

Interpreter use during surgical consent for Asian patients with limited English proficiency

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ABSTRACT

AIM: The aim of this article was to evaluate interpreter utilisation during surgical consent processes for Asian patients with limited English proficiency (LEP) at Waikato Hospital, New Zealand.

METHODS: We retrospectively analysed clinical data from 540 Asian patients who underwent surgical procedures at Waikato Hospital during 2022 and 2023. Patients were categorised into three English proficiency groups based on clinical documentation: proficient, suspected LEP and definite LEP. We used Chi-squared tests to assess associations between English proficiency, interpreter use and ethnic background.

RESULTS: Of 540 patients, 173 (32%) were classified as definite LEP and 14 (2.6%) as suspected LEP. Among definite LEP patients, 136 (78.6%) received interpreter services while 37 (21.4%) did not. No patients with suspected LEP received interpreters. Interpreter use varied significantly across ethnicities, with Indian patients significantly less likely to receive interpreter services compared with non-Indian patients among those with definite limited English proficiency ($\chi^2=7.82$, $df=1$, $p=0.005$). Definite LEP patients were significantly older (mean 65.4 years) than proficient patients (mean 47.4 years).

CONCLUSION: Significant disparities exist in interpreter service provision during surgical consent, particularly affecting Indian patients and those with suspected LEP. These gaps raise concerns about informed consent validity and equitable healthcare access. Systematic improvements in interpreter service protocols and clinician training are needed to ensure compliance with national guidelines and ethical care standards.

Effective communication is fundamental to patient-centred care, particularly during surgical consent processes where patients must fully comprehend the risks, benefits and alternatives of procedures before providing informed consent. New Zealand healthcare policies emphasise clear and accurate communication between clinicians and patients to uphold principles of autonomy, patient safety and equity.¹ However, limited English proficiency (LEP) presents a significant barrier for many migrant populations, particularly among growing Asian communities in regions such as Waikato. Individuals with LEP are defined as speaking English less than “very well”.² Without appropriate language support, LEP patients may struggle to understand medical information, leading to increased anxiety, misinterpretation and potential breaches of informed consent.

Professional interpreters play a relevant role in addressing communication barriers and ensuring compliance with ethical and legal requirements. The *Code of Health and Disability Services Consumers’ Rights* (Right 5.1) grants New Zealand

patients the right to competent interpreters when necessary. Despite this mandate, previous research highlights inconsistencies in interpreter utilisation within healthcare settings, with informal translation by family members and friends often substituting for professional interpreters.³ Such practices raise concerns about miscommunication, loss of patient autonomy and potentially compromised clinical outcomes.

Shared decision-making supports patient-centred care⁴ and relies on clear communication, which may be challenging in multilingual and intercultural settings. Language barriers including misunderstanding can hinder information transfer and treatment decisions.⁵ Overcoming these barriers is relevant for ensuring LEP patients understand their healthcare options and can actively participate in decision-making.

“Existing literature suggests that language barriers in healthcare contribute to disparities in treatment access and quality of care, which can translate into reduced or delayed access to needed surgical care.”⁶ Studies indicate that the availability of professional interpreters significantly improves

patient comprehension and consent validity, yet interpreter use remains inconsistent due to cultural differences, cost and clinician or patient hesitation to engage interpreters.^{7,8} Unfortunately, research from the United States of America (USA) has shown that professional interpreter utilisation for surgical consent can be as low as 55%, despite being mandated by federal policy.^{9,10} Previous Australasian research also indicates that interpreter use during surgical consent processes is particularly lacking, with many LEP patients not receiving adequate language support.^{3,11} Moreover, gaps persist in interpreter utilisation among specific ethnic groups, particularly Asian populations in New Zealand.

Health New Zealand – Te Whatu Ora Waikato strongly recommends the use of authorised interpreters provided by its contractors and does not endorse the use of family or friends to interpret. According to its procedures, interpreting services must only be provided to patients who, without the use of the interpreting service, cannot effectively communicate or understand issues relevant to their interaction with staff.

This study aims to identify gaps in current professional interpreter use for Asian patients (Level 1 ethnicity) in the Waikato Region by assessing five key groups (Level 2 ethnicity), based on their population relevance according to the 2023 Census (Indian 5.2%, Chinese 2.7%, Filipino 1.7%, Cambodian 0.36% and Korean 0.34%). By analysing retrospective clinical data from Waikato Hospital during 2022 and 2023, this research seeks to identify disparities in interpreter use across different Asian ethnic groups, assess access to professional interpreters and evaluate compliance with national guidelines.

Methods

Setting

This retrospective study analysed routinely collected clinical data from Asian patients who underwent surgical procedures at Waikato Hospital, a 759-bed tertiary public facility, during 2022 and 2023. We examined patient and interpreter service records to assess evidence of English proficiency and gaps between interpreter requests and actual service provision. We specifically evaluated compliance with national guidelines in surgical consent processes for Asian patients with LEP, including use of qualified interpreters, documentation of verbal or written consent and healthcare professionals' observations on patient

comprehension. Ethical approval was obtained from the Auckland Health Research Ethics Committee (RD024137, approved 18 December 2024).

Data sources

We analysed clinical data and interpreter service records routinely used at Waikato Hospital. Data extracted into Microsoft Excel included National Health Index (NHI) numbers, patient age, prioritised ethnicity, country of birth, surgical procedure dates and interpreter service provision documentation where available. Additionally, each patient's clinical notes were reviewed to assess available evidence of English proficiency. Interpreter service use was verified against official data from the Hamilton Multicultural Services Trust listing all NHI-identified patients receiving interpreter services between July 2021 and December 2023, inclusively.

Study sample

The study included adult patients (≥ 18 years) of Asian ethnicity as recorded in medical records. Specifically, patients of Chinese (Mandarin and Cantonese), Indian (Hindi and Punjabi), Filipino, Cambodian (Khmer) and Korean linguistic backgrounds were included, along with patients who self-identified with these ethnicities but were born outside these regions. Eligible participants had undergone surgical procedures at Waikato Hospital during 2022 and 2023. Patients born in New Zealand or those with significant communication difficulty related to pre-existing conditions were excluded.

Interpreters

The Waikato Hospital has an external provider for interpreters. The interpreters hold recognised qualifications (including National Accreditation Authority for Translators and Interpreters, New Zealand Society of Translators and Interpreters and university-level interpreting credentials) and must complete either a rigorous 9-week training programme with practical assessment or provide verified evidence of existing equivalent qualifications, with all interpreters participating in ongoing professional development through mandatory workshops and mentoring.

Study measures

The primary outcome was the proportion of LEP patients receiving adequate interpreter services during surgical consent processes.

Patients were categorised into three English

proficiency groups based on clinical documentation:

1. **Proficient:** Clear documentation of effective communication with no noted language barriers.
2. **Uncertain/suspected LEP:** Evidence of communication challenges or inconsistent language barriers noted.
3. **Definite LEP:** Clear documentation of LEP and/or official interpreter requested or indicated as necessary.

Official interpreter service use was assessed through documentation of interpreter requests and verified against patient notes and referral letters. Given that this information was not routinely recorded, manual searches were required.

Statistical analysis

We used descriptive statistics to summarise demographic characteristics and interpreter use across patient groups. Chi-squared tests assessed associations between English proficiency status, interpreter service utilisation and ethnic background. Statistical significance was set at $p < 0.05$. All data were organised and managed using Microsoft Excel version 16.0. Statistical analyses were performed using R version 4.4.0 (R Core Team, 2024, R Foundation for Statistical Computing, Vienna, Austria).

Results

Among 540 patients, 173 (32%) were classified as having definite LEP while 14 (2.6%) had suspected LEP, indicating nearly one in three Asian patients may require interpreter services (Table 1). Of the definite-LEP patients, 136 (78.6%) received interpreter services while 37 (21.4%) did not. No suspected-LEP patients received interpreters, nor did any of the 353 patients classified as proficient in English.

Interpreter use varied significantly across ethnic groups among patients with definite LEP ($\chi^2=14.85$, $df=4$, $p=0.005$). Indian patients comprised the largest proportion (51.2%, $n=257$), followed by Chinese (28.5%, $n=143$), Cambodian (21%, $n=38$), Filipino (15.7%, $n=79$) and Korean (4.6%, $n=23$). Among patients classified as suspected and definite LEP, only 60.7% ($n=17/28$) Cambodian and 56.9% ($n=29/51$) Indian patients received interpreters. In contrast, interpreter usage rates among definite- and suspected-LEP patients were higher in other ethnic groups: Chinese (87.2%), Filipino (100%)

and Korean (85.7%). These findings indicate disparities in interpreter access, with Indian patients significantly less likely to receive interpreter services compared with non-Indian patients among those with definite LEP ($\chi^2=7.82$, $df=1$, $p=0.005$).

Patients with definite LEP were older than English-proficient patients, with mean ages of 65.4 and 47.4 years, respectively. Among patients with definite LEP, the majority were aged 46–75 years (58.8%), followed by those aged 76 years and older (28.4%). These findings indicate that language barriers are more common among older patients, highlighting the importance of prioritising interpreter services for this demographic.

Discussion

This study evaluated interpreter use during surgical consent processes for Asian patients with LEP at Waikato Hospital. The findings highlight significant disparities in interpreter service utilisation, with notable differences across ethnic groups and age demographics. While interpreter services were provided to most LEP patients, 21.4% did not receive professional language support during surgical consent, indicating an important gap in addressing language barriers in clinical practice.

A major finding in this study is that Indian ethnicity was associated with significantly lower interpreter service utilisation, indicating a failure in the equitable provision of healthcare. Equity in this regard would require that health services are provided according to assessed need across demographic groups. This disparity may be influenced by factors such as lower recognition of language needs by clinicians, patient reluctance, cultural differences or systemic barriers in interpreter access.^{7,12} Despite national guidelines mandating professional interpreter use, no suspected-LEP patients received this service, indicating probable deficiencies in language barrier identification. Given their documented communication challenges, failure to provide interpreter services to this group increases the risk of misunderstandings, and therefore increases the risk of failing to receive fully informed consent to surgery. Although a previous study utilising data from multiple cross-sectional national surveys reported that recent experiences of racism were highest among Asians, it is difficult to assess its influence in the current study due to significant within-group differences in interpreter utilisation (ranging

from 59.7% among Indian patients to 100% among Filipino patients).¹³ However, due to the negative impact of racism on healthcare experiences, this should be considered in future research.¹⁴

Some patients who did not receive formal interpreter services relied on informal interpreters, particularly family members. Clinical notes revealed instances where family interpretation was noted as problematic. These findings suggest family members may introduce inaccuracies or biases, potentially influencing patient responses and clinician decisions, and thus posing risks to patient autonomy.

A strong association emerged between age and LEP status. Definite-LEP patients had significantly higher mean age compared to proficient patients. This aligns with previous research indicating older migrant populations experience greater difficulties accessing healthcare due to linguistic and cultural barriers.¹⁵ These findings highlight the necessity of prioritising interpreter services for older patients, who may be particularly vulnerable due to reduced health literacy and increased need for healthcare interventions generally.

The current findings suggest several areas for improvement in interpreter service provision. Given the significant proportion of Chinese and Indian patients classified as having definite LEP, targeted efforts should ensure these groups have adequate interpreter access. Considering the strong association between older age and LEP status, interpreter services should prioritise elderly patients to ensure their informed participation in surgical decision-making.

This study has several limitations, particularly arising from the historical lack of standardised systems for recording interpreter requirements and use, resulting risks of incomplete data capture, misclassification of language needs and consequent bias. Since suspected-LEP patients are more likely to be misclassified, this could explain why none of them received interpreter services. The use of *ad hoc* interpreters (such as family members or untrained staff) was not assessed in this study. Additionally, variations in clinician recording practices may have contributed to inconsistent documentation. The study's reliance on recorded information accuracy means missing or inaccurate documentation regarding interpreter use could impact findings, particularly where interpreter services were informally arranged. The lack of available detail regarding the context of consent processes from both patients and staff

prevents the inclusion of more granular variables in the current analysis.

Clinician training on interpreter use should include recognition of the risks inherent in relying on informal translation by family members; this appears particularly relevant among Indian patients who may face systemic barriers accessing language services. Training programmes should emphasise ethical and legal obligations of providing professional interpreters. Additionally, implementing policies encouraging interpreter services for all suspected-LEP patients, rather than leaving decisions to clinician discretion, could help eliminate disparities in service provision. Also, the inclusion of a language proficiency and interpreter use field in surgical informed consents could prompt clinicians to comply with those policies. Previous studies have found that surgeons often resort to using untrained staff or family members to obtain consent for elective surgery when professional interpreters are not readily available. Therefore, delays in the current interpreter provision process should be explored as a potential contributing factor to this non-compliance.¹³ Moreover, feedback from interpreters could also enrich the informed consent process by providing valuable cultural insights.¹⁴

Further research is needed to explore underlying reasons for disparities in interpreter use, particularly among Indian patients and older adults. Qualitative studies involving clinician and patient perspectives could provide valuable insights into barriers and facilitators of interpreter access. Future studies could also examine the implications of interpreter access on surgical outcomes and patient satisfaction to reinforce the importance of equitable language services in healthcare. The quality of interpreter performance, while critically important to patient outcomes, was beyond the scope of this research and represents a key area for future investigation.

Conclusion

This study highlights significant disparities in interpreter use during surgical consent processes for Asian patients with LEP at Waikato Hospital. Despite national guidelines mandating professional interpreter services, a substantial proportion of LEP patients did not receive adequate language support, particularly among Indian patients and those classified as having suspected LEP. These gaps raise concerns about informed consent validity, patient autonomy and equitable healthcare

access.

Older patients are more likely to experience language barriers, emphasising the necessity of prioritising interpreter services for this demographic. The reliance on informal interpreters highlights potential risks associated with miscommunication and compromised clinical decision-making. Addressing these challenges requires systemic changes, including enhanced clinician training, structured protocols for identifying LEP

patients and improved interpreter service access.

To ensure patient-centred care and uphold ethical principles, hospitals should implement policies mandating interpreter use for all patients with suspected as well as definite LEP, reducing reliance on clinician discretion. By fostering healthcare environments that prioritise linguistic inclusivity, healthcare providers can enhance communication, improve patient safety and promote equitable surgical care.

Table 1: English proficiency status and interpreter use among five key Asian ethnic groups.

	Proficient		Suspected LEP		Definite LEP		Total
	Interpreter used	Interpreter not used	Interpreter used	Interpreter not used	Interpreter used	Interpreter not used	
Indian	0	206	0	5	29	17	257
Chinese	0	59	0	6	68	10	143
Filipino	0	69	0	0	10	0	79
Cambodian	0	10	0	3	17	8	38
Korean	0	9	0	0	12	2	23
Total	0	353	0	14	136	37	540

LEP = limited English proficiency.

COMPETING INTERESTS

Nil.

ACKNOWLEDGEMENTS

Funding: Samantha Turnwald was awarded a Health Research Council of New Zealand (HRC) 2024 Ethics Summer Studentship for this research.

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<https://nzmj.org.nz/journal/vol-139-no-1635/interpreter-use-during-surgical-consent-for-asian-patients-with-limited-english-proficiency>

CITATION

Richly P, Turnwald S, Menkes D. Interpreter use during surgical consent for Asian patients with limited English proficiency. *N Z Med J*. 2026 May 29;139(1635):50-56. doi: 10.26635/6965.7141.

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