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Patients with non-English language preference: Data from an Australian healthcare facility on reported use of professional interpreting services

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Abstract Patients with a non-English language preference (NELP) require services in a language different from that spoken by English-speaking healthcare practitioners. National guidelines advocate professional interpreting services, but little is known about patients' perspectives and factors that secure interpreting for them. A total of 1,120 NELP patients in Melbourne were surveyed from 2016 to 2020 in their preferred language. Patients report high awareness and utilisation of free interpreting services, predominantly initiated by healthcare staff rather than themselves. This points to cultural competence among healthcare staff as crucial for them to identify the need for interpreters. Alongside this, some patients rely on family members for linguistic mediation. This may result from patients not (self-)reporting their NELP or from contextual considerations. Amongst the latter are patients' privacy concerns and a lack of understanding that interpreters are bound to observe ethical principles such as confidentiality and impartiality. These responses underscore the need for explicit explanations from healthcare providers and interpreters to patients about their roles and the protocols they observe.

Keywords: Patients with non-English language preference, healthcare interpreting, healthcare interpreters, healthcare professionals

1. Introduction

In the past 50 years, the increased movement of people across borders has resulted in increased levels of immigration. Many individuals arrive in new countries with little or no proficiency in the language(s) spoken in their new home. As a consequence of this, healthcare, as a key public service, has often been one of the first settings in which interpreting services have been provided in countries that have witnessed high levels of immigration. The provision of interpreting services to remove language barriers between healthcare professionals and patients has become commonplace in Australia (Garrett, 2009; White et al., 2018).

At the time of the last census (2021), Australia had a population of 25.4 million, of whom just over 7 million were born overseas (Australian Bureau of Statistics [ABS], 2022). Census data also allows for the quantification of the number of residents with a lower or limited proficiency (LEP) in English, i.e. who have a non-English language preference (NELP). Of the 7.01 million overseas-born residents, 4,152,771 speak a language other than English at home (ABS, 2022). From this cohort, 701,539 (16.9%) selected responses in the 2021 census collection to state that they speak English “not well” or “not at all” (ABS, 2022). It is possible and perhaps likely that those who provided no response to this question (43,666 residents) and a certain number of those who reported that they speak English “well” (1,272,735 residents) have a NELP (ABS, 2022). In relation to the latter group, this relates to those who may over-estimate their linguistic skills and who may, when in ill health, not be able to effectively communicate in English. Overall, this may indicate that the designation ‘NELP’ relates to a sizeable proportion of Australia’s population. This raises the issue of the way healthcare, as a key public service, enables equitable access to healthcare services for residents who cannot easily or who cannot at all communicate with healthcare professionals and for the services provided to healthcare professionals in order for them to communicate effectively with NELP patients. This paper examines the reported behaviour of NELP patients in relation to interpreting services, drawing from data from a large public healthcare facility in an area of Melbourne with a high percentage of residents born in predominantly non-Anglophone countries.

2. Background

2.1 Linguistic profiles and communication practices of patients with NELP and their engagement with healthcare services

The need for healthcare professionals and NELP patients to be able to communicate effectively with each other is uncontroversial. The issue of linguistic discordance has become recognised as a problem that cannot usually be adequately resolved via a healthcare professional speaking more slowly or more loudly (McKenzie et al., 2015) or using non-verbal communication only (Mohammad et al., 2015). These strategies offer little guarantee that effective communication can be attained, and they are risk laden as they ignore the issue of patients’ limited ability to “understand doctors’ recommendations in English” and their restricted ability to “discuss symptoms in English” (Karliner et al., 2008, p. 1557; Berdahl & Kirby, 2019; Fryer et al., 2013). Further, in healthcare interactions, diagnostic terms, descriptions of treatment and terms referring to medical procedures are especially challenging for NELP patients to comprehend (Binder et al., 2012; Brooks et al., 2016; Shaw et al., 2015). Notwithstanding these obstacles to functional communication, the use of English is still reported in interactions in which at least one party is unlikely to understand it well, even in a simplified form (Lowell et al., 2012; Schwei et al., 2018).

A perhaps more common strategy to address linguistic discordance is for family members or friends to take on the role of broker to mediate linguistically between healthcare professionals and patients with NELP. Despite the risks associated with untrained individuals taking on this role and the possibility that they may intentionally or unintentionally censor or distort what others are saying, the practice of others taking on the role of 'ad-hoc interpreter' is reported in many studies (e.g. Mahmoud et al., 2014; Rosenberg et al., 2008). The use of family members as ad-hoc interpreters remains a practice that appears to be condoned by some healthcare professionals (e.g. Hilder et al., 2017) or as something that family members might feel is their right or even obligation (Hadziabdic et al., 2014; Roberts & Sarangi, 2018). Some studies report findings that some NELP patients strongly prefer family members over professional interpreters and express this preference explicitly (Edwards et al., 2005; Rhodes & Nocon, 2003). Drawing on data gained from patients who say they prefer family members to interpret for them, Gray et al. (2022, pp. 106-115) identify the following motivational factors: high level of trust; reliance on the brokering or advocacy role of a family member; shared knowledge of patient's health and social situation; continuity of availability; familiarity with language variety; and (perceived) ability to locally contextualise medical advice.

While some patients may wish to rely on family members or friends to linguistically mediate for them, research on the effects of non-professionals interpreting for others in healthcare settings points to direct or anecdotal evidence that this can be unsatisfactory (Bagchi et al., 2010; Joseph et al., 2017) and can even have dangerous outcomes (Flores et al., 2012; Hunt & de Voogd, 2007). Official guidelines in Australia warn against the use of family members as linguistic mediators and list risks that can follow from this, e.g. inaccurate interpretation, withholding information, non-ethical behaviour and non-observance of patient confidentiality (Migrant & Refugee Women's Health Partnership [MRWHP] 2019, p. 19). Recent healthcare policies strongly discourage family members from mediating linguistically and instead clearly advocate the use of professional interpreting services (Australian Commission on Safety and Quality in Health Care, 2021, p. 15).

Particularly in urban, high-growth areas of Australia, translation and interpreting (T&I) services are a standard feature in government and publicly funded services and beyond. These services are a consequence of policy at both the national and state/territory levels. For example, the national *Australian Charter of Healthcare Rights* (2008) states that patients have "a right to be informed about services, treatment, options and costs in a clear and open way", with an even clearer message issued in the second person: "You can use interpreters if English is not your first language. Interpreter services are free and can be provided in person or by phone" (Australian Commission on Safety & Quality in Healthcare, 2008, p. 2). The Department of Health and Human Services (2016, pp. 9,12. original emphasis) is even clearer in defining patients' rights: "You have a right to an **accredited interpreter** if you need one when using a publicly-funded healthcare service, such as a hospital or community health centre" and "Interpreters should be provided at important points during your care, such as when discussing medical history, treatments, test results, diagnoses, during admission and assessment and when you are required to give informed consent".[1]

While a declaration of a person's right to interpreting services in healthcare settings is clear, what is less clear is how the need for interpreting services is (self-)identified. If a patient at a healthcare facility requests interpreting

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[1] In 2018, the term "certified interpreter" was adopted which reflected a change from the credentialing authority, NAATI (National Accreditation Authority for Translators and Interpreters) to signal that from this point it conferred *certification* on tested and assessed potential practitioners, rather than *accreditation*.

services, then the identification of need is clear and patient-based. Where the person does not request these services, the question arises as to which stakeholder is in a position to request these services on the basis of which factors. In Australia, resources such as the *Guide for Clinicians Working with Interpreters in Healthcare Settings* (MRWHP, 2019) advise healthcare professionals as to how they assess a patient's need for an interpreter and how to interact with a family member who may want to take on the role of ad-hoc linguistic mediator. But from the patient's perspective, factors that may account for why they may not request interpreting services in the first place are a lack of knowledge that these exist (Kale & Syed, 2010), lack of knowledge that they are free (Czapka et al., 2019) or an expectation that the healthcare service would know that they need to be provided in the first place (Hadziabdic & Hjelm, 2014, p.4).

The consequences of not knowing that presenting patients require an interpreter may lead to primary healthcare providers developing strategies to deal with such a sudden need. For example, eight ambulatory clinics in New England developed the following course of action for NELP patients, most of whom had Spanish as their first language (L1): "need for interpreter services [was determined] between the initial intake at the front desk and triage through nursing staff' or through staff members' personal familiarity with the patient and their linguistic profile (Vandervort & Melkus, 2003, p. 363). However, this practice relied on the ad-hoc sourcing of Spanish-speaking in-house staff which is a practice now no longer advocated by the US Affordable Care Act (2016) which instead requires the provision of professional interpreting services (Department of Health & Human Services, 2024). In any case, reliance on unqualified bilingual staff is not feasible for many healthcare providers, and it is unworkable in larger facilities with a wider span of preferred languages of patients. Thus, a more formalised process is needed to enable the identification and timely sourcing of an interpreter.

If a person does not request an interpreter and there is no information about the need for one, there are characteristics of their spoken or other behaviour that point to a possible need. The easiest one to identify is an apparent absence of any ability to use English (Okrainec et al., 2014). Further characteristics include the following: visible or audible difficulty in expressing themself; responses that are conspicuously limited; reliance on others to interpret or even speak in their name; and inability to understand verbal messages (Western Sydney Local Health District, n.d.). Where these characteristics are present, it is incumbent on the healthcare provider to *offer* the patient interpreting services. How such an offer is formulated is important. Formulations such as "you won't need an interpreter, will you?" are defensive and uninviting, and the negative syntactic construction, together with a tag question, may not be understood clearly (Centre for Culture, Ethnicity and Health [CEH], 2014, p. 1). More importantly, such a question locates the 'need' as one that only the patient has. Shifting the 'need' from the patient can be achieved via an impersonal, passive construction such as "Will an interpreter be needed?", but current best practices in the provision of interpreting services advocate an invitation more in line with patient-(or person-)centred care, e.g. "In what language do you prefer we offer our services?" (CEH, 2014; Gee et al., 2010).

The intention of formulating the offer in this way is based on the desire to facilitate the provision of interpreting services so that both the patient and the healthcare provider can effectively communicate with each other. However, such offers may nonetheless be met with ambivalent or even negative responses. Such responses may be motivated by a belief that the patient will need to pay for the interpreting services, out of a sense of embarrassment or bravado about their inability to communicate in English, concerns that an interpreter may not observe confidentiality and pass on information to others, or a persistent preference for family members or friends (Hsieh et al., 2010; Willoughby et al., 2018; Zendedel et al., 2018). Where the NELP patient is not sure or declines the offer of an interpreter, current guidelines require healthcare staff to provide assurances in relation to the services being free, that an interpreter will observe confidentiality and privacy, that the risks of miscommunication are outlined and that the need for an interpreter applies to the healthcare professional too (MRWHP, 2019, p. 9). We return to the point of patients knowing that not only the healthcare professional but also the interpreter observes confidentiality below.

Following this, a staff member in a healthcare facility needs to determine the preferred language of the patient (Gee et al., 2010). This can often be learnt from others accompanying the patient or via visual aids that list the names of languages in the languages themselves for the patient to identify their language. This strategy presupposes literacy skills, and not all patients may be able to read. Where neither strategy is available, information on the country of birth of the person and contacting via telephone an interpreter speaking a language used in that country can frequently enable identification of the patient's preferred language. This includes instances where the patient's preferred language may not be the national or majority language spoken in that country (Hlavac, 2011), but where the patient has sufficient proficiency in that language to convey to others what their preferred language is (Hlavac, 2019).

The above points are provided to healthcare professionals across various fields of health so that these may contribute to their knowledge in and application of cultural competence when working with NELP patients (Johnstone & Kanitsake, 2007; White et al., 2019). Where this is provided, the number and proportion of requests for interpreting services is, in an aspirational sense, likely to more closely reflect the actual need for them. For example, the first and second authors report how facility-wide cultural competence training and a proactive approach to NELP patients resulted in an increase in the number and percentage of Occasions of Service (OoS, i.e. formal interaction with any service personnel member from Northern Health) that are interpreter-mediated over a 10-year period from 27,501 (11.7%) of 233,839 to 68,740 (20.5%) of 335,637 (Beagley et al. 2020, p. 1647). However, other studies in Australia (Abbato et al., 2018; Garrett, 2009; Sturman et al., 2017; White et al., 2018) as well as outside Australia (e.g. Diamond et al., 2009; Ngai et al., 2016; Taira & Orue, 2019) show that the ability to provide interpreting services still does not always match demand.

Some studies isolate variables within their NELP patient samples to examine the experiences of cohorts according to linguistic profile and language preference (Lor et al., 2016; Mui et al., 2007; Ngo-Metzger et al., 2003). These variables can include length of residence (Harpelund et al., 2012; López et al., 2015; Njeru et al., 2015), (self-) identified level of linguistic proficiency (Green et al., 2005; Michalec et al., 2015; Rajbhandari et al., 2021) as well as other features.

Lastly, a point made above is patients' knowledge that interpreters are required to treat all information relating to the patient in confidence. This is an ethical principle that interpreters are bound by (Australian Institute of Interpreters and Translators [AUSIT], 2012). Amongst interpreters and within interpreting studies as an academic discipline, the issue of ethics and the development of codes of ethics has been largely 'inward-looking'. In other words, interpreter codes of ethics have been seen as a didactic tool for trainees and practitioners alike (Floros, 2020; Pöllabauer & Topolovec, 2020) and as an attribute that interpreters view as a hallmark of the professionalisation of interpreting, primarily to themselves (Tseng, 1992; Gonzalez, 2019), and secondarily to outsiders. If clients, in this case, patients, do not know that an ethical code applies to interpreters, then it is possible that they are unaware that certain standards of practice - not only confidentiality but also others such as impartiality, competence and accuracy - can and should be expected of them.

In Australia, where this sample was gathered, a national code of ethics for interpreters has been in place since 1996 (AUSIT, 2025). The verification of training in ethical practice and testing of knowledge of that code, the AUSIT Code of Ethics and Code of Conduct (2012) are prerequisites to any candidate wishing to gain certification as an interpreter in Australia (National Accreditation Authority for Translators and Interpreters [NAATI], n.d.). Regardless of their level of credentials, training or membership in the professional association, *all* interpreters in Australia are bound by this code (AUSIT, 2012).

In light of the above review of previous studies, this paper addresses the following research questions amongst a cohort of NELP residents, including who might (be likely to) make use of interpreting services. What is the length of residence of the informants in Australia? Do informants report difficulties communicating in English with healthcare professionals? Do informants rely on family members to linguistically mediate for them? Do informants know they have a right to free professional interpreting services in healthcare settings? Do informants use professional interpreting services? Who is the person who requests interpreting services for them? Are informants aware of an ethical code that applies to interpreters?

3. Methodology

3.1 Setting and site

This is a quantitative study focusing on NELP patients that examines key attributes of their use of professional interpreting services and beliefs about interpreter ethics. On the basis of the three authors' previous or current affiliations and contacts, the setting of the study is a major public healthcare facility, Northern Health, that has a number of facilities servicing a catchment area of approx. 1.5 million people across Melbourne's northern suburbs. In the two local government areas (LGAs) where most facilities of Northern Health are based, the percentage of residents born in non-English-speaking countries is 39.9% for the LGA Hume (Profile.id, 2023a) and 37.6% for the LGA Whittlesea (Profile.id, 2023b). In 2018, the percentage of OoS at Northern Health involving patients born in a predominantly non-English-speaking country was 47% (157,541 out of 335,637) (Beagley et al., 2020). In relation to the proportion of those NELP residents born in non-English-speaking countries in the two local government areas that are within the catchment area of the healthcare facility, the estimated percentage of NELP residents is between 8.3% and 13.7% for Hume (Profile.id, 2023a) and between 6.8% and 11.2% for Whittlesea (Profile.id, 2023b). These levels are substantially higher than those across Greater Melbourne (between 5.4% and 10.0%) and significantly higher than Australia-wide levels (between 2.7% and 2.9%) for the same features (ABS, 2022).

3.2 Questionnaire survey tool

NELP patients generally record low participation rates in surveys, even where explanatory statements, consent forms and the survey itself are translated into their languages (Squires, 2008; Wallin & Ahlström, 2006). To source and secure responses from NELP patients, the first author initiated a survey method tool and modality appropriate to the target informant cohort [2]. This additional survey tool was designed by Transcultural and Language Services (TALS), an entity of Northern Health, in collaboration with community stakeholders. The in-house interpreting services department within TALS is the provider of all interpreting services at Northern Health, either through its 44 in-house staff interpreters or by sourcing interpreters externally through commercial interpreter agencies. The selection of questions undertaken by the in-house interpreting services department reflected general content guidelines contained in previous iterations of what is now known as the Victorian Healthcare Experience Survey (Victorian Agency for Health Information, 2022), which is a formal collection tool of patient experience responses.

3.3 Informants, sample and data collection

Potential informants were contacted on the basis of data available to the in-house interpreting services department that the patient had been identified as NELP either via patients' referrals to Northern Health, by eliciting this at the time of presentation, or just before, during or even after a medical OoS. In the majority of instances, patients identified as NELP had already been users of interpreting services for at least one OoS at Northern Health or at some other publicly funded (healthcare) facility. In a small percentage of instances, it was evident that NELP patients had not been users of interpreting services previously. This was due either to the inability to source an interpreter at the time of the OoS or due to a patient's clear and repeated refusal of interpreting services.

A logistic and personnel-related circumstance of data gathering relied on a data collector being available to approach the NELP patient at a time outside their OoS, i.e. usually just before or just after the OoS. Our efforts to avoid the data collector being the interpreter with whom the patient had just been working (in those languages where capacity allowed this) led to a reduction in the number of potential informants we were able to approach. The number of NELP patients approached was only a fraction of the number of NELP patients available to us during the collection periods.

The survey was conducted over three iterations, each of two months' duration (1 July to 31 August) in three different years: 2016; 2018 and 2020. In these three two-month periods, approx. 2,100 potential informants were approached by a survey collector who addressed potential informants in their first or preferred language, stating that a survey on patients' experiences of interpreting services was being conducted with the invitation for them to participate in a 10-minute verbally administered questionnaire. Consent was provided verbally, and 1,120 or just over 50% of the approx. 2,100 potential informants participated.

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[2] Approval to gain data in a deidentified format from patient informants was enabled through a Quality & Service Improvement project, granted by the Northern Health Cultural Responsiveness Plan Committee for 2016, 2018 and 2020 and confirmed by the Research Ethics and Governance Office of Northern Health (2016-2020).

4. Results

4.1 Linguistic and demographic profile

Sixteen languages other than English (LOTEs) were reported as preferred languages amongst the 1,120 informants who responded to the questionnaire. Data gatherers questioned each informant in their individual LOTEs and recorded their responses in written English. In the case of 38 informants, the language used could not be identified as this information was not recorded by the data gatherer before submitting their batch of completed questionnaires to the last author. These patients' language background is identified as 'unknown'.

Table 1: No. of informants and their preferred languages

		2016	2018	2020	Total
Infor-mants	No. of potential informants with NELP who were approached	approx. 2,100 over 3 years			
	No. of participating informants	278	291	551	1,120
Data collector	Interpreter known to informant	257	271	537	1,065(95.1%)
	Interpreter not known to informant	19	11	14	44 (3.9%)
	Trainee interpreter	2	9	0	11 (1.0%)
Preferred language of informant	Arabic	43	38	100	181
	Greek	30	31	108	169
	Assyrian/Chaldean*	31	40	93	164
	Italian	29	42	77	148
	Turkish	25	21	69	115
	Macedonian	26	12	33	71
	Persian	17	22	20	59
	Vietnamese	30	12	10	52
	Mandarin	14	11	18	43
	Cantonese	12	11	0	23
	Punjabi/Hindi/Urdu**	0	15	15	30
	Serbian	9	3	0	12
	Nepali	0	0	8	8
	Croatian	5	2	0	7
	Unknown	7	31	0	38

**Assyrian and Chaldean are separate languages but are serviced by the same in-house interpreting staff.*

***Punjabi, Hindi and Urdu are three languages that are serviced by the same in-house interpreting staff. These staff members identified responses not by the informant's preferred language but by their own names as the data collectors, and we are therefore unable to distinguish the specific language preferences of their informants. For this reason, informants from both clusters of languages are listed together.*

To match the groups of preferred languages recorded in our sample with the frequency that these languages are nominated as the preferred languages of NELP patients overall, we compared these to the languages requested for patient OoS from a representative, 12-month period within the overall collection period of our sample. Table 2 shows the number and percentage of informants in the 16 languages shown in Table 1. Table 2 shows in the far-right column the percentages of requests for interpreting services for these same languages over one randomly chosen 12-month period within the data collection period, 1 July 2019 - 30 June 2020. Within this period, 76,743 requests for interpreting services for over 100 languages were received, with 92% of these requests met.

Table 2: Representation of informants' preferred languages in 2016/2018/2020 sample and for Northern Health overall in 2019/2020)

		No.	%	% of interpreting requests in 2019/2020 (total = 76,743)
Language	Arabic	181	16.1	25.1
	Greek	169	15.1	7.9
	Assyrian & Chaldean	164	14.6	11.9
	Italian	148	13.2	9.5
	Turkish	115	10.2	10.3
	Macedonian	71	6.3	7.3
	Persian	59	5.2	2.4
	Vietnamese	52	4.6	3.7
	Mandarin	43	3.8	2.5
	Punjabi/Hindi/Urdu	30	2.7	3.8
	Cantonese	23	2.0	2.5
	Serbian	12	1.0	0.9
	Nepali	8	0.7	1.1
	Croatian	7	0.6	1.1
	Unknown	38	3.3	N/A
	Sub-total			88.7% (i.e. 68,039 of 76,743 requests)
	Other			+ 11.3% (i.e. 8,704 relating to requests for all other languages)
	Total	1120	100	100

Demographic data on informants' length of residence in Australia is contained in Table 3.

Table 3: Informants' length of residence in Australia (in %.)

Year / Period	< 5 years	5-10 years	>10 years
2016	29.1	14.4	56.5
2018	26.1	19.9	54.0
2020	20.7	19.3	60.0
Average	24.1	18.2	57.7

Comparison of Tables 1 and 2 shows that the distribution of languages reported by informants in our sample is generally representative of the distribution of languages spoken by patients who receive interpreting services at Northern Health. Just over half have resided in Australia for over 10 years; cross-tabulation with data of all users of interpreting services was not possible as information on patients' length of residence is not systematically collected.

4.2 English language proficiency, linguistic mediation and experiences in using interpreting services

The remaining results relate to how and through whom NELP patients communicate with healthcare professionals with a focus on their experiences working with interpreters. These are presented in Tables 4 to 9. Questions asked of informants are provided in the table captions.

Table 4: Informants' selected responses in relation to difficulty in communicating in English (in %). (Q.: "Do you find it hard to communicate with doctors, nurses or other health professionals in English?")

Year / Response	Yes	Sometimes	No
2016	72.5	25.5	2.0
2018	70.1	24.7	5.2
2020	74.9	19.9	5.2
Average	73.2	22.5	4.3

Table 5: Informants' selected responses to the use of family members as linguistic mediators (in %). (Q.: "Do you use a family member to interpret for you when visiting a health service?")

Year / Response	Yes	Sometimes	No
2016	29.5	34.8	35.6
2018	19.9	40.2	39.9
2020	28.5	37.7	33.8
Average	26.5	37.7	35.8

Table 6: Informants' reported knowledge of their right to free professional interpreting services (in %). (Q.: "Do you know it's your right to access professional interpreters free of charge when using a health service?")

Year / Response	Yes	No
2016	86.1	13.9
2018	82.5	17.5
2020	85.9	14.1
Average	85.0	15.0

Table 7: Informants' reported use of interpreter services at any healthcare service (in %). (Q.: "Have you used an interpreter when visiting a health service in the past?")

Year / Response	Yes	Sometimes	No
2016	84.7	10.4	5.0
2018	83.5	8.2	8.2
2020	87.1	8.3	4.6
Average	85.5	8.8	5.6

Table 8: Person identified as requesting interpreting services for informants (in %). (Q.: "Who requested the interpreter for you?")

Year / Requester of services	Healthcare staff members (incl. GPs)	Patient / member of patient's family
2016	59.7	40.3
2018	70.8	29.2
2020	64.4	35.6
Average	64.9	35.1

Regardless of whether informants had worked with an interpreter in the past, they were asked the question, "Did you know interpreters are bound by a code of ethics?" Table 9 shows their responses.

Table 9: Informants' knowledge of ethical standards applying to interpreters (in %).

Year / Response	Yes	No
2016	46.4	53.6
2018	58.1	41.9
2020	61.8	38.2
Average	57.1	42.9

Tables 4 to 9 show that informants typically report difficulty when attempting to communicate in English, with a substantial number relying on family members to mediate for them, at least sometimes. Informants' knowledge of their right to and actual use of interpreting services is high, but this is not accompanied by a similarly high percentage of informants who report requesting interpreting services. Awareness of ethical standards for interpreters is similarly mixed. These results are discussed further in Section 5.

5. Discussion

The informant sample, consisting entirely of NELP patients, was substantial with 1,120 informants (Okrainec et al., 2014). The data was collected over a five-year period encompassing three cohorts. The sample was based on three corpora collected at two-year intervals and enabled some degree of longitudinal comparison (Beagley et al., 2020; Karliner et al., 2017). The representation of the linguistic profiles of the informants was, at least in general terms and for most of the language groups listed, reflective of the proportion that these languages represent amongst NELP patients who present at Northern Health (cf. Table 2).

Over half of all informants from all collection periods had resided in Australia for 10 or more years, and over three-quarters for five or more years. This indicates that NELP informants in this sample encompassed not only those who had recently arrived in Australia but also residents with medium-length and longer periods of residence. Looking at relevant statistics from Northern Health, the overall number of patients born in countries in which English is not predominantly spoken was considerable: patients in this category constituted 47% of the 335,637 OoS provided at Northern Health in 2018 (Beagley et al., 2020), with the overwhelming majority having resided in Australia for more than 10 years. To return to our sample, the high representation (57.7%) of informants using interpreting services who had resided in Australia for more than 10 years is attributed to this demographic cohort being such a large group. At the same time, the high representation of those with a period of residence greater than 10 years shows that ongoing and long-term residence in another country is not a predictable indicator of a reduced need for interpreting services.

These findings contrast with those of Harpelund et al. (2012), who recorded the length of residence amongst 2,866 migrant users of interpreting services from six major migrant communities in Denmark. In the Danish study, an overall drop in the need for interpreting services was recorded amongst those who had resided in Denmark for 15 or more years compared to two other cohorts who had been in the country for 7 to 15 years or 3 to 7 years respectively (Harpelund et al. 2012). However, Harpelund et al. (2012, p. 463) caution that responses may have been influenced by informants' belief that *not* reporting the need for an interpreter and claiming proficiency in Danish was socially desirable, perhaps given the political context at the time of data collection where user-pay fees for interpreting services had been introduced for residents who had been in the country for 7 or more years. It is possible that policies, like those in Denmark, that provide free interpreting services only for those who recently arrived may have the following effect: those who have recently arrived in the country may feel free to readily report using such services, while longer-term residents may be more reticent in reporting a need for interpreting services, due to the requirement that they will have to pay for these themselves. Such a possible situation contrasts with the profiles of Australian NELP residents who are subject to healthcare policies in Australia that view interpreting services as a right for those who need them, regardless of length of residence, cf. Australian Charter of Healthcare Rights (Australian Commission on Safety and Quality in Healthcare, 2008).

Over 95% of informants stated that they either find it hard or sometimes find it hard to communicate with health professionals in English. Data gatherers noted that some informants who provided a 'sometimes' response stated that this related to their variable perception of interpreter need, which, in turn, was determined by their self-rated ability to communicate depending on the topic or context or on their level of health at the time. These findings of complete or substantial inability to communicate are congruent to those of Karliner et al. (2008), Berdahl and Kirby (2019) and Fryer et al. (2013) and indicate that strategies such as adjustments to the volume or pace of spoken English (McKenzie et al., 2015) or reliance on non-verbal gestures (Mohammad et al., 2015) are not effective or desirable. It is also important to note that patients' physical or psychosocial symptoms and conditions play a major role here. Where some patients may have an ability, when in good health, to functionally communicate with others in English, this ability may be reduced when they present to a healthcare facility due to a health-related condition.

In general, responses indicate that effective communication with healthcare professionals was achieved via other means, i.e. usually a linguistic mediator. Reliance on a family member or friend to be that mediator, at least in some interactions, does occur but is not universal. In fact, many claim that they did not rely on them at all – over two-thirds of the 1,120 informants stated this, at least in relation to healthcare settings, i.e. the sector in Australia where the provision of professional interpreting services is likely to be most comprehensive. The remaining proportion of the sample reported using family members sometimes, if not regularly. Although the use of family members to linguistically mediate is contrary to national healthcare policies, it may be that the healthcare setting itself determined the use of professional interpreting services. This may drop in contexts outside large hospitals such as GP clinics or pharmacies, both of which record low uptake of interpreting services (Chang et al., 2011; Phillips & Travaglia, 2010). The large proportion of 'sometimes' responses also points to patients' awareness that their reliance on different forms of linguistic mediation could refer not only to a comparison of one healthcare consultation to another but also to the same interaction itself. For example, an interaction may commence in English, only for family members to then mediate and conclude in the presence of an interpreter who may have arrived late due to a lack of pre-allocation. Benda et al.'s (2019, p. 584) ethnographic study of 103 communication episodes over 47 hours recorded eight distinct communication strategies, with some patients encountering up to five different strategies during their stay in an emergency department.

The overall percentage of informants who were aware of their right to free professional interpreting services was high – 85%. This points to the likely effect of public awareness campaigns via written information in LOTEs and due to verbal assurances provided by healthcare professionals and/or interpreters themselves. Written as well as verbal dissemination of information on patients' need for interpreting services and their right to these may be a key factor. Diamond et al. (2010, p. 1083) found that fewer than half of the 135 surveyed hospitals in the US provided information on patients' right to interpreting services, which they saw as a cause for variable levels of awareness of this right amongst samples of NELP patients in US public healthcare facilities (Flores et al., 2008; Whitman & Davis, 2008). The high rate of awareness recorded amongst informants in this sample points to the effects of public awareness campaigns of the right to and availability of interpreting services (incl. in commonly spoken LOTEs) and/or the use of interpreting services as a lived experience of large numbers of informants.

The reported use of interpreting services for any kind of health service was very high – 91.8%-95.4%. Frequency and regularity of use of these services were not elicited. However, the greater overall proportion of those who nominated professional interpreting services compared to those who (sometimes) relied on family members suggests that a substantial proportion of healthcare interactions that these NELP informants were party to were interpreter mediated. Thus, the use of interpreting services was reportedly widespread but not uniformly high, and it is possible that, as stated above, variation in use was determined by features such as availability, setting, time of day, preferences for onsite or remote interpreting, etc. In some US-based studies, low to moderate levels of use of interpreting services in clinics and hospitals were recorded by López et al. (2015) and Benda et al. (2019), while Schenker et al.'s (2011, p. 712) study of 234 NELP in-patients recorded that use of professional interpreting services varied from 14% to 17% depending on interaction type. In that study, most instances of linguistic discordance were 'addressed' via the use of bilingual family members, hospital staff or by trying to 'get by' in limited English. In addition to the variable rates of use of interpreting services amongst GPs mentioned above, very low or even zero use was recorded in studies that examined interactions of pharmacists and NELP patients, even in hospital-based pharmacy outlets (Chang et al., 2011; Kotovicz et al., 2018; Phokeo & Hyman, 2007). It is possible that those informants who reported variable rates of use of interpreting services did so due to their experience of using interpreting services in some settings, but not in others.

Nearly 65% of informants reported that it was healthcare professionals (including GPs via information shared with Northern Health) who requested interpreting services for them. This data reported by NELP patients suggests a widespread and high degree of ability amongst healthcare professionals to recognise the need for interpreting services and the ability to secure the same. It is not clear whether these services were requested despite the reticence or reluctance of patients, nor can we conclude that the ability to recognise and secure interpreting services is universal amongst all healthcare professionals that informants encountered. On the other hand, this statistic also means that, if information from GPs or other referring healthcare professionals did not mention the need for interpreting services, then the need (and securing) of interpreting services may have happened only at presentation to Northern Health, or even subsequent to an initial OoS during which it was evident that interpreting services would be needed for further OoSs. As a result, some informants may have gone without an interpreter for their first OoS.

The reported high level of staff members as the initiators for the need for interpreting services is reflective of what some other studies report. As

Vandervort and Melkus, (2003, p. 363) wrote: "… clinics relied on front office staff and nursing triage personnel to determine the need for interpreter services and to inform the clinician". This raises the question whether, given that 85% of informants of this sample reported knowing that they had a right to free interpreting services, why did they report that they were the initiators of these services in only 35% of OoS? It is not clear whether the knowledge of free interpreting services was learnt before presenting at a healthcare facility (via LOTE publications and through other channels) and perceived as a general right that applied to them and did not require pre-notification from them. Or it may be that this knowledge was learnt based on experience at healthcare facilities where others had been responsible for providing them with this service in the first place.

Knowledge of interpreters being bound by an ethical code was claimed by 57.1% of informants. A substantial proportion of the informants, 42.9%, did not know that interpreters must abide by ethical principles. One of those principles is confidentiality, i.e. the knowledge that information shared with an interpreter will remain confidential, which is the basis for trust that a patient needs to have when confronted with a person usually unknown to them, such as the interpreter. Confidentiality is not the only professional practice that patients rate as highly desirable. For example, a high level of accuracy (Rosenberg et al., 2008), a high level of confidence that the interpreter will convey everything to them and from them (Jacobs et al., 2007), and a position of neutrality with the absence of "any value judgement being made" (Hadziabdic et al., 2009, p. 464) are qualities that patients have reported valuing positively in interpreters. All of these are instances of principles contained in ethical codes for interpreters, including the AUSIT Code of Ethics (2012), i.e. confidentiality, accuracy, competence and impartiality. Further principles include professional conduct, clarity of role boundaries, maintaining professional relationships, professional development and professional solidarity. NELP patient knowledge of the individual principles was not elicited.

As stated in Section 2, the development of ethical codes has been seen as a milestone marking the professionalisation of interpreting. This development of ethical codes has been accompanied by the assumption that interpreters, familiar with the code of ethics that applies to them and knowing that they are obliged to abide by it, will act in an ethically responsible way while working professionally. Interpreters' observance of ethical principles is perhaps assumed to have the effect that others around them, in particular, the users of interpreting services, will *recognise* interpreters' ethical practice as such and *infer* from this that interpreters have a code of ethics that guides their behaviour. Thus, it is by implication that the users of interpreting services are perhaps thought to 'know' that interpreters have a code of ethics. However, there has been little 'outward-looking' research to see if users of interpreting services hold this view (Costa & Briggs, 2014; Ozolins, 2015; Sleptsova et al., 2014). The percentages from the 2016 iteration of the survey showed that over half of the informants did not know that interpreters were bound by ethical standards. However, the responses showed a progressive increase in informants' level of awareness that interpreters are bound by a code of ethics. This may, at least in part, be due to an increase in the proportion of OoS being attended to by in-house interpreters whose explanation of their role to patients (as well as healthcare professionals) includes mention that they observe, amongst others, the ethical principles of confidentiality, impartiality and accuracy (Beagley et al., 2020).

6. Conclusion

Residents with a non-English language preference constitute a substantial proportion of the Australian population. This study has examined the self-reported ability of a cohort of NELP patients to communicate directly with healthcare professionals and their use of professional interpreting services. Our cohort of NELP patients includes recently arrived as well as long-standing residents. The limited ability to communicate effectively with English-speaking healthcare practitioners calls for intervention, here often but not exclusively provided by professional interpreters. The provision of professional interpreting services is a consequence of policy-based guidelines as well as the operationalisation of these policies that advocate the ready (self) identification of a NELP patient. Patients' knowledge of free professional interpreting services is high, and yet it is more often the healthcare professional who identifies and enables the provision of interpreting services. Knowledge of a right to service is a prerequisite for patients to know how to request this service. However, this knowledge alone does not translate into high levels of patients consistently requesting this service. Informants' limited proficiency in English is likely to be a barrier to their ability to request these services. The ability of healthcare professionals to identify linguistic discordance and the capability to apply cultural competence skills to offer healthcare services in the preferred language of the patient is required for them to be the protagonists who can ensure the provision of interpreting services.

Alongside this circumstance is the practice – sometimes occasional, sometimes frequent – that some NELP informants attempt to have family members linguistically broker for them, an occurrence that Crezee et al. (2024) also report on. Such family members appear to be 'pressed into service' and may serve as ad-hoc mediators for the initial stages of an interaction that is subsequently mediated by a professional interpreter after the identification of NELP status and sourcing of the latter. The presence of a family member, who may occupy multiple roles – from chauffeur and chaperone to support person, from co-narrator of the patient's medical history to linguistic mediator – can allow the patient to have the belief that the family member can take on this latter role, especially as they are likely to have a high level of trust and confidence and a belief that they will advocate on the patient's behalf. This contrasts with the variable level of knowledge that patients have about the (sanctioned and formalised) role that the interpreter occupies, which includes observing confidentiality and other principles such as impartiality, linguistic competence and accuracy. It may be that public messaging in LOTEs about the availability of interpreting services and about the rights of NELP patients to these services is having the effect of increasing informants' awareness of interpreters in general. Moreover, it may be informants' knowledge of what interpreters do – either through personal experience or anecdotally – that brings about this effect. In fact, our study showed a modest but steady increase in informants' awareness of the role of the interpreter as well as their functions and obligations over the three iterations of data collection point to.

We would like to see further studies that centre on NELP patients and their responses. This could include studies with data samples based not only on reported behaviour but also on observed behaviour. Where the presence of a professional interpreter becomes more common and recurrent, this may influence the way that NELP patients view them; notions of them as a compatriot or linguistic conduit may give way to ones where interpreters are viewed as key enablers of access to healthcare services, subject to similar occupational and ethical standards as healthcare professionals are.

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