Using family members as medical interpreters: An explanation of healthcare practitioners'
normative practices in pediatric and neonatal departments in Australia

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Abstract

According to the Australian Bureau of Statistics (2016), both international tourism and migration of people with low English proficiency (LEP) to Australia are increasing. Thus, healthcare practitioners (HPs) increasingly use interpreters to communicate with patients with LEP. Although qualified interpreters are the most suggested and policy-endorsed mechanism for communicating with patients with LEP, family members (FMIs) are also used as interpreters. This study investigated a) when do health professionals consider it appropriate to use FMIs and b) what characteristics of family members health professionals believe make them suitable to act as FMIs. As part of a larger project examining the decision-making processes of HPs regarding interpreter use, 69 HPs from neonatal and pediatric departments in one hospital in Queensland Australia were interviewed. Results indicated HPs thought the appropriateness of using FMIs depended on the type of information, such that it was either completely acceptable (e.g., explaining some basic, or non-medical information) or completely unacceptable (e.g., confidential information or consent). However, in an emergency, when no other options were available, FMI's were used. The characteristics of suitable FMIs included age, level of English proficiency and medical understanding, and the relationship between patient and FMI. Results were to some extent consistent with Queensland government policies but there were notable differences, including using children and regarding FMIs as first preference. Improving HP's knowledge of policies may increase their confidence in their practice and appropriate use of FMIs, thereby improving their care delivery to patients and families with LEP.

Word count (245)

Keywords: Medical interpreter, Family member interpreter, child, health communication,

In Australia 28.2% of the population (6.7 million people) was born overseas (Australian Bureau of Statistics, 2016), with many from non-English-speaking countries (e.g., China, Philippines, Vietnam, Italy, Malaysia, Germany). Australia is also a popular tourist destination for people from non-English-speaking countries (e.g., China and Japan as the #1 and #3 top holiday visitors to Australia from March 2017-March 2018; Australian Government, 2018). As such, more people with low English Proficiency (LEP) are both visiting and moving to Australia, and thus seeking medical care in Australia (Australian Bureau of Statistics, 2016). As a result, healthcare practitioners (HPs), who are primarily monolingual English-speaking, must use interpreters, or learn other ways to communicate with these patients effectively. Effective communication with people with LEP is important, as previous research has shown that poor communication in healthcare contributes to increased wait times in hospitals and higher costs (Robinson, 2011), medical mishaps (Hewett, Watson, Gallois, Ward, & Leggett, 2009), and low patient adherence to medical advice (Brooks & Menachemi, 2006).

Traditionally, researchers and policy-makers have recommended formally trained and professionally qualified interpreters as the best mechanism to communicate with patients with LEP. However, HP's experience frequent barriers to their appropriate use and instead may opt to use a family medical interpreter (FMI) (Hilder et al., 2017; Rosenberg, Leanza & Seller, 2007). The situation may be more complicated in pediatric and neonatal units, where family centered care (FCC) is the primary model of care. In these circumstances, HP's are communicating with both a patient and their parents, and are collaborating with parents in the child's care (Gooding et al., 2011; Kuo et al., 2012). However, little is known about who HPs use as an interpreter or when and why they use family. The current study investigated a) when do health professionals consider it appropriate to use FMIs and b) what are the characteristics of family members that

health professionals perceive make them suitable to act as interpreters. We then examine the extent to which health professionals' beliefs and decisions align with research recommendations, and government and hospital policies.

Use of qualified interpreters

Researchers have identified benefits for patients of using qualified interpreters, including patients reporting higher healthcare visit satisfaction with the use of a qualified interpreter (Garcia, Roy, Okada, Perkins, & Wiebe, 2004; Diamond, Schenker, Curry, Bradley, & Fernandez., 2009; Gerrish, Chau, Sobowale, & Birks, 2004), and improved clinical care to a level approaching that received by an English-speaking patient (Karliner, Jacobs, Chen, & Mutha, 2007). Focusing more specifically in departments where the patient is a child, it is essential the primary care giver(s) to the child understand medical guidance, can articulate their child's needs and medical history, share in care and decision-making, and ask any questions they may have (Cleveland, 2008). Benefits of qualified interpreter use for family members of the child patient include increased feelings of support and understanding for both family member and physician, and adhering to a family centered model of care (Kuo et al., 2012). Evidence regarding the benefits of qualified interpreters has led to the development of hospital and government policies regarding the use of different types of interpreters.

In Queensland, where the current study was conducted, the Languages and Services Policy (2016) states that language services in Queensland "aim to provide people who have difficulties communicating in English with the same access to effective and efficient services and programs as English-speaking Queenslanders" (p. 1), with an obligation to use a qualified interpreter "unless the situation is urgent and/or life threatening and a qualified interpreter is not available" (p.5). Queensland Health has developed policies and guidelines for health

professionals, where the order for use of a medical interpreter are face-to-face qualified interpreter, telephone qualified interpreters, bilingual staff, and then a family member or friend (Gold Coast Hospital and Health Service, 2017). An unaccredited bilingual speaker (such as a family member) is only to be used when a qualified interpreter is unavailable to interpret in medical emergencies, and for “simple day-to-day communications” (p. 3). These policy and procedure documents lack a clear description about what characteristics of the FMI would make them suitable or unsuitable to function as an interpreter, except that children under 18 years of age are not appropriate.

Despite the goal to make access to interpreter services more effective, nearly half of all patients with LEP visiting hospitals in Queensland in the last 12 months did not receive a qualified interpreter (Gold Coast Hospital and Health Service [GCHHS], 2017). Instead, patients reported using a family member or a friend to interpret for them. More generally, researchers have found an underuse of qualified interpreters. For example, Diamond and colleagues (2009) found that doctors admitted to underusing interpreter services, instead opting to “get by” using bilingual staff and FMIs. Underuse of qualified interpreters is reportedly because of the perceived and actual limited availability of interpreter services (Flores, et al., 2008), inadequacy of services (Gerrish et al., 2004), high costs (Jacobs, Shepard, Suaya, & Stone, 2004), increased consultation times and time constraints more generally (Kravitz, Helms, Azari, Antonius, & Melnikow, 2000), and the convenience of using a family member or bilingual staff member (Diamond et al., 2009). Underuse of qualified interpreters has also become normalized among HPs (Hsieh, 2015).

This raises the question of what HPs consider is the function of an interpreter. In general, HPs trust qualified interpreters because they regard medical interpreters as conduits, who

translate information word-for-word, who do not add or change words or information, and are free from bias (Dysart-Gale, 2005). HPs are sceptical of the accuracy of information translated by a FMI (Valero-Garcés, 2005). Interpreter codes of ethics and training also espouse this view (e.g., National Accreditation Authority for Translators and Interpreters, 2018). Previous research has noted the problematic nature of treating interpreters as simply conduits of information such that there may be a role for interpreters to provide cultural or contextual understanding, as well as translating meaning (Leanza, 2005; Kaufert & Putsch, 1997). Family members may have more to offer than a simple translation of information. Previous research has found that HPs and patients alike find benefits in using an FMI, including more trust and less need for explanation when family could fill in the gaps, especially when they came from family-centered cultural backgrounds (Edwards, Temple and Alexander, 2005; Hilder, et al, 2017). Moreover, patients talked about how in some cultures it is normal for children to take care of their parents, including interpreting for them. Further, family members thought their personal knowledge made the patient more comfortable, and many did not perceive any disadvantages to being used.

The current study

In summary, there is evidence that the use of qualified interpreters benefits LEP patients, and, in many countries, policies state that qualified interpreters should normally be used. Yet there is also evidence of a significant underuse of qualified interpreters, with FMIs frequently used instead. Although previous research has found that HPs report trusting qualified interpreters more (Dysart-Gale, 2005), some HPs and patients have argued for the benefits of using FMIs (e.g., Hilder, et al., 2017). However, research has not examined HPs' decision-making regarding when they would use a FMI, and what characteristics of FMIs they perceive make them suitable to use as a FMI, nor how this aligns with hospital and government policies. There is little

guidance given to HP's on what characteristics make FMI's suitable (or unsuitable). Little is known about what happens in practice. As a starting point to address this gap, the current study examined the following research questions:

RQ1: In what situations do HP's in neonatal and pediatric units think it is valid to use a FMI?

RQ2: What characteristics of family members do pediatric and neonatal HPs consider make them suitable to use as an interpreter?

Method

Context

This study was conducted in a large metropolitan tertiary hospital in Queensland in the neonatal intensive care unit (NICU), special care nursery (SCN), and pediatric units (inpatients, outpatients, and intensive care unit [PICU]). The hospital services a population where 36% of people were born overseas and 55% had one or both parents born overseas. A significant number of these people were born in non-English speaking countries, including China, Japan, India, and Philippines, and a non-English language is spoken in 14.9% of households (ABS, 2016). The area is also a significant overseas tourist destination, attracting approximately 1.1 million international visitors in 2017 (International Visitor Survey, Tourism Research Australia).

Participants

A total of sixty-nine participants ($F = 59$ and $M = 10$) were recruited, including doctors ($n = 11$), nurses/midwives ($n = 51$), and allied health practitioners ($n = 7$). Allied health practitioners included pharmacists, dieticians, a social worker, and a speech pathologist. Participants ranged in age from 25 to 64 years old ($M = 36$ years). Forty-two participants worked in neonatal units and 27 in pediatric units. Twenty-seven percent of HPs ($n = 19$) reported that

they spoke a language other than English. Participants had varying levels of medical experience (6 months to 38 years).

Procedure

This study formed part of a larger study examining decision making about interpreter use. Ethical approval was obtained from Griffith University and Gold Coast Hospital and Health Service Human Research Ethics Committee. The research team recruited participants directly from the units, via flyers distributed throughout the units, at information sessions, and via email. Health professionals contacted the research team if they were interested in participating, and interviews were organized at a suitable time. Recruitment continued until interviewers agreed that saturation had been reached, and a representative sample of neonatal and pediatric units, health professions, and monolingual and multilingual staff in this facility were interviewed.

Interviews were conducted privately in the hospital unit following informed consent. Interviews were approximately 20 minutes and were digitally recorded. A 15-question verbal protocol analysis (VPA; Ericsson & Simon, 1993) was used. VPA is an interviewing method often used to capture cognitive processes such as decision-making. The questions were not descriptive nor explanatory but rather designed to elicit actual thoughts (Ericsson & Simon, 1993). Each interview commenced with the question: ‘What have you thought about when deciding whether or not a patient or a patient’s family member needs a translator¹?’. Other questions included: ‘What contributes to whether a person is a suitable translator?’; ‘What have you thought about when deciding who the most appropriate person to translate information is?’; and ‘What do you think determines whether a person should not be used as a translator?’. Latter

¹ The terms interpreter and translator were both used in interviews, as many health professionals use the terms interchangeably.

questions included the participant's thoughts on using various interpreters including formally qualified, bilingual staff, family, children, and computer-mediated translation tools.

Analysis

Interviews were transcribed verbatim by members of the research team and a transcriber and checked for accuracy. Thematic analysis, based on Braun and Clarke (2006), was used to generate the themes from the interview transcripts. Themes were generated inductively. The first author began by highlighting all references to the type of interpreter used and then coded sentence by sentence all references to characteristics of FMIs that would make them suitable as interpreters. The same process was used for all references to situations when HPs would use a FMI. Initial grouping of themes was undertaken by the first author, in consultation with the second and third authors to ensure consistency until final themes were determined. Once the data had been coded, the entire data set was reviewed to ensure that all responses were adequately represented by the themes.

Results

Although many HPs in our sample explained situations in which they had used FMIs in the past, some had limited experience using interpreters and responded based on hypothetical future decisions. Most HPs, including both those with experience using FMIs and those without experience, explained that they would be reluctant to use FMIs because of confidentiality or legality concerns. However, all participants described situations in which they would use a FMI. Our analysis revealed three themes describing the situational factors that influenced HPs' decisions whether to use FMIs, and three themes regarding characteristics of a suitable FMI. Results did not differ between HPs who spoke another language and those who only spoke English, nor by health profession.

Situational Context- When would HPs use a FMI?

One of the main factors that HP's used to decide the appropriateness of using a FMI was the type of information, which was classified as either appropriate or inappropriate to be translated by a FMI. Theme 1, *information characteristics*, outlines the defining characteristics of information that made it either appropriate or not and why. Theme 2, *Its an emergency*, shows how the ultimate decision to use a FMI instead of a qualified interpreter was whether the situation was considered an emergency. Finally, theme 3, *FMIs as first choice*, gives voice to the minority of HP's who thought using FMIs was completely acceptable or even their first choice.

Information characteristics. The first consideration by HPs when deciding whether a family member was suitable to act as an interpreter was the type of information to be translated. Information was classified as either basic or serious and/or confidential. FMIs were seen as suitable interpreters by 54% of HPs (n=37) for basic information, which was defined as non-medical, and included "*very basic things like I need to get her out of bed or she needs to cough more or things like that.*" [112]. Other examples of basic information were communicating about caring for their children.

Uhhh in small day to day activities of caring for the baby...yes in reality we do it quite a lot. A partner interprets for the mother or the mother interprets for the father uhm and I guess we do that without [pause] thinking about it. [127].

In contrast 'serious' information, which was defined as end of life decisions, consent, medicolegal, or complex medical information, was often specifically cited by HPs as inappropriate information for FMIs to translate (43%, n=30). Many HPs highlighted conversations about consent to be a very serious conversations that necessitated a qualified interpreter rather than a FMI.

...it's not the best option when it comes to important things like getting consent and talking through you know [pause] life or death issues or serious diagnosis um [pause] ... when it comes to anything sort of medico-legal or really serious [pause] it's not good to use a family member [219]

One HP described information as being on a continuum of seriousness, again suggesting that information can be classified as suitable or not suitable for using a FMI.

... I don't know, on a grading scale from zero to ten ... like for the zero, one and two that would be fine using a family translator but for the more important decisions like probably three or four onwards I would actually use someone more official I think [118]

HP's explained that their decision not to use FMIs for serious information was due to the risk resulting from either inaccurate translation and/or legal requirements. There was a mistrust that a FMI would accurately pass on the medical information to the patient, and inaccuracy of translation could have serious consequences; either for the patient or the health professional.

Information was also classified as confidential or private. Some HPs thought certain information should not be shared with family members because it was private, something that they "*may not feel comfortable sharing ... with the family member*" [218]. Mothers were particularly described as having a right to confidentiality that should not be jeopardized by using a FMI. Again, confidential information was contrasted with basic information, "*[family are] ok for mother crafting and general discussion but not for confidential private issues [pause] the mother is entitled to confidentiality*" [103].

Confidential information was defined vaguely although some specific examples were given. For example, the following HP considered sexual and mental health information as confidential.

if you're asking them about sexual things you don't want to involve family... because if the baby comes in and its very unwell doctors might ask have you had any STD's or something like that you don't want to get just anyone to ask all the questions [004]

History of domestic violence and mental health were other examples.

... you wouldn't be going asking partners about domestic violence and [pause] all that type of stuff [pause] any social type of things that really, if we've got any concerns about a woman's [pause] mental health [pause] that probably shouldn't go through a partner or for them to give us their interpretation [001]

FMI's were also considered inappropriate for confidential information because it could make the family member uncomfortable. For example, children might be embarrassed by translating some information for a mother; *"well you might want to be discussing your mother looks like she's in pain... is she not passing clots, has her bowels moved you know what I mean, children might find that a little bit embarrassing to talk about"* [011].

A final consideration raised by a small number of HPs was how emotionally distressing the information was. In these instances, HPs questioned using a FMI because of the distress the FMI might experience.

It's an emergency. Despite stating that FMI's should not be used for serious information, many HPs explained that they would use a FMI in an emergency, where *"there is no one else and somebody needs to translate immediately"* [120]. In these scenarios, HPs did not consider any ideal characteristics of the FMI other than them having enough English proficiency to serve as a FMI. When HPs spoke about using FMI's in such situations, they almost always prefaced their response with this not being ideal; *"a last resort when you have no choice"* [016]. HPs explained that in acute situations, time was a factor and qualified interpreters were a privilege

... you've got a time factor here you've got time, it takes time to organise a translator and we don't sometimes have the [pause] privilege of time on our side to go okay let's just get a translator because we've got three hours here... [005]

One example of a time-sensitive situation given was resuscitation; *"so we don't want to go there unless it's an acute resus situation"* [016]. It is evident that the decision to use a FMI for most HPs ultimately depended on perceived situational necessity, even in contexts such as consent and detailed complex medical information, where HPs strongly thought FMIs should not be used.

FMIs as first choice. A few HPs (7%, N= 5) described preferring to use a FMI over a qualified interpreter. For example, one HP discussed how FMI's are ideal, as they know the patient and vital information about the patient.

...If they have any family and friends that would be the best if they know the person and they know the person's wants and needs and all that. But if that's not available, we'll have to use the hospital's translator service [210]

Although some of HPs preferred to use a FMI as a first-choice, they often decided not to use a FMI because of concerns about breaching hospital policy, and perhaps breaking the law.

...someone needs to have surgery and the daughter is bilingual ... and can relay to the other person and everyone is happy that they do understand then I guess why not...but I don't know where the legal standpoint ...who's liable ... is the issue I guess [214]

Some who preferred to use FMIs would use the FMI but also call the phone interpreter to ensure there was "documented evidence".

... I would often use a family member if there's a suitable family member, if they're ok [pause] but if it was something where a parent would have to give consent or something

like that, I'd always try and get a ... phone interpreter or something ... just to be absolutely positive that we've got that documented evidence. [104]

Ideal characteristics of a FMI

We identified three themes that described what HPs considered were characteristics that made a family member suitable to be a FMI: *Do they speak medical*, *Close but not biased*, and *Children aren't my preference but*. Many HPs required that FMIs would have a combination of these characteristics. A couple of HPs also raised that they would not use a FMI who was too emotional but this was not the focus for most HPs.

Do they speak Medical? Unsurprisingly, HPs considered the basic English proficiency of the FMI to be a necessary characteristic.

.... You have to be pretty comfortable that their English comprehension is better than the person you're interpreting for because if it's not then it's pretty pointless. So if you don't gauge that they know what you're talking about, you can't use them [217]

Thus, HPs explained that family members were not appropriate for use if they did not have good English proficiency, whereby their "*level of understanding*" was a "*pitfall*" of using FMIs [016]. Ideally, the FMI would not only have comprehensive English proficiency, but would also have some medical understanding. Medical terminology was thought of as requiring an additional level of English understanding, with HPs describing FMIs' lack of medical understanding as making them less ideal to use than qualified interpreters. "...*maybe if* [they speak and understand English] *but there's still a concern that they're not translating medical terminology or information correctly* [127].

However, HPs' approach to assessing whether a FMI had proficient English was vague. At times, their evaluation was based on whether they felt comfortable with the FMI's knowledge

and English proficiency. HPs described this as "*a judgement call as to whether they can understand what you're saying to them to be able to translate it, cause often their vocabulary is not as big or wide so you have to take that into consideration*" [014], without explaining how they made that evaluation.

Close but not biased. Oftentimes, in addition to considering the family member's level of English proficiency and medical understanding, HPs also considered the relationship that the FMI had to the patient. HPs had varying views on which patient-FMI relationships made them suitable to be a FMI. In general, regardless of who the patient was, HPs thought that FMIs should have a close relationship to the patient. For example, "*uncles and aunts*" were described by one participant as inappropriate, but "*close family member*" such as "*siblings*" were appropriate to be a FMI [206], and a mother-in-law "*you know that's too personal*" [004]. Although close patient-FMI relationships were generally the ideal, HPs differed in their perceptions as to whether to use one parent. For example, some HPs thought that for couples, particularly when their child was the patient, it was acceptable to have one parent be a FMI for the other parent and child.

...think that's great because then at least then they can reiterate something as well...

they're bilingual so they can help their wives and translate for their wives and so that little thing that you've forgotten you can always say hey I forgot to tell you this [011]

Conversely, some HPs were concerned with having one partner interpret for the other because the interpreting partner may not be reliable and could compromise the accuracy of the information that was interpreted.

You want to make sure that the information is being passed on so I guess the concern you have is that you might say something to the father but you don't know if it's something important whether the father would say or the mother, the partner would say something to

the partner in that intensity that you think you are trying to portray so I guess that's the risk there of how reliable and will it be watered down because of they want to protect their family member [116]

For some HPs the suitability of a father functioning as the FMI was influenced by his cultural background. Although HPs were not explicit about which cultures they were referring to, they described not wanting to use male partners from certain cultures as FMIs if they "*feel like the relationship between them is a little bit uhmm overbearing uhmm I think for the woman...*" [111]. HPs expressed concern that "*he might not tell her everything to protect her or in some cultures it's not her business, he's the man of the house or whatever*" [107]. One HP even described offering the female an interpreter when the male family member is not present, to ensure that he could not override her ability to hear the medical information for herself.

...if it is a culture where there is male dominance we would.... also offer the opportunity when he is not present for a translator if she feels it is needed... also to the point of you don't know if there's hidden agendas in there [010]

Children aren't my preference BUT! A special case of FMI-patient relationship was children translating either their own, their sibling's, or their parent's medical information. The decision to use a child as a FMI was largely based on their age. Despite explaining, sometimes very passionately, that they preferred not to use children as interpreters at all, 39% (n=27) of HPs explained that their choice to use a child as a FMI was "*dependent on the child's age and things like that*" [103]. Ten HPs specified an age threshold of the child that they would find appropriate, which ranged between ages 12 and 18. Specifically, 7 HPs said they would use a child over the age of 15, and 3 HPs said they would use a child over the age of 12 if they had proficient English. Usually, age was considered a marker of maturity that made a young FMI suitable to

handle interpreting in a medical setting, “*Depends on the age and the maturity uhm again it would be no different to an adult if they were, if they were mature and uhm their age appropriate like maybe over the age of 12*” [012]. Some HP’s described how they “*just test the English*” of a child FMI [112] before deciding to use them. This shows that HPs often expected a combination of some age of the child FMI and other characteristics before they were deemed appropriate to be a FMI. For example, being above the age of 16 in the following example was only sufficient if the child also had strong English proficiency;

Well I’ve used family members as translators before if they’re like 16 or 17 you know like the older kind of kids but I have to make sure that they’re ... comfortable in speaking in English and that they sort of understand what we’re speaking [009].

Lastly, many HPs stated they would only consider using a child of a certain age as a FMI in certain situations, such as an emergency or for basic information.

Discussion

The present study examined HPs’ decision-making regarding the use of FMIs in neonatal and pediatric hospital care. As FCC continues to be the desired model of care in pediatric and neonatal units in hospitals, it is essential that families can have 2-way conversations with their HP (Kuo et al., 2012). For LEP patients and families, achieving FCC requires an interpreter. Consistent with previous research (Hilder et al., 2017), we found that many HPs considered that FMI use may be appropriate and justifiable. However, most HPs were reluctant to use FMIs, and believed that FMIs should not be used due to confidentiality and/or legality concerns. HPs also cited concerns with the accuracy of the information should the FMI be biased in some way, reflecting the previously noted concern that the FMI would not sufficiently act as a conduit translating the information (Dysart-Gale, 2005). After describing these concerns, many HPs then

said “but” and described when they would use a FMI, as well as describing who would be suitable to use as a FMI. Thus, while the injunctive norm is that FMIs should not be used, the descriptive norm for virtually all HPs was that FMIs could be used in certain situations. A few HPs even explained that a FMI would be their first choice for an interpreter. Our findings thus highlight the lack of consistency in beliefs about the use of FMI.

Most HPs described situations in which it was either completely acceptable (e.g., explaining some basic, or non-medical information) or completely unacceptable (e.g., confidential information or consent) to use a FMI. These considerations were generally consistent with the relevant policies, in that basic non-medical information does not always require a qualified interpreter (GCHHS, 2017). However, what was consistent was that an emergency was the ultimate deciding factor. In an emergency, if there were no other options, HPs explained they would use virtually any FMI with some English proficiency. Ideal characteristics of the FMI were disregarded out of perceived situational necessity.

When describing ideal characteristics of a FMI, unsurprisingly, HPs considered it important to assess the family member’s level of English proficiency and medical understanding. However, HPs did not appear to have a clear or systematic way of doing this. This lack of consistency in assessing English proficiency and medical understanding is a point of concern, as was some HPs’ tendency to ascribe to widely held stereotypes or generalizations about cultures and gender roles when considering the appropriateness of the family member to act as an interpreter. This approach to decision making using heuristics based on group level characteristics is subject to bias (Dragojevic & Giles, 2014), and may lead to inaccurate decisions.

In terms of the patient-FMI relationship, it was clear that most HPs were working from an individualistic frame of reference when they considered FMI suitability. Some felt men from certain cultures were unsuitable FMIs, even though they may have been providing cultural context to the medical situation. In Australia, individuals are seen to have the right to make decisions for their own health (see Smith, Dixon, Trevena, Nutbeam, & McCaffery, 2009 for a review of patient involvement in healthcare decision-making), whereas other cultures act less as individuals and more as a family unit in decision-making and sharing stressors (see Knight et al., 2010 for an explanation of familism in Latino families). In contrast, other HPs (albeit a minority) saw the potential of FMIs to not simply translate information word-for-word (i.e., act as a conduit). These HPs felt that FMIs could add history, cultural context, and a sense of trust that a qualified interpreter could not. These findings add to a growing body of literature that both acknowledges the advantages of using FMIs for medical interpretation (Hilder et al., 2017; Edwards, et al., 2005), while also questioning whether the view of interpreters as conduits is appropriate. Overall, being able to trust the medical English proficiency, as well as the unbiased translation of the FMI (including consideration of the FMI's cultural background) was the main characteristic HPs considered when choosing to use a FMI.

Finally, children were a special case of FMI use in terms of age and suitability of them acting as a FMI. Again, while the injunctive norm was that HPs should not use children as a FMI, in practice most HPs stated they would or had used a child as a FMI. This is a concern, as regardless of whether they are used to translate 'basic' or more 'serious' information, the policy in Queensland and, indeed in many other countries, states that children under the age of 18 years should never be used (GCHHS, 2017).

Limitations and Future Research

Results from our study suggest two main directions for future research. First, our study used self-report interviews with HPs who self-selected to participate in the interview. Future research should examine in situ the decisions HPs make regarding the use of FMIs in medical care, which in turn would allow us to better understand the process by which HPs elect to use a FMI. Although our sample was representative of staff in the departments of interest (with slightly less doctors than other specialties in the sample), observing these situations would help to determine the effectiveness of care of HPs generally when a FMI is used. For example, is patient compliance and understanding better when they have a FMI or a qualified interpreter and what does that look like?

Second, policies for Queensland government, and indeed many other states and countries, do not explain, nor were HPs in our study certain of the degree of understanding family members needed. Beyond the challenges of translating information from one language to another to achieve shared understanding, future research should consider culturally disparate understandings of illness, its causes, and its appropriate treatments. For example, do some illness descriptions make sense in other languages? Is it sufficient for only the father or only the mother who is proficient in English to be made aware of the medical information for their child? Can HPs reasonably assume that one spouse will adequately transfer that information to the other spouse? Is that type of information sharing appropriate across cultures? Without clear guidance around this issue, HPs' decisions will be influenced by their personal beliefs. Research in this area would assist with the standardization of interpreter policy use regarding one spouse functioning as a FMI for translating medical information to the other spouse.

Conclusion

The use of interpreters is essential to the provision of high quality healthcare for people who speak a different language to their health professional. Although research and policy regard qualified, formal interpreters as the most appropriate interpreters to use, in practice, many health professionals are using FMIs. Our findings demonstrate that health professionals report using FMIs in a range of ways that are both consistent and inconsistent with research and policy recommendations. This includes the not infrequent use of children under 18 as FMIs. In addition, our study demonstrated the difficulty and biases involved in deciding who is suitable to use as a FMI in healthcare. Increased understanding of HP use of FMIs and their effectiveness can help improve care delivery, and help achieve FCC.

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