levers and barriers to normalisation of interpreted consultations in this setting. A lever suggests a positive influence and a barrier a negative influence. Assessing these vis-a-vis one and another, we can assign a ‘weighting’ regarding the likelihood of normalisation (high, medium, low). For instance, the first row relates to policy and its relevance for normalisation. Reading across the table, we see that the lever around policy at practice level has a modest influence on uptake and is ‘countered’ by a barrier relating to policies at national level. We conclude that, in relation to the theme ‘policy’, the likelihood of normalisation of interpreted consultations is LOW.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Levers to uptake</th>
<th>Barriers to uptake</th>
<th>Likelihood of normalisation of IC*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>POLICY</strong></td>
<td><strong>L1.</strong> Some practices have policies of inclusive access for all service users: ‘policy of inclusion’</td>
<td><strong>B1.</strong> No knowledge of national policy about intercultural health. <strong>B2.</strong> Scepticism about availability of resources to implement national policies generally.</td>
<td>The lever around policy at practice level has modest influence on uptake and is ‘countered’ by the barriers relating to policies at national level. <strong>LOW</strong></td>
</tr>
<tr>
<td><strong>KNOWLEDGE</strong></td>
<td><strong>L2.</strong> During educative dialogue, researcher provided information about the available pilot service to GPs.</td>
<td><strong>B3.</strong> GP and ethnic minority service users’ knowledge of the available pilot service is limited.</td>
<td>The impact of information provided by researcher to GPs was modest (for practical reasons, given the scale of the research). Overall, the knowledge base of the pilot service was very low. <strong>LOW</strong></td>
</tr>
<tr>
<td><strong>ABLE WORKFORCE</strong></td>
<td>None documented</td>
<td><strong>B4.</strong> No training was planned or provided to general practice staff re implementation of interpreted consultations.</td>
<td>Training was absent and there are no documented levers around this. <strong>LOW</strong></td>
</tr>
<tr>
<td><strong>TIME PRESSURE &amp; FINANCIAL PRESSURE</strong></td>
<td>None documented</td>
<td><strong>B5.</strong> Uptake of available service was associated with serious time pressures by general practice staff. <strong>B6.</strong> Uptake of service was associated with loss in earning power for some general practice staff.</td>
<td>The time pressure is a major issue for GPs across the board. The financial pressure is problematic for some GPs. There are no levers around either of these. <strong>VERY LOW</strong></td>
</tr>
</tbody>
</table>

*IC = Interpreted Consultation
### Table 3.2 Skills among General Practice Staff for Implementation of Interpreted Consultations

<table>
<thead>
<tr>
<th>Theme</th>
<th>Levers to uptake</th>
<th>Barriers to uptake</th>
<th>Likelihood of normalisation of IC*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TASKS &amp; DUTIES</strong></td>
<td>L3. Many new tasks and duties are compatible with existing administrative staff roles and identities.</td>
<td>B7. New skills for assessing need for interpreting and choosing appropriate interpreting mode occur ‘on-the-job’ – without formal training or support.</td>
<td>The lever relating to skills compatibility is ‘countered’ by a barrier relating to a gap in skills base for implementation work. MEDIUM</td>
</tr>
<tr>
<td><strong>TRAINING</strong></td>
<td>None documented</td>
<td>B8. Training for implementation of interpreted consultations was not emphasised by many GPs.</td>
<td>The need for training was not initially emphasised by many GPs; following educative dialogue, there was a favourable response to suggestions around training for GPs. MEDIUM</td>
</tr>
</tbody>
</table>

### Table 3.3 Professional Relationships and Confidence between GPs, interpreters and service users

<table>
<thead>
<tr>
<th>Theme</th>
<th>Levers to uptake</th>
<th>Barriers to uptake</th>
<th>Likelihood of normalisation of IC*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INTERPRETERS FROM CURRENT SERVICE</strong></td>
<td>None documented</td>
<td>B9. GPs and service users have mixed confidence re knowledge and expertise of interpreters from current service.</td>
<td>Taken together, these barriers undermine confidence between the parties involved in an interpreted consultation. VERY LOW</td>
</tr>
<tr>
<td></td>
<td></td>
<td>B10. GPs and service users have limited understanding about roles, responsibilities and professional needs of interpreters.</td>
<td></td>
</tr>
<tr>
<td><strong>ALTERNATIVE STRATEGIES</strong></td>
<td>None documented</td>
<td>B11. GPs and service users expressed some confidence in informal strategies (friend/family member as interpreter) used along with, or in preference to, the available service.</td>
<td>Confidence in alternative strategies circumvents use of interpreted consultations available through the pilot service. VERY LOW</td>
</tr>
</tbody>
</table>

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*IC = Interpreted Consultation
Table 3.4 Interactions in the Interpreted Consultation

<table>
<thead>
<tr>
<th>Levers to uptake</th>
<th>Barriers to uptake</th>
<th>Likelihood of normalisation of IC*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSULTATION GOALS</td>
<td>L4. Some GPs consider that the use of a formal interpreter enables ‘better’ consultations.</td>
<td>B12. Use of interpreter can be a challenging communication event for the GP which frustrates the work of the consultation.</td>
</tr>
</tbody>
</table>

*IC = Interpreted Consultation

Finally, Table 3.5 describes the overall likelihood of normalisation per domain. Here, we consider the weighting for normalisation per theme in each domain and provide an overall weighting for the domain. For instance, the weightings for normalisation in Table 3.1 for policy (LOW), knowledge (LOW), able workforce (LOW), time pressures and financial pressure (VERY LOW) are given an accumulative weighting of VERY LOW.

Table 3.5 Overall Assessment of Likelihood of Normalisation

<table>
<thead>
<tr>
<th>2. Organisational setting</th>
<th>2. Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>VERY LOW</td>
<td>MEDIUM/LOW</td>
</tr>
<tr>
<td>3. Relationships and confidence</td>
<td>4. Interactions in the interpreted consultation</td>
</tr>
<tr>
<td>VERY LOW</td>
<td>MEDIUM/LOW</td>
</tr>
</tbody>
</table>

This whole system analysis shows there is no single strong component in the entire system. There are two very weak components. We conclude that the likelihood of normalisation of interpreted consultations in these general practices is very low. There are a range of
actions required to address the weaknesses documented. In Chapter 4 we discuss the study findings further and set out a series of recommendations to improve the likelihood of normalisation.
CHAPTER 4 DISCUSSION

The aim of the research was to explore the experiences and uptake by general practitioners of paid interpreters available through a pilot scheme provided by a commercial company. A related aim was to consult with other stakeholders, service user representatives and the independent interpreters to contextualise general practitioner accounts and experiences. Our final aim was to generate information about potential solutions that might improve uptake of paid interpreters. We have used a sociological model, the Normalisation Process Model (NPM) to conduct a whole system analysis of the likelihood of normalisation of interpreted consultations by these general practitioners in this setting.

The previous chapter provides a ‘whole system’ analysis and from this we conclude that the likelihood of normalisation of interpreted consultations in these general practices is very low. In this chapter, we summarise for each domain of the NPM and discuss a series of recommendations to improve the likelihood of normalisation in the future.

A key point about these recommendations is that most of them require effective inter-agency collaboration between all key stakeholder groups:

- NGOs working with ethnic minority communities
- The commercial interpreting companies providing interpreting in medical settings
- Academics with expertise in interpreting in medical settings
- The Irish Translators’ and Interpreters’ Association (ITIA)
- General practitioners using the commercial interpreting companies
- The Irish College of General Practitioners and
- Relevant offices in the HSE.

This means that all stakeholder groups can shape the various ideas and activities featured in these recommendations.

There are two fundamental issues running through these recommendations. First, the likelihood of normalisation will improve if Irish general practices have more commitment to (see L1 above), and capacity for (see B5 and B6), incorporating interpreted consultations into their routine work. To date, there is a ‘gap’ between commitment and allocation of resources to enhance practice capacity. Second, there is a need for more attention to the issue of training for the professional groups involved. Given the limited knowledge and skills of general practitioners about interpreting (see B7, B8, B10 and B11), general practitioners would benefit from training about language barriers, interculturalism, good practice in interpreting, and skills for working in interpreted
consultations. Given the accounts of variable quality in interpreting practice reported here (see B9 and B12), all interpreters working in medical settings should be fully trained and professionally accredited. This view is supported by recent research by the NCCRI (2008) which recommended improvements in training and accreditation across the interpreting sector. Following implementation of these recommendations around training for general practitioners and interpreters, multiperspectival monitoring and evaluation of service provision and service use should be undertaken.

Summary of Findings

4.1. Organisational Context and Setting

From the quantitative analysis we know that, despite an increase in uptake during the study period, overall levels of uptake remain low. We also know that uptake is confined to a particular set of practices. This low uptake of formal interpreters in general practice resonates with international (Jones, 2007; Greenhalgh et al., 2007) and national literature (MacFarlane et al., 2008).

Our findings from the qualitative analysis show that there are 2 documented levers to uptake and 6 documented barriers in relation to the contextual aspect of the implementation process. Below we discuss levers and barriers in relation to this domain and see that all the levers are ‘countered’ by barriers.

4.1.1 Policy

One lever to implementation is a policy of inclusion (L1), that is, a policy within a general practice to provide general practice services to service users with medical cards and/or from disadvantaged or marginalised communities, including ethnic minority communities. This policy may be formal but, in most cases, is informal. It seems from the quantitative and qualitative data that highest frequency users of paid interpreters are more likely to come from practices with policies of inclusion.

However, we know that in such practices, use of the pilot interpreting service is not that frequent and is rarely exclusive. Our overall assessment is that local policies of inclusion have a modest impact on the implementation process. However, they are a necessary element for implementation. General practitioners are the key decision makers in their general practice ‘organisations,’ therefore they hold the mandate to develop a clear policy. It is important that they do this because equity of access is a core value of the
HSE and, of course, because of national equality legislation (e.g. Equal Status Acts, 2000 and 2004 see http://www.equality.ie/index.asp?locID=106&docID=226).

A clear policy of this kind would then promote the commitment and will across the workforce in the practice and drive behaviour towards practical implementation of interpreting services in routine daily activity of the surgery. This would result in positive value being assigned to the work of implementing interpreted consultations. In this scenario, the workforce would have a shared sense of the value of the practice being accessible, offering support for language barriers and, in this way, offering what general practitioners in this study have described as their aspiration to provide holistic care to this group of service users.

While some general practitioners mentioned that developing policy at practice level is difficult to do because of a lack of time, the educative dialogue we engaged in during this study raised awareness among general practitioners about the importance of policy in all of the above respects. In fact, when we asked them to rate the four levers documented in the study, they rated policy at practice level as the strongest lever.

Recommendation 1
General practices, as ‘local level’ organisations, should develop clear written policies of inclusion that reflect HSE core values and national equality legislation. There is an important role for the Irish College of General Practitioners in this area.

As mentioned at the outset, each lever in this domain has a ‘counter-barrier’. In terms of policy, a barrier to implementation is that general practitioners have little or no knowledge of national policy (B1) and an attitude of scepticism about the availability of national level resources to support them to implement policy on the ground (B2).

National policy is another necessary element for implementation because its role is to offer a framework, context and content for the development of policy at practice level. What needs to be achieved is congruence between national and local level policies. There needs to be shared agreement about what supports are necessary, what resources are required and available, and how best to deploy them in order to increase the chances of successful implementation of interpreted consultations in general practices.

This presupposes ongoing dialogue between national policy makers and practitioners so that there is resonance between aspirational and practical aspects of policy (local and national) and actual experience on the ground. This dialogue model of policy development is in line with current national and international thinking with regard to improving the policy-practice relationship (Nutley, Walter and Davies, 2007). We see a
valuable role for the Irish College of General Practitioners as mediators in this dialogue because they hold a mandate to support their general practitioner membership on the ground and to represent that membership at national level. Importantly, our study shows the deep value of wider participation in a dialogue of this kind: the inclusion of ethnic minority service users.

This involvement of service users is in line with the HSE Transformation programme (http://www.hse.ie/eng/Publications/corporate/transformation.html) and the recent National Intercultural Health strategy (HSE, 2008). Clearly, representatives of the interpreting sector will have important contributions to make as well. There may already be established structures and systems capable of engaging all key stakeholders in this ongoing dialogue to formulate congruent policy and identify best practice to manage language barriers in general practice. At the practical level, to support ongoing dialogues of this nature, we propose the use of Participatory Learning and Action (PLA) research (the educative dialogue feature of this study was grounded in the ethos of PLA). PLA research is oriented towards identifying concrete positive solutions to commonly shared problems, such as this problem of implementation of interpreted consultations (Chambers, 1994).

**Recommendation 2**

The HSE Social Inclusion Unit, under the auspices of the 2008 HSE National Strategy on User Involvement and following on from the HSE National Intercultural Health Strategy, should continue their work on the development of congruent policy about language barriers with the involvement of service users, the Irish College of General Practitioners, the interpreting sector and national policy makers with a remit for general practice. We recommend the use of a participatory dialogue approach to this process.

### 4.1.2 Knowledge as an Underlying Resource

The second lever to implementation is receiving knowledge (during the research process) about the available pilot interpreting service from the researchers (L2). During the study the research team were committed as ‘brokers’ to sharing insights, knowledge and experience across the stakeholder groups. We fostered the generation of rich and complex knowledge about key issues. This was a feature of the educative dialogue in our study. This process involved ‘learning’ or ‘awareness-raising’ on the part of all the stakeholders involved about the language barrier as a problem and interpreting services as an available resource to address that problem. Some general practitioners said that the educative dialogue impacted on them. For non-users it motivated them to consider

[17](http://www.hse.ie/eng/Your_Service_Your_Say/Service_User_Involvement_in_the_Health_Services/)
using the service. For infrequent users, it motivated them to be more active and responsive in requesting and accessing the service than they currently are. For highest frequency users, it engaged them in a reflective process about their use of the service, the ups and downs of their experiences and ways of improving experience in the future. These findings endorse **recommendation 2** above because the impact of *dialogue* is apparent.

The ‘counter-barrier’ here is that, overall, general practitioners’ knowledge of the available service was very limited, in some cases was patchy and in others was absent (B3). This was an interesting finding given that there was an initial interagency advertising campaign at the beginning of the pilot. However, this was not located in a sustained, wider implementation project which should have been provided by the HSE. This was a missing element of the endeavour and it would have incorporated a variety of supports:

- identified leaders to promote implementation
- provided training for the workforce charged with implementation
- involved the ethnic minority community centrally in the dissemination of knowledge within their own communities about the free interpreting service.

The outcome for many general practitioners, who describe being inundated with flyers and advertisements every day, was that briefly-glimpsed information about the pilot interpreting service was lost, binned, used once and then forgotten about. Taking this on board, some general practitioners suggested ways in which awareness of the service could be improved and we need to draw on these as a resource for future advertising and information dissemination.

The outcome for the ethnic minority community was that, as they were never in possession of advertising information about the service they could not act as leaders to promote uptake and individual service users could not request or prompt its use. In the educative dialogue service user representatives were astonished that the service was available, that it was free, that they had the right to ask for it. They want involvement in the dissemination process and they emphasise that their local networks are a powerful resource for advertising and promoting uptake of the service.

This disjunction between knowledge provided about the service and knowledge gained on the ground raises a general point: providing information is one thing but ‘hearing’ and ‘acting’ on it is another.
Knowledge about the available service needs to be disseminated more effectively using a combination of approaches. Peer to peer networks could be utilised more thoroughly. It would be ideal if general practitioners with positive experience of using the service would share their experiences with other general practitioners for instance, at ICGP CME meetings or other general practice conferences. Similarly, service users familiar with the service could share that knowledge with a broader range of service users through the community organizations with which they interact. At the same time, knowledge and insights from across key stakeholder groups needs to seen as a resource in a formal HSE led dissemination process. We also need to ask what role qualified trained interpreters might have in this process? All of these approaches would of course be located in, and resourced by, national equality legislation mentioned above.

**Recommendation 3**
Advertising and dissemination processes need to be reviewed. This should be done with direct input from key stakeholder representatives who have ideas about how this can be achieved. This review could be part of the HSE led participatory dialogue outlined in Recommendation 2 and should be seen as a *shared and supported* task across stakeholder groups. It should be complemented by other approaches and resources: use of peer to peer networks and, also with reference to national equality legislation.

**Recommendation 4**
The reviewed advertising and dissemination process should take place as part of a broader, HSE initiated project designed to guide and support the implementation of interpreted consultations in routine general practice.

### 4.1.3 Able Workforce

There is no lever for implementation in relation to the workforce in the practice (general practitioners, administrative staff). There is one documented barrier: no training was planned or provided to the workforce to support the work of implementing interpreted consultations (B4).

The implication of this is that there was no opportunity for the workforce to learn about the range of tasks and duties involved. They had no opportunity to develop tacit or overt agreements about how to manage the workload.

This is a barrier to implementation of interpreted consultations because the workforce needs to know the full range of tasks involved and they need to assess their capacity to deliver on those tasks and to consider and plan the allocation of tasks across the workforce.
This highlights the importance of training in the implementation project referred to under **Recommendation 4.**

### 4.1.4 Time

There are no levers to implementation that relate to time but there are two clear barriers. The uptake of the available service is associated in general practices with serious time pressures (B5) and these time pressures are associated with loss in earning power for some practices (B6).

Time pressures are problematic and stretch the capacity of general practices as organisations. The bottom line here is that the time involved, from administrative staff arranging interpreters to general practitioners engaging in lengthy interpreted consultations, makes it very difficult to ‘fit’ interpreted consultations into the normative constructions of time in a surgery where a ten minute slot is allocated to each service user. The extra time involved also puts pressure on the system in terms of finance. General practitioners, who have power as decision-makers in relation to policy, are, at one and the same time, required to be business managers. The bottom line here is that while the interpreting is free, it represents a financial loss for the practice as an organisation. The impact of this is that the will and motivation to implement interpreted consultations is diminished for some general practitioners.

Some general practitioners respond to the time and money pressures by simply accepting that the practice needs to devote extra time to this work. One general practitioner clearly describes the culture of 10 minute appointment slots and asks can this be re-examined, and can we change it? Others obviously have already, in practice, moved towards changing the culture within their organisation. They now allocate a double appointment slot for interpreted consultations. However, this is a very small minority of general practitioner participants.

Other general practitioners emphasise that they would want financial incentives to do this. This reflects the culture of seeking incentives for certain kinds of work in Irish general practice. However, it would not be HSE policy to provide such incentives. The negotiation of the new general practitioner contract is on-going and it is hoped to replace current systems for ‘fee-per-item payments’ for certain additional services.

This raises interesting questions: what is the work of the general practitioner? What work is considered ‘extra’ and why, and by whom? This relates back to our earlier point about
the general practice as an organisation, its policies regarding access and inclusion and the question: who is it that the general practitioner serves?

To address these questions, we recommend that Irish general practice examines its organisational culture and the practices that unfold there and the extent to which these practices do or do not provide equal access and equal treatment for service users with limited English proficiency. This ought to be done with particular reference to international policies and recommendations about people’s right to have access to primary health care (Alma Ata Declaration, WHO, 1978; Chan, 2008).

**Recommendation 5**

Irish general practice should examine its organisational culture and the extent to which that culture does or does not support equal access and equal treatment for service users with limited English proficiency, with particular reference to international policies and recommendations about people’s right to have access to primary health care. The ICGP and the Irish Medical Council would have a central role in this in terms of supportive education and training initiatives\(^\text{18}\).

### 4.2. Skills

It is interesting to consider whether low uptake of the available pilot interpreting service, documented in the quantitative analysis, is linked to the skills of those involved in the implementation process. Based on the qualitative analysis of this domain of the NPM, we see that there is one lever and two barriers to the implementation process.

A major lever is that some new tasks and duties required for the implementation of interpreted consultations are administrative ones that are clearly compatible with

\(^{18}\) The UK General Medical Council sets the standards for knowledge, skills, attitudes and behaviours that medical students should learn at UK medical schools. These standards are set out in Tomorrow’s Doctors (2003), which is available at http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/tomorrows_doctors.asp
existing administrative staff roles and identities (L3). They do not need any training about the actual tasks and duties involved in phoning the interpreting service, managing appointment bookings for interpreted consultations and so on. These tasks reflect the work that administrators are already doing on a daily basis and there is evidence that some have streamlined this into their workload.

However, administrative (and other staff) may need training about the nature and extent of the work involved in the implementation process. There are a range of additional tasks and duties that do require certain new skills. For instance, identifying the need for, and mode of, interpreting required demands a new skill. For the general practitioner, the task of participating effectively and comfortably in an interpreted consultation demands a new skill. At present, there is no training in place for these tasks and the skills they require. This represents a barrier to the implementation process (B7). An additional barrier is that training for implementation of interpreted consultations is not emphasised by many general practitioners (B8).

During the educative dialogue we raised awareness among general practitioners about the complexities of the language barrier as a problem for service users, and also the complexities of the work involved in implementing interpreted consultations in routine general practice. From this, many general practitioners endorsed the idea that training would be beneficial for them and their staff and that this would support uptake of the interpreting service.

It is important to think about how and when this training might be delivered to general practitioners because, again, there are questions about time, effort, energy and organisational capacity required to respond positively to training initiatives.

General practitioners in this study had some interesting ideas about content, design and delivery of a training ‘package’. They need to be involved in the development of a training package because they know best what is likely to evoke a positive response from their colleagues. For the same reason, service users and interpreters should be involved in the design and delivery of this training. All key stakeholders need to bring their perspectives and expertise to this task. It would be helpful if the training package was evaluated in a formative and participatory manner to ensure that it continues to meet stakeholders’ needs over time. This is important because principles of best practice, in any field, develop over time based on research, policy, community needs and changing patterns of migration. At the moment, in the United Kingdom there is some debate about what constitutes best practice. This debate has arisen around a recent increase of inward migration and emerging research findings from more settled immigrant communities (Adams, 2007; Jones, 2007; Greenhalgh, 2007; Greenhalgh et
al., 2006). This highlights that ongoing monitoring of training for the implementation of interpreted consultations is required to ensure it remains ‘fit for purpose’.

**Recommendation 6**

A training package about the implementation of interpreted consultations should be designed and monitored in a participatory manner with input from all key stakeholder groups and made available to general practice staff. Key content for the training package would be general information on interculturalism, the impact of language barriers for service users, good practice in interpreting, and skills development for working in interpreted consultations. This participatory design would ensure that the training package is, and remains, responsive to all stakeholder needs and developing principles of best practice. The package could be designed as, or include, a practice based demonstration at the practice itself or at ICGP Continuing Medical Education meetings. This action could be part of the HSE initiated participatory forum outlined in recommendation 2.

### 4.3. Relationships among the Network of Actors

In this domain of the NPM, the evidence is that general practitioners have concerns about the credibility of the information mediated in the interpreted consultation by the pilot company interpreters. General practitioners have mixed confidence in the pilot company interpreters in terms of qualifications or training, competency to deal with cultural, gendered and political layers of communication in the triad and their general professionalism, for instance awareness of codes of conduct (B9). Their negative experiences are strongly corroborated by evidence from service user representatives and the independent interpreters. Interestingly, there is a considerable distance between these accounts of negative experiences with some pilot company interpreters and the stated company policy.

For the general practitioners, the result of this mixed experience is that they become uncertain about what makes for a good, professional interpreted consultation. What are the signs of an unacceptable consultation? General practitioners realise that they have limited understanding of the complexity of the interpreter’s role and relevant principles of
best practice related to that role (B10). We chose one single issue, the perceived ‘off centre’ conversation in an interpreted consultation, to explain how easily the confidence of actors in the network can be undermined, leading to misunderstanding and frustration. We know that a significant number of signed-up practices only used the pilot service once or twice in the early days and never again. Why? Did they experience interactional difficulties like the ‘off centre conversation’? Were they unsure about aspects of the interpreter’s performance? Did they become aware of gaps in their own sense of confidence in the work of the interpreted consultation? General practitioners are left unsupported with regard to professional confirmation/disconfirmation of the validity of the subjective criteria they currently use to assess their experiences.

The issue of confidence and what might constitute viable agreed criteria for assessing knowledge and expertise in the network is of considerable importance because all parties are participating in a challenging and complex consultation. Underpinning the cohesion of the network involved in this consultation is the issue of culture. Culture is transmitted via language and we must not underestimate the complexity of language and the challenges inherent in interpreting, an activity designed to bridge language barriers but which must also attempt to ‘connect’ across cultures. The service user who necessarily brings their cultural specifics into the consultation must be facilitated by the two professionals involved. The interpreter is there to bridge language barriers and linguistic culture gaps and needs to be able to handle this with ease and professionalism. The general practitioner is there to seek out and use the service user’s perspective as a resource for the clinical and therapeutic elements of the consultation (Toon, 1994). Therefore, it is crucial that the professionals have confidence in themselves and each other’s cultural competency and know that the hidden cultural layer of the communication is well handled. Interpreters and general practitioners must be supported to achieve cultural competency. The recommended training package (recommendation 6) and the monitoring and evaluation process (recommendation 7) could offer these supports. With regard to evaluation processes (recommendation 7) we re-state the imperative of service user involvement so that they can provide feedback on their experiences of interpreted consultations. The HSE Social Inclusion Unit, as part of its commitment to consultation for the implementation of the NHIS will continue to promote feedback from service users.

**Recommendation 7**
Together with implementation of recommendations around training for general practitioners and interpreters, formative monitoring and evaluation of service provision and service use of interpreted consultations in general practice should take place, be independent and take into account all stakeholders’ perspectives.
Finally, general practitioners have some confidence in alternative strategies, particularly informal interpreters (B11). There is no evidence that general practitioners are rejecting pilot company interpreters because they have more confidence in the informal interpreters. This acts as a barrier to uptake of the interpreting service in the sense that it allows general practitioners to circumvent the service and still, from their perspective, ‘get by’ with service users who have limited English. The ethnic minority community representatives concur that the use of informal strategies is very common. So, in practice, and in keeping with findings from previous international and national studies (e.g. Greenhalgh et al., 2006 & 2007; Woloshin et al., 1995; MacFarlane et al., 2008) informal strategies are used with considerable frequency. There are complex and mixed finding about the merits and demerits of using informal interpreters (Greenhalgh, et al., 2006; Green et al., 2003; MacFarlane et al., 2009). These warrant further consideration to fully attend to the range of service users’ needs, preferences and experiences. We are conducting research (2009-2011) at the Department of General Practice, NUI Galway and the Centre for Participatory Strategies, Co. Galway with the HSE Social Inclusion Unit to explore these complexities in more detail. This research is supported by a Health Research Board Partnership Award and will involve dialogue about these complexities between representatives of ethnic minority service users, interpreters, cultural mediators and general practice staff (administrative and clinical).

4.4. Interactions in the Consultation

This domain of the NPM focuses on what actually happens when the implementation process brings general practitioner, interpreter and service user together in a consultation. The findings from the quantitative analysis tell us that these are longer consultations. Overall, the majority are telephonic rather than on-site. Interestingly, the demand for on-site interpreting was growing exponentially compared to the growth rate for telephonic interpreting. Given that the average time for on-site consultations is one hour, this is an interesting anomaly because general practitioners have described time pressures as a barrier to uptake, and yet some are investing significant time in the on-site mode.

What is it like to be in an interpreted consultation? Findings from the qualitative analysis provide answers to key questions: For the general practitioners, is the work of the interpreted consultation being achieved in a timely and effective manner? Rarely. In some cases, this is simply because, by their nature, interpreted consultations require an additional investment of time. In other cases, this may be because of poor interpreting practice. Are the roles of general practitioner and interpreter clear and unambiguous? Often, they are not. Is the flow of communication achieved with relative ease? There are
mixed experiences here. Overall, it seems very effortful. Can the interpreted consultations be meaningful for everyone? Does the service user feel that they have been treated appropriately and received appropriate medical treatment? There are many accounts of meaningful encounters and positive experiences in the interaction from general practitioners in this study. We conclude that the interpreted consultation can enable general practitioners to achieve the work of the consultation (L4), and on the other hand it can deflect from the work (B12).

What we see here is that when the service user, interpreter and general practitioner are navigating the complexity of the interaction together in the consulting room, all the factors that we have already described across the four domains of the NPM come to bear on real people in real time and space.

Does the organisational policy and culture of the general practice support a long consultation if it is necessary for the service user? Do the general practitioner and interpreter have necessary training and skills for participating in the triad? Do they feel confident and comfortable in their respective roles? Is the knowledge that is shared and mediated between these people authentic for each of them? Does it have veracity for each of them? This all feeds into the experiences of the immediate interaction for everyone involved. If the time is made available, and if the interplay of roles feels positive to the people involved, this enables the positive flow of communication, gives a feeling of authenticity and a sense of confirmation in who they are and what they are doing in this interaction.

Our recommendation, finally, is to put the previous recommendations – which relate to organisational context and settings, skills, and relationships in the network – in place. This would positively affect the immediate interaction of the consultation in the way we have just described. This is an example of the ways in which organisational issues do shape individual behaviour (May, 2007).

Finally, in reverse, it is interesting to consider how positive experiences of the immediate interaction in the consulting room might, in fact, motivate action at organisational and institutional levels. If there are enough general practitioners who know the benefits of successful interpreted consultations, who can speak of those benefits and share them with colleagues, this could be a strong contributing factor in organisational and institutional change. If there are not enough general practitioners with these positive experiences of interpreted consultations, it is hard to imagine this change coming about. General practice has an important advocacy role to play in contributing to improved responses to language barriers in Irish general practice.
At the same time, we draw attention to the way in which this research has shown that the community of service users are more than willing to share their expertise and energy and bring their potential solutions to the table for discussion. Service users also have an important advocacy role to play. When service users are enabled and resourced to participate, they will bring their unique perspective to the table, without which there will be an ‘emptiness’ to solutions.

We need to acknowledge the scope for these different kinds of contributions because this is a shared healthcare experience for which shared solutions can be generated. As explicated in all recommendations, we urge the use of participatory approaches to create partnerships, support dialogue and generate solutions. This will lead to the identification of sustainable, workable and effective strategies for improving the management of language barriers in Irish (multicultural) general practice.

**Conclusion**

General practitioners have identified language barriers as a major issue for them in their work in our newly multicultural society. Following their call for resources for language interpreters, the HSE provided a free pilot interpreting service for general practitioners in the former ERHA region. However, actual uptake of the service was very low. The present study was designed to gain comprehensive and in-depth knowledge about the uptake and experience of using the available, pilot interpreting service.

The quantitative and qualitative findings confirm that use of the service is very low and indicate that this is related to a range of organisational, professional and interactional issues. The specifics of these issues have been described in detail in this report. Recommendations to improve uptake of the available, pilot interpreting service in general practice, have been made on the basis of our ‘whole system’ analysis of the findings based on a sociological model, the NPM. Where possible, these recommendations have been located in mainstream activities or structures within the HSE and, also, related to existing policies and legislation which should be a resource for the implementation of the study recommendations.

Our study findings and recommendations have relevance for related projects about information, language and communication that are taking place across the HSE, for example, the development of an Emergency Multilingual Aid (2009) which is part of the HSE’s intention to develop a comprehensive, coordinated approach to the whole area of interpreting.
Our study findings and recommendations also have relevance for the HSE at a more general level in terms of the challenge of introducing change or innovation in Irish health services. The introduction of change or innovation does, by definition, disrupt existing and routine patterns of practice and interaction. The complexity of the challenge involved is easily underestimated. The experience of implementing Primary Care Teams in Ireland is a good example of this whereby existing and routine patterns of primary care work are required to change in very significant ways and ‘success’ is difficult to achieve. Our analysis in this project highlights some key issues that are relevant to implementation projects in the HSE.

For any projects in general practice, it is crucial to consider the unique relationship that general practitioners have to the HSE. General practitioners are not obliged to ‘sign up’ for available services. However, for those that do sign up, there is an awful truth that general practitioners, as frontline service providers in the community, are inundated with work. They describe themselves and their work situation as being one of crises management a great deal of the time. Implementation of any project has to take this into account. It is important to find ways at the very outset to encourage and support ‘buy in’.

For this reason, projects ought to be generated in a participatory manner to encourage ‘buy in.’ Dissemination of knowledge and information ought to be done in various ways but with an emphasis on peer to peer activities for sharing knowledge and information. However, ‘buy in’ to a project is not the end of the roll out phase or implementation work. There needs to be careful leadership for the entire implementation process and effective ways to iteratively monitor and evaluate experiences on the ground. A key and general lesson arising from this research is that it is valuable to create mechanisms to develop positive relationships within, and across, stakeholder groups so that there can be dialogue and effective ‘feedback loops’ about implementation processes.

A participatory approach and the use of an educative dialogue is an important model for the development and strengthening of implementation projects. It is not standard to use this approach yet it has a tremendous amount to offer the HSE transformation programme.

Finally, we highlight the value of relevant theoretical approaches to HSE implementation projects. In this study, the NPM offered a comprehensive, whole system analysis. The NPM provided rich analysis about the workability of a new service and whether or not it could be integrated into routine practice. A key benefit is that an NPM analysis identifies areas for targeted action that need attention before further development takes place. The NPM could be used with great effect in the development and assessment of other planned services in the HSE.
Overall, there is much to be gained from collaborative partnerships between the HSE and communities of service users and academics to advance health policy, service delivery and research knowledge in Ireland. Such collaborative partnerships will advance the development of primary care, as a new direction for Irish health care, leading, ideally, to quality and fairness for all.
REFERENCES


### APPENDIX A

Participant Type and ID Numbers (#) matched with Quotation Codes

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<th>Participant Type</th>
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