



Background

Personalised communication is essential in effective palliative care (Silva et al., 2016). Yet language barriers coupled with diversity in cultural and faith backgrounds can make personalising information and care planning complex. Healthcare professionals may draw on help from family

and friends or interpretation services (Jaitly et al. 2023). In UK medical schools there is a lack of teaching about effective communication with people who do not identify English as their primary language. This should be a pressing concern as the 2021 UK census shows that 8.9% of the population does not identify English as their primary language.

Aims

This project aims to co-develop, pilot and evaluate learning resources for working with interpreters during end-of-life consultations. We report here on workshops undertaken to develop this work.

Methods

Two facilitated workshops, three hours each were planned to explore the experiences of a diverse range of attendees, who had delivered and/or received care, where the primary language was not shared. The workshops enabled discussion about practice working with interpreters when it was positive, and when it was challenging to understand what action was taken. In small groups attendees considered what would the healthcare worker need to know and do to work effectively with the interpreter for two scenarios. The first, was breaking bad news in a hospital ward to the patient, the second was over a telephone to a relative.

Results

29 people attended the workshops that explained how both language and culture play a significant role in communicating with patients. The workshops highlighted that both language and culture play a significant role in communicating with patients. In an ideal situation, family and friends should not be expected to interpret consultations, especially in the emotional context of end-of-life discussions. The complexity of changing healthcare needs makes this challenging.

Attendees explained that healthcare professionals can lack the confidence to use interpreters, and some do not know how to access them. It was agreed it was vital to brief and debrief the interpreter, and that nuanced training in how to do this is needed. Telephone interpretation is easy to access but can be the hardest to do well. Attendees greatly valued hearing about other people's experiences as a way of learning. Table 1 provides examples of difference between ideal practice, and reported realities with ideas to bridge the gap.

Conclusions

These results underscore the need for culturally safe education to improve communication through working with interpreters during end-of-life consultations. The next project step is to develop and pilot the learning packages targeting medical students, internal medical trainees, and palliative care nurses.

Table 1

Ideal practice	The reality in practice	Strategies to bridge the gap
Family, friends and other staff are not routinely asked to interpret	<ul style="list-style-type: none"> • There can be an assumption that if you understand a language, you can speak it, this is not always so • If the person is not used to interpreting it is not easy to translate speech 'on the go' • Concern that being asked to interpret places additional stress on family who may be processing their own emotions to 'bad news' • Out of hours and emergency situation might need to use family • Have used translation apps 	<ul style="list-style-type: none"> • Best practice to use interpretation service but this is not always possible • Time to prepare the family and explain what is being discussed. Better to do in person than over the telephone as you can see emotions and offer support to family and patient • Especially when using staff or family, break communication into shorter phrases to make translation easier • Translation apps may not be relevant as some languages do not have translation for palliative care etc
Patients and family are fully involved in decision to use in an interpreter	<ul style="list-style-type: none"> • Families may want to interpret and to be the person the interpreter talks to rather than the patients • Cultural norms may be in conflict with western medicine which holds patient choice central to care 	<ul style="list-style-type: none"> • Involve family and patients in discussions about having an interpreter • Have competence and confidence in managing large group consultations where family patient and interpreter present
Interpreters are fully briefed about the nature of the end-of-life consultation and can opt in or out of the activity	<ul style="list-style-type: none"> • Occasions where at time of consultation interpreter have said not able to do that • Occasions when interpreter seemed to be in public place or with children on a telephone consultation 	<ul style="list-style-type: none"> • Having time to prebook the interpreter and agree ways of working. • Build in time for debriefing • Consider ahead of time specific medical terms which might present a challenge to interpretation
Interpretation is good quality and easy for patient to follow	<ul style="list-style-type: none"> • Telephone consults are the hardest to do well 	<ul style="list-style-type: none"> • Break down communication into short sentences • Interpreter may make the first call, leave a voice message in preferred language, then ring back which is more likely to get a phone pick up and patient is briefed about use of the interpreter in their own language • Consider ahead of time specific medical terms which might present a challenge to interpretation

References

- Silva, M. D. et al., C. (2016). Interpreting at the End of Life: A Systematic Review of the Impact of Interpreters on the Delivery of Palliative Care Services to Cancer Patients With Limited English Proficiency. *Journal of pain and symptom management*, 51(3), 569–580. <https://doi.org/10.1016/j.jpainsymman.2015.10.011>
- Jaitly J, Bronnert R. (2023). 118 Spoken languages of patients known to a hospital specialist palliative care team and access to interpreting services. *BMJ Supportive & Palliative Care* 13:A52
- Office for National Statistics (ONS), released 29 November 2022, ONS Website, statistical bulletin, Language, England and Wales: Census 2021

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