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Policy and Practice Brief

The benefits of working with Aboriginal interpreters at Royal Darwin Hospital

The Northern Territory of Australia is the heartland of Aboriginal languages with approximately 100 languages spoken. In the NT at least 60% of Aboriginal peoples speak an Aboriginal language as their first language. Of the 14 languages considered strong in Australia, 12 are in the NT. Language is more than a communication tool; it is a pivotal aspect of culture which supports and strengthens Aboriginal and Torres Strait Islander people's health and wellbeing. Research globally has found interpreters improve patient experience and outcomes but in the NT interpreters in hospitals are underused by health providers, despite 40 years of evidence documenting benefits to both patients and providers.

At Royal Darwin Hospital (RDH) between 60% to 90% of patients are Aboriginal; 60% speak an Aboriginal language and approximately 17% access an interpreter. Poor communication in NT health services has resulted in death, absence of informed consent, unnecessary elongated hospital stays, amputations without patient permission, discharge against medical advice and distrust of healthcare providers. Culturally unsafe communication is also a common way patients experience racism. These intercultural communication challenges also place large amounts of stress on the medical staff, who have reported feeling dismayed and frustrated by their inability to deliver culturally competent care.

Research internationally has shown that patients who feel culturally safe, and are supported to communicate in their first language, experience improved health outcomes. Good communication between patient and provider also improves staff satisfaction (reduces burn out) and reduces self-discharge rates. Speaking first language has been deemed a human right by the NT Ombudsmen and the United Nations Declaration on the Rights of Indigenous Peoples.

Recognising system failures at RDH, a new model of Aboriginal interpreter use in which interpreters were embedded in a renal medical team for 4 weeks in 2019 was piloted. This research was a collaboration between RDH, the NT Aboriginal Interpreter Service and Menzies School of Health Research. This research is the first to demonstrate the importance of interpreter use for providing culturally safe care for Aboriginal language speaking patients in Australia.

We provide here a summary from two recent publications relating to the pilot. When citing this report, we request the following citations be used.

1. Kerrigan, V., McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., Cass, A., Hefler, M,. Ralph, A. P. (2021). **From "stuck" to satisfied: Aboriginal people's experience of culturally safe care with interpreters in a Northern Territory hospital.** *BMC Health Services Research*

2. Kerrigan, V., McGrath, S. Y., Majoni, S. W., Walker, M., Ahmat, M., Lee, B., Cass, A., Hefler, M,. Ralph, A. P. (2021). **"The talking bit of medicine, that's the most important bit": doctors and Aboriginal interpreters collaborate to transform culturally competent hospital care.** *International Journal for Equity in Health*

What did we do? In 2019, Menzies School of Health Research collaborated with RDH and the NT Aboriginal Interpreter Service to conduct a pilot in which Aboriginal language interpreters were embedded in a team of renal doctors for 4 weeks.

Why did we do it? Cultural safety advocates for changing systems which enables a transfer of power from service provider to health care consumer. Cultural safety practitioners argue patient outcomes will improve when health systems no longer diminish and demean an individual's cultural identity.

How we did it: Two Yolŋu Matha and two Tiwi interpreters were embedded in a renal medical team for 4 weeks in 2019. The renal department was chosen due to the extremely high rates of Aboriginal patients (>90%). We collected qualitative data to evaluate the impact of the pilot including interviews with Aboriginal language speaking patients (Yolŋu and Tiwi), non-Indigenous doctors and Aboriginal interpreter staff.

What was the aim? To explore what happens when Aboriginal language speaking patients and health providers work consistently with interpreters during ward rounds. Ward rounds are a time when crucial clinical decisions are made.

What we found: Whilst English is the operational language of RDH, it is not the language most spoken amongst renal patients. Almost 90% of patients were Aboriginal and nearly 80% spoke one or more of the 15 languages identified in the unit. The most spoken languages were Yolŋu Matha and Tiwi, followed by Kunwinkju and Anindilyakwa. The power imbalance between Aboriginal language speaking patients and English-speaking providers was equalised through the presence of interpreters.

RDH renal unit: 15 languages counted over 17 days.

Yolŋu Matha Tiwi, Kunwinkju, Anindilyakwa, Kriol, Burarra, Murrinh-Patha, Ngan'gikurunggurr, Warlpiri, Maung, Wurlaki, Ngarinyin (WA), Garawa, Yumplatok (Torres Strait Creole) & Ngaringman. 11 languages were unknown.

FYI: the European Union has 22 official languages.

Patient experience: Without access to interpreter's patients described feeling "stuck" and disempowered when forced to communicate in English; treatments were inflicted on frustrated, distressed and misunderstood patients. Patients signed surgical consent forms without understanding what they were consenting to. We also found patients who experienced communication problems would self-discharge from hospital, exercising the limited power they had. The same patients would re-present to hospital sometimes requiring admissions to the Intensive Care Unit.

During the pilot, consistent access to interpreters meant Tiwi and Yolŋu patients were able to question the treatment offered, exercise choice and make decisions based on their priorities. Yolŋu Elder Matthew was hospitalised over 5 years without interpreter access. He said once he could speak his first language his power increased.

Yes I was more forceful with my treatment and making decisions and also I had more choices ….I was more forceful, making decisions based on things I wanted. - Matthew, Yolŋu Elder and RDH patient

After receiving access to trusted interpreters who shared patients' worldviews, patients reported feeling "satisfied" with their care and empowered. By embedding Aboriginal language interpreters in the medical team, the power dynamics between doctors and Aboriginal clients shifted towards cultural safety. This improved patient trajectories and reduced self-discharge rates.

> *The trust is massive…I feel when they come here (interpreters), I feel really good not only because I'm related to them, but I feel like the flow of the conversation is going faster. We are all understanding each other…. It's just a good feeling when it's flowing, and everyone understands.*
> - Matthew, Yolŋu Elder and RDH patient

Health providers: Before the pilot, frustrated doctors unable to communicate effectively with Aboriginal language speaking patients acknowledged their personal limitations and criticised hospital systems that prioritised perceived efficiency over interpreter access. Doctors reported that, patient centred communication is not prioritised due to the way hospital processes are implemented. The hospital often operates above capacity, resulting in pressure to process, treat and discharge patients quickly. Dr. Jack understood the benefits of interpreter-mediated communication but explained he doesn't use interpreters because the hospital's priority is "*staffing and budgets and chaos and patient numbers in bed block".* Dr. Jack said it's *"like the patients aren't even there".*

> *I've been communicating with people for years who really didn't understand what we were saying to them.* -Dr William, RDH renal specialist

Staff attitudes contributed to interpreter uptake and availability. Pre-pilot, accessing interpreters in the hospital was described by Dr. William as "*extremely difficult*". Three main reasons were identified to explain this. Firstly, there is a perception amongst hospital staff that using Aboriginal interpreters is unnecessary, disrupts workflow and is a waste of scarce resources. Secondly, there is a small pool of Aboriginal interpreters in the NT. Thirdly, Aboriginal interpreters themselves deal with a large burden of illness.

During the pilot, knowledge of Aboriginal cultures improved, and doctors adapted their work routines including lengthening the duration of bed side consults. Our research warns against the argument that spending time communicating is a waste of resources. Health providers should be aware of not engaging in 'false economies'. Time spent communicating in the patient's first language resulted in better time management overall.

> *You spend less time chasing your tail, miscommunicating about something over and over again.* – Dr Jack, RDH registrar

Furthermore, attitudes towards culturally safe communication in the hospital changed: doctors recognised the limitations of clinically focused communication after experiencing the benefits of communicating in patients first language.

> *We've completely changed trajectories of illness and probably will save lives based on this project.*- Dr Sean, RDH registrar

Aboriginal interpreter experience: interpreters who previously felt unwelcome within the hospital reported feeling valued as skilled professionals. The disposition of hospital staff towards working with interpreters was noted by interpreters who reported feeling unwelcome. Interpreter Joanna described doctors as "*intimidating"* and "*just like police".* Many interpreters chose not to take hospital jobs because they had a bad experience or had heard from colleagues the hospital was an unpleasant place to work.

> *Most of the interpreters don't like coming back here because I think they find the staff rude or something, that they don't speak to them.* - Carly, Yolŋu Matha interpreter, NT AIS

During the pilot, interpreter's health literacy improved, and they became active participants in the Multi Disciplinary Team sharing power and responsibilities with doctors to ensure patient wellbeing. This model of working "with" not "next to" clinicians' contrasts with guidelines which present interpreters and healthcare providers as separate. These beneficial outcomes occurred because doctors changed their behaviour which allowed interpreters to surpass the "invisible role as mere linguistic conduits" (Álvaro Aranda).

CONCLUSION

A culturally unsafe system which diminished and neglected patients' needs was overturned by a small but significant system change. Doctors, interpreters and patients request the model of embedded interpreters in the renal team continue.

> *Balanda doctor and Yolŋu interpreter all the time. I need to see that happen.*- Patricia, Yolŋu Elder and RDH patient

Our research found when doctors collaborate with Aboriginal language interpreters they have the potential to deliver culturally safe care. Aboriginal language speaking patients who feel culturally safe have better health trajectories which resulted in less demand on health services. Despite stated benefits, resistance to interpreter use remained amongst some members of the multi-disciplinary team. Systemic changes are required to ensure the benefits of collaborating with interpreters during the pilot are sustained and scaled up. Continued education of hospital staff about the delivery of culturally safe care, together with mentoring and support for interpreters to ensure a culturally safe workplace should be prioritised. We contend that investment in culturally safe communication is key to closing the gap and may likely rival investment in other aspects of healthcare.

RESEARCH RECOMMENDATIONS

Our research found RDH staff were socialised into an institution which diminished Aboriginal cultures, as displayed by poor patient language documentation (Mithen), low attendance rates at cultural awareness training (Kerrigan et al), low uptake of Aboriginal interpreters (Communicate study group), and low levels of staff knowledge of Aboriginal languages. Low uptake of Aboriginal interpreters has been blamed on supply issues. However, as we observed even when interpreters were readily available resistance to working with interpreters continued.

The research identified patterns of ingrained behaviour requiring institutional attention to ensure the delivery of culturally safe care. Poor attitudes to culturally safe communication create a self-perpetuating cycle of staff dissatisfaction which contributes to a culturally unsafe service. These issues can be addressed through better staff cultural education and updated hospital policies and practices.

Recommendations for Royal Darwin Hospital and related institutions

1. Responsibility for booking interpreters should be delegated to identified staff members in each Multi-Disciplinary Team.

2. Language documentation at RDH must be addressed. Language was documented for only 44% of Aboriginal patients and in some cases, languages were identified as “Aboriginal” or “local” language reflecting the lack of importance staff place on information (Mithen et al).

3. Additionally, there were seven separate RDH administrative and clinical forms which provided space to document patient language (Mithen et al). Of those seven forms, one of the most used forms, the patient list was not included. The patient list was used by doctors and the multidisciplinary team from the start of their shift, and consistently throughout the day. We recommend language be documented on the patient list alongside name and date of birth. This would ensure language discordance is considered at the same time as clinical discussions and it would also improve familiarity of Aboriginal languages in the NT.

4. Staff assert interpreters are not required because the patient speaks “good English”. The habit of judging a patient’s English proficiency must be overturned. It is the language proficiency of the provider that requires assessment. If the provider does not speak the patient’s language, an interpreter is required

5. Staff commonly state patients do not require an interpreter because they did not request one. This assertion ignores that all exchanges between healthcare providers and patients are “power laden” in favour of the provider (Ramsden; Jennings et al). A 1979 Australian government commissioned report on the need for Aboriginal language interpreters in hospitals stated: “*It is generally assumed that the more powerful* (health provider) *of the two parties will get his message across*.” Healthcare providers control both clinical treatment and communication. Just as a patient is not expected to request a nephrologist or a nurse, they should not be expected to request an interpreter.

6. Poor language documentation may be due to the low level of knowledge of Aboriginal languages. Both cultural awareness and cultural safety training should be regularly undertaken to improve awareness of local Aboriginal cultures, cater for the high turnover of staff and to encourage the self-reflection required to deliver culturally safe care (Kerrigan et al). Clinical competencies, technical expertise and theoretical knowledge prioritised by institutions are only part of delivering comprehensive care (Pannick et al).

7. A collaboration with Menzies, RDH and the NT AIS resulted in the *Ask the Specialist: Larrakia, Tiwi and Yolŋu stories to inspire better healthcare* cultural safety and communication education package. The package has been piloted and we recommend rollout across the service.

8. Patients should be registered with healthcare facilities using their correct names, not their colonised names. Names give people an inalienable connection to country and kin hence interpreters can assess language needs based on a patient’s surname. The format of Australian legal documents often forces name changes to conform with White norms which is a form of assimilation (Bargaillie).

Recommendations for NT Aboriginal Interpreter Service: Future models must consider how best to support, develop and retain the Aboriginal interpreter workforce (NT Ombudsmen).

9. Re: support, Aboriginal interpreters may face the same social and cultural determinants of health which lead to their family members being hospitalised. Employers must understand and adapt to the personal circumstances, family and cultural obligations interpreters juggle alongside the expectations of non-Indigenous colleagues who work within “‘Western’ models of clinical governance and management” (Topp et al).

10. Re: development, there is a small pool of trained Aboriginal interpreters overall and even fewer trained in health communication. NT AIS interpreters require health training to ensure they are equipped, and confident, to work in the clinical setting. This training could be developed as a collaboration between the NT AIS and the NT Department of Health.

11. Re: retention, the small number of trained interpreters may be associated with employment conditions. All interpreters involved in the pilot were employed casually by the NT AIS. Casual employees face irregular and potentially insufficient work hours, resulting in fluctuations in earnings and are also much less likely than permanent employees to have access to on-the-job training (Gilfillan).

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