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Types of interpreter services at a border town hospital in Ghana: implications for linguistic rights and access to healthcare

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Abstract: A global priority captured by the United Nations' Sustainable Development Goal 3 is universal access to quality, essential healthcare services. However, linguistic barriers have been found to be a cause of poor or unequal access to healthcare, especially for migrants for health purposes (MHPs). This paper presents types of interpreter in a border town health facility in Ghana and the implication for access to healthcare in the context of linguistic rights protection. Using data obtained from interviews with 13 health workers and one quasi-official interpreter, we show that communication in this health centre is mostly facilitated by ad hoc interpreters including relatives and friends, other patients, medical personnel, and a unique group called Ambulances who accompany patients to the hospital. We demonstrate how the use of ad hoc interpreters as supplementary inclusion measures facilitates access to healthcare and protects linguistic rights. We conclude the paper by advocating for training of trainers of medical interpreters, training of ad hoc interpreters for professionalization, and the development and implementation of regular workshops and systematic guidelines on multilingual communication. This paper adds to the discourse on language as a crucial determinant of healthcare access and a key factor in the attainment of sustainable development.

Keywords: healthcare access; migrants for health purposes; linguistic justice; ad hoc interpreters; supplementary inclusion measures

1 Introduction

Language barriers have been identified as one of the obstacles to achieving Sustainable Development Goal 3 (SDG 3), which aims for universal access to healthcare. These barriers hinder communication between patients and healthcare providers, negatively impacting the quality of care and contributing to health disparities (Al Shamsi et al. 2020; Lee 2003). This is why we consider linguistic justice and the protection of linguistic rights, a concept enshrined in the 1998 Universal Declaration of Linguistic Rights, as being critical to achieving SDG 3, especially for migrants. Linguistic justice is defined as “the realization of equitable access to social, economic, and political life regardless of linguistic repertoire” (Nee et al. 2022). The declaration emphasizes individuals’ rights to use and preserve their languages without discrimination in public and private life (Milambiling 2018), including in healthcare. There is consensus among some scholars (De Schutter 2008; Lewis 2017; Patten 2014; Réaume 1991) that linguistic rights and principles of linguistic justice should apply to public institutions, including hospitals, to enhance access to services. According to Musau (2003: 155) linguistic rights are necessary if linguistic justice is to prevail in Africa as “linguistic human rights are aimed at the promotion of linguistic justice.” One of the approaches Patten (2014) identified for the safeguard of linguistic rights are supplementary inclusion measures (SIMs), which are defined as temporary measures aimed at helping users overcome linguistic obstacles especially when language learning is unrealistic or

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proficiency is yet to be achieved (Shorten 2022). Examples of SIMs include the translation of public documents and the use of interpreter services (Shorten 2022). In the literature, the term interpreter services tends to be used to refer to:

any intervention involving an interpreter that was intended to enhance language access for an LEP [limited English proficiency] patient, including the use of any type of medical interpreter (from trained professional interpreters to ad hoc interpreters, including family members, friends, and untrained medical or nonmedical staff). (Flores 2005: 2)

Traditionally, the term “ad hoc interpreter” as an interpreter type has been used to define any person who has not received any professional training in providing interpretation services (Flores et al. 2003; Nápoles et al. 2010; Paradise et al. 2019). Pöchhacker (2006) has established that healthcare institutions use interpreters to overcome language barriers. Various studies have been carried out on types of interpreters and different variables including interpreting quality (Dubslaff and Martinsen 2005; Flores et al. 2003; Rosenberg 2002), interpreter roles (Angelelli 2004; Dysart-Gale 2005; Hsieh 2006, 2008), and the impact of interpreter types on patient outcomes such as satisfaction, communication, utilization, and clinical outcomes (Flores 2005; Heath et al. 2023; Karliner et al. 2007). Previous studies have not examined the relationship between interpreter types and the protection of linguistic rights. Although translation and interpreting play a major role in asserting linguistic rights and in ensuring linguistic justice, existing literature on linguistic justice has neglected to discuss or even acknowledge the linguistic rights of migrants despite increased migration flows in the world (Bonotti et al. 2022). This paper seeks to contribute to the discussion on types of interpreters and migrants’ access to healthcare with a focus on ad hoc interpreters as SIMs.

2 Context

West Africa, like other geographical regions in Africa, is linguistically diverse. Of the 16 countries in West Africa, five use English as their official language, 10 use French, and one uses both English and French as official languages. However, there are also shared languages along the arbitrarily created borders which facilitate communication in border towns (Betek et al. 2018). For instance, Ewe is spoken in both Aflao in Ghana and Lomé in Togo, whereas Nzema is spoken in Elubo in Ghana and Noe in Côte d’Ivoire.

There is often movement across borders for trade, educational exchanges, and social connections, especially for families with cross-border ties (Lidak 2014; Sampath 2015). Individuals also cross borders to access healthcare for reasons such as proximity, lower cost, or better care quality (Miller-Thayer 2010; Peralta-Santos and Perelman 2018). Chachu (2022) refers to these individuals as migrants for health purposes (MHPs). In this paper, we focus on how MHPs in one of Ghana’s border town facilities access healthcare through the use of interpreters.

Ghana uses English as its official language and is surrounded by neighbouring countries (Togo, Côte d’Ivoire, Burkina Faso, Mali) who use French as their official language. Chachu (2022) posits that Ghana’s relatively better healthcare system attracts migrants from neighbouring francophone countries. She indicates that it can be challenging for health personnel to communicate with MHPs from these countries if they do not speak English or any of the shared border languages. These communication challenges, broadly designated as language barriers, influence healthcare quality and outcomes.

Despite these challenges, research indicates that MHPs and health workers adopt strategies to facilitate communication with each other, where there is no shared language (Ansah and Orfson-Offei 2022; Chachu 2022; Kwame 2023). Prior to this study, no clear evidence of the use of professional interpreters has been reported in Ghana (Ansah and Klugah 2021; Ansah and Orfson-Offei 2022; Chachu 2022; Glover-Meni et al. 2024). There are equally no local policies in place for the provision of medical interpreters (Lare and Chachu 2023). Additionally, until very recently, there was no official training in public service interpreting in Ghana, and medical interpreting seems to be at Phase I of professionalization (Hale 2007; Mikkelsen 1996; Tseng 1992) – a phase where anyone can be called upon to provide the service and there is very little understanding or confidence in what practitioners do.

In light of this, ad hoc interpreters seem to be the dominant types of interpreters in medical settings in Ghana (Ansah and Orfson-Offei 2022).

The health facility in this study is located in the south-western part of Ghana, near the border with Côte d'Ivoire, with Akan and Nzema being the primary languages of the community and English being the language of business in the health facility.

3 Methodology

3.1 Study design and objectives

This paper adopts a case study approach, drawing on qualitative data collected through semi-structured interviews conducted in June 2019. The objective of the study was to investigate how migrants from francophone countries with limited English proficiency communicate with healthcare providers in Ghana. Data collection included interviews with 13 healthcare personnel at a selected health facility in a town at the Ghana-Côte d'Ivoire border. The choice of a border town health facility in Ghana is premised on the fact that they are more likely to encounter MHPs. Upon receiving permission from relevant health authorities including the medical director of the health centre, we collected responses from health personnel using an open-ended, semi-structured interview guide. The interview guide (see the Appendix) consisted of four sections: demographic information, language repertoire, communication strategies, and perceptions of language use in the hospital, particularly in interactions with patients from francophone countries, as compared to other patients.

With a total of 28 questions, interviews lasted between 30 and 45 min. With the permission of the participants, the interviews were recorded using voice recorders and later transcribed. Participation was voluntary, and participants were selected through purposive sampling, as we specifically sought health workers who had experience engaging with patients from neighbouring francophone countries without a shared language. This was to ensure that the issues of language barriers and interpreting could be discussed in detail with the participants.

The data from all the interviews were analysed using thematic analysis (Braun and Clarke 2022). Key themes on the use of interpreters at the border town facility were extracted for discussion. These are presented in Table 1. For the purposes of this paper, we focus only on the theme “types of interpreters” and discuss the implications of this for linguistic rights and healthcare access.

3.2 Study participants

Fifteen health personnel volunteered to participate in the study, but we excluded two participants because they had not personally interacted with patients from francophone countries or experienced the language barriers and need-for-interpretation scenarios we had envisaged.

Table 1: Identified themes and subcategories on the use of interpreters.

Theme	Subcategories
Types of interpreters	Ad hoc interpreter, family member as interpreter, other patient interpreter, medical staff interpreter, community interpreter (“Ambulance” interpreter)
Interpreter qualifications	Untrained interpreter, lack of medical knowledge, knowledge of medical jargon
Interpreter availability	Available personnel, solicited patient escort, time-consuming
Perceived language skills	Language proficiency varies, multilingual proficiency, cross-border language skills

Among the professionals we interviewed were one physician assistant, one secretary, one dispensary assistant, two public health specialists, four nurses or midwives, two doctors, one radiology technician, and one principal health assistant. At the time of the interviews, they had been working in the hospital from 3 months to 38 years and were aged between 25 and 58 years. Seven respondents were female and six were male. Further information on the respondents can be found in Table 2.

Besides the interviews with healthcare workers, we also conducted an in-depth interview with one of the non-professional interpreters. Health personnel in the facility referred to these interpreters as Ambulances: the term “Ambulance” as used in this article should therefore not be confused with the specially equipped vehicle used in medical emergencies. These individuals accompany patients to the facility and serve as interpreters. Three such individuals are well known to medical staff at the facility and are actively recommended to patients when they happen to be on the premises and the need for interpretation arises. These Ambulances, two male and one female, are proficient in multiple languages, speaking various Ghanaian and cross-border languages including Akan, Dioula, Fulfulde, Hausa, and French. While their specific language combinations vary, they consistently accompany patients, often extended family members, from neighbouring countries to the hospital at no cost, facilitating communication between medical staff and patients. Patients who come from Mali, Niger, or Côte d’Ivoire to the healthcare facility in Ghana only have to bear the transportation and feeding costs of these interpreters. However, their services are often solicited in advance when MHPs want to visit the facility. The Ambulance that we were able to interview was introduced to us by the medical director. She had accompanied an MHP for consultation and she consented to speak with us after interpreting for the MHP. We adapted the interview guide for health personnel for her interview as we had no prior knowledge of the existence of this category of interpreters. The interview with her lasted for about 30 min and was recorded once we had obtained

Table 2: Demographic data on health personnel.

Medical personnel	Ethnic group	Duration of practice at health facility
HP1M Physician assistant, Outpatient department	Nzema	38 years
HP2F Secretary, Hospital administration	Ewe	8 years
HP3F Dispensary assistant	Ewe	8 years
HP4M Public health professional, Disease control unit	Akan	Almost 4 years
HP5F Public health specialist, Public health department	Fante	3 months
HP6M Nurse, Children’s ward	Nzema	8 years
HP7M Nurse, Emergency unit	Nzema	3.5 years
HP8F Doctor, Radiotherapy unit	Refused to indicate	9
HP9F Doctor	Refused to indicate	Refused to indicate
HP10M Radiology technician, X-ray department	Nzema	25
HP11F Midwife, Obstetrics and gynaecology unit	Akan	Almost 3 years
HP12M Nurse, General adult’s ward	Dagomba	1.5 years
HP13F Principal health assistant, Children’s outpatient department	Nzema	30 years

her verbal consent. The interview was conducted in Akan, transcribed, and then translated into English. In this paper, her quotations will be cited in English.

3.3 Ethical considerations

Clearance to conduct the interviews was obtained from the College of Humanities Ethical Review Committee of the University of Ghana (ECH 001/18–19). Site-specific approval was obtained from the management of the hospital. In addition, informed consent was obtained from all research participants.

The respondents are anonymized and pseudonymized using non-identifiable codes. For example, HP1 refers to Health Professional One, with an M or F at the end of the designation indicating whether they are a male or a female; thus we have HP1–13 with either F or M at the end of the number for the 13 respondents. The Ambulance is referred to as A.

4 Results

A study on interpreting in health centres is only relevant if there is a demonstrated need for interpreting services based on the number of health seekers from francophone countries that health personnel have to attend to on a regular basis. A larger number of health seekers may also mean more need for interpretation services. In this results section, we present the frequency of migrant patients from neighbouring countries and the four types of interpreters available at the health facility as reported by study participants. We also discuss various observations made by study participants on the use of these different types of interpreters. It can be seen from the data in Table 1 that only ad hoc interpreters were used at the health facility. The four types of ad hoc interpreters recorded were friends and family, other health facility users, health workers, and Ambulance interpreters.

4.1 Frequency of receiving patients from neighbouring countries

Our interviews revealed that the border town hospital received patients from nearby francophone countries (Côte d'Ivoire, Niger, Mali) on a daily basis, with estimates of between 5 and 45 percent of patients from such countries every day, depending on the unit or department; see Table 3 for the frequency of encountering MHPs. We had responses from different units including the Antiretroviral Therapy (ART) Centre, the Outpatient Department, the Emergency Unit, the Radiotherapy Unit, and the Maternity Unit. Unfortunately, neither the patient records unit nor hospital administration could provide us with statistical data. However, reported data from the interviews indicate that there is a considerable flow of patients from neighbouring countries who visit the border town facility to access healthcare. These numbers across hospital units also point to the need for interpreters since almost all the health personnel interviewed do not speak French nor do they have any shared languages with which to communicate with the MHPs they encounter.

4.2 Interpreters

Interpreters in legal, health, and social services seem to often rely on their linguistic abilities without institutionalized training, resulting largely in the use of ad hoc interpreters (Hale 2007). In Ghana, apart from the judicial service that hires full-time legal interpreters (mainly multilingual staff with no prior training), most other services rely on ad hoc interpreters (Chachu 2022). Studies on interpreter-mediated communication from Senegal and Burkina Faso show that non-professional interpreters, such as accompanying individuals or other health workers, are frequently used (Diop 2016; Yoda and Batchelor 2019).

Table 3: Reported frequency with which each participant encountered patients from francophone countries.

Medical personnel	Estimated number of patients from francophone countries
HP1M	5 per day, 10 on clinic days
HP2F	3–4 per day
HP3F	About 5 per day
HP4M	3–4 per day
HP5F	9 out of 20 patients per day
HP6M	More than 5 per day
HP7M	1 out of 5 patients per day
HP8F	20 per day
HP9F	Uncertain
HP10M	10–15 per week
HP11F	Uncertain
HP12M	2–3 per week
HP13F	2–9 per day

Similarly, our findings from this study confirm that Ghanaian healthcare settings rely on ad hoc interpreters. These interpreters fall into four types: friends or relatives of patients; other health facility users; healthcare professionals; and Ambulance interpreters. From the interviews, three out of the 13 respondents reported that they used friends or relatives of patients, nine indicated using other patients, 10 said they relied on healthcare professionals, and two reported using Ambulance interpreters. We now present our findings on how these types of interpreters support access to healthcare in the selected facility.

4.2.1 Friends or relatives

The first category of ad hoc interpreters includes friends or family members who accompany patients. These individuals are chosen based on perceived language skills rather than formal qualifications or medical knowledge. As one health worker (HP1M) explained, “what these francophone patients often do is that they come with someone who speaks English. And this person does the interpretation.” HP11F also stated: “Sometimes they come with relatives who speak Twi or understand Twi and a little English. So sometimes we communicate with them through their relatives.”

While this is common practice, using friends and family as interpreters can impact patients, health workers, and the interpreters themselves (Habib et al. 2023). Some health workers refuse to speak through relatives or friends when they have to discuss sensitive issues, such as sexuality or sexually transmitted infections. HP1M commented that “with a condition like HIV ... we try to let the patient understand and then we find out from the ward whether there are staff members who are able to express themselves in French”. Using other medical staff instead of interpreters who are relatives maintains patient confidentiality, particularly given the stigma often associated with such illnesses.

The health personnel we interviewed also doubted the accuracy of interpretations in some cases. For example, HP1M reported: “I saw that one of them was having difficulty expressing himself. This was the interpreter himself, so I stopped him.” HP11F also indicated that she does not have confidence in some of the interpreters who are relations because when “you want vivid explanation, the person would not give you details”. In our interpretation of the data, the interviewee is referring to specific information when she mentions “vivid explanation”. She also indicates that “sometimes, when you ask these interpreters to ask the patient a particular question, they ask a different question” and she is able to tell this by the kind of answers she receives. This clearly demonstrates that the quality of information received can be compromised in such a situation.

4.2.2 Other health facility users

The second category involves other patients in the healthcare facility or their caretakers. From our findings, in cases where there are no relatives or health personnel available to interpret, hospital staff seek out other patients or members of the public who speak the patient's language to serve as interpreters. This would usually happen in maternity clinics (during antenatal or postnatal care), the outpatient department, or the radiotherapy unit, where the conditions of other patients do not need urgent attention. HP10M indicated the following: "Sometimes I easily rely on my clients. And if I want to ask something from a patient and I wouldn't know what to say, I'll just seek their attention and ask: 'Is there anybody here who can speak French?'" HP11M mentioned that "at times, there are some patients' relatives in the ward or patients who speak French, then we call them to do the interpretation". HP4M also stated "sometimes too as they [MHPs] are here, they have people who understand Twi and some French so sometimes we call them to come and help". HP10M adds that "there is a strong reliance on other patients or their caretakers to support when there are communication challenges".

However, this seems not to be the optimum solution as feedback from health personnel indicates that this can lead to misinterpretation, as they are sometimes unable to gather the necessary information during consultations. According to HP6M:

We search for translators, those who understand Twi and the [languages spoken in Côte d'Ivoire] and they would come and do the translation. I know that it is always a problem professionally ... Because sometimes when you say one thing, they also say another thing. How would I know they are saying something else? When I ask them what I said, the interpretation they give me shows that they didn't even hear. They didn't even get what I was saying.

HP4M stated that he feels bad about not being able to speak directly with the patient and expressed concern about using an interpreter who is also a patient. According to him, "it breaks confidentiality" and he wishes it could be avoided.

4.2.3 Healthcare professionals

The third interpreting approach we observed was relying on healthcare professionals who speak and understand French or any of the local languages spoken by the patients. Such people are called upon to interpret or translate medical documents in French whenever the need arises. In this case, the staff had knowledge of medical terminology, enabling them to ask relevant questions and provide accurate interpreting between patients and medical staff. HP12M reports: "sometimes I involve one of the staff then they'll come and (interpret)." HP7M corroborates this by saying that "if you take a staff [member] too, one out of seven can speak their [the MHP's] language. If you are fortunate to be on duty with them it becomes easier." In this case, the MHPs' languages include French and other shared border languages including Nzema and Twi. It was impossible to arrive at a very reliable estimate of the number of staff members who act as ad hoc interpreters as there is no official data available.

One perceived advantage of relying on health personnel for help in interpreting is the fact that they have an understanding of medical jargon and can probe further with the right questions, which makes it more likely that diagnosis and treatment will be easier. This was confirmed by HP6M when he stated that "the person should be a medical personnel speaking French". HP11F also indicated that it would be good to train multilingual midwives in interpreting because "there are certain things that if you are not a midwife, you will not understand". About 80 percent of our respondents indicated a preference for health personnel as interpreters over the other types of interpreters mainly because they are more confident of the communication process since the health workers have the required medical jargon.

4.2.4 Ambulance interpreters

The Ambulance interpreter that we interviewed is a Ghanaian woman in her forties. Although a member of the Hausa ethnic group, she grew up in the Akan-speaking community of Koforidua, thus affording her a rare level of

language proficiency in the languages that are dominant in both the northern and the southern regions of Ghana. Married to a Nigerien, she is fluent in French, Akan, Dioula, Fulfulde, Krobo, Zaberma (known locally as Zamerama), and Hausa, though she does not speak English; she therefore communicates with health personnel and patients using a shared language. She stated how she is often contracted by her husband's extended family to accompany sick or labouring relatives to the hospital when they are likely to encounter language challenges. In her words: "For some, at the time they arrive, no one can communicate with them, so when the doctor comes the person speaks through me to the doctor."

At the time of the interview, she reported she had been serving as an Ambulance interpreter for over 20 years and visits the hospital about "twice a week" sometimes with multiple clients or trips in a day; as she put it: "Today I came here [earlier] and I have come back again." According to her, of the other two Ambulance interpreters, one is a Malian gentleman who has resided in Ghana for an extended period, acquiring proficiency in Twi. The other is a Nigerien gentleman who has also spent significant time in Ghana.

From her account, the three interpreters, who all belong to minority ethnic groups, are contacted by migrants from francophone countries who require language assistance. They are not compensated financially, however, their transportation and meals are covered during their period of service. Interestingly, there seems to be a gender-based division of labour, with the female interpreter typically accompanying female patients and the male interpreters accompanying male patients.

The Ambulance interpreter seems to view her role as a cultural broker (Angelelli 2004). She narrated a situation where she had accompanied another lady to the hospital for fertility issues. According to her, after examination, the doctor indicated that the patient's womb had to be removed. However, the Ambulance kept this information from the patient and rather informed the patient's husband, because she assumed he would be emotionally and psychologically strong enough to take the news and comfort his wife, which possibly stems from patriarchal cultural norms.

5 Discussion and conclusion

As mentioned earlier, previous studies on the types of interpreter services used in healthcare facilities in Ghana found ad hoc interpreters to be dominant (Ansah and Klugah 2021; Glover-Meni et al. 2024). Prior studies, however, focused on autochthonous linguistic communities. Very little was found in the literature on the question of migrants' linguistic rights in public institutions such as hospitals. One of the aims of this paper was to discuss whether access to healthcare, as enshrined in SDG 3, is safeguarded irrespective of the linguistic repertoire of migrants in Ghana. Responses from study participants of the selected border healthcare facility show that healthcare personnel make an effort to communicate with migrant patients irrespective of their linguistic repertoire and therefore do not hinder migrants from getting access to healthcare. This finding corroborates the ideas of Patten (2014) on SIMs making communication between the institution and persons with limited proficiency in the usual language of business possible, so these persons can access the institution's services. Consistent with Bonotti et al. (2022), we see the use of ad hoc interpreters here as SIMs for MHPs. These ad hoc interpreters include family and friends, healthcare professionals, other health facility users, and Ambulances. An interesting finding was that almost as many respondents reported using healthcare professionals as using other health facility users, and these were the two highest ad hoc interpreter types used. Another important finding was that the health personnel reported challenges with two types of ad hoc interpreters, namely friends or relatives and other health facility users. These issues include perceived misinterpretation, inaccuracies, and disclosure of sensitive patient information. The interview with the Ambulance interpreter, for example, revealed the disclosure of sensitive information to a third party – consistent with patriarchal cultural norms (Diabah and Amfo 2018). These issues were not reported for medical staff serving as ad hoc interpreters. The findings reported here suggest that there is higher satisfaction with the use of healthcare professionals than with other types of interpreters. It is possible, therefore, that MHPs who used interpreter types other than other health personnel were limited in their access to quality and essential care and therefore less likely to be satisfied with the services; however, further studies are needed to confirm this.

This study has a limitation inasmuch as the diagnostic value of the data collected, and its applicability to other contexts, cannot be easily determined. Further research is required to revise, consolidate, and identify more general diagnostic tools and to test whether the same argument could be applied to the rights to access to healthcare in contexts other than Ghana. However, in this context, we make three recommendations. Firstly, ad hoc interpreters operating in healthcare institutions should be given training in public service interpreting. Secondly, in order to achieve this, there must also be training for trainers of medical interpreters. Finally, regular workshops and systematic guidelines on multilingual communication and migrant patients' linguistic rights should also be implemented to ensure continued respect for linguistic rights and enforcement of linguistic justice in health facilities.

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Appendix: Interview guide for research project (health personnel)

Project title: Understanding language dynamics in health care access among francophone migrants in Ghana

Demographics

- (1) Age
- (2) Gender
- (3) Tribe/ethnic group
- (4) Profession/trade
- (5) Department/unit in the hospital
- (6) How long have you been working in the hospital/unit/department?
- (7) What is the name of the health sector you work in?

Languages repertoire

8. How many languages do you speak (both local and international)? – Mention them all.
9. Which of these languages are you most proficient/comfortable in?
10. Which of these languages do you use:
 - a. At work?
 - b. At home?
 - c. At church/mosque?
 - d. At social functions?
11. Have you ever studied French? At what level? For how many years?
12. How would you describe your knowledge of the French language? (very basic, basic, intermediate, proficient)

Communication strategies and perceptions of language use in the hospital

13. In your years of practice, have you come across francophone patients? In which health facility?
14. How many? (rough estimate)
15. What language or languages did you speak with the francophone patients?
16. Did you experience difficulty communicating with the francophone patients?
17. Where you didn't understand the patient, what did you do?
18. Where you didn't understand the patient, how did you feel?
19. Did you feel that the patient understood whatever you were communicating with them?
20. Where you felt the patient was not understanding you, what did you do?
21. Where an interpreter was used, did you feel confident that the person was communicating exactly what you or the patient wanted to say?
22. Did you feel comfortable having to express yourself through another person? Explain your answer.
23. How did difficulty in understanding each other affect the healthcare process?
24. Do you think there is the need for professionally trained interpreters in the health sector? Explain your answer.

Perception of interactions with francophone patients relative to other patients

25. How would you describe your experience with the francophone patients you encountered as compared to anglophone patients?
26. Aside from communication difficulties, would you say they are different in relation to other patients? Explain your answer.
27. Are francophone patients more open than other patients or vice versa? Explain your answer.
28. Have you noticed any trend among francophones about their communication of health issues?

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