Hot Topic

Why are some voices not heard? Exploring how maternity care can be improved for women with limited English

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Abstract

There is a robust body of evidence, accumulated over decades, which shows that limited English proficiency is a key factor associated with poorer maternal and neonatal outcomes. Our work as midwives and researchers has led us to believe that this is a complex, multi-dimensional issue, which we explore in this article.

We discuss challenges of interpreter use by clinicians and with current interpreting service provision. We propose a range of solutions to improve care for this group of women. Finally, we argue that language must be viewed as an independent variable in research, as it is often conflated with, or hidden by, wider discussions of ethnicity and migration status.

We hope this article will illuminate the challenges of providing high-quality care for women with limited English proficiency and set out a clear road map for reducing this continued inequity.

Language as a key determinant of maternal health

The Confidential Enquiry into Maternal and Child Health (CEMACH) report *Why mothers die 2000–2002* noted that '*there is a particular risk for women … who have little or no command of the English language*' (Lewis 2004:251). Nearly two decades later, these findings were mirrored by the most recent MBRRACE-UK report and the Healthcare Safety Investigation Branch (HSIB) report into intrapartum stillbirth during the COVID-19 pandemic (Knight et al 2021, HSIB 2021).

Women with limited English proficiency face a range of challenges to access timely, high-quality maternity care: for example, initiation of routine maternity care can be delayed as women might find it difficult to book appointments and understand referral pathways, and telephone triage services often rely on the ability to speak English (Cardwell & Wainwright 2018, McKnight et al 2019). Without accurate communication with maternity care professionals during consultations, there is a risk that vital information will be missed and that informed consent cannot be achieved (Birthrights & Birth Companions 2019, Bridle et al 2021).

In recognition of these issues, and in order to protect women and ensure equitable access to medical care, National Health Service (NHS) and National Institute for Health and Care Excellence (NICE) guidelines direct staff to use an external language provider for women with limited English (NICE 2010, NHS England 2018). Indeed, the availability of telephone interpreting services means that clinicians should have access to interpreters 24 hours a day, in any setting and at a cost incurred by the trust/board.

With full access to interpreters — albeit often by phone rather than in person — and clear guidance that they should be used, the reasons why outcomes remain poorer for women with limited English are therefore not immediately apparent. One explanation of why communication needs remain so poorly met is that research frequently fails to analyse language needs in isolation from other variables, such as migrant status and/or ethnicity.

Why does the inequity in outcomes remain?

In this section, we critically analyse two aspects of current service provision which we believe are central to the issue: first, assessment of proficiency in English and the subsequent engagement with interpreter

support; and, second, challenges with the use of interpreters.

Multiple reviews of adverse maternal and neonatal events reiterate a common theme: despite a lack of proficiency in English, some women are not provided with an interpreter (Cardwell & Wainwright 2018, Birthrights & Birth Companions 2019, Knight et al 2021). There are a number of reasons why this may be including that, in the spectrum of women who speak perfect English and those who speak none, there is a substantial 'grey' area. Maternity care professionals currently receive no training on how to assess English language proficiency. This very likely leads to clinicians assuming that women have more advanced linguistic skills than they do, particularly if women are diffident or appear to have stronger speaking ability than comprehension. In other cases, a clinician may rely on a woman's own assessment of whether an interpreter is necessary. While this may enable autonomy and facilitate choice, some women may underestimate their own language needs particularly with regard to medical terminology. Bhatia & Wallace (2007) note that women may also refuse an interpreter because of concerns about compromised confidentiality. Conversely, women have reported being denied their request for an interpreter (Thalassis 2013).

Moreover, language difference is not always perceived as problematic by maternity professionals. Recent literature demonstrates that health professionals regularly employ a variety of communicative strategies to navigate understanding (Roberts & Sarangi 2005), with midwives excelling at reformulating information in a way that demonstrates an orientation to patient-centred care and promoting active participation (Baraldi & Luppi 2015). In addition, it may be that midwives used to a diverse patient population regularly 'get by' without incidence and are developing an (over) reliance on translation software despite a potential for unreliability (Parsons et al 2014, Cox & Maryns 2021).

Midwives work within an increasingly pressurised maternity care system: workforce challenges within maternity services are well documented (Cull et al 2020). Standardised appointment times cannot accommodate the additional time necessary for interpreted consultations so time pressures may result in reluctance to use interpreters (Phillimore 2015). Maternity professionals may also feel that having an interpreter in the room makes conversations feel impersonal, affecting their ability to form a strong relationship with women (Defibaugh 2014).

A misjudgment of women's language needs at the initial appointment can have consequences throughout the perinatal period. This initial appointment is a crucial opportunity to understand pre-existing health conditions and important medical and social history. Additionally, in many cases, interpreters are booked for further appointments based on this assessment, so there can be a knock-on effect for future care. We have also noted that, while in some NHS trusts/boards there is clear documentation when an interpreter is required (such as a 'flag'), in other systems it is less explicit, making it necessary to go back to the record of the initial midwife appointment. Furthermore, some systems don't record language spoken, but country of origin, which is unhelpful if multiple languages are spoken in that country. Although these may appear to be small frustrations, we believe they can discourage health care professionals, working within an already highly pressurised system, from using interpreters.

The use of family or friends to interpret is also problematic and there is clear guidance that this should not take place (NHS England 2018). There are a number of ways in which reliance on untrained individuals can present practical and ethical dilemmas, for example, family or friends may omit, misunderstand or mistranslate information, compromise privacy or potentially place women under duress, inadvertent or otherwise (Angelelli 2004, Flores et al 2012, Moyer 2013, Cox & Maryns 2021). Despite an established awareness of the potential for communicative errors, the HSIB report into stillbirths during the first phase of the COVID-19 pandemic (HSIB 2021) identified that relatives were frequently used to translate when women were accessing unplanned maternity care, such as attendance at the triage unit.

An additional point to consider is that of health literacy, as even among the general population who speak English as a first language, 42 per cent of adults lack adequate health literacy skills to understand and use everyday health care information (Public Health England & UCL Institute of Health Equity 2015). Written information is vital to ensure women understand and have the time to make decisions about their care, with the input of partners or family if they wish. However, even if patient information is available in a woman's primary language, it may not be written at a level of general comprehension (Public Health England & UCL Institute of Health Equity 2015).

We believe that there are shortcomings with the current provision of interpreter service. Brooks (2021) analysed 12 antenatal appointments and found that, unbeknownst to the midwife, there were frequent misunderstandings during interpreted consultations, both by childbearing women and informal and professional interpreters. This was compounded by midwives struggling to explain scientific terms clearly. There is a lack of transparency around industry-specific interpreter training, and as interpreters work across a variety of health care settings, they may be unfamiliar with the range of specific terminology used in maternity care. It is difficult to ensure interpreter

continuity, meaning women — and clinicians — have to form new relationships at each appointment. Furthermore, some languages requested prove to be unavailable: in a review into stillbirths during the first phase of COVID-19, the HSIB noted '*the ability of healthcare services to deliver interpretation services does not appear to be resilient and it may not be feasible in all circumstances*' (HSIB 2021:81).

Recommendations

In this section, we propose key actions to improve care for this group of women. We have tried to avoid insipid recommendations which overlook the complexity of the issues and instead focus on powerful measures with a long-term impact.

Creation of a specialist midwife role — improving care for women with limited English language proficiency

Central to the role would be ensuring this group of women are represented in Maternity Voices Partnerships. While the specialist midwife role itself should be developed with the extensive input of the service-user group, it is likely to include adaptation of patient information, quality improvement, and education and training for maternity care professionals.

Patient information should be adapted to ensure it is available in a variety of languages, at an appropriate level of health literacy. This could be achieved through adapting information to rely less on language by increased use of pictures — ideally pictures which explicitly represent medical conditions, such as a woman with measles or a child with Down's syndrome. Creativity should be utilised to trial alternative means of disseminating information, such as audio or video. As one example, antenatal clinics commonly have televisions in their waiting rooms, which are used to disseminate health information in addition to advertising. Space could be given for local initiatives, such as a gestational diabetes and lifestyle choices video, narrated by a local health care professional in Tamil and Urdu. Such 'grassroots' initiatives foster inventiveness in meeting the language and health needs of the community, and again can be guided by service user groups. An important aspect of the role would be relationship building with other specialist midwives nationally, enabling best practice locally to be shared.

We suggest that a useful quality improvement exercise would be auditing a sample of notes of women who were identified at booking as needing an interpreter and establishing whether an interpreter was provided at each appointment. Reviewing the results of such an audit would help identify areas for improvement: for example, languages which are commonly spoken locally but for which interpreter access is inadequate, and variation in interpreter use among clinicians. We propose that the role includes in-service training in advanced communication skills for clinicians and other client-facing staff (such as administrative and support staff). This recommendation is discussed in more detail below.

Advanced communication skills training for clinicians

We recommend that pre-registration and in-service training for maternity care professionals should include advanced communication skills. Such training should include assessing English proficiency, effective use of interpreters, and communicating directly with women where an interpreter is declined or unavailable. Crucially, professionals must be taught how to ensure effective communication has taken place, using techniques such as teach-back and chunk and check (The Health Literacy Place 2021).

The NHS has a highly diverse, multilingual workforce. However, current guidance specifies that staff should only use language skills to help patients make appointments and identify communication needs, not to translate clinical information (NHS England 2018). We believe this is short-sighted and that enabling staff to use additional language skills, where they feel confident to do so, would improve the quality of care and reduce unnecessary health service expenditure on interpreters. We advise that an NHS audit of staff languages is commissioned, so that this specialist skill can be recognised and used most effectively.

Improvement of interpreter provision

We propose that national guidelines are developed for interpreter training, support and annual review and that compliance is monitored. Such training should include medical terminology and an assessment of health literacy to reduce misunderstandings.

We recommend that efforts are made to ensure continuity of in-person interpreters as far as possible as this enables a relationship of trust to be developed between midwife, woman and interpreter and aids clear communication (see also Bridle et al 2021). Bilingual health advocates, directly employed by the local NHS trust/board, have been used within maternity services to interpret and ensure women have the information and support they need to make informed decisions about their care (Hatherall et al 2016). We suggest this approach is adopted more widely to supplement the provision of outsourced interpreters.

Consideration should also be given to the introduction of community-based bilingual doulas and breastfeeding specialists (Happy Baby Community 2021). These staff may also be able to highlight cultural insensitivities or discrimination within existing care. We acknowledge that, in smaller communities, advocates may know the woman or her family personally, and telephone interpreters may be the best solution in order to maintain privacy.

Language as a protected characteristic

NHS commissioning guidelines on interpreting and translation recognise the potential for linguistic difference to affect access to health: in specific reference to 'patients who do not speak English', there is an emphasis upon '*the need to reduce inequalities between patients with respect to: their ability to access health services; and the outcomes achieved for them by the provision of health services*' (NHS England 2018:16).

The Equality Act (2010) protects against discrimination based on any of nine 'protected characteristics', including sex, age, and disability status. Given that language concordance is seen to play an integral role in outcomes and experience, we recommend that consideration is given to designating language as a protected characteristic. We believe this would go some way to ensuring that recommendations become standards, redressing potential discrimination and legally enshrining the right for women to have access to linguistically concordant health care.

Separation of language ability as a variable within research

Migrant status and ethnicity are associated with increased risk of poor maternal and neonatal outcomes compared to non-migrant or White women (Knight et al 2021). However, these issues are rarely examined independently, and there is little recognition that limited English proficiency, irrespective of ethnicity or immigration status, is associated with poorer outcomes. Conflating ethnicity, migration and linguistic proficiency obscures the very different underlying causes for each. Poorer outcomes for migrant women are likely to be due, at least in part, to poor prior health care, deprivation and hesitance in seeking help. Ethnicity might impact care due to racism, microaggressions, discrimination or the perception that discrimination might take place. Linguistic ability, on the other hand, affects the ability of women to communicate effectively with maternity care professionals, which is required, indeed essential, for safe and high-quality care. We feel it is vital that researchers begin to analyse language needs as an independent variable, so that communication challenges are better understood and can be addressed.

Conclusion

Despite clear guidance on the use of interpreters and widespread availability of interpreting services, women with limited English proficiency continue to experience worse outcomes and report poorer experiences of maternity care.

We are not powerless to make meaningful changes. The first step in improving care for this group of women is the creation of a specialist midwife role who would work with service users to advance their interests.

It is vital that clinicians receive advanced communication skills training, and that current inadequacies in interpreter provision are addressed. Inclusion of language as a protected characteristic under the Equality Act would legally enshrine the right for women to have appropriate interpreter access.

Finally, we assert that analysing communication challenges independently from ethnicity and migrant status enables us to see that improving communication is a highly modifiable risk factor and in many cases is low-cost and straightforward to implement.

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We are a writing collective comprising five midwives (academics, educators, and practising clinicians) and a sociolinguist. This essay grew from many conversations over the last year about the challenges women with limited English face in accessing maternity care.

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