POLICY BRIEF:
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ADDRESSING CLINICAL RISKS TO PATIENT SAFETY FOR REFUGEES AND MIGRANTS: HOW CAN WE ENSURE THAT INTERPRETERS IN THE IRISH HEALTHCARE SYSTEM ARE TRAINED AND ROUTINELY USED?

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EXECUTIVE SUMMARY

Migration brings linguistic and cultural diversity to Ireland. This means that it is becoming more common for healthcare providers and service users who do not have a shared language and culture to meet in consultations. These cross-cultural consultations are a feature of primary and secondary care delivery in urban and rural settings in Ireland. However, there is a lack of trained interpreters in Ireland to support communication in these consultations. Family members, friends, online translation tools, voice recognition apps and paid, but untrained, interpreters are frequently used. This situation presents clinical risks to patient safety, negative health outcomes and unnecessary healthcare costs. When a trained interpreter is used to support communication in cross-cultural consultations, these risks are reduced, leading to more equitable health outcomes and efficient use of health services. Making the use of trained interpreters the norm requires systemic changes that rely on multiple, co-ordinated actions to inform educational and workforce reform. This policy brief describes nine evidence-based policy options to inform government action to underpin such reform.

THE PROBLEM: THERE IS A LACK OF TRAINED INTERPRETERS IN IRELAND FOR HEALTHCARE CONSULTATIONS.

Migration is rising in Ireland, with important economic, social and cultural benefits. While the majority of people who move here report that they speak English well, the available Census data show that 86,602 people describe themselves as speaking English 'not well' or 'not at all' (CSO, 2016). As a result, it is becoming more common for healthcare providers and service users who do not have a shared language and culture to meet in consultations. These **cross-cultural consultations** are a feature of primary and secondary care delivery in urban and rural settings in Ireland (Clifford and Ryan, 2023).

What typically happens in these consultations? Family members (including children), friends, bilingual staff, online translation tools and voice recognition apps are frequently used to provide support with language and cultural differences (O'Reilly-de Brun et al., 2015; Clifford and Ryan, 2023). These **informal, ad hoc supports** are problematic (see Box 1) and are not in line with World Health Organization (WHO) policy, the Health Service Executive (HSE) Intercultural Health Strategies and legal instruments for promoting the right to health for all, including Ireland's 2014 Public Sector Duty (WHO, 2023; HSE, 2008, 2019).

[1] These data are not yet available from Census 2022.

[2] A failure to provide linguistic supports for persons with limited or no English could act as a barrier for such persons in accessing healthcare services, and could amount to discrimination on the ground of race (source MacFarlane, 2018). In 2019, the Irish Human Rights and Equality Commission (IHREC) invited the HSE to prepare an Equality Action Plan (EAP) to improve the use of interpreters in general practice services in CHO2. The IHREC response urges more system-level changes: see https://www.ihrec.ie/app/uploads/2023/08/Account-of-EAP-HSE-interpreter-services-28-March-2023.pdf

Box 1. Problems with informal, ad hoc supports for communication in cross-cultural consultations

■ **Family members and friends** are not trained as interpreters and are unlikely to have appropriate medical vocabulary, leading to inaccurate and incomplete transmission of information. Use of **children** as interpreters gives rise to additional problems:

- A child may not be available (during school hours) or may be missing out on schooling.
- The authority of parents may be compromised by a reliance on their child to interpret.
- There may be emotional trauma, fear or shame on the part of the parent and/or child – both may be embarrassed.

■ **Body language** is an everyday communication tool the general practitioner (GP) may use to signal friendliness/comfort to a service user, but is unreliable as a diagnostic support. Different cultural backgrounds can lead to misunderstanding of body language.

■ Bilingual or multilingual materials, including computer translational tools, cannot provide accurate renditions of symptoms to both parties and cannot cope with psychological/mental health/social health issues or the complexity of cultural interpretations of health and illness.

The use of paid interpreters from commercial agencies, or interpreters that have been provided by the HSE for Ukrainian beneficiaries of international protection, are more formalised responses. However, the use of these interpreters is also problematic because many of them are not accredited, trained interpreters. They are often individuals who are recruited primarily on the basis that they speak English and another language. These interpreters are not tested to establish if they can interpret competently and they may be unaware of role boundaries and ethical principles. An interesting comparison is the 30 per cent pass rate of candidates taking the Diploma in Public Service Interpreting exams organised by the Chartered Institute of Linguists in London. Overall, the reliance on informal, ad hoc supports and untrained interpreters in healthcare consultations is very concerning. These responses lead to **clinical risks that undermine patient safety** because they:

- cannot provide accurate, comprehensive and nuanced health communication, resulting in incomplete information exchange (McGarry et al., 2018)
- result in inappropriate diagnoses and treatment as well as missed opportunities for health promotion and disease prevention (McGarry et al., 2018; Chauhan et al., 2020; Clifford and Ryan, 2023)
- lead to **unnecessary healthcare costs** due to non-adherence of patients to suggested therapies (caused by lack of trust in communication with their care providers), higher emergency department use, longer hospitalisations and inefficient use of resources, e.g. repeat appointments and unnecessary tests (MacFarlane et al., 2009; McGarry et al., 2018).

For over twenty years, refugees and migrants have expressed their deep concern and frustration about the frequent use of informal, ad hoc supports and the use of untrained interpreters in the Irish healthcare system (MacFarlane et al., 2009; MacFarlane, 2018; Phelan et al., 2021). Similarly, healthcare providers report feeling uncertain about how to work with this new and diversifying population in this context; they feel worried about what they are missing in these consultations due to communication problems; and they stressed that they cannot provide care in the way that they have been trained to do or in the way that they deliver care to service users with whom they have a shared language (Pieper and MacFarlane, 2011; McCarthy et al., 2013; Tobin and Murphy-Lawless, 2014; Markey, Tilki and Taylor, 2018; Clifford and Ryan, 2023).

Given Slaintecare's emphasis on one universal health service for all, **providing the right care, in the right place**, at the right time, we need to ensure that the interpreters in the Irish healthcare system are trained and routinely used.

THE SOLUTION: MAKE THE USE OF TRAINED INTERPRETERS[3] THE NORM IN IRISH HEALTHCARE.

When a trained interpreter is used to support communication in cross-cultural consultations, this raises the standard of care to equal that of patients without communication barriers (Karliner et al., 2007) and leads to more equitable health outcomes (McGarry et al., 2018). Investing in interpreted consultations has an initial financial outlay but there is potential for reducing healthcare costs in the longer term (Bischoff and Denhaerynck, 2010; Kwan et al., 2023).

What exactly does an interpreter do? According to the code of ethics for community interpreters from the Association of Translators and Interpreters Ireland,[4] **the role of a trained interpreter is to facilitate information exchange in an impartial way** that enables the healthcare provider and patient to interact meaningfully. As mentioned above, being bilingual is necessary but not sufficient for competent interpreting. There are specific specialist skills such as using the first person ('I'), consecutive interpreting, whispered simultaneous interpreting, specialised notetaking techniques, glossary development, and sight translation of documents. In addition, interpreters need a deep understanding of the importance of ethical role boundaries, including confidentiality, impartiality, neutrality, how to request clarification and repetition, and appropriate approaches to ensure that cultural barriers do not impede communication (Phelan et al., 2020). Trained interpreters manage assignments actively but do not act as advocates for patients or take on the role of health professionals. Trained interpreters can work alongside cultural mediators, who have a complementary advocacy and 'bridging' role focused on improving the delivery of health services to communities that experience marginalisation (Martin and Phelan, 2010).

> If there is no trained interpreter and you cannot explain the problem, how can you [migrant] clarify the problem, how can you get quality care from the GP?
>
> (MacFarlane et al., 2009).

> … sometimes what we [midwives] were doing was say your husband spoke English, well we'd ask him to help us … then we were kind of finding some of the things were a bit personal and it really wasn't that suitable and … we were kind of a bit dubious then thinking maybe that really isn't very ethical, you know to go that route
>
> (Tobin and Murphy-Lawless, 2014).

[3] The focus of this policy brief is on spoken language interpreting rather than sign language interpreting.

[4] https://www.atii.ie/

THE CHALLENGE: PROGRESS CO-ORDINATED ACTIONS FOR MAKING TRAINED INTERPRETERS THE NORM IN IRISH HEALTHCARE.

Normalising trained interpreters in Irish healthcare requires systemic changes (MacFarlane et al., 2020MacFarlane et al, 2021; Puthoopparambil, Phelan and MacFarlane, 2021, Markey, MacFarlane and Manning, 2023). **Systemic changes rely on multiple, co-ordinated actions** to *promote discontinuation* of inadequate supports and to *implement new routines* to integrate the use of trained interpreters into daily practice (MacFarlane, 2018). Such actions are complex to progress for three overarching and interconnected reasons:

1. **Interpreting in Ireland is unregulated**; the current situation that allows anyone who speaks English and another language to work as an interpreter (Phelan, 2017) leads to the aforementioned quality deficits in interpreting practice. Thus, the mere provision of 'interpreters' in healthcare is not sufficient to safeguard against clinical risks to patient safety. Interpreters need to be trained and regulated.

2. The availability of resources for using interpreters (e.g. through the new HSE national system for accessing interpreters) is crucial. However, national and international research shows that this does not guarantee increased use of interpreters (MacFarlane and O'Reilly de Brun, 2009; MacFarlane et al., 2020; LeMaster et al., 2023). **Healthcare providers report that it is challenging for them to 'fit' interpreted consultations into their workflows** in increasingly busy practices. Thus, they often favour the pragmatism of the aforementioned informal, ad hoc supports because these allow them to 'get by' (Clifford and Ryan, 2023). Furthermore, quality deficits in interpreting practice, due to the lack of regulation, mean that healthcare providers who do use interpreters from commercial agencies may not experience the full benefit of working with a trained interpreter (Teunissen et al., 2017). This undermines their motivation to develop new routines to fit interpreted consultations into their workflows.

3. **People who work as interpreters with commercial agencies have inconsistent amounts of work and poor hourly rates of pay.** According to the Association of Translators and Interpreters Ireland, current rates for healthcare interpreters vary between €15 and €30 per hour. The amount paid to translation companies that provide interpreters is considerably higher. Interpreters are not paid for travel time and can only claim travel expenses if they travel to another county. This leads to a high turnover of interpreters in what could be an attractive career pathway that addresses a fundamental need in our increasingly linguistically diverse society.

> "I [GP] gave her a treatment, without an interpreted consultation … that wasn't at all appropriate. So today (after working with a trained interpreter) we revised that, I told her to get rid of that (previous) prescription"
>
> (Teunissen et al., 2017).

> "I mean the fundamental problem with interpreting as we know is that there are noset 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"
>
> (MacFarlane and O'Reilly de Brún, 2009).

POLICY ACTIONS

To address clinical risks to patient safety for refugees and migrants, Ireland needs trained interpreters that are routinely used in healthcare consultations. This requires **educational and workforce reform**. The Department of Health has taken an important step in this direction by supporting a new educational initiative for accredited interpreter training. The Department has funded bursaries for micro-credentials[5] in interpreting at University of Limerick (UL) (2023 and 2024) and Dublin City University (DCU) (2023). However, additional policy actions are required, including:

1. Continued, upscaled investment in accredited training in UL and DCU because the number of interpreters who have accessed this training to date is insignificant compared to the total number on the market.[6]

2. Introduce a phased approach to mandatory training by, for example, recommending that successful completion of interpreter training will become a requirement for employ ment of interpreters in health care settings by 2030.

3. Oversee the development of a national testing system for spoken language interpreters.

4. Establish a national register of qualified interpreters and promote a move away from procurement through private companies to use of this register.[7]

5. Review the working conditions for interpreters and develop a framework for strengthening this as an attractive and viable career pathway.

6. Work with CORU, Ireland's regulatory body for health and social care professions, to review and improve mandatory education for undergraduate and postgraduate healthcare professionals regarding their knowledge and skills for using trained interpreters.

7. Work with professional associations of health and social care professions to promote continuous development opportunities for trained healthcare professionals to ensure that they have knowledge and skills for using trained interpreters.

8. Support a participatory implementation research programme in the *Refugee and Migrant Health Partnership*[8] to build evidence about how to integrate the use of trained interpreters in clinical settings as normal practice.[9]

9. Oversee the development of a critical incident system for clinical settings to document barriers to the successful use of trained interpreters as normal practice.

[5] Micro-credentials are short, accredited courses designed to address skill gaps in the Irish economy. They can be taken over time to accrue a full certificate or diploma, making them attractive and accessible to people in employment who wish to upskill..

[6] The number of interpreters working on the market is unknown because it is unregulated, but there are at least four commercial interpreting companies in addition to numerous interpreters who work freelance.

[7] This has been achieved in Ireland for sign language interpreting: see RISLI (Register of Irish Sign Language Interpreters) (risli.ie).

[8] The goal of this partnership is to improve refugee and migrant involvement in Irish public health policy making. See https://www.ul.ie/news/university-of-limerick-and-department-of-health-to-collaborate-on-migrant-and-refugee-health

[9] See Appendix 1 for current and planned research.

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APPENDIX 1:

Participatory implementation research to build evidence about how to normalise the use of trained interpreters in clinical settings as normal practice: Principal Investigator: Professor Anne MacFarlane, Participatory Health Research Unit and WHO Collaborating Centre for Participatory Health Research, School of Medicine and Health Research Institute, University of Limerick.

Research projects underway:

Examine the use and normalisation of trained interpreters by Irish General Practice Nurses.

Examine the use and normalisation of trained interpreters by Irish Speech and Language Therapists.

Examine the dynamics and interactions of interpreted consultations in Irish GP clinics for Ukrainian Beneficiaries of Temporary Protection (BoTPs) from the perspective of GPs, Ukrainian BoTPs and interpreters.

Explore migrant service users' experiences of Irish primary and secondary healthcare services, with a focus on language and culture.

Involve migrants and health managers in the development of an intervention to improve health managers' risk assessment and management of cross-cultural consultations in the HSE.

Conduct a systematic integrative analysis of levers and barriers to the normalisation of trained interpreters in healthcare.

Research projects in development:

Examine the use and normalisation of trained interpreters by Irish physiotherapists.

Compare in-person and online participatory methods to support quality improvement plans to increase the use of trained interpreters in Irish general practice services.