

month. Five per cent required an interpreter more than five times a month and 20 per cent were unable to give an estimate. It should be noted that these figures may not reflect the true extent of interpreter-use as records are often not kept.

Where interpreters were employed but not available, or where professional interpreters were not employed, various other methods of conveying information were used. This included using family members, as well as pharmacy and nursing staff who spoke the particular language in question, to interpret. Using interpreting staff from an agency and offering patients leaflets in different languages and diagrammatic information were other methods adopted.

Self-medication schemes were in operation in 48 of the respondent hospitals (76.2 per cent). Various means were used within these schemes to provide information to patients with language barriers, including professional interpreters (16.7 per cent), relatives (10.4 per cent) and volunteers (10.4 per cent). In 8.3 per cent of hospitals, patients were not entered onto self-medication schemes where language barriers existed. Almost a third of hospitals (31.3 per cent) said that they did not experience problems when they included non-English speaking patients in their schemes.

— In-patient interviews

The next stage was to carry out in-patient interviews at Glenfield Hospital. This involved asking ward staff to identify 100 in-patients at Glenfield Hospital who had Asian surnames and were aged 18 or over.

Interviewees (51 males and 49 females) were asked to give their age, identify their first language and state their proficiency in both spoken and written English. They were also asked to state by what methods they received information about their medicines.

Patient ages are set out in Panel 1. Gujarati was identified as the first language of 72 per cent of the interviewees, with other first languages including Urdu, Bengali, Tamil, Hindi and Punjabi. The self-stated proficiencies of patients in spoken English are set out in Panel 2. With regards to written English, 43 per cent could read English and 57 per cent could not. In addition, 81 per cent

Panel 1: Ages of patients interviewed at Glenfield Hospital

Age range (years)	Number of patients
18–29	4
30–60	35
61–74	46
75 and over	15

Panel 2: Proficiencies of patients in spoken English at Glenfield Hospital

English ability	Number of patients
Can speak English	42
Can speak English with difficulty	30
Cannot speak English	28

stated that they were able to read other languages, primarily Gujarati (64 per cent). The ability to speak English varied with age, with older patients generally being less able to speak English.

Over half of the patients interviewed (54 per cent) felt that they would have difficulty explaining their problems to staff because of their limited spoken English.

Patients stated that they received information about their medicines in a variety of ways. Only 56 per cent said they were able to read the labels on their medicines, with 29 per cent relying on relatives to help. Most (71 per cent) tried to read patient information leaflets given to them but 65 per cent would have found it useful to have them in their own language.

— Pilot study

The need for an interpreting service at Glenfield Hospital was assessed in a pilot study that was conducted over a four-week period. During this time, a pharmacy-led interpreting scheme was set up, with four members of pharmacy staff and two other hospital staff members (one from the respiratory physiology department and one from the general office) who, between them, spoke Gujarati, Hindi, Punjabi and Urdu. The service was advertised to staff at out-patient clinics, to pharmacy staff and ward staff. Each time a member of the team was contacted, a form was completed detailing the reason for the approach, the time taken to clarify information, the language used. Staff were also asked to indicate instances where language barriers were broken down by means other than the translating service (eg, using patients' relatives and friends).

During the pilot study period, the team was contacted on 49 occasions. Nine requests were from pharmacy staff in the wards, 13 from the tuberculosis clinic, five from the respiratory physiology department and 22 from the out-patients department.

The following are examples of the results obtained:

- 28 (57.5 per cent) of requests were for Gujarati, reflective of the population in Leicester, with other languages being Punjabi, Urdu, Hindi, Bengali and Thai
- 20 of the requests were for female patients and 15 for male patients (gender was not stated in 14 requests)
- The pharmacy translating team spent 15.5 hours interpreting during the study period (approximately 4 hours a week)
- Over the study period, 44.9 per cent of interpreting was carried out by adult relatives, 2 per cent by child relatives and 53.1 per cent by the translating team and other hospital staff

— Implications

The questionnaire sent to trusts identified that there are currently no formal interpreting services available within hospital pharmacy departments. Instead, a variety of different means of communication are used. Many of these rely on a variety of untrained individuals, such as relatives and friends, a situation that can potentially lead to confusion and error. While being readily available, relatives and friends are not necessarily familiar with all the terminology needed to explain how to take medicines. In addition, relatives may themselves have limited English, and omissions, additions and alterations to the intended message can occur. Confidentiality can also become an issue when using relatives to interpret.^{2,3} Moreover, using a bilingual child as an interpreter has the potential danger of involving children beyond the scope of their stage of development.⁴

In some hospitals, patients are being excluded from self-medication schemes because of language difficulties. The self-administration of medicines is generally encouraged because it allows patients to be as independent as possible and can improve compliance significantly.^{5,6} If patients cannot access such schemes then such benefits might clearly not be realised.

Patients generally rely on reading labels and leaflets to understand when and how to take their medicines. However, many patients of Asian ethnicity who cannot understand spoken English are also not proficient in written English. Some leaflets are now available in different languages and more are being produced.

In general, pharmacy managers need to think about their local population and consider tailoring the services they provide accordingly, so that all patients have access to information they need about their medicines. Lack of compliance is a problem not limited solely to a section of the community, but success can be improved if all patients understand how they should be taking and using their medicines. This can only be achieved by giving more support to patients in using medicines, and empowering them to take a

more active role in managing their own care.

Much can also be achieved by basic patient counselling to improve comprehension and compliance and to promote the pharmacist as an adviser on medicines. This approach is likely to benefit indigenous as well as ethnic communities.^{7,8}

Conclusion

There are inconsistencies in the services provided to patients of Asian ethnicity across the UK. There is a need to address these inconsistencies and to ensure that all patients are given the opportunity to understand how to take their medicines.

The future

Following on from the four-week pilot study, consideration is being given to carrying out a further pilot of six months at Glenfield Hospital to evaluate whether an interpreting scheme should be set up on a permanent basis. There is also a need to carry out research about other compliance issues associated with ethnicity. In particular, many of the inpatients interviewed during the project explained that they had fasted at some stage for religious reasons. Some patients said that they continued to take their medicines as normal during this period,

while others indicated that they stopped taking their medicines or altered the timings, generally taking everything together first thing in the morning. There are issues associated with all of these options — stopping or changing regimens can clearly affect therapy, as can continuing as normal, because the effectiveness of many drugs can be substantially affected by the presence or absence of food in the alimentary canal. An interpreting service could be used to aid compliance and give a greater awareness of the issues involved during religious festivals through discussions with patients.

It would also be worthwhile to investigate the number of medication incidents that occur because of problems in communicating caused by language difficulties.

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