NEK CNE

National Advisory Commission on Biomedical Ethics NCE

Allophone migrants and the healthcare system

Ethical issues of community interpreting

Position statement n° 27/2017
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Abstract and Recommendations

According to the Federal Statistics Office, the principle language of nine per cent of the population in Switzerland is not a national language; of these people, approximately one third do not understand any of the national languages. The literature shows that when one of these persons falls ill the language barriers may become a considerable obstacle to their healthcare, both clinically – leading for example to over- or under-provision of treatments, to medical errors, re-hospitalisations – and ethically. In fact, in order for carers to make a correct diagnosis and set up an appropriate and effective treatment, it is indispensable that they fully understand the healthcare needs of the patient. An important constituent of this understanding occurs through language: language barriers may therefore diminish, complicate, and even prevent this understanding. Consequently, language barriers need to be eliminated by providing community interpreting and cultural mediation. Mutual understanding in the healthcare field meets the legal and ethical standard requirements – such as the principles of equality of treatment and non-discrimination, adherence to good clinical practices and to professional secrecy – as well as ethical requirements, such as the protection of the dignity and of the autonomy of the patient. The right to access healthcare, particularly to emergency care, is legally established and must be guaranteed for all patients, independently of their situation, their need for healthcare or their legal status.

Switzerland is a multilingual country and problems associated with mutual understanding are frequent. The requirements put forward in the present position statement thus apply to each patient, independently of origin, residence or legal status (citizen, immigrant, asylum seeker, refugee or undocumented migrant). However, these problems are accentuated for migrants, who are often considerably more vulnerable. The injustices that they are likely to experience depend not only on their spoken language and their ability to make themselves understood, but also because they are culturally foreign, on the implicit associations that they create, as well as on other problems, such as traumas, their meagre understanding of matters of health, on loneliness and on insecurity, to which they are exposed.

To remove the language barriers of migrant patients, it is not enough to understand the language that they speak, one must also access their perceptions of the illness, of health and of the cure, which for them means a choice that is free of any outside interference, an understanding of the available healthcare system, their values, ideals and expectations. The healthcare services are also culturally specific. Community interpreting must also be accompanied by cultural mediation; this involves skills that each health professional needs to be aware of.

Access to communication is a prerequisite for everyone to have access to universal human rights.

In view of the developments in our societies, the creation of measures adapted to the healthcare of migrants and the needs of healthcare institutions will not be able to be made based exclusively on spontaneous and sporadic initiatives that differ from one canton to another between healthcare institutions and healthcare providers within a hospital or ambulatory setting or in private practice. It must be sustained, notably by financing secured at the national level by coherent choices of healthcare policies that meet the obligations of a state governed by the rule of law, notably in respect of patients' rights.

Accordingly, the CNE unanimously formulates the following recommendations:

1. Community interpreting is needed to guarantee the rights of people throughout the healthcare system when there exists a linguistic barrier.

- Access to this service must be guaranteed.
- An offer of community interpreting and cultural mediation capable of responding to the needs of migrant populations should be implemented uniformly throughout Switzerland.
- The training of interpreters and cultural mediators must be ensured.

2. Health professionals must be made aware of the intercultural challenges specific to patient care.

3. In Switzerland, there is a lack of systematic statistical data on the health of migrants and on the prevalence of language barriers. These data are indispensable for the development of a coherent and effective health policy.

1. INTRODUCTION

Language barriers in the healthcare systems may cause objective mistakes, such as false diagnoses or over- or under-treatments. Not to take account of language-linked obstacles may in this sense be construed as a professional fault, a breach of the duty to exercise due care, and also imperil the principle of equality within our healthcare system, as this amounts to discrimination. Language barriers not only concern people from a migrant background. Firstly, language barriers may also exist for Swiss citizens, and secondly, not all migrants are faced with language barriers. The aim to eliminate language barriers in healthcare therefore represents an opportunity to improve the quality of healthcare for all, including Swiss patients when they are treated outside the linguistic region in which they live.

The present position statement does not concern all migrants but only a smaller group: Those among them, who by not understanding any national language of Switzerland, are confronted with specific problems relating to accessing the healthcare system. An improved management of allophone patients and the elimination of language barriers represent a decided advantage for all patients, whom for one reason or another and independently of their legal status find themselves in this situation.

According to the Federal Statistics Office, **people from a migrant background** made up 35.4% of the total population in Switzerland in 2014 (SFO 2016b), and 9% of the population (about 700 000 people) have a first language that differs from the national languages (SFO 2016a). Among them, 200 000 understand neither a national language nor English (Group of network experts SH4E 2016, 1). Moreover, an estimated 70 000 to 180 000 foreigners (referred to as undocumented migrants) live illegally in Switzerland (Spang & Zuppinger 2010, 197).

In 2015 in a high-level meeting on the health of migrants and refugees, the Member States of the European region of WHO defined and adopted a framework for collaborative action on the health of refugees and migrants. In a final document entitled *Stepping up action on refugee and migrant health*, they reiterated that: "The refugees and migrant risk or lose their lives, endure tremendous hardship and suffering, have often undergone a dangerous and sometimes traumatic journey, do not speak the local language and are fearful. Migrant-sensitive health systems should aim to overcome barriers to health care such as language, administrative hurdles and lack of information about health entitlements, and answer the needs of all people, without discrimination, including on cultural and religious grounds" (WHO Regional Office for Europe 2015, 1.5).

In the report, "Migrant health Promotion", the WHO Secretariat defined future priorities, including: "to ensure that health services are culturally, linguistically and epidemiologically appropriate, and increase the capacities among the health workforce to understand and address the health issues associated with population displacement" (WHO 2016, 4).

The Constitution of the World Health Organization states that, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (WHO 1946). The Committee on economic, social and cultural rights gave an interpretation of the "right to the highest attainable standard of health" (Committee ESC, 2000, as defined in the International Covenant on Economic, Social and Cultural Rights (WHO 1966, art. 12). This right presupposes freedoms, which “include the right to control one’s health and body, […], and the right to be free from interference” (Committee ESC, 2000, art. 8); and other rights such as “the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health" (id.). In particular, the Committee ESC explains that “the notion of the “highest attainable standard of health” […] takes into account both the individual’s biological and socio-economic preconditions and a State’s available resources.” (Id., art. 9).

Studies show that **recourse to professional interpretation services is associated with an overall improved clinical care** of patients with limited language proficiency, reduces misunderstandings and errors of communication involving significant clinical outcomes, provides an improved understanding and patient satisfaction and to the results of the treatments (Karliner et al 2007; Flores et al 2012; Lindholm et al. 2012). Adequate communication fosters the creation of a therapeutic relationship - by establishing, thanks mainly to a better understanding of the patient’s life history, a trusting relationship and a partnership - allowing patient and physician to decide on a treatment plan, and ensure adherence to treatment, as well as to the patient’s autonomy (Rocque & Leanza 2015). It can also avoid additional costs for the health system; studies show that if interpreters are not used, this may lead, for example, to higher rates of readmission within 30 days and to significantly longer hospital stays (Karliner et al. 2007; Lindholm et al. 2012).

Professional, trained interpreters have a significantly lower likelihood of making errors of a potentially serious clinical consequence (Flores et al 2012). They possess a thorough knowledge of medical terminology, and are acquainted with the different aspects of the relationship between healthcare and the hospital setting (Björn 2005). Health professionals, in turn, must be aware of the intercultural issues, develop transcultural skills, and know how to recognise when it is important to use the services of a professional community interpreter (Alpers 2016; Krupic et al. 2016). It is also important that they identify those situations that need the services of an interpreter (according to the actual conditions, for example face to face, by telephone or by video) and that they learn to work with the latter.

Conversely, when it is considered not to use the services of a professional interpreter, but instead an ad hoc interpreter (in other words an “informal” interpreter) such as hospital employees, friends of the patient, parents or relatives, it was found that the patients feel embarrassed, guilty or uncomfortable (Rocque & Leanza 2015). The literature shows that the **use of *ad hoc* interpreters** such as hospital employees, friends of the patient, parents or relatives, **is taken badly by the patients** (id). Furthermore, **this practice may have detrimental consequences**: errors in translation may lead to certain questions by carers being omitted or misconstrued; in addition, certain information, such as secondary effects for example, risk being incorrectly translated (Lindholm et al. 2012). Also, as the *ad hoc* interpreters have not received specific training, they may not always remain neutral and may suffer emotional stress linked to their task. For example, when a young son or daughter acts as the interpreter, they run the risk of finding themselves in very difficult circumstances when they communicate a severe diagnosis (such as a cancer or a severely debilitating disease).

It should be emphasised here that access to healthcare and equality of treatment may also be jeopardised by a **lack of competence in healthcare** (see Bieri et al. 2016; Ackermann Rau, Sakarya & Abel 2016; Bonaccorsi et al. 2016; Sørensen et al. 2012; Sommerhalder & Abel 2007; BAG 2006; Institute of Medicine Committee on Health Literacy 2004; WHO 1998).

Indeed, continued observation of the state of health of the migrant population has shown this to be the case. In fact, the FOPH carried out two surveys in 2004 (GMM I) and 2010 (GMM II) on certain groups of the migrant population.[1] By examining the health situation, the health related behaviour and the use of the health system, the surveys revealed "marked differences between the diverse groups that make up the population in Switzerland. In many cases the state of physical and mental state of health of the people who were surveyed was found to be worse than that of the indigenous people" (FPOH 2004; FPOH 2010). The WHO report on poverty and social exclusion (WHO 2010) also underlines this: in Switzerland the health literacy of migrants is lower due to linguistic and cultural barriers. This leads to an inadequate knowledge, even a total lack of understanding of the health system and the preventive services, as well as a distrust of them and a failure to adhere, thereby leading to inequalities in the utilisation of the system and its services and, finally in the state of health of the persons in question.

In this opinion, the CNE is concerned exclusively with ethical issues created by the existence of language barriers when allophone patients, notably migrant patients, access healthcare. Questions and economic issues linked to community interpreting have been voluntarily excluded from the present discussion. Indeed, the assessment of the overall costs (costs generated directly by setting up an interpretation service, and the costs generated indirectly from the absence of such a service, namely the over- and under-provision of treatments, re-hospitalisations, diagnostic errors resulting in serious medical consequences, etc.) does not fall within the competence of the CNE. The following chapters provide some terminological clarifications and give information on **the migratory situation** and **ethico-legal provisions** that relate to the implementation of health policies at the national and international level. The fourth chapter reveals the principle **rights of patients** to be asserted when persons with a migration background are provided with healthcare. The probl ems that arise when language barriers exist are then discussed from the point of view of both the patients and the carers. The moral obligations that fall to the community in respect of the development of a **healthcare system that can provide a sustainable response** to the needs created by our changing society are also emphasised. The opinion is concluded by our recommendations.

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[1] In the resident population, immigrants originating from Turkey, Portugal, Serbia and Kosovo, and among the asylum seekers, Tamils and people from Somalia (GMMII). The monitoring of 2004 involved the migrant population from Italy, Germany, Austria and France, the permanent resident population from ex-Yugoslavia, Portugal, Turkey and Sri Lanka and finally the asylum seekers from Sri Lanka and Kosovo (GMMI). See: Monitoring of the health status of the migrant population (FPOH 2004; FPOH 2010).

2. DEFINITIONS

Those considered as **allophones** are patients who do not understand what is said and/or are incapable of making themselves understood because they do not master any Swiss national language. The Federal Statistics Office (FSO) states that the migratory status of a person is determined by the combination of four variables: the "country of birth", the "nationality at birth" and the "current nationality" of the person in question, as well as "the country of birth" of their two parents (FSO 2016b). The term, "migrant" is generally understood as "a person who establishes a (semi-) permanent new residence in a "place" other than that in which they habitually lived"[2] (Urquia & Gagnon 2011, 470). The International Organization for Migration (IOM) gives a more precise definition for migration: "The movement of a person or a group of persons, either across an international border, or within a State. The notion of migration encompasses any kind of movement of people implying a change in their habitual place of residence, regardless of the cause, the composition, the duration; it includes migration of workers, refugees, displaced and uprooted persons" (IOM 2007).

In the present opinion the CNE concentrates on **international migration**, which concerns people moving from one State to another (as opposed to "internal" migration that concerns people moving within a State). As previously mentioned, people decide to migrate for different reasons, such as globalisation or poverty, war, persecutions, changes or climatic catastrophes, access to healthcare, employment or education. Consequently, migrants in Switzerland do not constitute a homogeneous category. They may be economic migrants, refugees, asylum seekers, populations victims of trafficking, irregular (or illegal) migrants (WHO 2016). The common characteristic of the population that concerns us is the fact of being allophone: a characteristic that brings with it an additional factor of vulnerability in the context of healthcare.

This specific factor of vulnerability can be reduced by resorting to a service of community interpreting. As INTERPRET – the Swiss Association for Community Interpretation and Cultural Mediation, an independent association founded in 1999 – makes clear, **community interpretation** denotes "oral translation (consecutive translation) from one language to another of all that is said, *taking into account the social and cultural origin of the persons taking part in the interview*. It occurs in the context of a trialogue – "dialogue between three" – in which the community interpreter may be physically present or be in communication by telephone". (INTERPRET 2016, our added emphasis). Interpreters require technical knowledge (level of proficiency in the language, knowledge of consecutive interpreting, knowledge of the basic specialised terminology in the field in question), cultural and inter-relational abilities; moreover, they are familiar with the principles of professional ethics. The interpreters are therefore qualified persons who provide a **professional service**.

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2) "A migrant is a person who has established a (semi-)permanent new residence in a "place" other than that in which they habitually lived" (Urquia & Gagnon 2011, 470).

3. PRESENT STATUS

3.1 International context

In 2015 there were 244 million migrants, of which 20 million were refugees; 4.2 million new refugees have arrived over the last years in Middle-Eastern countries; 2.5 million refugees have arrived in Turkey since 2012 and, more than 1.2 million new migrants, asylum seekers and refugees arrived in Europe by the end of 2015 (WHO 2016, based on estimations by the United Nations Commission on Population and Development and by the Office of the UN High Commissioner for Refugees). It must be expected that "the movements of migrants and refugees will continue on a massive scale in the foreseeable future" (WHO 2016"). The challenges, including health, associated with migrants and refugees, are at both a national as well as a global level. It is estimated that 5% of these migrants and refugees need immediate access to healthcare services (id, 3).

Resolution WHA61.17 of the World Health Assembly, entitled "Health of Migrants" (WHO 2008) constitutes a reference document in relation to the development of healthcare policies for migrants. Among the measures that Member States are invited to undertake, the following may be mentioned: "to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race" (id, point 2); "to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery" (id, point 4); and "to raise health service providers' and professionals' cultural and gender sensitivity to migrant's health issues" (id point 6).

In its report on the health of migrants the Secretariat underlined four basic principles for providing guidance for an approach to public health targeted on migrants: 1) **to avoid disparities** in health status and access to health services between migrants and the host population. 2) **to ensure migrants' health rights**. This entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions. 3) to put in place lifesaving interventions so as **to reduce excess mortality and morbidity**; and 4) **to minimise the negative impact of the migration process on migrants' health outcomes** (WHO 2010, 109-110).

With this resolution in mind, WHO, in collaboration with the International Organization for Migration (IOM) and the Ministry of Health and Social Policy of the Government of Spain, drew up a report entitled Health of Migrants: *The Way Forward* (WHO 2010) – in which the need to ensure equitable access to the healthcare system is underlined. In regard to language barriers, the Report notes in particular that: "Provision of interpretation services and language-appropriate written materials is often the first and most critical intervention implemented to improve the migrants' experience in the health care system. Research shows that language barriers have a negative effect on access to care and prevention services, adherence to treatment plans, timely follow-up, and appropriate use of emergency departments. Misunderstandings of symptoms or mistranslations have resulted in delayed care, clinically significant medical errors, and death. From a clinical ethics and human rights perspective, accurate communication is essential to obtain consent for health interventions and treatment and to guarantee confidentiality and privacy about health information" (id., 62).

Within the Council of Europe the ministerial commission recommends, inter alia: "to promote knowledge among migrants about issues concerning health and the health system, and take measures to increase the accessibility of health services" (Council of Europe 2011, v) and, notably: "to overcome language barriers by appropriate measures, including interpreting services and access to translated information materials wherever necessary" (id, vi) and "to improve the adaptation of health service provisions to the needs, culture and social situation of migrants" (id, vii). In the Annex to the recommendation CM/Rec(2011)13, the guidelines to paragraphs 15 and 16 state that: "The provision of high-quality interpreting services, as well as translated versions of written information, should be promoted by relevant authorities in order to improve both the accessibility and the quality of health care for migrants" (id, E, 15) and that "Consideration should be given to all available methods of reducing language barriers, including translation by telephone and video, face-to-face interpretation, the provision of "intercultural mediators" and helping migrants to learn the language of the host country. Dependence on informal, untrained interpreters, in particular family members, should be avoided. (id E, 16).

In analysing the essential components of the **right to the best possible state of health**, the authors of the report, entitled *International Migration, Health and Human Rights*, remark that: "Migrant-sensitive health services may include interpretation, translated written materials and "cultural mediation" in hospitals and health centres. Introducing these services can assist in tackling language and cultural barriers – both of which can have negative effects on care and prevention services, treatment plans and appropriate follow-ups – as well as avoid misunderstandings (e.g. when a patient relates his or her symptoms) or mistranslations, which may result in delayed care, clinically significant medical errors, or, as a worst-case scenario, death" (IMO 2013, 19-20). Based on these analyses the authors underline the obligations of States: "The right to health is equally tied to the key principle of non-discrimination, which recognizes the "inherent dignity" of every human being, locals and migrants alike. […] Accordingly, states have an obligation to protect and promote the rights of migrants without discrimination of any kind. Furthermore, States are equally obligated to eliminate any discrimination that takes place in their respective territories. The **principles of non-discrimination and equal treatment of all**, including migrants, are applicable to elements of the right to health, such that states must ensure that health facilities, foods and services are available, accessible, acceptable and of good quality" (id, 51; our emphases).

3.2 Current context in Switzerland

The Federal Office of Public Health states that in Switzerland, "the migrants from the more vulnerable sectors of the population with a low level of training are in poorer physical and mental health than the average. It is more difficult for them to adopt a health-focused approach and to properly access our health system because of difficulties in understanding and socio-cultural barriers".[3]

In spite of the measures put in place to improve access to the health system (cf. 3.2.2), notably in regard to language barriers, these measures still **vary enormously** and **differ from one canton to another. The arrangements for community interpretation still need to be developed** in order to meet the needs of the allophone population throughout Switzerland and the **required financing has not yet been ensured on a sustainable basis**.

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[3] http://www.bag.admin.ch/themen/gesundheitspolitik/07685/07688/index.html?lang=fr

3.2.1 Needs according to healthcare situations

Swiss and international experience (see the program of the 2016 National Conference of the *Swiss Hospitals for Equity*)[4] encourages ways to differentiate the types of arrangements according to the healthcare needs. In Switzerland, one usually differentiates between, on the one hand, primary healthcare (surgery and internal medicine) – provided in hospitals or by physicians in private practice – and, on the other hand, specialist care, which includes public sector or private healthcare professionals.

In order to ensure the quality of healthcare and an efficient use of resources, it is helpful to think through the terms of action of community interpretation according to the types of clinical situations and consultations which arise, whether they be somatic or psychiatric:

- Acute care in an emergency and / or crisis situation
- General medical care and primary healthcare
- Specialised healthcare for chronic diseases

a) Acute care in an emergency and / or crisis situation

In these situations the accent must be placed on communication in order to ensure the quality of the anamnesis, the clinical examination, and with the aim of being able to inform the patients and family (in the case of a child) of the therapeutic measures that need to be taken. This type of situation is centred on a medical problem that requires a rapid response. This situation thus requires an interpreter to be available without delay who can translate the questions and responses of the patient in a timely manner. The anamnesis and the clinical examination must firstly ensure the quality of the diagnosis and then identify an adequate medical treatment. Whenever possible the patient must be informed of the course of the treatment, the desired effects, as well as the inherent risks. In order to be effective, it is essential that the interpreters be trained and are aware of the medical world, i.e. they master the technical language and understand the organisation of our healthcare systems. This type of service may be obtained by telephone (e.g. the National Telephone Interpreting Service, AOZ, M.E.T.I.S).

b) General medical care and / or primary healthcare

Patients who attend consultations for general medical care have medical needs that need to be assessed and treated. However, the consultation also provides the opportunity for the patients to be able to confide in the physician and talk about their suffering, in as far as the conditions allow, namely that the physicians have time, that they are available and that they can create an environment of trust. Taking into account subjective demands of the patient is essential for quality medical care; it allows treatments to be adjusted, patients to be reassured and steps to be taken such that the patient feels welcomed as an individual.

c) Specialised healthcare for chronic diseases

As with primary healthcare and general medical care, the physician must be able to follow the specific medical problem associated with chronic diseases (diabetes, oncological or psychiatric diseases, for example). The follow-up and treatments that result therefrom can be complex and require extensive

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[4] Consultable under http://www.hospitals4equity.ch/index.php/fr/news

explanations in order to establish a therapeutic alliance and adherence to the treatment. Furthermore, the illness affects the future of the patients, who may see themselves obliged to accept the hardship and the duration of the treatments and confront questions of life and death. In these situations the care is demanding, because one must be able to understand how the disease will affect the patient, the fears and psychological suffering that it will cause, in order to be able to offer them adequate support.

For these two types of situations, primary healthcare and specialised care for chronic diseases, the availability of community interpretation enables a continuity in healthcare to be offered. In fact, in order to be able to be associated with the process, the interpreter must be present in the role of an auxiliary healthcare worker, even, depending on the treatment, as a co-therapist. In order that the patient may really confide, it is essential that he/she be put at ease by the persons who receive his/her outpouring of sufferance.

The particular case of psychiatry should be mentioned. It is well known that the occurrence of psychiatric disorders is particularly high among migrants; in particular linked to the separation and violence they experienced. Psychosomatic disorders, anxiety and post-traumatic stress syndromes are particularly frequent.

In this specific context of healthcare, a relationship of trust is essential. Reliability as well as the continuity of the link to the therapist and the interpreter must be fully ensured during the course of the treatment, so as to be able to address the mental issues and to propose psychotherapy when this is indicated. The requirements needed to conduct a psychotherapy under these conditions are emotionally demanding and they have to explicitly take into account the presence of the interpreter as a third party (Nobs & Simon 2012). The interpreters must have had a training in community interpreting, and depending on the field they deal with, must be aware of the medical issues that they will meet. Physicians, nurses and other involved parties must also possess the special skills required for the provision of healthcare.

3.2.2 Offers in regard to community interpreting

Different organisations and facilities for community interpretation, which have proved their worth, exist in Switzerland. To improve the state of health of migrants living in Switzerland, the Federal Council charged the FOPH to put in place, as of 2002, the **National Migration and Health Programme**. This programme has a budget of 2 million francs and has been extended twice (thus covering three periods: 2002-2007; 2008-2013 and 2014-2017). It implements measures in the following four fields of action: 1) health promotion and prevention; 2) training and medical cover; 3) community interpreting and 4) research and knowledge management.[5] The programme, which forms part of the objectives of the global strategy "Health2020" (FOPH 2013a), whose measures aim, inter alia, to reinforce the equality of opportunity and to improve the quality of healthcare, has several projects such as: the website **migesplus.ch**, providing information on health and the healthcare system adapted to the mother tongues of migrants; the competence centre **Interpret** ensures a high-quality interpretation service; the **National**

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[5] Consultable under http://www.hospitals4equity.ch/index.php/fr/news

Telephone Interpreting Service, available 24 hours a day in 30 languages; the creation of the hospital network "**Swiss Hospitals for Equity**" (previously known as the *Migrant Friendly Hospitals*) developing competence centres for the healthcare for the migrant population.

Significant coordination work is needed to ensure that this offer can be correctly used by the requesting services. This work varies from one canton and healthcare service to another. Certain schemes integrate new technologies and propose video-conferencing. This type of service has not yet been implemented in Switzerland (the hospital in Solothurn is developing a pilot project for interpretation by video, to be completed by the end of 2017). In some cantons, there is a community interpretation service that is available to the public service. The interpreters then intervene promptly and directly in medical consultations.

3.2.3 Training

In this regard, the National Migration and Health Programme is developing projects to promote training. On the one hand, **the training of community interpreters to a good level** (by the competence centre **Interpret**); on the other hand, a **basic and further training of healthcare professionals**, by means of the **migesplus.ch** platform that provides information on health and migration to migrants and professionals, or the e-learning programme[6] likewise intended for healthcare professionals and promoting a professional approach in regard to migrant patients. It should, however, be noted that these measures require access to the internet; this access is not possible for all and in particular not to those particularly vulnerable and marginalised migrants.

3.2.4 Institutional and healthcare anchoring

Certain university hospitals, on their own initiative, have developed and financed healthcare facilities for migrants. Community interpretation represents an essential component of an equitable and quality healthcare system (Bischoff & Denhaerynck 2010). In this regard, national planning – with the twin aims of establishing sustainable financing and a quality certification for community interpretation and cultural mediation services – is needed to ensure an adequate and efficient provision of healthcare throughout the country and for each patient who is confronted with language barriers and/or problems of a transcultural dimension.

Here, it should be made clear that as the transcultural dimension, by definition, is bilateral, it is important that the services be also trained so as to be able to explain the specific requirements of the Swiss healthcare system. This applies to central and peripheral hospitals, outpatient care and private practices. The quality of the provided services of community interpretation should be monitored according to the types and methods appropriate to different situations, and should form part of the implementation of these provisions (Krupic et al 2016; VanderWielen et al. 2014; Green et al. 2005).

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6) cf. www.elearning-iq.ch

4. Ethical issues of community interpreting

At the international and national level, numerous legislative developments underline the rights of migrants to equality in healthcare and to the quality of the care. In this chapter, it will be specified which moral interests of migrant patients are protected by these rights, and the ethical obligations placed on carers in regard to migrant patient care. It should be emphasised that the rights of migrant patients and the rights and obligations of professionals toward them are complementary. This is the case, for example, for the right to informational self-determination, such as the expression of the independence of the individuals and/or of the patients in the handling of the information that relates to them, and which is protected by medical confidentiality. The use of an *ad hoc* translator risks, as we will see, to prejudice the rights to a fair treatment in the exercise of informed consent as well as to the protection of the personal sphere. Consequently, the sub-division operated below is for ease of reference only.sonnelle. Par conséquent, la subdivision opérée ci-dessous répond uniquement à un souci de clarté

4.1 The rights of patients

4.1.1 Protection: the particular vulnerability of migrants

From the ethical point of view, vulnerability begins by a substantive consensus. It is generally agreed that vulnerable persons have, in particular, the right to protection – or to special attention. The reason for this is based on the importance of equal dignity of each human being and equal rights of all. When persons are vulnerable it is because they find themselves in a situation where there is an increased risk that they may suffer harm (Martin, Tavaglione & Hurst 2014). Certain vulnerable persons are less capable of defending their own interests. Others find themselves in situations where their interests are more difficult to defend, even if their ability to defend them is not diminished. Accordingly, it is possible to be vulnerable in all sorts of ways, and for all sorts of reasons. We may all become particularly vulnerable to a particular injustice at a given moment, for different reasons. To protect vulnerable persons requires us to identify the injustice to which a person or a group of people is most exposed, the reasons that undermine a right, the means adapted for the protection, and the people who share responsibility for this protection.

Although Swiss residents outside their linguistic region, a migrant for example or a refugee, may suffer the same difficulties (such as an insufficient understanding of the language and ability in matters of health), those difficulties met by the migrant or refugee, risk being somewhat greater, as they may add to other factors that influence their state of health (such as the loss of a social support network, the lack of employment, the forced abandon of their country of origin and the ensuing traumas). These persons would therefore ultimately find themselves in a greater situation of vulnerability. Furthermore, among the migrant workers, for example a highly qualified foreigner working in Switzerland, could be able to compensate for shortcomings in skills in the national languages by an understanding of health matters – notably an understanding of the available healthcare services -, whereas an itinerant worker could find himself/herself unable to do this. From there, for a good understanding of the issues met when accessing the healthcare system, it is important to **differentiate the issues** and to **identify the particular burden on the individual or the group in question**.

Allophone migrants may have different types of vulnerability. When considering a plausible list of rights in the field of medicine (Tavaglione et al, 2015), it must be concluded that in general these rights can be undermined. The right to physical integrity is more difficult to defend for patients who do not understand the risks associated with an intervention that is explained in a foreign language, and who, for the same reason, do not have access to information on the treatment that is available to them. Their autonomy (cf. 4. 1. 3) will be limited by the absence of information on the available options. In certain cases, the options will anyway be limited by the health insurance contract, and thereby the freedom of choice of the patient. The difficulties associated with understanding a complex system of health, often new to patients, can exacerbate these obstacles, particularly when a language barrier also exists. The difficulty in understanding the available options and the limitation of the options both limit access to the provision of basic healthcare benefits. The risk run by these persons of being victims of implicit biases or of stereotyping may put into question the impartiality of the authority in the institutions. Contact with a healthcare system that in practice limits access by a language barrier and places limitations on the options can be construed as undermining the social foundations of self-respect (cf. 4. 1. 4).

The vulnerabilities of allophone migrants can therefore accumulate. Some may have a corrosive impact, one vulnerability leading to another (Wolff et De-Shalit 2007). The language barrier, limited healthcare cover, the risk of implicit associations, economic inequality (WHO Regional Office for Europe 2010; Guessous et al 2012) and the fragility of the right to residence, can all bring allophone migrants into a situation of accumulated or corrosive vulnerability.

This notion of vulnerability also depends on that which is recognised as being part of the moral rights of a given population. The situations of allophone migrants differ greatly (economic migrants, asylum seekers, refugees, undocumented migrants, etc.). In some of these situations the extent of their rights is politically controversial. It should, however, be noted that even in these cases it is clear that they have some rights. Since a language barrier can undermine these rights then it is a source of vulnerability.

4.1.2 Equality: equal access to healthcare

Equality is a fundamental value of our society and a **basic principle of the rule of law**. The Constitution affirms that "All human beings are equal before the law" (art. 8, para 1, Cst) and that everyone has the right to the means "indispensable to lead an existence in conformity with human dignity" (art. 12 Cst); **the principle of non-discrimination** emanates from this right (art. 8, para 2, Cst; art. 14 ECHR (Council of Europe 1950)). Moreover, the Federal Tribunal declared that the right of access to emergency healthcare, even for undocumented migrants, must be guaranteed (ATF 2005).[7]

Access to healthcare may be different from one person to another. There are many causes and diverse reasons for these differences: meagre economic resources, lack of understanding of healthcare, and language fluency. Generally speaking, the **social determinants of health** are these individual inequalities (among which are also age, gender, living conditions, socio-economic level, etc.) having an influence on the state of health of individuals or of groups of people (WHO 2009). Collective identities, such as the organisation of the health system and the context of migration also constitute the social determinants of health.

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[7] See also the position statement of the NCE (2005) and the advisory opinion of the Clinical Ethics Council of the HUG (2007).

As a result of new migratory flows, the resulting changes in civic stratification, the pace and magnitude of these changes, as well as the growing complexity of these phenomena and their permanence, the concept of "**superdiversity**" was introduced (Vertovec 2007) in order to address these underlying trends (Phillimore 2016).

These differences may be appraised from two perspectives: descriptive and normative. Indeed, on the descriptive level, one may simply note that inequalities exist; however, if they systematically and specifically penalise certain individuals or groups of people, for example in the access to the healthcare system, then they must be evaluated normatively from the ethical angle, because they confront us with inequitable conditions, even **discrimination** in regard to access to the healthcare system. WHO defines **equity** as: "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically." […]. This absence of equity also entails a failure to avoid or overcome inequalities that infringe on fairness and human rights norms".[8] In the interests of social justice, WHO in 2005 established a Commission on Social Determinants of Health, for which the reduction of health inequities constitutes an "ethical imperative" (WHO 2009). The idea being to reduce health inequities by addressing the social determinants of health.

More specifically, the principles of equality of treatment and an equitable access to healthcare as elements of the **right to the best possible state of health**, are legally recognised at the international as well as the national level, as stated above (cf. 3. 1 and 3. 2). In this regard, may be cited the International Covenant on Civil and Political Rights (UN 1966) which states: "The States Parties to the present Covenant, recognize the right of all people to enjoy the highest attainable standard of physical and mental health" (art. 12 para 1); the Convention on Human Rights and Biomedicine (Council of Europe 1997) states in Article 3 that "Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality". These different provisions ratified by Switzerland and which extend into constitutional law to equality and to the prohibition of discrimination define the conditions for a material equality of individuals and patients.

4.1.3 Autonomy: informed consent

Informed consent is a cornerstone of our healthcare system. It represents a means **to respect patients in their quality as a person** – and their fundamental right to personal freedom - ; it is translated notably as the right of informed consent for treatment, and implies a right to be given information, as stated in Article 5 of the Convention on Human Rights and Biomedicine (Council of Europe 1997). From the legal point of view, informed consent is an absolutely required condition to ensure the legality of any medical act *per se* affecting corporal integrity. The informed consent requires sufficient information in accordance with legal criteria. In the case where this information is lacking, for example because the patient does not understand, the consent is invalid and hence the medical intervention is illegal.

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[8] Found the 27th October under http://www.who.int/healthsystems/topics/equity/fr/

As it does, it concerns a guiding principle of the very widely adopted biomedical ethics: the informed consent, as an expression of individual autonomy, is based on a certain conception of the person. **This conception is culturally specific**, that is to say that it may vary according to cultures and give rise to different interpretations going from patient autonomy to that of the family (Ilkilic 2010). Moreover, to achieve true autonomy, the individual requires certain conditions (the absence of internal and external obstacles), such as for example an understanding of matters of health and an "education in health" (Roussille & Deschamps 2013). Furthermore, the autonomy of the patient may be harmed, on the one hand in the application of the biomedical model, when for example the patient does not understand the conveyed information or the proposed treatment options because of language barriers. Under these conditions, it is not easy to respect the principle of autonomy, because it is impossible for the patient to take an informed decision. On the other hand, the biomedical model may be inadequate when the patient comes from a culture, in which one submits to the medical authority, or where the decisions taken in the medical field are not a matter of individual choice but rather involve other people (such as relatives or a third party with authority in the social group in question) (Kai, Beavan & Faull 2011), or even when the relatives – present as *ad hoc* interpreters – feel that, in the name of respect towards the patient, certain information considered to be uncomfortable or disquieting should not be imparted to the patient (Hanssen 2004).

4.1.4 Dignity of the person and social bases for self-respect

We have seen that the vision of the patient as an autonomous individual is culturally specific. To force a person from another socio-cultural background to make independent choices – and who is socio-culturally unprepared to do so - may be felt as a **violation of his / her integrity** (id. 2004). The perception that each individual has of him/herself is subjective and depends on his/her cultural sensitivity; this does not mean that he/she will have only one identity: it may be multi-faceted depending on the influences acting on his/her development and on his/her life history. What is important is to identify those elements that the patient considers as essential in the perception of him/herself and of his/her place in the community or communities. To enter into the personal sphere of a migrant patient thus requires transcultural skills as well as the ability to interact linguistically. On the other hand, the health services are also culturally biased. Access to communication is a prerequisite to access the universal human rights of everyone. In order that medical care can be put in place, it is therefore indispensable that a mutual relationship between the patient and the professional be created. This relationship can be necessary to access the healthcare and to ensure that the treatment is correctly followed. The narrative dimension plays a central role in building this relationship, given that this is the means for the patients to revisit their life experiences, to express their inner self and emotions, and thus feel welcomed in their singularity (Davis, De Raeve & Tschudin 2006; Roach 2002; Tschudin 2003).

When a language barrier isolates the patient from the carer, and if this barrier cannot be properly and adequately overcome – notably by recourse to a professional interpreter or to another equally effective service – then the healthcare may be hindered: reaching out to the person in his/her diversity, even in their singularity (implying the need to know their preferences, ideas, fears, expectations, conceptions of their illness and health, etc.) as a basis for building a bond of trust and a positive relationship per se may not be enough. The migrant patients could then feel that the circumstances of their healthcare reflect a measure of disrespect or a denial of recognition – denial of their existence as an individual in their own right, that is to say, not afforded the same rights as other individuals -, and risks to undermine the perception of themselves and **impair the social bases of their self-respect**.

4.2 The ethical obligations of professionals

4.2.1 Quality and safety of healthcare

As the group of experts of community interpretation of the "Swiss Hospitals for Equity" underlined in its position statement concerning language barriers in healthcare, "the barriers are a serious obstacle to access to medical care, hinder the success of therapy, diminish the quality as well as compliance and menace the safety of patients. Communication problems can, moreover, lead to excesses, shortcomings or errors in treatment and give rise to additional costs (Group of experts of the SH4E network 2916). It should also be noted that inadequate recourse to the interpretation service (lack of awareness of procedures, available services, etc.) may cause harmful delays in patient care. Health professionals have the duty to ensure the safety and quality of healthcare – even when confronted by additional obstacles that require a greater effort.

4.2.2 Professional secrecy

Medical experience attests that confidentiality is essential in order for a therapeutic relationship to be established. Trust and openness are at the heart of this relationship and its effectiveness (Wolff et al 2012). The patient (migrant) who does not feel to be in a situation of trust will rightly hesitate to share his/her problems. However, in front of an *ad hoc* interpreter, the migrant patient is obliged to bring up sensitive subjects in an uncomfortable situation; this may have a negative impact on the acquired information. Studies show that *ad hoc* interpreters (especially when they are children) may ignore embarrassing subjects (such as questions on menstruation and bowel movements) (Lindholm et al 2012; Flores et al. 2012). In the presence of *ad hoc* interpreters patients most frequently avoid subjects dealing with mental health, and sharing intimate information becomes difficult or impossible (Rocque & Leanza 2015).

Moreover, allophone individuals who are part of a small group fear that the recourse to an ad hoc interpreter may lead to a loss of confidentiality.

4.2.3 Basic training and continuing education

The use of community interpretation services changes professional practice and requires the health professionals to adapt accordingly. It is also essential that they can receive training: this concerns an ethical obligation to be trained in the use of community interpretation. Once made aware of intercultural issues, they must be able to develop transcultural skills, learn to recognise those situations that warrant the services of a professional community interpreter (Alpers 2016; Krupic et al. 2016) in accordance with the indicated procedures (in-person, by telephone or video) and be prepared to work with the interpreter in the context of a trialogue – "dialogue between three").

4.3 Moral duties of the community

Our societies also need to be able **to continue to develop in a sustainable manner**. The magnitude and complexity of the migration phenomena force us to reconsider the fundamentals of social cohesion and to find solutions, such that this cohesion - that is so crucial for our security and our future – does not come under threat. As the transcultural dimension is by definition bilateral, it is therefore important that services also be created to explain the inherent requirements of the Swiss system of healthcare. It is essential to invest in the integration of the migrant populations if we want to guarantee the sustainable development of our societies. The concept of sustainable development, borrowed from ecology in regard to the limits of our natural resources, has been applied to the social sphere along with the responsibility to define more clearly the requirements that will allow our society to develop (Ferrari 2010).

Access to services, including healthcare services; the possibility to become responsible for one's own destiny as well as inter- and intra-generational equality are the foundations of a sustainable society. The manner in which we are going to welcome migrants is therefore crucial: if we can give ourselves the means to create a "language bridge", then we give them the opportunity to become part of our world. If this differs according to their legal status, nevertheless some issues are common to all: a welcome to others in their fragility and vulnerability, and sharing the unknowns of the future. This then means that we commit to a humanistic vision of our society.

5. RECOMMENDATIONS

Based on the abovementioned ethical and legal considerations, notably:

- The moral rights of patients, weakened by language barriers, to protection, to equal access to healthcare, to self-determination and to the respect of their dignity;
- The ethical obligations of professionals to ensure the quality and safety of healthcare, to respect professional secrecy and to be trained to utilise community interpretation;

the NCE unanimously recommended the following:

1) Community interpretation is necessary throughout the healthcare system in order to guarantee the rights of those persons, for whom a language barrier exists.

- Access to this service must be guaranteed.
- An offer for community interpretation and cultural mediation, capable of meeting the needs of the migrant populations, should be implemented uniformly throughout Switzerland.
- The training of interpreters and cultural mediators must be ensured.

2) Health professionals must be made aware of the specific intercultural challenges involved when caring for patients.

3) Switzerland lacks systematic statistical data concerning the health of migrants and the prevalence of language barriers. These data are indispensable for the development of a coherent and effective health policy.

This document was unanimously approved on the 26th January 2017 by the National Advisory Commission on Biomedical Ethics.

Table of abbreviations

ECPH	European Convention for the Protection of Human Rights and Fundamental Freedoms
OHCHR	High Commission for Human Rights
UNHCR	United Nations High Commissioner for Refugees
FSO	Federal Statistics Office
FOPH	Federal Office for Public Health
IOM	International Organisation for Migrations
ILO	International Labour Organisation
OMS / WHO	Organisation mondiale de la santé / World Health Organization
ONU / UN	Organisation des Nations unies / United Nations
UMAS	Unaccompanied minor asylum seeker

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