Cross-cultural communication barriers in health care


Abstract

Aim To investigate healthcare professionals’ perceptions of caring for people from ethnic minorities with poor or no English language skills when accessing health care.
Method Semi-structured interviews were carried out with 34 healthcare professionals to identify their perception of barriers encountered by those with poor or no English language skills.
Findings Five main themes were identified in relation to barriers in accessing health care: language; low literacy; lack of understanding; attitudes, gender attitudes and health beliefs; and retention of information.
Conclusion It is essential that all individuals are able to interact effectively with healthcare services. New and innovative approaches are necessary to meet the needs of people from ethnic minorities accessing health care.

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Keywords

Communication, culture, ethnic minorities, healthcare delivery, research

Background

The ethnic make-up of the UK population is affected significantly by international migration and becoming increasingly diverse (Rees et al 2011). This will have significant implications for the planning of future community services, economic goals, social cohesion and the nature of British culture. Trends confirm that between 2001 and 2009 the greatest estimated annual population growth in the UK was from China, the African Commonwealth (Zimbabwe, Somalia, Eritrea and the Republic of Congo), A8 Countries (those that joined the European Union (EU) in...
2004 – the Czech Republic, Latvia, Estonia, Hungary, Lithuania, Poland, Slovakia, Slovenia) and the Indian subcontinent (Rees et al 2011). This includes many countries where English is not the first language and some in which education is neither free nor mandatory.

In health care, language and literacy barriers adversely affect clinical effectiveness, medical decision making, medication adherence, and patients’ understanding of and access to services; in addition, most people are unwilling to admit to problems with language and literacy (Safeer and Keenan 2005, Katz et al 2006, Amalraj et al 2009, Ngoh 2009, Salazar 2010). Although doctors may avoid using jargon to counter language and literacy barriers, patients with language and literacy difficulties are more likely to be hospitalised (Safeer and Keenan 2005).

Pharmacist-patient counselling can improve medication adherence, but may not always be possible due to the heavy workloads in pharmacies (Raynor 1992, American Pharmacists Association 2004). Cultural variables in people’s perceptions and language are significant and may affect their behaviour (Jylhä 2007, Rau et al 2008).

Differences in interpretation are important, particularly where safety is a concern (Crilly et al 2008). Different cultural approaches (Hofstede and McCrae 2004) can influence how patients make decisions; for example, some may adopt a collective approach by consulting others or relying on family or friends, while others are more individualistic and make decisions on their own.

Despite facilities provided by the NHS, some first-generation ethnic minorities from the Indian subcontinent have cited difficulties in using healthcare services (Taylor et al 2010, 2011). Taylor et al (2010, 2011) investigated whether these individuals encountered any difficulties in using services and products designed and delivered in the UK. Those facing difficulties were predominantly female, had poor or no English language skills, and included long-term residents and recent arrivals to the UK. The problems cited included an inability to communicate needs directly to healthcare staff and the stress caused by not understanding what was happening in the healthcare environment.

Taylor et al (2010, 2011) noted that individuals’ poor English language skills were influenced by several contextual factors. These included not understanding the benefits of learning English; increasing needs associated with ageing; the expense of education in their country of origin; cultural factors, such as reliance on family; and intra-cultural negative attitudes from some males towards their female relatives learning English.

To improve patient experience, Wensveen (1999) suggested that it is not sufficient to design services that function well, but to ensure positive experiences for those who use and provide such services. However, this requires a reasonable degree of communication and, as Sanders and Dandavate (1999) recognised, the experience of communication requires an equal measure of contribution by the communicator and recipient of information, together with an understanding of the recipient’s comprehension and interpretation of the information. Therefore, increased awareness is required of the complex nature of human beings during the act of communicating (Boisaubin and Winkler 2000).

However, Rau et al (2008) advised caution against mistakenly ascribing differences in people’s goals or psychological variables to culture.

**Aim**

The aims of the research were to investigate healthcare professionals’ perceptions of caring for people from ethnic minorities with poor or no English language skills, particularly patients from Pakistan, India, Bangladesh, Nepal and Sri Lanka. It sought to determine whether patients encountered any barriers when accessing health care and, if so, the effect of this. The research aimed to identify whether there was an opportunity to adopt a more inclusive approach to designing aids or procedures that might help to reduce any barriers and contribute to improving the patient experience.

The research involved posing several questions, including:

- What were participants’ perceptions of caring for people from ethnic minorities, particularly those from the Indian subcontinent with poor or no English language skills?
- Did people from these backgrounds encounter any barriers, including language?
- Did other patient groups share similar difficulties?
- What was the effect of these barriers on workflow?

The research was guided by Evans et al’s (2002) empathic approach, which proposes understanding problems holistically by not making assumptions and involving as many stakeholders as possible. It was also guided by Storey’s (1999) and Castells’ (2000) perspective of the dynamic nature of cultures – people make culture through everyday living and social activity, and cultures are constantly changing and affected by context.
Method

An inclusive design approach was adopted to consider the needs of the widest range of users without the need for adaptation. In-depth, individual, semi-structured interviews lasting 40-45 minutes were carried out, using open-ended questions to encourage a full and meaningful response. Participant information emphasised that there were no right or wrong answers, participation was voluntary, no preparation was required and data were anonymised.

Purposive sampling focused on six healthcare professionals’ roles: physiotherapists, paramedics, doctors, nurses, pharmacists and receptionists. Inclusion criteria required participants to have experience of caring for people from ethnic minorities with whom they did not share a common language, particularly patients from the Indian subcontinent. Five healthcare organisations participated: two acute care, two primary care and an ambulance service from two counties in the Midlands.

The regional NHS research ethics committee and five research and development departments approved the research proposal, ethics documents and interview questions, and five NHS managers provided oversight. Certificates in good clinical practice and informed consent were gained and a research passport was compiled, including clearance from the Criminal Records Bureau. The study was conducted between September 2010 and March 2011. Departmental managers were provided with information packs and their permission was obtained to approach staff for inclusion in the study. The study information was distributed by hand in departments and/or by emails from managers, and interviews were conducted at healthcare sites or in residences. All 34 participants in the study signed informed consent forms. The interviews were recorded and the first interview was used to pilot and adjust the methodology.

Data were transcribed and grouped under themes as they emerged. The data were analysed thematically in Word 2007, and then formatted and refined in Excel 2007.

Findings

The participants included 20 females and 14 males, aged around 25-60 (the age of the participants was not requested). They included seven doctors, 11 nurses, four paramedics, five receptionists, three pharmacists and four physiotherapists. Some of these professionals were managers, but they were grouped with their respective professional role for the purpose of the study. Two volunteers were defined as second-generation ethnic minorities who met the inclusion criteria and were included to provide a broader perspective. Participants worked in various clinical areas, which were emergency departments, outpatients (including fracture clinics), an assessment unit, orthopaedics, stroke and older people’s care, gynaecology, oncology, pharmacies and receptions.

Except where other patient groups are specified, the findings focus on participants’ views on caring for adults from the Indian subcontinent with poor or no English language skills, and their families. To ensure an understanding of the patient’s context, participants were asked to clarify the generation of the patient or family, for example first or second-generation.

The principal findings are divided into two main categories: difficulties experienced and effect on workflow.

Difficulties experienced

Five overlapping difficulties were identified:

- Language barriers.
- Low literacy and anxiety.
- Lack of understanding.
- General attitudes, gender attitudes and health beliefs.
- Retention of information.

The proportion of patients from the Indian subcontinent who were cared for by participants in the study varied between 10% and 65%. Participants’ views of difficulties experienced by patients and the effect this had on their work varied considerably between departments. Some difficulties, such as communication barriers and anxiety, are common among indigenous patients, but are attributed to low literacy, dyslexia, infirmity, or various degrees of visual and/or hearing impairment.

Participants also experienced language barriers with other ethnic minority groups, including people from eastern Europe, Russia, France, Italy, China, Somalia and other African countries.

Language barriers

Participants prided themselves on resolving problems; however, for most, language barriers were the main obstacle in eliciting an accurate medical history, explaining and gaining pain scores, communicating reasons for patient transport delays, arranging appointments by telephone, explaining medication and side effects or diagnosing and communicating problems. One participant summed up the reason this interpretation was important:

‘Communication is 99% of our job’ (Nurse 5).
Physiotherapy for patients on older people’s care wards was delayed until visiting times so that family members could interpret information and tell the patient what the physiotherapist wanted him or her to do. Some participants observed that old and young first-generation females were particularly affected by language barriers, along with some males:

‘I don’t know why I haven’t thought of this before; we’re also talking about the younger generations because people come to the UK for marriage and all sorts of reasons, with language barriers’ (Paramedic 2).

Participants sympathised with patients who struggled to express their needs, but were confused over why even those who resided in the UK for a long time had not learned English when it was so important to their wellbeing. However, assuming it was a cultural issue, they said nothing for fear of causing offence:

‘Even common conditions like constipation require drawing the shape of stools. The problem is no one has pushed them to learn English – without it they don’t know to ask, or what’s happening around them’ (Doctor 5).

‘Some patients can look confused all the time and it is unclear whether this is because they do not follow the medical problem or the language’ (Doctor 7).

Nurses in outpatient departments cited difficulties when doctor-patient conversations were not conducted in English. In these cases, nurses had to ask the doctor to repeat the diagnosis in English and then find someone to interpret or explain this information to the patient. However, eight participants felt they had no problems or only occasional problems because the tasks they carried out were relatively simple, assessment was quick, they saw few ethnic minority patients, or communication with patients was absent or minimal, for example in pharmacies.

One pharmacist used interpreters or family support to check the progress of patients and to explain medication when working in the oncology department. However, conversation with patients was minimal in pharmacies because of time constraints and heavy workloads. Pharmacists stated that they assumed patients knew how to take medication because repeat prescriptions were frequently dispensed and the patient’s doctor had provided them with information or they had help at home:

‘There is no conversation at the moment, to say either they’ve got a problem or I’d like to help you find a solution. One hopes that information has gone into the patient and what we put on the label is a simple reminder, otherwise they’re just remembering and that could be dangerous’ (Pharmacist 3).

All medication was dispensed labelled in English. When asked whether labels should be in other languages, one pharmacy manager was adamantly against it, stating that English was essential to ensure he knew what he had dispensed. Medication was also prepared in Dosette boxes for patients – as required by the Equality Act 2010 – to make it easier for them to remember to take their medication and to confirm, visually, whether or not they had taken the dose for the time of the day:

‘Visually, it looks much easier than popping something out of a blister or opening a bottle and taking something out and reading a label’ (Pharmacist 3).

However, patient confusion about how to take medications is not limited to people with poor or no English language skills and problems are common among older people. Dosette boxes prepared for a fee also presented problems in terms of a lack of time, while selling boxes to patients to fill themselves was viewed with anxiety:

‘We can’t take everybody on, there’s a capacity problem. Patients can get medicines mixed up very, very easily’ (Pharmacist 3).

Only one doctor was optimistic that language barriers were a passing phase:

‘I think language barriers are a passing phase and that people coming to the UK will know English or will learn it’ (Doctor 4).

Low literacy and anxiety Low literacy among some patients was a problem. However, 17 participants felt that low literacy was easily overcome because they relied on patients’ families to interpret and relay information to patients. Nonetheless, one participant observed the long-term nature of the problem:

‘In the long term, the problem is how to take medication or to read literature on the procedures’ (Doctor 7).

One doctor in primary care felt low literacy meant patients were unable to articulate problems
accurately and more time was required for explanation, with information often having to be repeated several times. There was also concern for patients’ wellbeing:

“They don’t know their rights – that they could ask the local council for assistance if they are ill or old, or get help from social services for a care worker” (Doctor 5).

One doctor also observed that low literacy resulted in a lack of confidence across cultures, including patients with poor or no English language skills, and some indigenous older and teenage patients who preferred their doctor to select their treatment. One physiotherapist on the older people’s care ward echoed this concern, stating that some ethnic minority families waited until crisis point before seeking help. He also noted that a growing number of older first-generation females with poor or no English language skills were living alone and had difficulties coping:

“Some of the elderly female clients that we see, often they will be living alone, certainly with females living a lot longer than males. Often they are very vulnerable because they’re on their own – and yes, they may have family support, but often that’s not there. And this is certainly true in ethnic minority groups as well as the general population” (Physiotherapist 2).

For one pharmacy manager the difficulty was that determining low literacy needs based solely on appearance could be offensive:

“What I would benefit from is someone saying clearly, and with authority, what those patients’ needs are” (Pharmacist 3).

Receptionists commented that some patients made excuses about filling forms in outpatient clinics and nurses had to be called to help. Patient difficulties appeared to arise from poor or no English language skills, possibly low literacy, poor vision, dyslexia, arthritis or other frailties. Patients were not sent forms with questions about their condition with their appointment letters and when asked whether this would help to prevent problems with form filling in the clinic, outpatient receptionists agreed that it would give patients more time to get assistance to complete forms.

Receptionists at the main reception noted fear and anxiety among patients about finding various departments, particularly when these were in the hospital grounds outside the main building:

“She had no knowledge of English, or Hindi, we showed the map to tell her… We tried to show her the direction and she was scared she might go somewhere else” (Receptionist 2).

Lack of understanding Lack of understanding was recognised to be a cross-cultural problem cited by the majority of participants. Some first-generation females, who did not understand the role of professional interpreters, were said to consult the interpreter when offered a choice of treatment during physiotherapy, for example asking:

“What would you do?” Many females equated physiotherapy to a massage at hospital, requiring the notion of exercise to be explained before therapy could begin. This problem was alleviated if physiotherapy was related to yoga.

One reception manager (a second-generation, ethnic minority participant) worried that some families cancelled appointments without realising it could mean waiting several weeks for another, and that there was a lack of understanding about the purpose of ward procedures:

“They don’t grasp why the hospital has condemned crowding around a patient’s bed – the infection reasons, the restriction reasons. Why they say ‘no’ to bringing children. Why is the patient in the side room? Why have you got a gown on? Why it’s not suitable for them to keep bringing things in’ (Receptionist 3).

Some paramedics felt first-generation ethnic minorities did not understand their role and there was general agreement among participants that the public, across cultures, did not understand healthcare services. People used the emergency department inappropriately and 30-35% of calls to paramedics were unrelated to emergencies, although this was more common among indigenous people.

Nurses in emergency departments experienced difficulties during wound cleaning as some people from ethnic minorities used remedies such as turmeric on wounds, or toothpaste or oil on burns:

“A big problem is the management of burns. Application of toothpaste was common when I worked in Birmingham – and it is also fairly common here to find toothpaste applied to burns and scars. It’s not a good idea, you have to take it all back off again. They need to know how to cool it with water and use lint free dressing, cling film perhaps…Turmeric is a popular one as well, on cuts and grazes” (Nurse 7).
Some pharmacists recognised non-adherence to treatment as a problem experienced by all people, not only those with poor or no English language skills. Patients took medication at the wrong time of day or stopped their medication if they were concerned about the side effects without consulting a doctor or pharmacist:

‘Sometimes people don’t like taking things [tablets] because of the side effects that they have: some medicines keep you awake at night and maybe patients are taking them too late in the day so they can’t get a good night’s sleep. All those things can cause re-admissions you see, because they’ll stop taking them’ (Pharmacist 1).

General attitudes, gender attitudes and health beliefs Fourteen participants cited problems with gender attitudes, resulting in interpretation problems, wasted appointments or time and uncertainty over informed consent. Appointments were wasted in small outpatient clinics if staff’s gender preferences were not known in advance and if male family members, particularly Muslims, refused to allow a female patient to be examined by a male doctor even if a female nurse was present. It was frequently unclear whether the patient or family member was objecting to the examination. Other examples of gender attitudes influencing the delivery of health care included one first-generation husband refusing paramedics entry to the house even though his wife made the call, and a second-generation son refusing to discuss his mother’s condition with a female ward sister and insisting on speaking to a male consultant.

Female patients were more likely than males to get physiotherapy exercises right because they asked and repeated exercises several times, while over-confident males could hinder the process by reinterpreting or misinterpreting the physiotherapist’s instructions during translation. For one second-generation ethnic minority participant, some in her community were more demanding of services and less helpful:

‘Even if they’ve got families at home who can help to translate, they will say they’ve got nobody and some just take the NHS for granted. It doesn’t matter, they’ll sort it out… patients and families need to meet us half way: we’re trying to make their life easy, but if they give us all the obstacles: we need a translator, we need this, we need that, then we’re actually going through a lot of hurdles’ (Receptionist 3).

Participants cited other cultural factors, including religion and fear of offending patients as barriers to delivering care. Paramedics were expected to take off their shoes at a place of worship in emergencies by some ethnic minorities and found it confusing whom to address first: a female patient or a male family member. Some problems were beyond language, and correct diagnosis depended on understanding a patient’s comments in the context of his or her culture and health beliefs. This affected how patients perceived their problem. One participant commented that a patient attributed his illness to ‘a bad spirit’, which could have resulted in misdiagnosis:

‘If we hadn’t found someone from the same culture, he could have been sent to psychiatry’ (Doctor 7).

Retention of information Information retention was a cross-cultural problem for many patients. However, 21 participants said it was not a problem because they relied on family members to ensure that patients remembered information. One doctor commented that people of all cultures, when under stress, recalled only between 15% and 40% of what they were told. He suggested that the best way to get a message across and remembered was to talk to another person within the hearing of the intended recipient, for example to a mother while the child was listening or vice versa:

‘You often absorb more of a conversation that you are listening in to rather than the conversation you are taking part in… and one of the best ways to get information across to the child is to tell the parents and I am well aware that the child is absorbing what I am saying… Then I will check with the child to make sure that they have heard it’ (Doctor 3).

There was concern that too many hospital re-admissions arose as a result of patients not remembering instructions and adhering to medication regimens, with some devising their own strategies, such as using the tablet colour, for taking medication:

‘She knows she has to take the pink one at night’ (Pharmacist 1).

Some patients took another dose if unable to recall taking the first or mixed up medications:

‘The patient has got their tablets all mixed up – because patients come in and, literally, they’ve taken a strip of medicines out of one packet and put them in another packet or they’ve mixed...
them all together and you just think... how on earth did they do that?’ (Pharmacist 1).

In an initiative to reduce re-admissions, one hospital had begun telephoning oncology patients at home to determine how they were coping with the medication regimen.

**Effect on workflow**

The majority of participants felt that providing care for patients with poor or no English language skills affected the time required to deliver care, as well as the volume of work and costs, for example in relation to providing interpreters, and that barriers added to patient stress. Doctors and physiotherapists agreed that language barriers necessitated additional time to explain and carry out therapy:

‘I have to spend more time obviously, so it’s becoming more time consuming, which puts me under pressure’ (Doctor 5).

This was also responsible for increasing waiting times for other patients and affected target response times.

Wasted appointments or wasted time also affected workflow:

‘We could have offered that slot to somebody else who could have needed that translator – regardless of whether they come or not, we’re still paying for a translator. I don’t think some ethnic minority patients from the Indian subcontinent fully understand how much effort we go to make the arrangements for them’ (Receptionist 3).

However, there was unanimous agreement that ensuring all patients accurately understood information took precedence over cost:

‘I’ve only got half the stuff done – but it’s better to have what I’ve done accurate than to rush through things and not get it done properly’ (Physiotherapist 1).

Language barriers were common among many ethnic minority groups and some of the difficulties cited were also shared by indigenous patients. Participants’ comments and approaches suggested they dealt with problems as best they could, and that their focus was on delivering safe and effective care. Therefore, problems posed by patients with poor or no English language skills did not exceed the problems posed by other patient groups.

Inter-cultural differences were identified. Participants largely followed an individualistic approach to care, focusing on patient preference, while some ethnic minorities followed a collective approach, relying on family or consulting the interpreter when making decisions. Several findings agreed with the literature. Language barriers were cited predominantly among females, including those who had resided in the UK for a long time (Taylor *et al.* 2010, 2011). Low literacy and language barriers resulted in patients not understanding the healthcare environment, requiring that healthcare professionals adopt strategies such as limiting and repeating information (Safeer and Keenan 2005, Katz *et al.* 2006, Amalraj *et al.* 2009, Ngoh 2009, Salazar 2010). Pharmacists confirmed that communication with patients was minimal or absent because of heavy workloads in pharmacies (Raynor 1992, American Pharmacists Association 2004). Ways of improving understanding among patients and families and encouraging more pharmacist-patient communication in primary care, in particular, merit consideration to aid workflow and reduce concerns about hospital readmissions as a result of non-adherence to medication regimens.

While participants found solutions, the obstacles posed by language barriers have to be addressed repeatedly across healthcare services throughout such patients’ lifespans. Although family members were relied on, patients needed constant interpretation support, and language barriers adversely affected patients’ wellbeing and daily living, disempowering them and minimising social integration.

The findings of this study and previous literature (Taylor *et al.* 2010, 2011) confirm that many existing residents had not learned English and their needs were likely to increase with age (Safeer and Keenan 2005). The greatest recent population increases in the UK have been from countries where English is not the first language, and it is difficult to predict how many of these new residents would know or learn English. Therefore, there is a need to improve patient awareness, empower patients and engage with them positively to improve healthcare delivery.

As Sanders and Dandavate (1999) recognised, all stakeholders, both staff and patients, need
to contribute equally to the experience of communication, and it is possible to achieve this through one or more of three options. Society could accept the ongoing interpreter and translation costs for the myriad of languages; family involvement could be increased, even though there are associated problems as previously discussed, and patients would still need interpretation support; or communication in English could be promoted and encouraged in new ways. For example using visual communication aids to encourage more direct patient-staff communication and providing assistance for patients to learn English at home, with an emphasis on health care. Promoting English may be the most beneficial, empowering, sustainable and cost-effective option for patients, families and healthcare providers.

Although participants attributed patients’ poor motivation for learning English to cultural factors, Taylor et al (2010, 2011) noted that many contextual factors influenced individuals and families, such as not understanding the wide and long-term benefits of learning English or the increasing needs associated with ageing. It is essential to raise awareness of the benefits of learning English and reduce potential intra-cultural impediments, thereby improving motivation for learning and improving the patient experience.

Low literacy was perceived by participants to be less problematic in acute care because participants mainly relied on the patient’s family to explain the situation to the patient. This was, however, contrary to the literature (Johnson 2004, Safeer and Keenan 2005, Katz et al 2006, Amalraj et al 2009). Low literacy was linked to anxiety and a lack of confidence among patients, for example in terms of finding departments, selecting treatment, asking for help or completing forms. The suggestion of making information about patients’ needs available electronically to authorised staff, including pharmacists, across healthcare services may be helpful and merits consideration. Knowledge of language barriers and poor literacy could help to improve workflow and staff-patient interactions. Patient forms posted with appointment letters could give patients more time to get help and support to fill out such forms, if necessary.

Difficulties related to unhelpful attitudes, gender-attitudes and health beliefs of patients and their families were identified. A lack of understanding in some areas was more common among first-generation ethnic minorities, such as the role of paramedics and the need for particular procedures to be carried out. However, some problems were also identified among the indigenous population, such as reasons for delays in clinics, and inappropriate use of paramedic services and the emergency department. Some males inadvertently hindered healthcare delivery by misinterpreting information instead of seeking clarification. Some male gender attitudes also caused difficulties, particularly in relation to male family members refusing to allow male doctors to examine female relatives.

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Implicit in participants’ comments was the need to improve people’s understanding, which merits some re-consideration of information given to patients before and after appointments. Retention of information was a cross-cultural problem: patients were said to have difficulties recalling information under stress even when they had a good grasp of the English language, and participants confirmed that they relied on patients’ families to ensure those who did not understand adhered to treatment at home. However, this may compromise patients’ privacy, especially in relation to sensitive medical issues.

The main limitation of this research was that the sample was small and the focus was on one segment of healthcare staff and one ethnic minority group. More participants were sought, but recruitment difficulties and time constraints made this problematic. Future research might consider a larger and more diverse sample of healthcare professionals, and different ethnic minority groups and geographic areas.

Conclusion

The findings of the research suggest that improving the patient experience for people from ethnic minorities with poor or no English language skills is somewhat dependent on improving staff-patient communication. Although interpretation will always be necessary in an era of international travel, in the long term, learning English could help to empower patients and improve their healthcare experiences and wellbeing through improved communication and understanding. Therefore, investigating opportunities to promote and encourage learning of English merits consideration.

Implications for Practice

- Language barriers remain an ongoing obstacle in health care despite the significant resources expended in this area. New approaches to deal with language and literacy barriers are necessary to improve the patient experience.
- Some ethnic minority families lack awareness of the role of professional interpreters and particular healthcare professionals, and the need for certain procedures. Providing information on these areas before patient admission, for example, may help to prevent misunderstandings and patient anxiety.
- Enabling staff across healthcare services to access authorised information about patients’ needs, for example via electronic patient records, could help save time and enable staff to take appropriate action.
- Some ethnic minorities follow a collective approach to decision making. Emphasising to families, in advance, that the patient’s preferences are essential to ensure successful treatment and adherence is important.
- Promoting learning of English in those with poor or no English language skills is essential to ensure that these patients receive the best possible care and can take advantage of healthcare opportunities and support in the long term.

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