Original Article

Arab-migrant Cancer Survivors' Experiences of Using Health-care Interpreters: A Qualitative Study

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ABSTRACT

Objective: This paper is drawn from a larger mixed-method study that sought to explore the cancer experiences of Jordanian and Australian Arab cancer survivors and their family caregivers. This paper specifically focuses on the experiences of the Australian cancer survivors and their use of interpreter services to communicate with health-care providers (HCPs). **Methods:** Individual face-to-face interviews were conducted using a semi-structured interview guide. Data were manually thematically analyzed using an inductive approach. **Results:** Three key themes were identified which highlighted the communication issues the Arab-migrant cancer survivors experienced when using health-care interpreters: (1) "My language is weak" – needing someone to help them when communicating with their HCPs; (2) "I had a problem in the dialect" – the need to understand and to be understood by the interpreters; and (3) "I felt all the time that there is something missing" – not being heard by the interpreter. Low confidence in engaging and using the English language meant many cancer survivors were reluctant to seek support from cancer services or to attend workshops conducted in the English language. Despite the presence of professionally trained health-care interpreters in health-care communications, cancer survivors were frustrated when provided with interpreters who did not speak the same dialect, causing linguistic and cultural discord. This created confusion as information was often misinterpreted, resulting in the delivery and receipt of mixed messages. **Conclusions:** Despite the availability of professionally trained health-care interpreters, our findings identified the need for HCPs to ascertain linguistic and cultural congruence when arranging interpreter services.

Key words: Arab cancer survivor, interpreter, migrant, qualitative research

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Introduction

International migration has created countries with great ethnic and cultural diversity,[1] with current estimates that migrants account for 3.3% of the world's population.[2] Over recent decades, growth in migration has surpassed projections,[3] in part because of significant events such as the global financial crisis in 2008, the Arab Spring in early 2011, and the current conflict in the Syrian Arab Republic.[3] While many countries have witnessed increases in migrants, about half of all migrants are hosted by ten countries, with the United States alone hosting 20% of the global total.[4] As a percentage, this represents approximately 13% of the population of the United States, whereas 20% of Canada's population[5] and almost 30% of Australia's population are immigrants,[6] making these countries some of the most culturally and linguistically diverse countries in the world.

While migration offers enormous benefits for migrants, their families, and countries of origin,[3] planning for the effects of migration has often been neglected.[3] In particular, challenges remain in providing migrant-sensitive health-care services which ensure that migrants can overcome health system barriers, with sufficient skilled health-care workers to manage the needs of this population.[7] An important element of such systems is the availability of professional health-care interpreters. For patients with low levels of English-language proficiency, engaging a professional interpreter not only helps ensure effective communication in health-care consultations[8,9] but also improves patient safety and quality of care,[10] reduces unnecessary health expenditure,[11] promotes access to healthcare,[12] and reduces patient and family stress.[13] However, interpreting services are not always used when available[14] and organizational difficulties such as providing interpreters who speak a specific language dialect,[13] or are acceptable to the patient based on gender or ethnic background,[15] are commonly cited challenges which increase the risk of migrant patients receiving poor-quality health care.[15,16]

A number of studies also report patients' dislike of speaking through an interpreter as they can "lose their train of thought,"[17] feel "sidelined" when involved in conversations with health-care providers (HCPs) and interpreters,[18] and meaning and information can be lost in the translation.[12] For example, in a study which analyzed the original utterances between HCPs and patients when using interpreters, only less than half (46%) of HCPs' talk was translated into the patients' language.[9]

Similar findings have been reported in an Australian study[19] comparing oncology consultations of immigrants with and without interpreters versus Anglo-Australian patients. In this study, 20% of immigrant patients' emotional and informational cues were not translated by the interpreters. Further, oncologists spent less time providing cancer-related information to immigrants.[19]

Immigrants who are not proficient in the dominant language of their host country often struggle to communicate with HCPs and have poorer health outcomes.[20] This is particularly true for immigrant cancer survivors who have a poorer quality of life, worse psychological status, and higher unmet supportive care needs than other cancer survivors, with communication barriers and lack of access to health professionals who speak their language accounting for most of these needs.[21]

Despite Arabs comprising the second largest non-English-speaking background ethnic group in Australia,[6] a recent study revealed that Arab-migrant cancer survivors who had been living in Australia for up to 50 years still had a poor understanding of the health-care system and significant information needs.[22] In this paper, we aim to understand the Arab cancer survivors' experiences with health-care interpreters. This aim originated from unexpected findings which emerged during the qualitative data analysis, which was initially collected for other purposes.

Methods

Research design

This paper presents the Australian qualitative findings from a larger mixed-method study that sought to explore the unmet needs of Jordanian and Australian Arab cancer survivors and their family caregivers.[22] Interviews were undertaken between March 2016 and January 2017 with Arab cancer survivors. A semi-structured interview guide was developed to explore their experiences of unmet supportive care needs [Table 1]. The guide was pilot tested on three Australian participants for cultural acceptability before use. The Australian interviews included additional questions related to being a migrant living with cancer. Using a qualitative exploratory design, this paper specifically focuses on the Australian Arab cancer survivors' experiences of health-care interpreter services. This paper follows the consolidated criteria for reporting qualitative research 32-item checklist.[23] The Australian study received the ethical approval from the South Western Sydney Local Health District Human Research Ethics Committee (HREC/15/LPOOL/459) and Western Sydney University (H11469).

Sampling and recruitment method

Arab adult cancer survivors up to 5-year postdiagnosis, with any type of cancer, aged 18 years or older, and able to read and/or speak English or Arabic were invited to

Table 1: Interview guide
How did the diagnosis of cancer initially affect you?
What were some of the challenges you have faced since your diagnosis?
What in your experience are your greatest needs at the moment?
From whom do you usually seek help?
Where would you/do you go for help?
Who are the people and/or groups that have been your greatest sources of support since your diagnosis? What made them so helpful?
What do you know about cancer supportive care services?
What support services (if any) do you access?
Have you ever participated in a cancer support program? (If yes) If you have participated in a cancer support program, can you describe your experiences?
Do you find the current cancer support services suitable to your needs? (If no). Can you tell me why you haven't participated in a cancer-support program?
If you did decide to participate in a cancer support program, what type of program would you prefer? (e.g., face-to-face, small group meetings, telephone, mailed print materials, computer program (CD-ROM), internet-based program, online support group)
What do you think would be the best approach to communicate information about cancer and supportive care program services to people with a background like yours?
What could be improved to better help you meet your needs?
Could you describe your experience of being an immigrant and living with (being diagnosed with) cancer?
What could be improved to better support the unmet needs of immigrants with cancer?
In what ways do you think your experience as an immigrant with cancer differs from people with cancer who are born in Australia?
Probes
"Please tell me more about it?"
"What does that mean to you?"
"Is it possible to give an example?"

participate in the study. For the purpose of this study, we used the National Institutes of Health[24] definition of cancer survivor to mean the period from the time of diagnosis until the end of life.

Prospective participants were initially approached by cancer nurses working in two tertiary referral cancer therapy centers or by leaders of two Arabic community and religious organizations. The first author presented the study aim, eligibility criteria, the consent process, and the possible benefits of this study to clinicians at the cancer therapy centers and to leaders and community members at the Arabic community and religious organizations. Copies of the study brochure and participant information sheet and the contact details of the researchers were provided to clinicians and community leaders. All written study information was available in English and Classical (Qur'anic) Arabic (the official written language for Arabic). If prospective participants in the cancer centers expressed interest in the study, their contact details were provided to the first author (doctoral student) by the nurses. Similarly, those recruited through community organizations were only contacted if they agreed that their contact details could be provided to the researchers by the community leader.

Participants who agreed to be interviewed were asked to pass on the study details to friends, and family members who they felt might also be interested in participating (snowball sampling).

Study setting

The study was undertaken in South Western Sydney, Australia, an area of significant cultural and linguistic diversity with almost three quarters (74.1%) of the population speaking a language other than English at home.[6] Arabic is the second most common language spoken in this region after English.[6]

Data collection and data analysis

Face-to-face interviews were conducted with Arab-Australian cancer survivors. All participants were interviewed individually in a private room (i.e., interview rooms in the cancer center and the community organizations). Interviews ranged from 26 to 56 min.

The primary researcher (IA), a male doctoral student fluent in both English and Arabic, conducted all interviews in Arabic. Field notes were undertaken during the interviews to capture the nonverbal cues and the environmental context. The doctoral student received regular feedback and support on interview technique from his supervisory panel (experienced researchers). To help establish rapport, enhance trust, and attain prospective participants' interest,[25] the interviewer made initial contact (telephone and face-to-face) in Arabic. This also ensured that the interviewer and participants were able to understand each other's dialect. All interviews started by inviting the participants to "tell their story," an approach which not only helps build rapport but also shows respect for participants' experiences.[26] While being able to speak Arabic made the interviewer linguistically competent, care was taken to not assume "insider" status because of the significant diversity, including cultural and religious orientation, within Arabic communities.[26] The interviewer ensured that he was culturally sensitive by being sincere and respectful of participants' experiences and beliefs when talking about their cancer experience and emphasizing confidentiality. Interviews were conducted until the research team-determined data saturation had been achieved.

Interviews were digitally recorded and then transcribed and translated into English by a certified translator. The transcripts were not returned to participants for comment. The transcripts were checked by the first author (IA) against the audio recordings to ensure accuracy of the translation process. Initially, three authors (IA, JL, and CK) manually analyzed the transcripts thematically using an inductive approach.[27] Thematic analysis involved a number of steps. The first step was familiarization with the data, whereby each author read

the transcripts multiple times. Once familiarization occurred, codes were generated which were then clustered into broader themes. The themes were revised and refined until consensus was reached among the three authors.[27] To ensure the rigor of the analysis, two coauthors (BE and LR) appraised the analysis process in the audit trail, confirming that all possible codes/themes had been identified. To maintain confidentiality and privacy of participants' identity, pseudonym names were used in the quotes.

Results

Eleven cancer survivors agreed to take part in face-to-face semi-structured interviews to discuss their experiences of unmet supportive care needs. There was no participant withdrawal from the study. All participants were the first-generation immigrants – five participants were women and six were men, with ages ranging from 44 to 80 years. Most of the participants were diagnosed with prostate, breast, and spinal cord cancer [Table 2]. Three main themes emerged from the thematic analysis of the interview transcripts, highlighting Arab-migrant cancer survivors' experiences of interpreter services in health-care communication.

"My language is weak" – Needing someone to help

Language was described as a prominent barrier in health-care communication. Many participants in this study revealed that their limited proficiency in the English language affected their confidence not only to engage with healthcare services in general but also to communicate in the English language with HCPs. Mohammed felt that the language barrier prevented him from getting his message across to HCPs. Miscommunication in healthcare is more likely to occur when the recipient does not understand the speakers' intended message.

I think that my poor language will never help me to do the communication in a good way. Language is a big barrier

sometimes. Because my English language is not that good … My language is weak and I can't communicate with them (HCPs) easily because of my poor English* (Mohammed).
I am living with the Australian community, so the language is the first barrier (Hussin).
I can't speak English, so I need somebody to help me with this issue (Sara).
I prefer the Arabic language and Arabic doctor is better. Because he can understand me and I can understand him more than the western doctor (Ahmed).

Having limited English was a further challenge for participants who sought information about available cancer-support groups and wanted to participate in cancer workshops. One participant who was a doctor in his origin country shared how his poor language skills and limited confidence in his abilities prevented him from attending any of the cancer information workshops organized by the health service.

They are many organizations for cancer patients, but my English language it is not very good, I can only communicate a little bit (Hussin).

Mohammed also shared his experiences attending the health information seminars and the difficulties he faced with translation of the information being discussed:

There are many seminars and discussions about cancer, but the translation of such seminars or discussion prevented me of attending. So, that is the reason nothing else. I had a problem in the translation as well as the concentration during the seminar (Mohammed).

While some of the participants reported that they felt their English-language skills were good, they also highlighted the problems they continued to face in expressing their needs and in understanding medical terminology. Participants talked about their preference for using the Arabic language even when they had good English-language proficiency.

With my language (Arabic) I can deliver what I want in a better way, and there is many things can't be expressed in English, every language has its vocabulary, but for me I prefer talking with Arabic (Ahmed).
Was not good experience, she (doctor) was talking with me in English language. I am very good in English, nevertheless in the medical expressions, I had a problem. It's better using Arabic because in English it will be just like collecting data and taking information that are stipulated in the papers (Amal).

To enable communication with HCPs, participants were seeking help from family members who had better English-language skills and from professional interpreters.

One of my kids usually come with me, they translate everything to me (Hussin).
One of my sons is excellent in English, and he accompanied me in every appointment (Mohammed).

Table 2: Demographic characteristics of participants					
Participant name	Cancer type	Age	Gender	Country of birth	Recruitment site
Husam	Prostate cancer	80	Male	Lebanon	Community
Fatima	Breast cancer	44	Female	Iraq	Snowball sampling
Amal	Breast cancer	45	Female	Iraq	Hospital
Hadeel	Spinal cord cancer	70	Female	Iraq	Hospital
Mohammed	Prostate cancer	60	Male	Iraq	Snowball sampling
Hussin	Prostate cancer	80	Male	Iraq	Community
Ali	Prostate cancer	75	Male	Egypt	Community
Ahmed	Prostate cancer	70	Male	Egypt	Community
Manal	Breast cancer	45	Female	Lebanon	Hospital
Majed	Colon cancer	69	Male	Lebanon	Community
Sara	Throat and breast cancer	63	Female	Lebanon	Community

The interpreter was translating for me because my English is poor (Fatima).

The sentiments expressed by participants suggested that inadequate English-language skills contributed to lack of confidence and comfort in expressing their feelings and needs and hindered their attendance at health information workshops. Low confidence levels and limited proficiency in the English language may be significant deterrents impacting on Arab-migrant cancer survivors' ability to seek information and support from cancer-support services.

"I had a problem in the dialect" – Needing to understand and to be understood

Participants emphasized the need to use interpreters who spoke the same Arabic dialect and described how using interpreters with different dialects resulted in not being able to understand what the interpreter was trying to say or understanding some words incorrectly. The subtle nuances of language cannot always be translated literally and can differ depending on dialect used within a region.

There was a problem with translation. The translator there was from Lebanon and I am Egyptian, and there are many differences between the two dialects. At first, the translator was a Lebanese lady, but I asked them to change her, I wanted an Egyptian one. I can't understand her, for example, "badana" mean "start" for Lebanese people but for Egyptian mean "finished" (Ali).

Hadeel, an Iraqi cancer survivor, shared how hard it was for her to understand the Egyptian dialect of the health-care interpreter.

With the Egyptian translator, I had a problem in the dialect. Yes, I couldn't understand everything. The Egyptian dialect is hard to understand. Yes, you know it's very hard to understand Egyptian dialect. I can understand you (Jordanian interviewer) for example, nevertheless you are not a translator but your dialect is understandable (Hadeel).

As a result of the different dialects and nuances, some participants felt that it was hard for the interpreter to convey the meaning of the conversation, resulting in incorrect translation.

I think he couldn't convey the meaning, he was trying to convey what I am saying, nevertheless he couldn't do it successfully (Fatima).

What I am trying to tell you is that he was trying to translate the meaning while translating but he couldn't do such. I didn't say it was a bad translation no, I mean that the translation didn't give the correct meaning. Sometimes, the translation was inaccurate (Ali).

Despite the availability of professional health-care interpreters, the need to understand – and to be understood – was expressed by the participants in the study and for some resulted in inaccuracies which affected translation quality.

"I felt all the time that there is something missing" – Not being heard

Some of the participants expressed frustration with the health-care interpreter. They felt that the interpreter was not always listening to what they were saying. Interpreters were talking about the situation and exchanging opinions with doctors as if they were the actual cancer survivor without seeking the cancer survivor's input. This caused some participants to feel that the interpreters were careless and not listening to them.

They should listen to you and ask you what do you need and check if you understand him, but they are not doing that, they take one word from the things you are telling them and talk to doctors as (if they are) the patient (Ali).

While Ali acknowledged the interpreters were "*only doing their job,*" he also shared how he was not allowed to finish saying what he wanted to say and felt the interpreters lacked "humanity."

I have noticed that the interpreters they are only doing their job, but there is no humanity. They didn't let you finished your speech. It was a problem in the human side as well as the medical side (Ali).

Fatima and Hadeel explained that the interpreter skipped words, often not translating messages correctly. As Fatima could understand some English, she also felt that the interpreter was not accurately conveying information received from the oncologist as well. Both also reported that they felt that the interpreter "hid" information so as not to worry them.

Honestly speaking, while dealing with the Australian doctor, the translator was skipping words, and sometimes, he was careless in translating what I was saying. I felt all the time that there is something missing while translating, I felt that all the time. I can understand English a little bit (Fatima).

I think that she skips something, as she think that it's better not to tell me bad things (Hadeel).

Not being heard was similarly highlighted by Manal who, despite insisting on being provided with her biopsy results, was frustrated by her doctor's reluctance to provide this information because her spouse was not with her. Manal explains:

I picked up the result to my doctor, we were in Ramadan, she preferred to talk to my husband, I insisted on her to tell me. Anyway, I can't speak English very well, but my son aged 14 years talk to her, and he gave me a look of fear where I felt that there is something went wrong, he told me to be strong and don't be fright if I have a cancer, and I will be treated to until I get better, then I felt that they are hiding something and they wont to tell me about, then my doctor told me that I'm infected with cancer.

We are unclear as to the details of the conversation that took place between Manal's son and the doctor and how it was framed. However, what is clear is that the doctor's reluctance to initially provide Manal with her diagnosis caused her to feel information was being hidden from her. The doctor must have ultimately conveyed this information to Manal's son, which caused him to look at his mother with fear, and for Manal to then believe that the doctor and son were hiding something from her.

The sense of not being heard or feeling information was being hidden was explicitly stated to varying degrees by four participants. Their identity as migrants with cancer and living in an English-speaking country positioned them within the context of a vulnerable and minority group. These findings identify how important it is for health-care professionals to understand the communication challenges faced by migrant cancer survivors who use interpreter services, particularly in terms of interpretation quality and linguistic congruence.

Discussion

Low levels of confidence in using English were highlighted by Arab-migrant cancer survivors' in this study and for some meant that they were reluctant to engage in and access support services. There was also a level of frustration with not being able to use their native language (Arabic) to communicate their message directly with HCPs. Our findings are consistent with other studies which report migrants,[20,28] including Arab cancer survivors,[21,29] with low English language proficiency, being deterred from seeking health information. This was evident in this study with participants stating that language was a barrier to seeking information about cancer-support groups and participating in cancer workshops.

Despite some participants stating their English-language skills were "good" and that they could understand some English, they still reported a need for help from family members to overcome their low confidence when speaking in English. Speaking and understanding English such as that used in social interactions was not sufficient to enable participants to understand the medical terminology which can be challenging even for those who speak English fluently.[29,30] Arabs have strong commitment to family unity, and in this study, all but one of the participants were living within a very supportive family structure where everything was done for them, including language translation by younger family members born and educated in Australia. This could be problematic because there is no guarantee of the quality and accuracy of translation by family members.[29,31] In a study of Arab migrants living in Sweden, participants preferred using family members to translate in uncomplicated care situations; however, when personal issues were involved, their preference was for an interpreter as they feared their issues could be "spread" to others.[32] Participants also stated their preference for professional interpreters when important issues were discussed as they felt that medical concepts might not be translated correctly by family members.[32] These concerns are particularly relevant when communicating with Arab cancer survivors given the shame and stigma associated with a cancer diagnosis[33] and the need to convey information that is needed to inform decision-making related to cancer treatment and prognosis.

While using interpreters promotes communication between cancer survivors and HCPs, in this study, Arab-migrant cancer survivors experienced significant challenges when using interpreters to communicate with their HCPs. In this study setting, which is culturally and linguistically diverse, professional health-care interpreters are available by prior appointment (prebooked – either face-to-face or by telephone) or, in urgent cases, by telephone. Our findings clearly identified that many participants experienced significant issues with linguistic congruence and the quality of the interpretation. In particular, being provided with a health-care interpreter who spoke a different Arabic dialect was a source of frustration for several of the participants interviewed in this study and added a level of difficulty to understanding what the interpreter was trying to convey because of subtle nuances. The Arabic language is comprised of a collection of multiple dialects reflecting both geography and social class.[34] For example, the dialects of Saudi Arabia, Kuwait, United Arab Emirates, Qatar, Bahrain, and Oman are known as Gulf Arabic, while Egyptian Arabic covers the dialects of Egypt and Sudan. North African Arabic includes the dialects of Morocco, Algeria, Tunisia, Mauritania, and sometimes Libya, and Levantine Arabic covers the dialects of Syria, Lebanon, Palestine, Jordan, and Iraq.[34] The importance of Arabic dialects has previously been highlighted by Hadziabdic and Hjelm,[32] where three quarters (75%) of the Arab migrants surveyed stated that they felt it was important that an interpreter spoke the same dialect as them. Respondents also stated their preference for interpreters who shared the same origin and gender.[32] The same study found differences in Arabic dialects caused major misunderstandings between HCPs and cancer survivors, which made it difficult for cancer survivors to use health-care interpreter services and increased the risk of inaccuracy in the translation.[32] Again, we found that similar issues were raised by our participants, with some words (e.g., "badana") actually having a completely opposite meanings (start and finish).

While the presence of professional interpreters during health-care encounters cannot guarantee accurate translation,[35,36] it was concerning that several participants shared examples of where they felt that the interpreters had been inaccurate, skipped words, concealed information, or did not listen to them, resulting in sending incomplete information or questions from the participants to the HCPs. Hadziabdic and Hjelm[32] reported similar findings with 75% of Arabic-speaking respondents who had used health-care interpreters stating that interpreters should literally interpret without making any judgments and 60% reporting feeling uncertain whether what they said was correctly translated by the interpreter.

Pope *et al.*[37] explored conversations between pediatricians and patients with the use of interpreters and found that the most common interpreter error was forgetting to mention something said by the patient or by the pediatricians. Similarly, in a study designed to identify the characteristics and patterns of errors in Japanese–English interpretation during medical encounters, Anazawa *et al.*[38] identified that two of the most common interpretation errors were adding unspoken words or sentences and omitting some of the spoken words or sentences.[38] Interestingly, omission-type errors were more likely to occur within socio-emotional exchanges where "small talk" and utterances used to facilitate conversation and communication between HCPs and patients such as "OK," "Uh-huh", "Yes", "I see" or "Is that right" were omitted. Anazawa *et al.*[38] suggested that interpreters might have considered these small utterances irrelevant or less important to the medical matter being discussed, yet these small exchanges are often critical for building rapport and demonstrating empathy. Although the participants in the current study did not elaborate on the specific details that interpreters skipped during discussions with HCPs, it is possible that omitting content could have clinical consequences or at least (as seen in this study), people experiencing less than satisfactory communication with their HCPs.

Limitations

Our study findings may have limited transferability because it was conducted in only two cancer centers and community organization in South Western Sydney, Australia, and only focused on one language group (that is, Arabic-speaking people). Our study findings were based on Arab-migrant cancer survivors' experiences, and given the emotional context and cultural beliefs associated with a cancer diagnosis and the resultant treatment, our participants' experiences of engaging with the health-care system and using interpreters may have been colored by this. However, our results are generally consistent with other studies reporting the experiences of migrants and people with low levels of language proficiency when using interpreters in other health-care settings.

We know that patients' perceptions are important measures of patient-centered care[39] and patient–clinician communication is complex. While our study has not directly explored the complexities inherent in patient–clinician communication, a survey or different method of data collection, such as videotaped encounters, to assess the issues in using the interpreter in communicating with HCPs might have uncovered other important issues regarding communication between interpreters, HCPs, and patients (or as was the case in this study, cancer survivors).

Strengths

Despite the limitations, this study had several strengths. First, participants were interviewed in their first language (Arabic) promoting trust and a level of comfort and confidence to express themselves without fear of being judged for poor language skills. This increases the likelihood of generating findings that are credible[40] and useful for improving health services for this population. Second, while the researcher who undertook the interviews was fluent in Arabic, he was also from outside the health service, and thus, participants may have been more likely to be truthful in sharing their experiences because there was no risk to their future relationship with the health service.

Implications for health services

Based on our findings, there is a need to increase HCPs' awareness of the need to provide interpreters congruent with a cancer survivor's country of origin and ethnicity, gender, and dialect. In view of the fact that there are so many languages and dialects, it is important to report in the medical record not just what a cancer survivor's language preference is but also if they speak a particular dialect. This information would help ensure that the most appropriate interpreter is booked for the cancer survivors.

Providing migrant-sensitive health-care services is not simply a matter of making available professional health-care interpreters. Interpreters bring clarity in the mid of confusion. Therefore, ensuring the quality of interpretation is vital to ensure communication between patients and HCPs is complete and accurate. Further, as shown in this study, the quality of health-care interpretation has the potential to create fear and mistrust when patients perceive that they are not receiving all of the information being provided by HCPs and a feeling of not been heard or listened to when the information they provide is not fully conveyed by the interpreter to the HCPs. To this end, we highly recommend consideration be given to health-care interpreters completing mandatory continuing professional

development on an annual basis, much like that required by other profession such as nursing and medicine.

Three-way conversations (HCP, cancer survivor, and interpreter) are time-consuming. Providing additional consultation time for patients who require interpreters will help ensure that they can ask questions and seek clarification. Longer consultations will also help ensure that interpreters are able to focus on the accuracy of the translation and thus improve the quality of the consultation and patient satisfaction.

Finally, findings from this study highlight the importance of ensuring HCPs adhere to policies regarding the presence of a health-care interpreter when providing a serious diagnosis such as cancer and not conveying this information to children who may be present with their parent.

Conclusion

This study has explored Arab-migrant cancer survivors' experiences of using health-care interpreters and highlights the challenges immigrant cancer survivors with limited English language proficiency encounter. Despite the provision of professional interpreters, our findings reinforce the need for HCPs to take into consideration the countries of origin and dialectical differences of Arab cancer survivors when arranging for a professional interpreter to ensure both cultural and linguistic congruence. This study also highlights the need for interpreters to fully interpret the content of patient–HCP discussions and to confirm with patients that they are satisfied with the interpretation and provide an opportunity for patients to seek clarification/add further content.

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Conflicts of interest

There are no conflicts of interest.

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