Multilingual Manchester

Report

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Multilingualism in Rusholme Health Centre

Katie Faxon
Julia Kolkmann
Daniel Smithson
Joseph Woods

University of Manchester
School of Languages, Linguistics and Cultures
Samuel Alexander Building
Oxford Road
Manchester
M13 9PL

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Introduction

This report will document our research efforts and the data we have obtained in our study of multilingualism in the area of Rusholme, and particularly the Rusholme Health Centre (henceforth RHC). It will follow the adaptations we made to the plans and methodology, laid out in the first part, review the actual research carried out, and discuss and analyse the data gathered in order to create a qualitative image of multilingualism in the context of health services in the Rusholme community. The central question this report seeks to answer is how the NHS works in partnership with local health centres to provide for (linguistic) minorities and make sure that all services are accessible.

Methodology

In order to gather information about the language policies, we intended to approach the RHC itself, look at services the NHS Manchester offered that related to language policy and, finally, to ask patients about their language experiences at a local level, in the RHC and also on a bigger scale. This was intended to be conducted by asking the patients themselves about their experiences of NHS services in Manchester that are offered in response to language barriers, our focus being the translation service.

For conducting our primary research, we surmised that the least invasive way to conduct our survey would be to leave copies of our questionnaire in the RHC for a period of around seven days. We would leave enough copies to get the amount of samples we needed to have conclusive data and a representative sample of patients (approx. 20) along with some pens and a box for the patients to leave their answers in. This would allow the patients to answer the questions without being influenced by our presence and hence would elicit more truthful answers.

This approach required us to request permission from the RHC management. We therefore attempted to make contact, and subsequently handed in a questionnaire to the receptionist to pass on to the manageress. We were told that she would not be able to view it for a number of days due to absence and that we would be contacted by telephone with her decision. The initial response seemed positive.

This cost us research time, and unfortunately the eventual decision of the RHC was that we could not conduct our survey in the health centre because they were carrying out a survey of their own in the centre at that time. Another reason was that they did not want to inconvenience or upset their patients. After seeking advice it was decided that the best course of action would be to actively encourage participation in the survey by approaching patients coming out of the RHC and asking for their co-operation.

This approach had a number of drawbacks from our original plan, the foremost of which was the possibility of an observer's paradox occurring (Labov 1972: 209) and our results not being completely indicative of reality due to the participants' answers being affected by our presence. Although our team would not judge a participant because of any answer, participants who had immigrated to the country may feel self-conscious, when telling an exclusively white survey group that they did not wish to speak English when discussing their health matters. There was also a problem because we would not be able to survey patients who have difficulty speaking English due to the survey group only being able to speak English and German. This made it likely that most of our participants would not have been aware of the NHS translation service. There was also a minor ethical dilemma due to our subjects being potentially quite ill, and getting more upset by our request than a healthy person. We would therefore have to make sure that we were not too aggressive or insistent when requesting cooperation.

Thus, to make the people we approached feel at ease and to add credibility to our appearance, we wore our University of Manchester identity cards around our necks in plain view. We also split into two groups of two so that we could be sure not to overwhelm the subjects with numbers.

Working from our preliminary questionnaire included in our first report we used advice on http://www.aapor.org/Best_Practices.htm to make it more effective. Our questions, required

mainly one word or YES/NO answers, this would have been the case whatever method we had used. This was done in order to increase the likelihood of participation and to decrease any problems caused by language barriers when interpreting data, which seemed likely considering the nature of our project.

Our first two questions revolved around basic information that may not particularly affect our data but was necessary to take down. We then had questions focusing on which languages patients used in the domain of the RHC and with different staff in the centre. This was to establish the languages used in this particular public domain, and also to see if this varied depending on who they were speaking with. We also included questions to find out if the language they used was their preferred one to discuss health matters, as this could tell us if they had to adapt, and whether or not they were comfortable with doing so.

We then enquired about the NHS leaflets, which were the element that first raised our interest in the RHC. This was to establish how multilingual patients dealt with the NHS in a non-spoken medium, and if they found it easy to do. The last part of the questionnaire concerned the NHS translation service, particularly how useful it was to those who had used it.

Findings

We visited the RHC a number of times over the course of our survey for various reasons, and observed a number of multilingual media in and around the centre. In addition to our questionnaire enquiry about the availability of such media as leaflets/pamphlets and the interpretation service, we took note of and recorded images of some examples of multilingual literature and signage, as well as the automated check-in device. Finally, we made some enquiries about what was offered by the telephone interpretation service.

Numerous examples of multilingual media were found in and around the centre, including a dual-language Urdu-Punjabi poster and an Urdu translation of a leaflet on pregnancy. The Rusholme Jewels sculpture outside the centre also featured a notice in English, Urdu, Somali and another language. In the pharmacy just outside the centre we observed a Hepatitis C awareness poster in English and Urdu. Most of the material was NHS-printed, though there were some health- or community-related publications from third parties. Though we were

unable to gain staff interviews to ask about how language policy affected the decision of which media to make available, we were able to observe, from the examples we saw while at the Centre, that Urdu was the most common language used after English.

Also of interest to our research was the automated check-in system: a computer terminal with a touch-screen interface to allow patients to check in for their appointment without going to the desk. The check-in procedure is available in ten languages, and the system has been observed in other practices. The terminals and software are the products of a company by the name of PAERS (Patient Access to Electronic Records) Ltd showing that the NHS makes provisions for languages by employing the services of outside companies to successfully provide for its language needs.

Observation of the RHC provided information about the local domain of the health centre and what services are offered. However, it is clear that it is NHS Manchester who provides the majority of these services and funding for them. Information about language policy implemented by NHS Manchester was gained through analysis of information on http://www.manchester.nhs.uk, which provided information about services offered by them which, we can assume, is in response to the large number of minority languages spoken in Manchester.

The most interesting finding with regard to language policy was information about an interpretation service provided for central Manchester, which included the area of Rusholme. The service was set up in response to the Clarient Management Consultants Report, which was commissioned by the The Manchester Race and Health Forum and is funded by the Manchester Health Authority. The aim of this report was to identify strengths and weaknesses of NHS Manchester, reviewing existing services and to recommend place for improvement.

> "The Manchester NHS Interpretation Project was set up in 2003 and was responsible for developing an interpretation service which incorporates telephone and face to face interpreting in any language and provides translation of health information."
>
> (http://www.manchester.nhs.uk/local/translation_services.html)

This shows that language is clearly something that NHS Manchester has to make provisions for in its policies and a provision that has become more necessary as more members of minority ethnic groups have come into the Manchester community. Census information taken into consideration, when finding background information about the area of Rusholme, suggested that an increasing number of various minority languages were entering the already multilingual community. This is reflected in the fact that the interpretation service experienced an increasing demand for telephone and face-to-face translation services throughout 2005/06. The information found about the interpretation service shows that it is the responsibility of NHS Manchester to respond to the language needs of the whole of Manchester and that it is not merely the responsibility of the local health centres.

What is more, the website provided information about where the interpretation service was based: Kath Locke Centre, 123 Moss Lane East, Hulme, Manchester M15 5DD. Following this, we then went on to approach the centre, predominantly via telephone, asking questions about the services. The questions found that interpreters were available in Urdu, Punjabi, Arabic, Hindi, Bengali, Vietnamese, Cantonese, Mandarin, Farsi, Somali and French, the majority of which were available for speakers of Urdu and Punjabi. It was also found that when a language was not provided by the interpretation service, outside agencies were employed, which shows that the NHS Manchester aims to provide health care for all minority languages, by employing the help of third parties. The private company Language Line Services provides telephone translation service for the NHS Direct. This suggests that the NHS language policy affects the decision to provide such services, but does not extend to determining the languages offered, this being the decision of the company they employ. On the one hand, the passing over of responsibility to a specialised translations service should ensure the translation is performed competently and reliably, and that the scope of the company's offered languages is exhaustive enough to deal with nearly any situation. From another point of view, however, it means that the NHS does not have any executive control of the services offered besides the ability to offer and terminate contracts. Should the company decide that offering a particular service or language is not profitable; the decision is out of the hands of the Health Service. However by employing outside agencies they meet the primary need of making health care accessible for patients. This way those who face a language barrier are provided with reliable translations which the NHS staff cannot necessarily do themselves.

Patients' experiences of the NHS interpretation service are aimed to be addressed through the patient questionnaire that was conducted outside the RHC. Questions aim to assess the quality of the service they received if they have an awareness of the service and have accessed it.

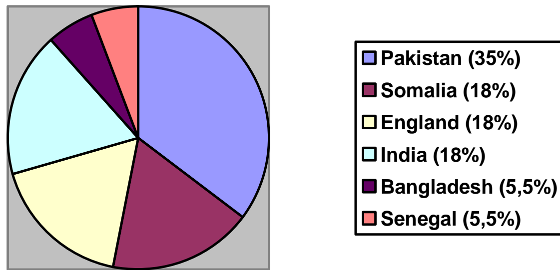
Questions were asked of the interpretation service about if any services were specifically provided for the RHC. It was found that there was a Somali drop-in question and answer session held at the centre periodically. This suggests that significant pressures might have been put upon the centre to provide for this language in the area of Rusholme and thus in the centre. The fact that the translation service has responded to this pressure suggests that NHS Manchester has general policies that have to be adopted in response to significant pressures on local health services but that generally the policy is set up at a higher level and adopted to local level rather than the RHC setting the language policy itself.

Disadvantages of the service are that appointments are hard to obtain, especially for languages that have the least provisions made for them by the service. These are usually the languages that require translation services. Appointments have to be made in advance and so for emergency health care it means that there is not a large provision made for potential language barriers. Information on the NHS Manchester website states that 48 hours notice is required to meet interpretation needs. However, information on the website is quite dated and it is possible that the reliability of the service and range of interpreters for different languages readily available has improved. Generally, the service is adequate for local health centres as the most serious matters that need to be discussed in this type of centre are likely to be appointments that are made in advance and so a translator can be booked in advance. For minor illnesses, although it would not be ideal, language barriers could be overcome by using the telephone service in the surgery. Essentially, NHS Manchester's language provisions meet the linguistic needs of patients adequately, spending a significant amount of money from a potentially tight budget.

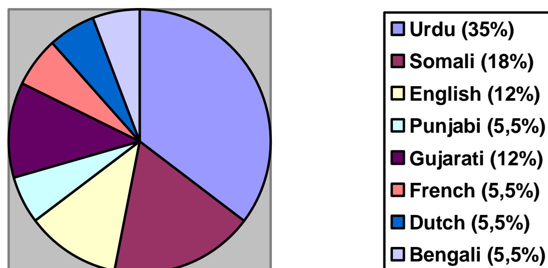
Through observation of materials in the RHC in the local domain and approaching the NHS Manchester interpretation service directly, we found information to suggest that the language policy provides adequate services for the centre, primarily provided by NHS Manchester, but adopted to the local needs of health centres. Our questionnaire intended to gain an insight into the patients' language experiences of the RHC itself and the interpretation service.

Permission problems meant that the questionnaire could not be conducted inside the RHC, and so help could not be offered to patients with the language (English) if needed. Although a sample size of approximately 20 was obtained from approaching patients outside the centre, it is felt it is not representative of the range of minority language users of the RHC or those who have used the translation service. Patients who offered responses were confident enough with their English to engage in our study, however, we did yield interesting results about what languages were used in the centre and how aware patients are made of the translation service. The responses to the questionnaire are shown below:

What is your country of origin?



What is your mother tongue?



At RHC, what language do you speak with…

- **the receptionist,**
- **the doctor,**
- **the nurse,**
- **other staff?**

English in all cases.

Is this the language you would prefer to discuss health matters in?

YES: 7 (41%) NO: 10 (59%)

Do you use any leaflets in your medical centre?

YES: 6 (35%) NO: 11 (65%)

Are these available in your language?

YES: 11 (65%) NO UNSURE: 6 (35%)

Do you know about the NHS translation service?

YES: 9 (53%) NO: 8 (47%)

Have you used the translation service?

YES: 4 (45%) NO: 5 (55%)

If so, how useful did you find it?

VERY USEFUL: 2 (50%) USEFUL: 2 (50%)

Was your language offered by the translation service?

YES: 4 (100%) NO: 0

Do you think language barriers have stopped you from accessing NHS services in the past?

YES: 0 NO: 17 (100%)

From these questions it was found that the RHC is a domain in which English is the primary language of communication between patients and staff, although 59% of respondents reported this was not the language they would prefer to discuss health matters in. This is understandable, as health issues are sensitive and people generally feel most comfortable and more able to make their problems clear in their mother tongue. Only 53% of the respondents were aware of the interpretation service and so perhaps an improvement on the part of the RHC would be to promote use of the service so that patients can gain an improved quality of healthcare rather than treating the interpretation service as just something to overcome major communication barriers that prevent access to healthcare. Yet again, though, this point confirms that the provision made in the language policy meets the need of patients by ensuring that healthcare is accessible (even if it is not to the standard the patients would like). Only 45% of the respondents who were aware of the service reported having used it, although there were mixed responses about how useful they found the service all respondents that used the service had their language provided for.

What this shows is that for patients at the RHC in particular, the provision made for language was adequate, with 100% of patients reporting that language barriers had not prevented them from accessing NHS services. Although the respondents to the questionnaire could be argued to be unrepresentative of all the minority users of the centre, information about the interpretation service itself and outside agencies that it employs show that the language policy is successful in ensuring that an interpretation service is made available for all

language users that need it. Information gained from the patients and observation of the materials found in the RHC suggest that the multilingual society is embraced and provided for, with signs in different languages welcoming patients to the centre.

Fishman (2001: 54) argues that a lack of language policy suggests a lack of support for minority language users, in other words, an 'anti-minority' policy, but what we have observed in the language policy of the RHC is almost the complete opposite of what Fishman describes. There is a clear system of support in place in the language policy of minority users, i.e. the interpretation service. It is successful because all languages required are provided for, even if this means contracting outside agencies. The language policy of the health centre observes the diversity of Rusholme and takes into careful consideration that minority language users may need an interpreter in order to access NHS services. Although 59% of respondents to the questionnaire reported that English was not the language they would prefer to discuss health matters in (respondents for whom English was not their mother tongue), this cannot be directly seen to be the responsibility of the language policy. As Matras (2009) reports, the loyalty a speaker may feel to their mother tongue may outweigh their need to communicate in domains such as a health centre. Communication in a domain such as this is a necessity; it is crucial to the language user's health and wellbeing. The language policy ensures that everyone within the community can access health care, in spite of language barriers, and that this is its main aim. Preference of language cannot be the priority as it would place increased pressure on the NHS and the health centre. What is important is clarity of communication and availability of information for patients. As observed, this is very well provided for by the interpretation service.

What could be improved within the centre is availability of leaflets in a variety of languages; many leaflets state that other languages are "available upon request". If the RHC took responsibility for requesting this information for their patients, more information would be readily available for them. The Somali drop in session is an example of conscious thought of the language needs of their patients. These are additional provisions made for the specific centre and not strict requirements of a language policy. The language policy meets the needs of the patients' communication needs, the RHC attempts, in places, to make minority language users feel at ease and included in the centre reflecting the sense of multilingual community.

Conclusion

This report set out to document our study of minority languages in Rusholme and has been primarily concerned with reviewing the services provided by the NHS and the Rusholme Health Centre.

Our study shows that the majority of patients at the RHC are adequately able to converse with the staff about their health issues in English, despite this not being their mother tongue. We have also found that the NHS provides a helpful translation service, however in most cases the patients must seek this out themselves according to their own needs. Unfortunately, our survey was not fully representative as we were only able to survey English speakers. However, it appears that an observer's paradox did not occur, as the participants were not reluctant to tell us that they would prefer to discuss their health matters in their mother tongue.

In sum, it can be stated that the language policy provided by the NHS, and NHS Manchester more specifically, caters adequately for the linguistic situation in the area of Rusholme. Even though most decisions and provisions are made on a local level, the NHS has a considerable say in implementing broader arrangements. Contrary to what acclaimed research suggests (e.g. Fishman 2001), we have gained new and interesting insights into language policy in more domain-based areas of public life and were able to refute the argument brought forward. Finally, on a more personal level, this study has enabled us to gain hands-on experience in linguistic fieldwork. We have learned how to deal with the many complications and difficulties we encountered in the course of carrying out our study. The most important insight for each of us, though, has been that even on a very small-scale level, innovative and determined research can lead to interesting – and sometimes unexpected – results, rendering the whole research situation very rewarding indeed.

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Appendix

Photographs: Multilingualism in the RHC

Rusholme Jewels

Multilingual display in the RHC

Multilingual poster in the RHC

Multilingual Hepatitis C poster in nearby pharmacy