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Debriefing with Interpreters Post Sexual and Reproductive Health Consultations with Refugees from Burma

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ABSTRACT

Context: Debriefing is an essential part of all interpreter mediated appointments but is critical in sexual and reproductive health (SRH) consultations. It allows both interpreters and health care providers (HCPs) to clarify specific issues, for instance, appropriateness of specific reproductive health terminology. However, the interpreters' code of ethics specifies that interpreters keep all participants informed of any side comments made by any party. Thus, interpreters who may be keen to discuss what they could not say during the consultation, may hesitate to do so, even if a debrief is offered by the HCPs

Objective: To explore the perspectives of HCPs, interpreters, and community members regarding uptake, organization, and utility of debriefing in primary care consultations in context of refugees from Burma.

Methods: We conducted semi-structured interviews with 17 community members from Burma and providers of refugee services closely involved with them which included general practitioners (n=8), nurses (n=14), interpreters (n=10), social practitioners (n=11), and practice managers (n=3). Interviews were audio recorded and transcribed. Research team members reached consensus on coding, thematic analysis and key results.

Results: Four major themes emerged namely: (a) Debriefing challenges (b) Ethical conflicts (c) Organizational difficulties (d) Potential solutions. For example, "Not one interpreter has ever agreed for a debrief session". An interpreter says, "I think debriefing is not permitted as patient is left out".

Conclusion: Given the identification that both HCPs and interpreters face ethical dilemmas, resolution or normalization of these conflicts will be central to increasing debriefing uptake. The findings from this study can guide culturally appropriate research initiatives to increase the uptake and utility of debriefing post interpreter mediated SRH consultations with Burma-born refugees.

Keywords: Debriefing; Debriefing with interpreters; Post interpreter mediated appointments; Sexual and reproductive health appointments; Sexual and reproductive health consultations; Refugees; Migrants; Burma; Myanmar; Interpreters

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ABBREVIATIONS

(ECA) English Classes in Australia; (CSO) Community Support Officer; (GP) General Practitioner; (HCPs) Health Care Providers; (NAATI) National Accreditation Authority for Translators and Interpreters; (SRH) Sexual and Reproductive Health

INTRODUCTION

Communication problems due to language and cultural differences between health care providers (HCPs) and patients from refugee backgrounds are widely recognized [1-4]. In addition, sexual and reproductive health (SRH) is known to be a difficult topic for HCPs to discuss, for reasons including discomfort with the topic [5], time limitations [6], feeling inadequately trained [7,8], age of the patient [9] and patient embarrassment [10]. Further, SRH conversations cover a range of highly sensitive topics in addition to contraceptive preferences and sexually transmitted diseases, such as sexuality, sexual violence or coercion and gender issues [11-14].

Often, refugees don't speak the language of the host country and rely on interpreters to mediate consultations with HCPs [15]. Interpreters are expected to manage these multilayered complex consultations with refugee patients as invisible translating machines [16]. The codes of ethics for interpreters [17-21] envision them as relaying verbatim information and deferring the control of the communication to HCPs and the patient. The interpreters' code of ethics across the globe specify that interpreters should keep participants informed of any side comments made by any of the parties or of their attempts to engage the interpreter in a private or any other conversation. Interpreters are discouraged from developing relationships with patients or making active judgments to facilitate provider patient communication.

Researchers, however, have noted that interpreters are hardly neutral participants. Social scientists have referred to them as "co-diagnosticians" when they deviate from the conduit role, align with providers to assist in diagnosing illnesses, educating patients, and providing emotional support to patients [22]. Based on these co-diagnostician roles there is a consensus across diverse disciplines that debriefing is an essential part of interpreter mediated interactions [23-25]. In line with these changing recommendations, HCPs are encouraged to debrief with interpreters post consultation [26-30].

Debriefing has multiple advantages. Firstly, it provides the interpreter with an opportunity to express feelings they may have experienced in the appointmentm. This is particularly important when sensitive or traumatic sexual and reproductive health (SRH) experiences are discussed [31-33]. At times the interpreter, particularly those from refugee backgrounds may have personally experienced similar events and these discussions may trigger these memories [34,35]. Secondly, it provides the HCP with an opportunity to clarify questions arising from the consultation, for instance, queries regarding preferences for particular words, language adjustments, cultural/religious issues on matters relating to standardized assessment [36-38]. Thirdly, it acknowledges the co-diagnostician role of interpreters and provides space for communication improvement initiatives [22].

During our research [15,39], and reviewing literature on cross cultural health, [26,36,40,41] it became clear that interpreters who may be keen to share information that they could not share during the appointment will hesitate to do so even if a debrief is offered. They may be reluctant to clarify points, discuss any general or specific feedback, or recommend corrective action. Whilst HCPs are encouraged to debrief with interpreters [26-30], but interpreters are constrained by a strict code of conduct where any transgression may warrant termination of their employment.

There is a clear practice gap between the interpreter's code of conduct and recommendations of clinical experts regarding debriefing. To our knowledge, there has been no research on implementation of debriefing sessions after interpreter-mediated consultations. The objective for this paper is to explore the potential practical application of debriefing post SRH appointments in primary care consultations in context of refugees from Burma. By juxtaposing the views of HCPs, interpreters, and patients, we examine the factors associated with uptake, organization, and utility of debriefing. We suggest practical guidance to implement a debriefing routine into SRH consultations.

METHODS

Study Design

This qualitative descriptive study is a part of a doctoral thesis exploring the SRH needs of refugees from Burma settled in Australia (**Figure 1**). The study was conducted in two parts where Part One (2015-2016) involved interviewing 29 providers of refugee services regarding their perspectives on SRH needs of refugees from Burma. In this study, providers of refugee services included HCPs (doctors, nurses, midwives), bilingual staff (interpreters, social workers, settlement workers, community liaison officers) and administrative staff (practice managers, reception staff) who work jointly to provide primary care services to refugees [15,39]. Based on the data collected in Part one a best practice resource was drafted to improve interpreter mediated SRH consultations. In Part Two (2020-2021) feedback was sought from providers of refugee services (n=17) and community members from Burma (n=17) regarding this best practice resource.

Ethics

The University of Melbourne Human Research Ethics Committee granted ethics approval for the research.

Setting

The research was based in the City of Wyndham where many people from Burma have settled after migrating to Victoria (Australia). Wyndham residents have a diverse cultural background. In 2018 almost half of newly arrived refugees were from Burma (26%) or the Thai Burma border (25%) [42]. The Census indicates that these numbers gradually increased until 2020 when the migration ceased due to COVID 19 restrictions. There are various languages from Burma and more than three quarters of refugees in Wyndham have no English proficiency (78.5%) [43]. for easy access to health care services, Australia has a telephone interpreter service which is free of charge and available 24/7 [44]. Other services that can provide face to face

interpreting are also available at local levels some of which are also free. Some community organizations such as primary care practices, schools, non-governmental welfare organizations employ bilingual people who have diverse roles of interpretation, cultural brokers, and community engagement [45,46].

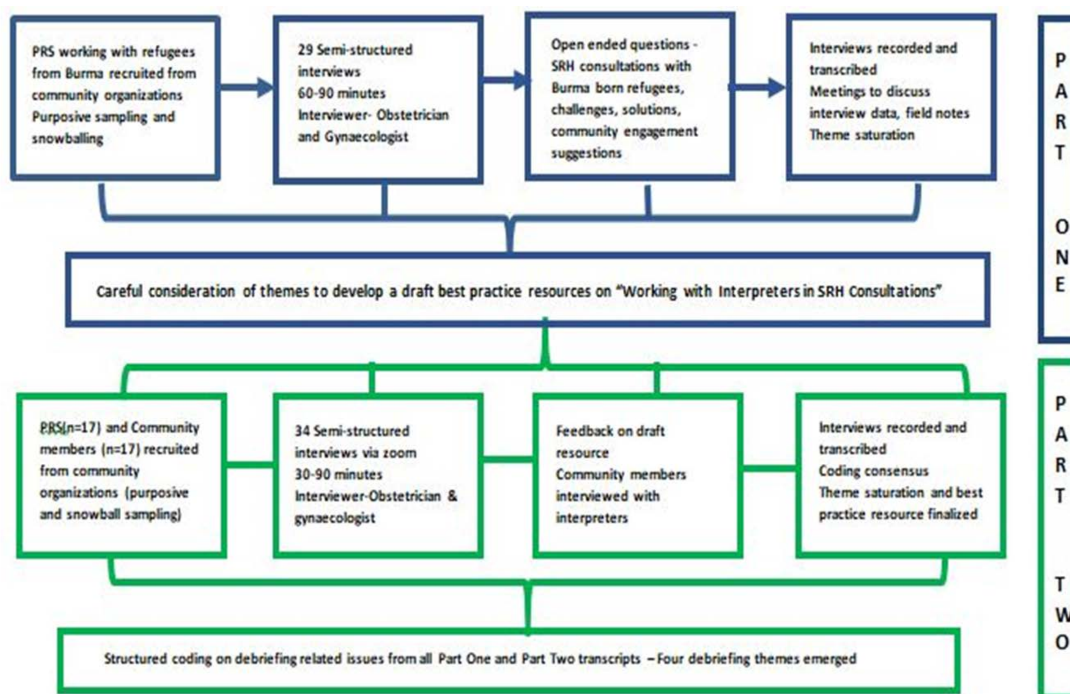

Figure 1: PRS: Providers of Refugee Services steps of Data Collection and Analysis

Participants

Overall, 46 providers of refugee services with more than 2 years of experience working with refugees from Burma participated in the study. We used a combination of purposive and snowball sampling to recruit a diverse sample with variation in age, gender, place of medical training, language proficiency, length of time in Australia and type of practice.

Community members were invited through a three step recruitment process (**Figure 2**) to share their views on the draft resource for "Working with interpreters in SRH consultations". In the first step, refugee women from Burma were invited to attend reproductive health information sessions. They were organized with the assistance of community leaders and helped in building rapport with refugee women. At the end of the session, interested participants were invited to participate in consent discussions (second step). In consent discussions professional interpreters were present who helped to explain the concepts of voluntary participation and informed consent for the study. Next, we scheduled one-on-one research interviews with participants who were supported by interpreters in their preferred language. Before the interviews were started, a third step comprised of seeking responses to simple questions such as "what will happen if you decide to stop the interview" were used to verify the participants' understanding of voluntary participation [47].

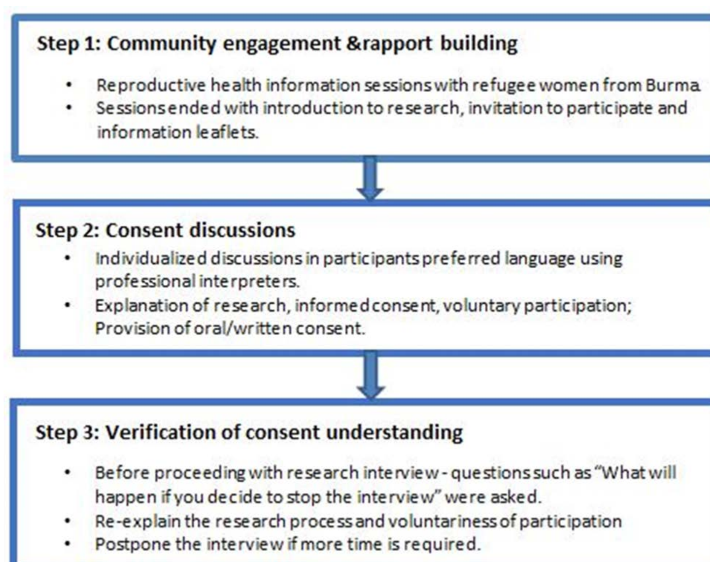

Figure 2: Three-step Recruitment Process for Community Members from Refugee Backgrounds

Our approach acknowledged that the expertise of the participants was essential to finalizing this resource. Community leaders helped to invite people to reproductive health information sessions but were not present for the consent discussions or research interviews. This was done to minimize coercive participation, and ensure that participants were fully informed about what they were being asked to participate in [48]. 17 community members (men (n=7) and women (n=10), more than 18 years of age) who spoke languages from Burma; out of which 16 had minimal English skills participated in the interviews. These 16 community members conversed with the help of interpreters in their preferred language. We aimed for maximal variation and included both male and female participants with diverse roles in the community.

Interviews

The PhD researcher, a woman of colour, obstetrician, and gynaecologist, working for last 15 years in multicultural health, conducted the interviews. Part one interviews were conducted face to face with 29 providers of refugee services and lasted 60 to 90 minutes. Interview questions related to perspectives on SRH needs, impact of limited English proficiency, access to interpreters, utilization of services and solutions to improve cross cultural SRH services from refugees from Burma. Part Two interviews were conducted online (via Zoom) and lasted 30 to 90 minutes. Part Two interviews were focused on obtaining feedback about the 'best practice resource' on working with interpreters in SRH consults. We interviewed 17 providers of refugee services and 1 community member in English. In addition, 16 monolingual community members in diverse languages from Burma were interviewed with an interpreter in their preferred language. (Figure 1) (Table 1).

Table 1: Data Collection Framework (SRH: Sexual and Reproductive Health)

Data Collection Framework		
Interviewer: Obstetrician and Gynecologist		
Characteristics	Part 1 Interviews (2015-2016)	Part 2 interviews (2020-2021)
Mode of interviewing	Face to Face	Online (via Zoom)
Participants	Providers of refugee services (n=29)	All key stake holders (Provider of refugee services n=17, Community members n=17)
Language of interviews	English	Providers of refugee services-English 1 community member-English 16 Community members-native languages from Burma
Interpreters	Not used	Videoconferencing with interpreters
Questions	Broad scoping interviews on SRH needs of refugees from Burma, utilization of interpreters, solutions to improve conversations.	Interviews were focused on obtaining feedback about the best practice resource on working with interpreters in SRH consults

The larger thesis explores SRH needs of refugees from Burma and concentrates on the development of a best practice resource on working with interpreters in SRH consults. This will be published in a separate paper. In this research article we explore debriefing and focus on responses to three questions to provider of refugee services and three to community members (Table 2). The questions opened dialogue about debriefing related advice in published guidelines, on ground problems in organizing debriefs, ethical conflicts faced by interpreters, and solutions in implementing debrief protocols. Community members who were service users in primary care practices were naturally unfamiliar with the concept of debriefing between interpreters and HCPs. Therefore, we provided community members with initial explanation on the process of debriefing and invited them to ask questions to ensure that they understood correctly. Only, when the interviewer was satisfied that the community participants understood debriefing that she proceeded with the research interview.

Table 2: Interview questions focused in the current analysis (HCPs: Health Care Providers, SRH: Sexual and Reproductive Health)

	Questions for Provider of refugee services
1	Can you tell me about your experience of debriefing after SRH conversations with refugee women from Burma?
2	Can you provide some examples of debriefing related challenges in SRH dialogue with refugee women from Burma?
3	Do you have any suggestions or recommendations to improve the debriefing related challenges?
	Questions for community members
1	What are your views about a separate debriefing conversation between HCPs and interpreters after appointments that focus on SRH?
2	Do you see any problems with the debriefing sessions?
3	Do you have any suggestions on how this should be done?

Using the "guided conversation" style [49] the initial scripted questions were followed by clarifications and probes to deepen the understanding about the subject. Field notes included nonverbal cues highlighted during conversation such as facial expressions, body language, tone of voice, the underlying emotions noted at the conversation, researcher reflections of the interview process and other contextual factors [50-52]. The interpreter mediated conversations started with a briefing session with the interpreter followed by a separate discussion at the end to allow them an opportunity to debrief about the research interview. These conversations were documented in field notes and aided in manifesting latent content [53-57].

Data Analysis

Throughout the recruitment period we met weekly to discuss emerging themes and refine the interview schedule and sampling framework. We followed a qualitative descriptive approach [58,59] for data collection and analysis. Qualitative description enabled us to remain true to the felt need of the interviewees and report their findings verbatim [60]. In addition, this low inference style simplified the coding process and we achieved consensus easily [61,62]. Data analysis was performed in two parts.

We initiated Part one data analysis with the first phase of data collection. The PhD researcher (AT) transcribed the Part one interviews (n=29) verbatim. We started coding in the weekly research meetings. All transcripts and field notes were thematically analyzed. All the research team members read the interview transcripts to gain a preliminary understanding of emerging themes. We noted our reflections and insights on

the transcript margins. We created a coding framework from our notes in the transcript margins and derived some broad themes from the data. Then, a core team of four (AT, MTS, LS, and LM) re-read the transcripts and performed in vivo coding on noteworthy phrases or concepts. This core team employed open coding to field notes and meeting records. We categorized the commonly arising codes into appropriate themes. In the third read of the interview transcripts, the core team reviewed the audio tapes, field notes and meeting records simultaneously to refine the codes and themes. All the research team members reached consensus on themes which held true across the data. Subsequently, after careful consideration of all the themes we drafted a best practice resource on working with interpreters in SRH consults.

We commenced the second part of data analysis with Part Two data collection. After initiating feedback interviews with 17 PRS and 17 community members a smaller core team of three authors (AT, MTS and ER) initiated a fresh round of structured coding looking at all the interview transcripts (Part one and Part Two interviews; n=63) focusing on debriefing related issues [63,64]. The three authors examined the debriefing related data with consideration of existing knowledge on this topic. In addition, the PhD student AT and MTS discussed the full and coded transcripts of monolingual participants with the interpreters involved with the interview to ensure a complete capture of cultural issues [65-67]. Each of the 63 transcripts was systematically checked against the codes and theme saturation was achieved on debriefing related issues. The results were read and agreed by all members of the research team to minimize interpretation bias.

We took multiple steps to ensure that the study findings are valid and transferable to clinical and research settings. The PhD student AT explicitly documented the progression of our research, and the records create an audit trail for future collaborators. AT maintained uniformity in data collection by asking the same questions in the same order. We preserved authenticity by purposefully selecting participants and allowing them to freely articulate their felt needs. In addition, we faithfully reported their lived experiences of SRH consultations. To preserve criticality, we conducted feedback interviews about our drafted resource from service users (community members) and providers of refugee services. During this process we deliberated on our dual roles of clinicians and researchers and acknowledged our biases. Finally, we have developed a trusting relationship with the community.

RESULTS

Participant Demographics

The providers of refugee services included general practitioners (GPs (n=8)), nurses (n=14), interpreters (n=10), social practitioners (n=11), and practice managers (n=3). There were 10 males and 36 female participants. Table 3 summarizes their demographics.

Table 3: Participant demographics: Providers of refugee services (GPs: General Practitioners)

	GPs N=8	Nurses N=14	Practice managers N=3	Social practitioners N=11	Interpreters N=10
Gender	5 female 3 male	All female	All female	9 females 2 males	5 female 5 male
Mean Age (Range)	47 years (29-64)	54 years (23-66)	52 years (43-66)	40 years (29-62)	32 years (23-44)
Ethnic background[1] (self-defined)	5 Australian 1 Indian 1 Burmese 1 Anglosaxon 1 German	7 Australian 1 Anglosaxon 1 Karen 1 Karenni 1 Indian 1 Dutch 1 Italian 1 British	1 Australian 2 Anglosaxon	4 Australian 5 Karen 1-Chin/ Burmese 1-Rohingya	5 Karen 1 Chin/ Burmese 1 Karen Burmese 1 Karenni 1 Mon/ Burmese 1 Rohingya
Language Proficiency (First Language) [2]	7 English 1 Burmese	13 English 1 Burmese 1 Karenni	3 English	5 English 3 Burmese 5 Karen 1 Thai 1 Chin 1 Rohingya	3 English 3 Karen 1 Chin 4 Burmese 1 Karenni 1 Rohingya
Experience in health care Mean (Range)	29 years (5-40)	31 years (17-48)	32 years (26-40)	10 years (0-38) [3]	7 years (5-8)

Experience in refugee health Mean (Range)	11 years (1-18)	9 years (2-16)	9 years (3-15)	6 years (0-10) [3]	8 years (2-12) [4]
Proportion of refugees from Burma seen in practice Mean (Range %)	71 (50-90)	64 (5-95)	83 (80-90)	80 (30-100)	100
Designated roles in services for refugee community	Primary care physicians Sexual health physicians Refugee health GPs Refugee researchers	Refugee health nurses Mother and Child Health nurses Women's health nurses Care plan nurses	Practice managers Client service Officers	Bilingual workers Social workers Community access workers Settlement practitioners	Interpreters Health promotion Officers Community Liaison workers

[1] Some participants have identified with more than one ethnic background.

[2] Some participants have identified with more than one first language.

[3] One social practitioner worked in a non-governmental refugee organization and helped mothers with young children in education, day to day work and occasionally worked in health promotion groups. Therefore, she felt that she had no direct experience in health care.

[4]Interpreters participating in the study were selected by purposive sampling and all of them worked with people from Burma

The community members (n=17) in our sample all identified themselves as refugees from Burma. Sixteen out of 17 community members reported that they spoke little or no English. Most had spent several years in Australia (range:4-20, average: 12). 16 participants were first generation refugees, and one was born in Australia. Their average age was 40 (range 19-61). Participants identified themselves as Karen (n=6), and Chin (n=5), followed by Rohingya (n=3), Karenni (2) and Shan (n=1). Most were schooled in refugee camps (n=10). All were married and majority had school-age children. Table 4 summarizes community member demographics.

Table 4: Participant demographics: Community members (ECA: English Classes in Australia)

Code	Age	Gender	Ethnicity	Country of birth	Language Proficiency	Time in Australia (in years)	Education & Occupation	Work experience (in years)	No living in household	Role in household	Family members Left in home country	Housing
P1	30	F	Chin	Burma	Chin Burmese	10	Schooling in refugee camp, ECA Homemaker	o	6	Daughter In law	4	House
P2	44	F	Karen	Burma	Karen English	14	Schooling in refugee camp, ECA Vocational training Education sector	6	5	Mother	12	House
P3	38	F	Karen	Burma	Karen English	12	Schooling in refugee camp, ECA Homemaker	0	7	Mother	0	House
P4	61	F	Karen	Burma	Karen Burmese English	11	Nursing degree from Burma Community health promotion activities	7	8	Mother in law	0	House

P5	52	F	Karen	Burma	Karen Burmese English	14	Schooling in refugee camp, ECA Homemaker	0	6	Mother in law	5	House
P6	39	F	Chin	Burma	Chin English	15	Schooling in refugee camp, ECA Vocational training Entrepreneur	10	6	Mother	0	House
P7	48	M	Karen	Burma	Karen Burmese	10	Schooling in refugee camp, ECA Laborer	5	7	Father-in-law	0	House
P8	32	M	Chin	Burma	Chin English	7	Bachelor of science in Malaysia ECA Health care sector	5	3	Father	2	House
P9	41	F	Shan	Burma	Shan (Tai) Burmese	4	Schooling in refugee camp, ECA Homemaker	0	5	Mother	3	House
P10	35	M	Rohingya	Burma	Rohingyan	14	No school in Burma ECA Cleaner	5	8	Father	15	Apartment
P11	19	F	Rohingya	Australia	English Rohingyan	19	Student Sales assistant	5	5	Daughter	7	Apartment
P12	46	F	Rohingya	Burma	Rohingyan Burmese	15	ECA Homemaker	0	5	Mother	9	Apartment
P 13	40	M	Chin	Burma	Chin	5	No school in Burma ECA Gardener	3	5	Father	2	Apartment
P14	39	M	Karen	Burma	Karen English	20	School in refugee camp, ECA Gardener	12	4	Father	0	House
P15	44	M	Chin	Burma	Chin Burmese English Malay	15	School in Malaysia ECA Shopkeeper	4	5	Father	2	House
P16	39	M	Karenni	Burma	Karenni Burmese	6	School in refugee camp, ECA Sales assistant	1	3	Father	5	Apartment
P17	34	F	Karenni	Burma	Karenni Burmese	6	School in refugee camp, ECA Homemaker	0	3	Mother	5	Apartment

Interview Themes

Debriefing was included as an essential component of cross-cultural interpreter mediated SRH consultations by all 63 participants. Four major themes emerged from the thematic analysis that focused on debriefing:

(a) Debriefing challenges

(b) Ethical conflicts

(c) Organizational difficulties

(d) Potential solutions.

All themes were evident in the views of HCPs, bilingual providers of refugee services, and community members. However, the themes focused upon differentially within the responses of different participant groups. Thus, debriefing challenges

were concentrated in the HCP (doctors and nurses) interviews. Ethical conflicts dominated the interpreter and bilingual practitioner conversations. Administrative staff focused on the difficulties of organizing debriefing sessions in actual practice. Bilingual providers of refugee services and community members came up with solutions on how to improve the uptake and utilization of debriefing sessions. Within these four themes, eleven sub-themes were identified (Table 5).

Table 5: Debriefing: Themes and Sub-themes (HCPs: Health Care Providers)

Themes and subthemes	
1. Theme: Debriefing challenges	
a)	No uptake of debriefing sessions
b)	Structural difficulties of debriefing
2. Theme: Ethical conflicts	
a)	Is debriefing permitted?
b)	Debriefing is gossiping about the patient!
c)	Power hierarchy between HCPs and interpreters
d)	Role conflict between verbatim translation and cultural brokering
3. Theme: Organizational difficulties	
a)	Scheduling follow ups require both patient and interpreters
b)	Workload of interpreters as next appointments are waiting
4. Theme: Potential solutions	
a)	Including patients in the debrief
b)	Making the patient aware and asking their permission to debrief
c)	Conceptualizing debriefing as a feedback session

Theme 1: Debriefing Challenges

The first prominent theme that emerged was the challenges faced by HCPs in conducting debriefing sessions with interpreters after a SRH consultation with a refugee background patient. This theme was divided into two sub-themes:

Sub-theme 1A: No uptake of debriefing sessions: HCPs said that they try to offer debrief after the clinical consultation. However, all agreed that the uptake of debriefing offers is minimal.

Not one interpreter has ever agreed for a debrief session. Whether they are on the phone or they are in person, they will just nod their head and leave with the patient. (GP 1, more than 10 years' experience in refugee health)

Even if the patient gets distressed after Pap tests or say something was not right in a sexual health appointment, interpreters have never agreed to a debrief. I sometimes hope that in these difficult sessions, they gave some feedback or cultural insights into how to do it better. The opportunity to offer debrief is difficult, and one has to offer it with the patient in the room and may be this is the deterrent for accepting a debrief. (Nurse 7, more than 15 years in refugee health)

Debriefing is absent from interpreter involving sexual health conversations. The interpreters are always hesitant to talk to us without the patient. In reproductive consults it is so obvious that they do not want to do a debrief. Say, in Pap smear conversations, both the patient and the interpreter look relieved at the end and there is a hurry to leave the room. Any offer to discuss further is almost always met with a no from all the interpreters I have worked with so far. (GP8, 18 years in refugee health)

In difficult traumatic revelations, where I am deeply affected, I can only imagine what goes through the interpreter's mind. I feel that all of us would benefit from a debrief. I have tried to offer it to the interpreters. They never express any wishes and just say that they are good and leave or disconnect the phone. (Nurse 12, Working with refugees for 12 years)

Sub-theme 1B: Structural difficulties of debriefing: Study participants identified a variety of structural problems involved with debriefing, including availability of time, place, patient's presence, and pressure from waiting appointments.

The appointment is for 10 minutes. The next one is scheduled straight after. Where do I fit in a debrief? I have specifically attended many workshops on working with refugee patients, all the mental health clinicians stress on debriefs but never talk about how to fit it the busy practice schedules. I wish Medicare had a category for interpreter mediated consults where debrief had an allocated spot. (GP2, 10 years of experience in refugee health)

Try to picture this. The appointment is over. The interpreter, patient and I walk together to the reception so that the follow up appointment can be scheduled. Where do I talk about the debrief? Do we finish early and tell patient to sit outside and wait for the interpreter? Do I ask when the patient is in the room? There is no clear structure when this debrief should be fitted in the schedule, (GP6, 18 years' experience in refugee health)

I always offer debriefs to telephone interpreters. I cannot see their facial expressions to decide if all was well within the appointment or if I missed the whole thing. I ask them is there anything else? Then, do they want to say anything in private once the patient leaves? They always say thank you and say we have nothing else to discuss. The conversation is then transferred back to reception so that follow up appointment can be scheduled. Maybe they do not have time to debrief (Nurse 11, working for 10 years in refugee health in regional Victoria)

It is true that there is not time allocated for this. I will tell you

how to do it. Inform the interpreter about the debrief before you start the appointment. When you finish ask the interpreter to hold the phone after the follow up is sorted. Then, discuss it or ask the face to face one to come back after the follow up is done. I always offer it, but no interpreters want to do it. They will just say all was okay. (GP 1, more than 10 years' experience in refugee health)

Theme 2: Ethical Conflicts

Unlike the challenges of debriefing, which predominantly arose from discussion with English speaking HCPs (doctors and nurses), the theme of ethical conflicts emerged with conversations involving bilingual providers of refugee services. It was evident that they did not regard debriefing as a routine part of appointments but viewed it through a specific lens of righteousness and ethics. This section is reported across four subthemes.

Subtheme 2A: Is debriefing permitted?: For the bilingual providers of refugee services, debriefing with HCPs was in direct contradiction to the expected behavior imparted in the interpreter training.

In our interpreter training we are strictly told that we should leave the room with the patient. We are not to have any private conversations with the doctor or nurse. So, when the doctor says do you want to talk after the patient has left, I am not sure what to do. I think debriefing is not permitted. (Interpreter 6, a health professional in Myanmar, escaped to Australia and working here as an interpreter for 2 years)

Is debriefing permitted as per the interpreter's code of ethics? I am not sure. I think it is not allowed as we are translating machines and we are not explaining patient needs in this role. (Interpreter 9, Working in health for last 7 years)

I think debriefing is not taken up by the interpreters because it creates a role conflict. They are expected to do machine like word-by-word translation. How do we expect them to say that they were mentally affected because they have to act like machines? (Social Practitioner 8, working in refugee health for more than 30 years) I work as cultural support worker on some days and interpreter on the other days. As a cultural support worker, I would sometimes debrief, but as an interpreter, never. The code of conduct from NAATI [National Accreditation Authority for Translators and Interpreters] says do not engage with the health professional once the patient leaves the room. (Interpreter 4, Work experience of 8 years).

Sub-theme 2B: Debriefing is gossiping about the patient: Another major issue identified was the ethical position of debriefing in a SRH appointment. Bilingual providers of refugee services stressed that SRH is considered a very private matter by people from Burma and questioned the moral correctness of debriefing.

If I speak with the doctor by myself the patient may think I am gossiping about them. The code of conduct from NAATI also says that we should not talk to the doctor on our own. This will cause trust issues. (Social practitioner 4, Interpreter experience of 10 years)

The patient will feel left out if I talk to the doctor. The patient may lose trust in me if I tell them to wait outside and talk by myself with the doctor.

Interpreter 7 Work experience in health 12 years. In private conversations the patients talk about really personal stuff. They are shy even to tell it to the doctor. After the appointment, client may feel that I am making fun or telling the doctor something I know about them which they did not want to tell the doctor themselves. So, debriefing would not be okay, and trust would be affected. (Interpreter 10, Work experience 4 years) I doubt if it is okay to do debrief. How to actually do it? We tell people that we are talking about them but not actually involve them. This will make them feel low and think we are some different people who are talking in English and not one of them. (Social practitioner 11, Work experience 26 years,)

Subtheme 2C: Power hierarchy between HCPs and interpreters: Perhaps, not surprisingly, interpreters interviewed for this research consistently noted the power dynamics between HCPs and themselves. Their custom of treating medical professionals with utmost respect widened this power gap further. Most interpreters described hierarchical tensions in initiating debriefing and left it to the HCPs.

If I keep talking to the doctor or nurse, after the appointment is over, I may waste their time. It is not my job to start debriefing. I have to do as the doctor wants me to do. (Interpreter 5, Work experience 4 years)

Our people feel that doctor is a respected member of the society. We must agree with everything that the doctor says. In the same way it would not be right for me to start a debrief session. The doctor or nurse should be the deciding people, I am just a voice for translating. (Interpreter 3, work experience 9 years)

The doctor will ask about birth control. The patient does not want to talk about it in my presence. They know me in the community. They cannot tell it to the doctor to send me away. I can see this as I can sense their discomfort. It is however not my place to say it in the middle of appointment. I want to tell things like this in debriefing. Still, I hesitate to give this feedback. I think doctor and nurse have important job and I should not bother them with this small information. (Social Practitioner 7, Community Liaison Worker and reception staff, Work experience 7 years)

Subtheme 2D: Role conflict between verbatim translation and cultural brokering: Participants were concerned that debriefing creates a conflict with the interpreters expected role as per the code of ethics. Experienced interpreters and HCPs explained this nuanced difference between interpretation and cultural brokering.

I have a lot of moral doubts about debriefing. I am told to just convert word to word and not change anything. In debriefing a few doctors asked me if they have understood the patient correctly. As an interpreter I am not supposed to answer those questions. If the patient has hesitated and not given full information about their periods, it is not my job to add any more information to it. (Interpreter 2, Work experience 5 years)

As a doctor I have offered debriefs and interpreters usually say no to it. I think interpreters would be confused about adding cultural information to the patient's dialogue. This is because they are expected to just translate for patient and not be their

support persons. (GP6, 18 years' experience in refugee health)

Interpreters would never debrief. That is why I left that job. I am now a community support officer or a CSO. I felt frustrated as an interpreter. I could not explain clients' speech and meaning properly. Let me give an example. The doctor asks how is sex? Is it painful? If I translate this literally the patient will get up and go. They will never ever talk to me again. So, I will say that how is talking between husband and wife and they will know. As an interpreter I just kept doing it but could not tell this to doctor. As a CSO I can tell this to the doctor or nurse in debriefing. (Social practitioner 4, Interpreter experience of 10 years, currently working in a managerial role in refugee welfare organization)

The ethical issues need to be discussed again and again. Interpreter trainers should be made to come on board and change the code of conduct. There is some merging required in interpreting and cultural support roles. Individual GP practices, councils, cultural organizations, or big refugee bodies all should focus on this and create enacted sessions on debriefing. Practice in these simulated sessions will make everyone better at it. Practice makes the man perfect. (Interpreter 3, Work experience 9 years)

Theme 3: Organizational Difficulties

Providers of refugee services discussed organizational difficulties they felt were important in conducting debriefing sessions. It is critical to delineate that HCPs have discussed structural challenges in debriefing sessions, however, administrative staff reported their own experiences of debriefing through an organizational lens.

Sub-theme 3A: Scheduling follow ups required both patient and interpreters: Some administrative providers discussed that interpreters are needed at every step in the practice including scheduling follow up appointments. The time after the appointment is spent doing this instead of debriefing.

As soon as the visit is completed the nurse and patient will walk to the reception with the interpreter. The doctor will be waiting to take the next patient. They would actually wait till the interpreter finishes and then with their help take the next patient to the room. The interpreters are block booked for the afternoon. So, they will have many patients to attend to. I don't know how we will fit in debriefing. (Practice Manager 3, Work experience in refugee health practice 15 years)

I am the practice manager here. We see mostly refugee people and have an onsite bilingual support worker. For a bulk billing practice, we should be seeing 5 to 6 patients every hour. I don't know where we should fit debriefing. (Practice Manager 1, Work experience in refugee health 9 years).

We are in the countryside. Our policy is to have 30-minute appointments with refugee people. We try to have face to face interpreters as much as possible. Even then there is no time for interpreter debriefing. These appointments often last for 45 minutes. (Nurse 11, working for 10 years in refugee health in regional Victoria)

Sub-theme 3B: Workload of interpreters as next appointments are waiting: Providers of refugee services, particularly those working in administrative roles, were concerned that interpreters may find it difficult to fit debriefing in their busy schedules.

The debriefing is for the benefit for interpreters and doctors. I can't say so much about the doctors, but the interpreters are exhausted by the end of the block booking session. Say they are booked from 1 to 4 o'clock. So, we should have 4 or 5 patients for them. However, there will be at least 8 to 10 patients they will see. There will be some walk ins which will have to be accommodated. They have too much workload. (Practice Manager 1, Work experience in refugee health 9 years)

Interpreters also get exhausted. Some of them become our friends in the practice. They tell us privately that they are affected by the traumatic stories of patients. It brings back their own memories. I would feel that debrief should be very important in these circumstances. But interpreters are overloaded with booked appointments, walk ins and even people who just come in to ask for help with government paperwork. On the ground, I must say there is no time for debriefing. (Practice Manager 3, Work experience in refugee health practice 15 years).

I think the best solution would be to plan the day where interpreters and doctors both have some time for debriefing. Many will tell you it is not possible. However, I will say where there is a will there is a way. How long will we keep getting by and not focus on doing it correctly? (Practice Manager 2, Work experience in refugee health practice 2.5 years)

Theme 4: Potential Solutions

Being true to the tenets of qualitative research diverse providers of refugee services reflected on their lived experiences of SRH appointments. The first three themes discussing the debriefing challenges were primarily brought out by HCPs and bilingual providers of refugee services. However, all participants jointly reflected on potential solutions for implementing a debriefing routine into everyday clinical practice. Community members resolved the ethical conflicts by suggesting innovative ideas of including them into the debrief or making the patient aware and asking their permission for a separate debrief. In addition, modifying debriefing into a feedback session was also recommended by some participants.

Sub-theme 4A: Including patients into the debrief: The first solution underscored by participants was that the patients can be included in debriefing sessions of SRH consultations. Many HCPs, interpreters and community members corroborated this:

My view will be to tell the patient that let's talk about our appointment. How did they feel about the conversation? I think declaring that the proper appointment is over. Then just talking for a few minutes to relax the patient, and the interpreter and asking them can we do it better. When the focus is away from private sexual matters patients will be more open to discussing things. (GP 1, more than 10 years' experience in refugee health).

I am a bilingual worker and feel that including the patients would be the best. The interpreter will be happy to involve the patient. Their internal difficulty about talking to doctor without patient will be over. It may be hard to provide feedback to the

doctor but still it will be a start. (Social practitioner 5, Work experience 3.5 years)

I go to the doctor and have to talk through interpreters. I understand that interpreter may feel awkward about talking when we are not there. If they tell us that the doctor and the interpreter will talk for a few minutes about the appointment. We would not worry and just wait outside the room or just sit there and wait for them to finish. I think interpreter may be able to tell the doctor a few things which we could not say. Interpreters do know us well as they are one of us. (Community member 1, Homemaker living in Australia for 10 years)

Sub-theme 4B: Making the patient aware and asking their permission to debrief: Interestingly, community members valued honesty and revealed little hesitation in leaving the room to facilitate debriefing when requested.

Honesty is valued. Even we would not mind interpreter talking to the doctor without us if we knew this is going to happen and we are clear about the reasons for it. (Community member 4, working in Australia for 7 years)

Say I had a private conversation about marriage problems. The doctor may not know about our families and culture. The interpreter will be able to tell them. We do not leave our husbands. We may not be able to tell this to the doctor ourselves. The best time to talk about this kind of thing would be after the appointment. I think just tell the patient to wait outside and interpreter and doctor talk to each other. (Community member 6, working in Australia for 10 years)

I think an ethical way to do it would be with the patient's permission. This will include an open disclosure and reduce the dilemmas of the interpreter. (Community member 11, Student and part time sales assistant).

As an interpreter I would not mind doing a debrief if the patient knew about it and gave their permission. (Interpreter 3, Work experience 9 years)

Sub-theme 4C: Conceptualizing it as a feedback session: When participants were asked how to do debriefing better, many thought that it would be better conceptualized as a feedback session.

The word debrief could be a problem. I believe that changing it to a feedback session would be better. More interpreters will accept to participate in the session. (Social practitioner 3, Working in a non-governmental refugee welfare organization for 10 years).

Most patients will be simply grateful to the doctor. The interpreter will be very respectful to the doctor. So, it will be hard for our community to say anything to the doctor out of respect or thankfulness. But calling debriefs as feedbacks for improvements will be more useful. It will be a start and may get people talking. (Community member 9, Homemaker living in Australia for 4 years) If time is allocated at the end of an appointment for feedback in every interpreter mediated conversation, at least some discussion would happen on communication improvements. (Community member 2, Working in regional Victoria for 6 years).

I think feedback would be great. I have seen this only in Australia. In Burma and camps, we just said yes to everything. We are learning to say our mind. Interpreters can feedback on our behalf or discuss anything of their own. But it would be better to tell us. (Community member 12, Homemaker and mother living in Australia for 15 years).

DISCUSSION

This study has produced what is (to our knowledge) the only qualitative data set to ground the reality of debriefing in interpreter mediated SRH consultations with people from refugee backgrounds. The findings have established a lack of consistent guidance at a national level on debriefing implementation in SRH consults in primary care. Three key findings relating to debriefing were especially prominent in this study: first, the considerable challenges involved in organizing debriefing sessions; second, the tremendous ethical conflicts and moral dilemmas faced by interpreters about debriefing; and third practical limitations of a health system already compromised by time constraints, double booked clinics, and overworked professionals. In addition, by juxtaposing the views of HCPs, interpreters, and patients, we have identified pragmatic solutions for future research and implementation.

Our data supports the "unifying theoretical model of trust and communication" put forward by the landmark paper of Robb and Greenhalgh [68] in the context of interpreted consultations. The authors described three different types of trust namely "voluntary", "coercive", and "hegemonic" which can be aptly applied to the complexity of decisions involved in debriefing [68,69]. We have uncovered some of these complexities of trust in our data. The minimal uptake of debriefing is an example of "hegemonic trust" where the interpreters are subservient to their code of conduct and lack the critical perspective, skill or autonomy to resist it. Individuals in lower hierarchical positions will avoid confrontation with published norms and are most vulnerable to this pathological kind of trust.

Next, the issues of "voluntary trust" are evident in the ethical and moral dilemmas of debriefing. "Voluntary trust" implies that all professionals including doctors, nurses, and interpreters must voluntarily follow a rigorous code of conduct. Interpreters raised issues of contradictory advice received in training about debriefing. They are instructed to function as conduits only and perform word by word translations. This advice has understandably prevented them from initiating debriefing on their own or accepting it when offered. The expectation of debriefing symbolizes a breach in "voluntary trust" to the interpreters. Finally, the "coercive trust" exists given unequal power relations in the society at large. The coercive trust issues are more obvious in interactions with recent immigrants whose social isolation, minimal English skills and cultural norms generally disallow conflicts with medical systems. Many interpreters pointed out that their hierarchical position and cultural norms do not allow them to initiate debriefs. In other words, they are coerced to be passive in the presence of medical professionals.

Integrating these complex trust issues with communication theories is vital to improve the uptake and utility of debriefing. Robb and Greenhalgh state that "all actual conversations are a mix of 'communicative' and 'strategic action' " [68]. Debriefing can also be summarized as an intricate mix of the two. Open

communicative action between HCPs and interpreters through continuity of positive encounters over multiple debriefing sessions will enforce voluntary trust and breakdown many hegemonic and coercive trust barriers. In addition, if HCPs use positive strategic actions to consciously modify interpreter behaviors, they will be empowered to speak up in debriefing sessions.

Robb and Greenhalgh [68] note that patients are never allowed to book interpreters for themselves; this task is undertaken by staff at the GP practices. They state that patients' trust and communication will improve if the booking system involved the service users. In our study, we asked monolingual community members to think of solutions to improve debriefing. Once familiarized with the concept and intention of debriefing they welcomed the idea of communication improvement and conceptualized it as feedback for the appointment. Patients valued honesty and preferred being informed about the debriefing. Further, some stated they did not mind stepping out of the room during the session if required. Some preferred to be included in part or full discussion.

Our study has focused on SRH consultations with refugees from Burma. We extensively searched multidisciplinary literature including health and social sciences, anthropology, communication, and migration related publications to find any practical experience of debriefing. To the best of our knowledge there is no published research reporting the experience of HCPs or interpreters with debriefing sessions. Participants confirmed the low uptake of debriefing in interpreter mediated SRH consultations. In theory debriefing is widely promoted but the reality is that most HCPs found it difficult to recall ever having a debriefing session. Neglecting to debrief, not only has potential negative impacts on mental health of interpreters [33] but also may leave many unresolved doubts and questions in the clinician's mind [36,70] which could increase the possibility of medical errors or result in inadequate patient care [71-73].

Table 6: Steps to increase the uptake and utility of debriefing post interpreter mediated Sexual and Reproductive Health (HCPs: Health Care Providers, SRH) consultations with refugee background patients

Three Steps to Increase the Uptake and Utility of Debriefing		
Preparation Routine	**Managing Ethical Dilemmas**	**Organizational Aspects**
Introduce debriefing at the start of the appointment	Modify interpreter code of conduct to permit meaningful translation instead of verbatim interpretation	Time allocation for debriefing during appointments.
Telephone interpreters can be requested to stay on the phone after follow-up appointments have been scheduled	Multiple practice workshops to simulate debriefing scenarios for training of HCPs and interpreters.	Work spacing for interpreters and HCPs so that no one is rushing to the next appointment
Face to face interpreters can be requested to return to the room after the patient has left	Acknowledging SRH as a specialized subject and upskill interpreters with expertise and vocabulary in SRH	Community engagement to co-design useful and meaningful resources to facilitate understanding of debriefing in SRH consults.
Enquire from patients if they would like to make any comments about the consultation.	Increasing awareness and agency about debriefing that anyone including patients can initiate it.	Posters in the practice which state, "This practice supports debriefing post appointments to improve conversation" and explain the purpose of debriefing
Use the time for communication related feedback and understanding any cultural context of language	Community sessions on how to work with interpreters will increase awareness about debriefing in general.	Bilingual community members to work at reception- This will free the interpreters to take part in debriefing

Findings from our study show that there is a need to increase awareness of the concept and value of debriefing and develop an implementation plan to support its uptake. The decision on when there is a need to debrief and how to facilitate it is more complex than stated in existing best practice guidelines that "it is essential to have a debriefing conversation with the interpreter post appointments". Based on participant's experiences in this study, we have proposed a series of steps to increase the uptake and utility of debriefing post SRH consultations with refugee background patients (**Table 6**).

LIMITATIONS OF THE STUDY

It is necessary to draw attention to the limitations of this study. First, it is beyond the scope of qualitative research to identify the extent and impact of difficulties experienced by HCPs and interpreters about debriefing following any interpreter mediated SRH consultation. Indeed, large-scale surveys, supplemented by qualitative studies, would help to build a wider picture of the barriers experienced by providers of refugee services regarding debriefing including those related to SRH with different refugee groups.

Second, exploring such difficulties by interviews, as opposed to observing SRH appointments in practice, may be considered a shortcoming of this study. Video-recording interpreter mediated interaction is a well-established method of research in primary care. However, it has been argued that video recording consultations has the potential to alter the behavior of all participants. A further limitation of the observational approach is that patients may not consent to the consultation being recorded particularly when it is about a sexual matter. Similar findings were confirmed by Chapple et al (2004) who found that patients who withheld consent to participate were concerned about 'embarrassing' problems and confidentiality issues [74].

The interviews were conducted by an obstetrician and gynecologist. It is possible that participant's disclosure would differ if the interviews had been conducted by GPs, or native speakers of Burma, on the basis of their shared professional or cultural background. However, it is also possible that being interviewed by someone who does not share this professional role, and

therefore has a distance from their working life, could encourage more open disclosure. Future research could ascertain if these differences exist.

CONCLUSION

There are currently major gaps between ethical codes of conduct for interpreters in healthcare and the realities of medical interpretation in relation to debriefing. Given the identification that both health care professionals and interpreters face ethical dilemmas, resolution or normalization of these conflicts will be central to increasing debriefing uptake. Further, lack of organizational support such as time allocation and workload distribution may be overcome by taking a pro-active role regarding debriefing during interpreter mediated SRH consultations with refugees from Burma. Finally, we propose models of interpretation that acknowledge and legitimize the interpreter's role as a mediator, a culture broker, an advocate, and an equal team member to improve uptake and utility of debriefing. We believe an open and honest discussion of these issues will be a start point for solving the ethical dilemmas and practical difficulties in the application of much needed debriefing post SRH consultations with refugees from Burma.

Several findings from this study have implications for future research. First, additional research on debriefing experience post appointments about medical issues other than SRH is vital to increase the uptake of debriefing. While it was not an aim of the research, many interviewees indirectly commented on the current system in the tertiary hospitals where debriefing remains unexplored. Thus, research initiatives could explore debriefing in mainstream tertiary services. Thirdly, our findings may not be valid for other refugee communities. We believe that this study has a wider potential for exploring how the concept of debriefing plays out in other refugee settings or even other geographical locations.

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CONFLICT OF INTEREST

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