General guideline

Navigating language barriers in health and social care

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www.pharos.nl/taalbarrieres

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This guideline was developed by representatives of professional associations and patient organisations, a representative of Pharos (Dutch Centre of Expertise on Health Disparities) and a project group led by the Dutch Patients Federation.

The professional associations and patient organisations that have contributed are:

- BPSW - Dutch Association of Social Workers
- KAMG - Association of Public Health Physicians
- KNMP - Royal Dutch Pharmacists Association
- KNOV - Royal Dutch Association of Midwives
- NHG - Dutch College of General Practitioners
- NIP - Dutch Association of Psychologists
- NIV - Dutch Association of Internal Medicine
- NVOG - Dutch Society for Obstetrics and Gynaecology
- NVvH - Dutch Society for Surgery
- NVvP - Dutch Society for Psychiatry
- ORT&V - Order of Registered Interpreters and Translators
- SIZ - Dutch Foundation for Intercultural Care (formerly SGAN)
- V&VN - Dutch Nurses' Association

The project group consisted of an independent chairman, researchers of the Amsterdam Center for Health Communication from the University of Amsterdam, a guideline methodologist from Amsterdam University Medical Centre, and the project leader, the project support officer and the lead manager of the Dutch Patients Federation. The names and affiliations of the members of the working group and the project group can be found in chapter 9.

The aim of this guideline is to improve the quality and accessibility of health and social care provided to patients and their family and friends, with communication recommendations when it comes to conversations with a potential language barrier. The recommendations in this guideline are based on scientific evidence, professional insights, and patients' perspectives. Just like with any other guideline, the recommendations are not statutory provisions.

There might be specific circumstances in which a health or social care professional thinks it is in the patient's best interest to diverge from the guideline, for example in case of emergency. There might also be logistical reasons as to why certain health or social care professionals are not able to follow the guideline, for example when they do not have access to interpreters, for financial or other reasons, they have insufficient time for conversations with a language barrier, or they have a shortage of staff. However, this does not alter the fact that this guideline is meant to serve as a measure and a guide to improve the communication between health and social care professionals and their patients.

Organisations that have authorised the guideline:

- BPSW - Dutch Association of Social Workers
- KAMG - Association of Public Health Physicians
- KNOV - Royal Dutch Association of Midwives
- NIP - Dutch Association of Psychologists
- NVvH - Dutch Society for Surgery
- ORT&V - Order of Registered Interpreters and Translators
- SIZ - Dutch Foundation for Intercultural Care (formerly SGAN)
- V&VN - Dutch Nurses' Association

Organisation that has approved the guideline on a managerial level:

- NHG - Dutch College of General Practitioners

Organisation that supports the guideline on a managerial level:

- KNMP - Royal Dutch Pharmacists Association

Organisation to which this quality document serves as a guideline:

- NIV - Dutch Association of Internal Medicine

Organisation that has issued a No Objection Certificate:

- NVvP - Dutch Society for Psychiatry

Organisation that is still in its authorisation phase:

- NVOG - Dutch Society for Obstetrics and Gynaecology

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Table of contents

1. Summary 8
2. General introduction 13
   2.1. Reason and relevance 13
   2.2. Objective 15
   2.3. Target audience 15
   2.4. Methodological approach 16
   2.5. Scope of the general guideline 16
      2.5.1. What are language barriers? 16
      2.5.2. Other factors that influence communication 16
   2.6. Legal meaning 17
   2.7. Descriptions of the most important terms 18
      2.7.1. Types of language support 18
      2.7.2. Conversation types 20
      2.7.3. Additional commonly used terms 20
3. Patients' perspectives 22
   3.1. Experiences 22
      3.1.1. No choice 22
      3.1.2. Refusing care or help 23
      3.1.3. Strain on adult family members and friends 24
   3.2. Wishes and needs 25
      3.2.1. Knowledge and trust 25
      3.2.2. Types of language support 25
4. Module 1: Identifying a language barrier 26
   4.1. Clinical question 26
   4.2. Recommendations: 26
   4.3. Foundation 26
      4.3.1. Why is it important to identify if there is a language barrier? 26
      4.3.2. Who is responsible for identifying the language barrier and its extent? 27
      4.3.3. At what point can a language barrier and its extent be identified? 27
      4.3.4. How do you identify a language barrier and its extent? 27
   4.4. Considerations 30
      4.4.1. Identifying language barriers prior to an appointment 31
      4.4.2. Identifying language barriers at the start of an appointment 31
      4.4.3. Reporting a language barrier in the patient's record 31
5. Module 2: Choosing the most suitable type(s) of language support 33
   5.1. Clinical question 33

5.2. Recommendations: 33
5.3. Foundation 34
5.3.1. (Limited) common language 34
5.3.2. Healthcare professional that speaks the patient's native language 35
5.3.3. Professional interpreter 36
5.3.4. Adult family member or friend who interprets 38
5.3.5. Digital tools 40
5.3.6. Translated material 41
5.3.7. Communicating with nonverbal communication 42
5.3.8. A person brought in ad hoc as an interpreter 42
5.3.9. Cultural mediator 43
5.4. Considerations 44
5.4.1. (Limited) common language 44
5.4.2. Healthcare professional that speaks the patient's native language 45
5.4.3. Professional interpreter 46
5.4.4. Adult family member or friend who interprets 47
5.4.5. Digital tools 48
5.4.6. Translated material 48
5.4.7. Nonverbal communication 49
5.4.8. A person brought in ad hoc as an interpreter 49
5.4.9. Cultural mediator 49
6. Module 3: Evaluating the performance of communication goals 50
6.1. Clinical question 50
6.2. Recommendations: 50
6.3. Foundation 50
6.3.1. Why is it important to evaluate communication goals? 50
6.3.2. Who is responsible for evaluating communication goals? 51
6.3.3. When can communication goals be evaluated? 51
6.3.4. How do you evaluate communication goals? 52
6.4. Considerations 53
7. Distribution and implementation 54
7.1. Distribution 54
7.2. Implementation 55
7.2.1. Broad awareness and education 55
7.2.2. Organisation of care: time 56
7.2.3. Organisation of care: access to types of language support 56
7.3. Financial impact of implementing the guideline 59
7.4. Advice for stakeholders 60

7.5. Advice per group of stakeholders 61
7.5.1. Professional associations and scientific associations of health and social care professionals 61
7.5.2. Providers of care and support 61
7.5.3. Patient organisations and informal care organisations 61
7.5.4. Professional associations 62
7.5.5. Health insurers 62
7.5.6. Ministry of Health, Welfare and Sport 62
7.5.7. Municipalities 62
7.5.8. Association of Dutch Municipalities 62
7.5.9. National Health Care Institute 63
7.5.10. Dutch Healthcare Authority 63
7.5.11. Inspection for health and social care 63
7.5.12. Professional associations of interpreters 63
7.5.13. Provision of education and refresher courses for health and social care professionals 63
7.5.14. Provision of education and refresher courses for interpreters 63
7.5.15. Organisations for accreditation and registration of interpreters 64
7.5.16. Knowledge institutions (including Pharos, Movisie, the Netherlands Youth Institute, the Trimbos Institute and Vilans) 64
7.5.17. Local and regional cooperations, like obstetric care networks (VSVs) and regional support organisations for healthcare (ROSes) and general practitioners (RHOs) 64
7.5.18. Developers of digital tools 64
7.5.19. Developers of digital records and templates for referrals 64
7.6. Indicators and monitoring 64
7.6.1. Indicators for implementing the guideline 64
7.6.2. Indicators for implementing types of language support 65
8. Knowledge gaps 66
8.1. Awareness and behavioural change 66
8.2. Use and effectiveness of types of language support 67
8.3. Outcomes 67
8.4. Knowledge about implementation 68
9. Methodology 69
9.1. General background information 69
9.2. Composition of the working group and sounding boards 69
9.2.1. Guideline working group 69
9.2.2. Project group 70
9.2.3. Sounding boards 71
9.2.4. Other experts who reviewed this guideline 71
9.2.5. Other contributors 71

9.3. Declarations of interest 72
9.4. Authorised parties 72
9.5. Publication date 72
9.6. Process information about the development of the guideline 72
9.6.1. Establishment of the project 72
9.6.2. Preparation phase 72
9.6.3. Development phase 73
9.6.4. Closing phase 77
10. Attachments 78
Attachment 1 Definitions and descriptions of terms 78
Attachment 2 Summary systematic review 84
Attachment 3 Summary of the focus groups 88
Attachment 4 Evidence-to-decision table 93
Attachment 5 Mail National Health Care Institute about the funding of interpreters [original Dutch] 95
References 96

1. Summary

Background

Around 2.5 million people in the Netherlands do not speak Dutch as their native language. They came here to work, study, for family reasons, or to flee their home country. Some of these people cannot communicate with healthcare professionals without language support. Now that the first-generation immigrant population is getting older, their need for care and support increases. This means that, in practice, language barriers between patients and health and social care professionals occur more frequently.

Providing the right language support in cases of a language barrier has a positive effect on the patient's health. Providing the right language support facilitates shared decision-making and offering appropriate care and support leads to more satisfaction for both the patient and the health or social care professional. That is why it is so important to mitigate language barriers as much as possible. This evidence-based guideline was developed for health and social care professionals and offers recommendations and tools in deciding whether language is in fact a barrier, in choosing the right type(s) of language support, and deciding whether the communication goals have been achieved.

How this guideline was developed

This general guideline was systematically developed in accordance with the AQUA guidelines. A guideline working group was established for this purpose, consisting of representatives of health and social care associations, patient representatives, and professional interpreters. Their practical experience and expertise were combined with scientific insights and the expertise of the project group.

To establish a scientific foundation for this guideline, a systematic review (1) was carried out along with various focus groups with health and social care professionals, patient and client representatives, and interpreters and cultural mediators. The GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach was used to assess the quality of evidence and to formulate the recommendations. A more comprehensive description of all the parties involved, and the methodological approach can be found in the modules themselves and in the methodology of this guideline.

Target audience

The target audience of this general guideline consists of anyone who may experience a language barrier in conversations within health and social care. This pertains to health and social care professionals, support staff, patients, and patients' family and friends, who might all encounter language barriers that can negatively impact the quality of care, assistance, prevention and support. For a more detailed description of the target audience, see paragraph 2.3.

Module 1 Identifying a language barrier

Key question:

How can health and social care professionals and support staff identify a language barrier and its extent and whether this negatively impacts the quality of care and support?

Recommendations:

1. Check if the patient's record or their referral letter mentions which language(s) the patient speaks and whether language support is needed.
2. If there is no information available about the languages they speak and their potential need for language support, ask the patient open-ended questions in Dutch or a common language to identify a potential language barrier. Have this conversation before or at the start of the appointment. If a family member or friend made the appointment, direct these questions to them instead.
3. In the case of a potential language barrier, determine whether language support is needed based on the type of conversation you are expecting to have.
4. When there is a language barrier, write down in the patient's record which languages they speak and the language support that might be needed. In consultation with the patient, ensure this information is also provided during handover or referral.

Explanation:

When possible, it is important to identify whether there might be a language barrier before an appointment. This allows for the possibility to reserve extra time for the appointment and, if needed, to hire a professional interpreter. One way to identify a potential language barrier is by asking the patient open-ended questions when they call to make an appointment. For example: 'How well are you able to describe your symptom(s) in Dutch?' If it is not possible to determine whether there is a language barrier beforehand, ask these questions at the start of the conversation. After the appointment, write down in the patient's record whether there is a language barrier, how much language support is needed and if the patient or health or social care professional prefers a specific type of language support, as well as the feasibility of this request.

Module 2 Choosing the type(s) of language support

Key question:

How can health and social care professionals, patients, and patients' family and friends determine which types of language support are the most suitable to assist communication? And who decides which type of language support is used?

Recommendations:

1. When there is a potential language barrier, determine together with your patient which type(s) of language support is/are the most suitable. Base this on the type of conversation you are expecting to have and the feasibility:

    a. Communicate in Dutch, or if that is not possible, in another common language with the patient if the communication is sufficient for the expected subject matter of the conversation.
    b. If you are expecting this conversation to be about a complex, sensitive or impactful topic, hire a professional interpreter or transfer the patient to an equivalent health or social care professional who speaks the patient's native language. Preferably also do this during the initial consultation.
    c. Consider letting an adult family member or friend act as an interpreter for the patient if the expected conversation will be relatively simple. Make sure that the family member or friend is over the age of eighteen. An adult family member or friend should only be

allowed to act as an interpreter if both them and the patient consent to doing so, if they trust one another, and if the family member or friend speaks both languages well.

d. If the patient has adequate literacy and technology skills, consider using digital tools for an appointment when the expected subject matter of the conversation is relatively simple, or use it to support other types of language support. It is best to use a digital tool with sentences that have already been translated. Only use a unencrypted translation app to translate single words or simple sentences and never share personal information.
e. Also offer material in simplified Dutch or in another language when this is beneficial for patients who do not necessarily experience a language barrier. Only provide material in a language the patient, or family member or friend understands well.
f. Use nonverbal communication such as gestures, images, drawings and communication cards to support other types of language support.
g. Do not allow someone who is not the patient's family member, friend, or health or social care professional to act as an interpreter outside of emergency situations where no other types of language support are available.

2. When a patient does not consent to using a professional interpreter or to transferring to another health or social care professional who speaks the patient's native language, ask for the reason. Reiterate why you think this type of language support is necessary. If the patient still does not consent, write this down in their record with their reason.

3. Consider offering the patient other types of language support when the communication goals are not being achieved.

    a. Consider involving a professional interpreter ad hoc over the phone, meaning not booked in advance, when it appears the communication goals are not being achieved during the appointment. If that is not possible, consider scheduling a new appointment with a professional interpreter present.
    b. Consider transferring or referring the patient to a health or social care professional who speaks the patient's native language if the communication goals are not being achieved with a professional interpreter.
    c. Consider involving a cultural mediator if the communication goals are not being achieved with a professional interpreter and if it is not possible to transfer or refer the patient to a health or social care professional who speaks the patient's native language.

Explanation:

When choosing the most effective type of language support, it is important to take into consideration (1) the patient's preferences, (2) the patient's language proficiency, (3) the subject matter and complexity of the conversation, and (4) the feasibility of the type(s) of language support. If the patient has an adequately high language proficiency, Dutch should suffice to a certain extent as a common language for effective communication. Advanced speakers often require little to no language support, while for novice speakers this is only the case for simple conversations.

Access to an interpreter is a precondition for providing proper healthcare in line with the Dutch Healthcare Quality, Complaints and Disputes Act (WKKGZ), the Dutch Medical Treatment Agreement Act (WGBO), and professional standards. Every sector has a different policy for financing an interpreter and it is not always well organised. This means that in some sectors the healthcare provider pays for the interpreter. On the website www.zoschakeltueentolkin.nl you will find up-to-date information about the financing policy of each sector. Many healthcare professionals also do not get extra time for appointments involving a language barrier.

Module 3 Evaluating the performance of communication goals

Key question:

How can health and social care professionals assess whether the communication goals are being achieved when there is a language barrier?

Recommendations:

1. Ask the patient to explain in their own words what you have discussed. Do this at multiple points during the conversation, most importantly, at the end. The best way to do this is the teach-back method. Write down in the patient's record if chosen type(s) of language support are sufficient.

Explanation:

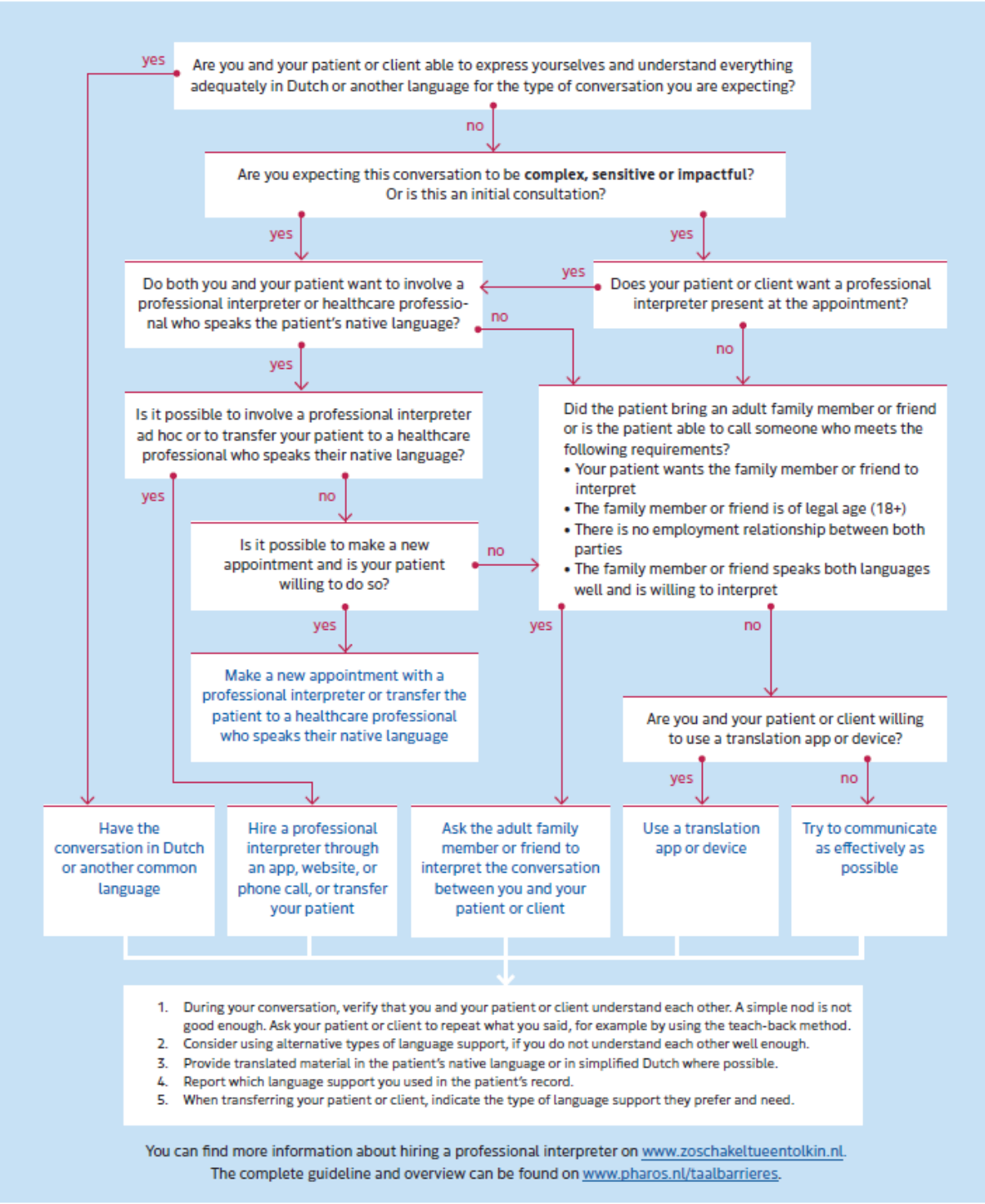
In every conversation, regardless of the severity of the language barrier, it is important to check if the type(s) of language support that were chosen actually contribute to achieving the communication goals. For this, you can use the teach-back method, for example: 'I want to make sure I explained everything clearly. Can you tell me what you are going to do or say when you get home?' or 'I want to make sure I explained everything clearly. Can you explain in your own words: (1) what the issue is, (2) what measures you can take, and (3) why it is important that you do so?' Ask the questions in a neutral manner without judgement, so the patient or client feels comfortable enough to answer honestly. For recurring issues such as difficulties understanding, consider using extra language support or making a new appointment with a professional interpreter present.

Decision tree

The decision tree on the next page was developed by the project group and the guideline working group based on recommendations and was refined by feedback given from the commentary round.

Language barrier? This is how we solve it together!

Dutch Guideline Navigating language barriers in health and social care | decision tree for health and social care professionals.



2. General introduction

2.1. Reason and relevance

Every health and social care professional strives to provide proper and appropriate care. Everyone is entitled to 'the highest achievable standard of physical and mental wellbeing'(2). This would be impossible without healthcare that is available, accessible, acceptable and of high quality. For care and support to be of high quality, they need to be suitable. When health and social care professionals decide with the patient what is needed and desired, this leads to better and more appropriate care and support. Health and social care professionals are fully committed to this. Providing proper healthcare in cases of a language barrier can be equally as challenging for health and social care professionals as for patients and their family members and friends.

Providing proper and appropriate care and support is the responsibility of professionals, managers and administrators. Article 2 of the Dutch Healthcare Quality, Complaints and Disputes Act (WKKGZ) obliges healthcare providers to 'provide proper healthcare' (3). The Dutch Medical Treatment Agreement Act (WGBO) establishes the rights of patients, such as the right to information, informed consent and shared decision-making (4). An important aspect of the WGBO is the healthcare providers' obligation to provide appropriate care. The Child and Youth Act includes provisions that ensure it is, in this regard, equivalent to the WGBO. In addition, communicating with and informing the patient is part of the code of conduct for health and social care professionals, such as the code of conduct for the social worker (5) and de KNMG-code of conduct for doctors (6).

Language is essential in providing and receiving proper and appropriate care. Language is needed to discuss the problems a patient experiences and their care needs and desires. Language is essential for health and social care professionals to comply with the obligation to inform (see above), to explain what a treatment involves, and which complications may occur. Language is also needed to align the care offered with the patient's needs and to build trust between the health or social care professional and the patient. Language is also indispensable for properly assessing the patient's boundaries. Language is the basis of health and social care.

Proficiency in the Dutch language is not self-evident. On 1 January 2022, more than 2.5 million people, nearly 15% of the Dutch population, were born outside the Netherlands. (7). These people came to the Netherlands to work, study, for family reasons, or to flee their home country. In 80-90% of the cases, newcomers do not speak Dutch upon arrival. (8). Learning Dutch is important, but it can also be difficult and time-consuming. As of 2024, it is required to have a minimum CEFR proficiency level of A2 in Dutch to pass the civic integration exam (for a description of the language proficiency levels, see attachment 1). This level is often insufficient for discussing complex topics without language support. Even when someone is able to speak Dutch in their daily life, it does not mean that they can manage this in conversations about health. Sometimes words that even native speakers have difficulty understanding are used in these conversations.

Providing proper and appropriate care and support is more difficult when there is a language barrier. For patients, it can be difficult to explain their experiences, symptoms, and problems in a non-native language. For health and social care professionals, it can be difficult to understand what the patient means or to comply with the obligation to inform if it is unclear whether the patient understands them. When misunderstandings occur, this can lead to frustration or even anger among both health and social care professionals and patients.

A language barrier can have negative healthcare outcomes. When there is a language barrier between the health or social care professional and the patient, this leads to increased

miscommunication, decreased satisfaction from the patient and the health or social care professional, a lower quality of care, and reduced patient safety and therapeutic compliance.(9–12) A language barrier can also cause certain topics to be avoided or unaddressed, sometimes unintentionally, such as the patient's history (13), sensitive information and concerns (13,14), the patient's feelings and symptoms (15), and details of the illness or condition (16).

A language barrier can stand in the way of providing care and support. To ensure proper healthcare and prevent adverse outcomes, it is essential to offer language support. Nevertheless, Dutch healthcare professionals frequently do not sufficiently recognise language barriers and do not always utilise professional interpreters or other strategies to come up with a solution for the language barrier. (17,18). Across the rest of Europe, many health and social care professionals, patients, and patients' family members and friends also do not know when or why to use a professional interpreter or other tools to provide appropriate care, such as using family members or friends as interpreters or using translation applications. (19,20). As a result, the accessibility, quality, and safety of care often suffer.

Coming up with a solution for a language barrier or offering language support is not always easy. There is often not enough time or funding to hire a professional interpreter, such as in cases of emergency. Translation applications are not equally reliable for all languages. Family members and friends are not always adequately proficient in both languages. Some Dutch words do not have an accurate translation, or the translation may have a different meaning. There are many factors to consider when choosing the most suitable language support.

The current 'Quality Standard for Interpreter Use with Non-Dutch Speakers in Healthcare' (21) **is due to be replaced.** Professional associations and patient organisations developed this quality standard in 2013 to support health and social care professionals in choosing whether or not to use an interpreter. The quality standard is due for actualisation in terms of content, format, and scientific foundation.
Firstly, new research results have become available over the past few years. Secondly, the current quality standard focuses only on the use of professional interpreters and adult family members and friends as interpreters, while other methods are also available, such as digital tools or cultural mediators. Lastly, the current quality standard has been implemented only to a limited extent and many health and social care professionals are unfamiliar with it.

That is why at the end of 2019 the Johannes Wier Foundation for Healthcare and Human Rights made an appeal to the Quality Board of the National Health Care Institute to prioritise the development of a new developmental instrument for navigating language barriers in health and social care (22). The appeal was signed by more than 200 professional organisations and interest groups, professors and experts by experience. The plea received broad support from both the National Health Care Institute and the Ministry of Health, Welfare and Sport (23). Funding for the development of the general guideline was provided by the Netherlands Organisation for Health Research and Development (ZonMw). The Dutch Patients Federation also contributed financially to the project.

The used terms. The term 'general' was used because the recommendations can be applied to the entire health and social care field. During the project, the term 'guideline module' was used. Based on the comments, it was decided to use the term 'guideline'. The term 'guideline' is clearer than 'guideline module', particularly because three modules have been developed. The document meets the definition of a guideline in all aspects.

2.2. Objective

The objective of this general guideline is to improve the accessibility, quality, and affordability of health and social care for people who do not speak and understand Dutch well. This is achieved by providing evidence-based recommendations for language support, aimed at both health and social care professionals and patients. The recommendations provide answers to the three key questions established by the guideline working group:

1. How can health and social care professionals and support staff identify a language barrier and its extent and whether this negatively impacts the quality of care and support? (Module 1)
2. How can health and social care professionals, patients, and patients' family and friends determine which types of language support are most suitable to facilitate communication? And who decides which type of language support is used? (Module 2)
3. How can health and social care professionals assess whether the communication goals are being achieved when there is a language barrier? (Module 3)

2.3. Target audience

The target audience of this general guideline consists of anyone who may experience a language barrier in conversations within health and social care. This pertains to health and social care professionals, support staff, patients, and patients' family and friends, who might all encounter language barriers that can negatively impact the quality of care, assistance, prevention and support. A description of what is meant by 'health and social care' can be found in attachment 1.

Around 2.5 million people in the Netherlands are not native Dutch speakers. The amount of people who may experience a language barrier is expected to increase in the coming years due to the arrival of refugees, migrant workers and international students. (24–28). Learning the Dutch language takes time and is not achievable for everyone. Even patients who are able to express themselves in Dutch in everyday situations may find it difficult to express themselves in a non-native language when discussing emotional topics. Patients and health and social care professionals need knowledge and skills to adequately navigate language barriers to ensure that all patients have access to proper healthcare. This helps reduce health disparities, lower unnecessary and avoidable healthcare costs, and promote a more inclusive society.

Health and social care professionals include, but are not limited to: doctors, pharmacists, nurses, caregivers, health promotors, social workers, allied health professionals such as physiotherapists, exercise therapists, skin therapists, occupational therapists, speech therapists, and dietitians, obstetricians, maternity carers, dentists and other oral care professionals and psychologists. This applies to their work within the scope of the Health Insurance Act, the Long-Term Care Act, the Child and Youth Act, the Social Support Act, the Public Health Act and other laws and regulation regarding healthcare. Or, looking from another perspective, their work within the scope of the Medical Treatment Agreement Act (WGBO) or the Dutch Healthcare Quality, Complaints and Disputes Act (WKKGZ).

Furthermore, this guideline is practically relevant for policy advisors, managers and administrators of health and social care organisations, such as health centres, hospitals, professional associations, education institutions, patients' associations, health insurers, municipalities, the Health and Youth Care Inspectorate (IGJ), guideline developers and knowledge institutions.

2.4. Methodological approach

The AQUA guidelines (29) were followed for the development of this general guideline. This means that scientific insights were combined with practical experiences and the expertise of members of the guideline working group to formulate concrete recommendations.

The guideline working group consisted of representatives from various professional associations, health and social care professionals, patient representatives and professional interpreters. The objective of the working group was to analyse and prioritise problem areas, determine key questions, and formulate recommendations for each question.

For the scientific foundation, recent studies were systematically analysed and additional research was conducted to fill in missing information. The modules and methodology of this guideline include a more comprehensive description of all parties involved (Chapter 9).

2.5. Scope of the general guideline

2.5.1. What are language barriers?

This guideline focuses on navigating language barriers for people whose native language is not Dutch or who do not yet speak or understand Dutch.

During this project, multiple people have requested that the guideline also include communication with deaf or hard of hearing individuals. This was unfortunately not possible due to project planning and budget restrictions. However, the guideline working group does consider this an important and valuable addition and recommends investigating how this can be achieved.

2.5.2. Other factors that influence communication

This guideline focuses on finding a solution for communication barriers that arise when two or more people do not speak the same language or have insufficient proficiency in it. However, when a language barrier exists, there are often additional factors that can complicate communication and the provision of care and support. In many cases, language and culture together play a decisive role in intercultural health communication (30). It is important to consider several aspects that may influence intercultural health communication, even if these factors fall outside the scope of this guideline.

When discussing language barriers, it's important to note that communication is not only affected by the language barrier itself, but also by cultural differences. Adequately navigating cultural differences is very important in conversations within health and social care (31–34). There may be cultural differences regarding illness, disorders, care, and medication (31,32). This perception can, for example, be influenced by someone's religious beliefs, norms and values (31), or through their experiences with healthcare in other countries. A patient may have religious beliefs about their illness or condition, or hold a particular worldview that makes it difficult for them to answer questions from a health or social care professional. In cases of cultural differences between health or social care professionals and patients, it is especially important to handle these differences consciously, demonstrate respect for the patient, explain the causes and consequences of the illness or condition and clarify why the health or social care professional seeks to make decisions together with the patient (31).

In many cultures, the family, and sometimes the community, play an important role in the care and support process (31). For some patients it may be important not to be responsible for or be directly

involved in the decision-making, but instead to involve the family – if present – in the care and support process. This can also lead to some patients preferring to have an adult family member or friend act as an interpreter instead of using a different type of language support. As a health or social care professional, be aware of the potential role of the patient's family in the care and support process, and pay attention to the family if this is desirable for both the patient and their family.

Intercultural communication can be influenced by prejudices and assumptions from health and social care professionals about patients who are from a different background than their own (31). If health and social care professionals make generalisations about patients based on their experiences with or opinions on another patient of the same origin this can result in discrimination or unequal treatment. To prevent this, health or social care professionals should be aware of their own prejudices and assumptions, whether intentional or not, about patients with a migration background. It is no coincidence that recent Dutch reports recommend training health and social care professionals on culturally sensitive practice (33,34).

The patients' background and their different customs can also affect communication. A language barrier can increase when a patient has experienced difficult or shocking events (35), has little trust in the health or social care professional or the healthcare system (16,36), has little knowledge about the healthcare system (32), has lower healthcare literacy (37,38), has an intellectual disability or poor working memory (39), is elderly (40), or struggles financially (40). During the care and support process, it is important that health and social care professionals take the above factors and similar ones into account. This can be done, for example, by taking some time to ask the patient about their expectations and needs or to explain the Dutch healthcare system to them.

It is crucial that health and social care professionals be aware of the factors stated above, as they can considerably influence the care, support and communication. Effective communication with the patient is needed to properly address these factors. That is why it is important to navigate the language barrier by using the most suitable type(s) of language support.

2.6. Legal meaning

Guidelines are not statutory provisions but evidence-based insights and recommendations. Once a professional association authorises it, a guideline is considered part of the 'professional standard'. Guidelines are primarily based on the 'average' patient and do not apply to each individual case. There might be specific circumstances in which a health or social care professional thinks it to be in the patient's best interest to diverge from the guideline. Practical reasons might also require health or social care professionals to deviate from guidelines, such as time, funding or limited staff capacity. If the guideline is not followed because of personal reasons, this would preferably be documented stating the main reason.

2.7. Descriptions of the most important terms

A comprehensive list of definitions can be found in attachment 1.

2.7.1. Types of language support

Communicating through a (limited) common language	Communicating through a language that both the health or social care professional and the patient speak to a certain extent. The extent to which speaking Dutch or another common language is possible, depends on the language proficiency of the patient and the health or social care professional, particularly in relation to the type of conversation. People who speak a language at an A2 or pre-intermediate level, such as people who have just passed their civic integration exam, can talk about simple symptoms, such as pain or an itch, in Dutch, but do not know more complex terms. They therefore require support to discuss these terms. Most importantly, for someone to comfortably share their story, their language proficiency needs to be higher in order to communicate efficiently in a (limited) common language.
Cultural mediator (also: culture coach, key person and in some cases: spiritual caregiver) (41)	Someone who facilitates communication between people who speak different languages and come from different cultural backgrounds. Cultural mediators provide information about culture-related values, lifestyles, beliefs, assumptions, and socio-cultural norms. They do so by clarifying culture-specific expressions and concepts that could cause misunderstandings. 'Cultural mediator' is not a registered profession in the Netherlands. This means that there is no standardised Code of Conduct and that cultural mediators do not fall under a legal, professional framework. They also do not need to take any language tests. Some cultural mediators are also sworn interpreters, and they can fulfil both roles in consultation with the consent of both the patient and the health or social care professional.
Digital tools	All digital or online programmes and applications used to navigate language barriers, both during a conversation and in surrounding moments. Digital tools are being used to translate instantaneously, unlike, for example, translated material. Some examples of digital tools are applications with domain-specific pre-translated sentences, free translation applications, in which you can enter or record whatever you want, and other forms of artificial intelligence that are not primarily intended as a translation application but can be used as one.
Adult family member or friend who interprets or translates (21,42–44)	These can be the patient's relatives, friends or acquaintances that are being asked to interpret before or during the conversation. They will either join the conversation in person or attend over the phone. They act as the patient's representative or trusted person. They have no duty of confidentiality, do not work according to professional standards and are not bound to a professional code of conduct.

Nonverbal communication also known as: 'getting by' (45)	Communication that does not involve language, such as the use of hand gestures or drawings.
A person brought in ad hoc as an interpreter (46)	These are people that are asked ad hoc to act as an interpreter for the conversation. This could be anyone: another health or social care professional, a different staff member, or even a patient in the waiting room. They have no duty of confidentiality, do not work according to professional standards and are not bound to a professional code of conduct. **Please note:** in interpretation, the term 'ad hoc' refers to an interpreter service that was not booked in advance.
Interpreter also known as: professional interpreter (21,47–51)	An interpreter is a professional who has completed an accredited interpreter degree programme and/or passed the required exams regarding their language proficiency, interpreting skills and attitude. They also have to meet the requirements regarding annual refresher courses. Interpreters speak the languages at C1 level, the highest registered level, or B2 level (for a description of the language proficiency levels, see attachment 1). Interpreters are impartial and take no stance in the conversation; an interpreter is not allowed to add or omit information and is only allowed to mediate on a linguistic level, unless otherwise agreed upon. An interpreter is expected to accurately convey the intentions of both the health or social care professional and the patient. Interpreters that are registered with the Register of Sworn Interpreters and Translators (RBTV) must meet the quality and integrity requirements, including the legally established duty of confidentiality.
Translated material (52)	All types of written material that have been translated from Dutch into another language. This can be in printed or in digital form.
Healthcare professional that speaks the patient's native language	In the case of a language barrier, a health or social care professional may refer or transfer a patient to another health or social care professional who speaks the patient's native language. The health or social care professional that speaks the patient's native language has the same competencies and can provide the same care or support as the health or social care professional that has transferred or referred the patient. **Please note:** getting a fellow health or social care professional involved to interpret does not fall under the category of 'Health or social care professional that speaks the patient's native language', but under 'A person brought in ad hoc as an interpreter'.

2.7.2. Conversation types

Complex conversation (53,54)	A conversation can be complex for various reasons. It is up to the health or social care professional to decide if a conversation is complex, or is expected to be. When making that decision, consideration may be given to whether one or several of the following points apply: • The patient's health or support needs are unclear. • Several somatic, mental and/or social issues occur simultaneously. • The patient is possibly suffering from mental/ behavioural problems or anger/ aggression issues. • Detailed or complex information is being requested or shared. • Difficult decisions regarding treatment or referral are being made. • There is a lack of clarity surrounding the effects of the treatment or the other options available. • The patient or their representative has explicitly been asked for informed consent regarding a treatment. • The patient considers participating in a clinical trial.
Simple conversation	In this guideline, a conversation can be considered simple when it is not complex, sensitive or impactful. It is up to the health or social care professional to decide if a conversation is simple, or is expected to be.
Sensitive conversation	A conversation can be considered sensitive by the patient and/or family member or friend. Some examples of subjects a lot of people consider sensitive are sexuality, domestic violence, conflict, cancer, mental health, and the end of one's life. Some topics can be sensitive for one patient, but not for another. It is up to the health or social care professional to decide if a conversation is sensitive, or is expected to be.
Impactful conversation	A conversation is impactful when the outcome could have serious consequences to the patient and/or the adult family member or friend. These include the delivery of bad news, conversations about a surgery or heavy treatment, or filing a report, for example to Veilig Thuis, the national centre of reporting domestic violence or child abuse. It is up to the health or social care professional to decide if a conversation is impactful, or is expected to be.

2.7.3. Additional commonly used terms

Patient, also known as client or care recipient (55)	Depending on the context, the term 'patient' refers to the client, care recipient, the patient's/ client's legal representative or to a person or citizen.
Social care (56)	The sector that implements the Child and Youth Act, the Social Support Act and, in part, the Public Health Act. Municipalities and social organisations work together on health, well-being, and safety, with the aim of promoting a comprehensive approach to health and support and enabling the full participation of citizens.
Language barrier	A communication barrier that arises when two or more people do not share sufficient proficiency in the same language.
Teach-back method (57)	A technique health and social care professionals can use to check whether or not the patient has understood the message is to ask the patient to explain in their own words what was just discussed

Healthcare (58–61)	The core of the healthcare sector consists of all providers of care focused on cure-based or long-term care and nursing. In financial terms, this mainly refers to care that is funded through the standard health insurance or the Exceptional Medical Expenses Act (AWBZ). In addition, sectors such as Youth Care, childcare, boarding institutions including asylum seekers' centres, socio-cultural work, elderly welfare, social support services, and occupational health and safety services also fall under healthcare (Statistics Netherlands, CBS)

3. Patients' perspectives

During the development of this general guideline, groups known as 'sounding boards' were consulted. These groups were established and led by the three patient representatives from the guideline working group. The sounding board consisted of representatives of experts by experience, i.e. patients who experience language barriers (for the board's composition, see paragraph 11.2.3). In total, there were three sounding boards across the country: one in Amsterdam, one in Amersfoort and one in Helmond. The groups were periodically asked to share their ideas and advice on different topics.

Additionally, each sounding board took part in one formal focus group to get a better perspective of how they would like a language barrier to be solved (wishes and needs) and how that language barrier is actually solved (experiences). Before the focus group, the sounding board was asked to turn to people who deal with a language barrier in their daily life, in order to list as many different wishes, needs and experiences as possible.

Here follows a summary of the findings of the sounding board, in which the emphasis was placed on the patient's perspective, phrased exactly how the members of the sounding board (patient representatives) did.

3.1. Experiences

3.1.1. No choice

All sounding boards indicate that patients [and patient representatives] are currently unable to assess the types of language support available to overcome a language barrier, because, in their experience, they are not given a choice.

When patients are asked what they would consider when making a choice about how to navigate a language barrier, they often indicate that they do not have any option other than to bring their own 'interpreter', such as an adult family member or friend, or sometimes a random passer-by. This is due to the fact that patients notice that some health or social care professionals are not willing to use a professional interpreter. Patients are usually not aware that they have the right to request a professional interpreter and are not actively informed of this by the health or social care professional.

> **'I have no choice, because the doctor does not do anything [to navigate the language barrier].'**
>
> Patient representative, Amsterdam

> **'Requesting a professional interpreter is not necessarily discouraged, but it is certainly not encouraged either.'**
>
> Patient representative, Amsterdam

When patients request a professional interpreter themselves, they are often told that this is not an option, due to costs, for instance.

In current practice, many health or social care professionals ask the patient to bring someone who can interpret for them. Sometimes a letter, such as an appointment confirmation, indicates that the patient must bring their own interpreter. If the person accompanying the patient is able to interpret, they are asked whether they can come again for the next appointment. Follow-up appointments are often scheduled based on the adult family member or friend's availability to act as an interpreter. If the person accompanying the patient is not able to interpret, the patient is asked to bring someone who is able to interpret for the next appointment. Patients are dependent and vulnerable, which often means they are unable to make demands or to continue requesting a professional interpreter. That is why

they usually bring someone to interpret, because they feel that health or social care professionals make little effort to navigate the language barrier.

Whether the patient is able to bring an adult family member or friend to interpret for them depends on the patient's social network. Patients with a large social network, who can rely on the help of an adult family member or friend, usually do so. Oftentimes, they bring an adult family member or friend, such as an available son or daughter, to the appointment. However, many adult family members and friends, including some patient representatives, see this as a strain and an obligation. Patients often feel dependent on an adult family member or friend, and are reluctant to ask them to accompany them again.

'A man went around with a bladder infection for six months. He kept postponing the visit to the doctor [because he did not want to burden family members and friends by asking them to interpret for him]. He tried to heal himself with herbs. This way, the problem just kept festering.'

Patient representative, Amsterdam

A large social network or a family-oriented culture does not therefore guarantee that an adult family member or friend can or will be brought along to act as an interpreter. There are examples of patients postponing care or seeking help because they do not want to burden an adult family member or friend. This often leads to worsening symptoms and problems, resulting in unnecessary visits to the emergency department or out-of-hours GP services. This care could have been prevented if a professional interpreter had been requested sooner.

Patients with a limited social network, or no social network, such as refugees who have recently arrived in the Netherlands, have more difficulty finding an adult family member or friend to bring along as an interpreter. In many cases, the adult family member or friend does not have sufficient proficiency in Dutch to interpret effectively. These patients sometimes ask random passers-by in the street to interpret for them out of desperation, or they wait in the waiting room until someone who speaks their language arrives and take this person ad hoc into the consultation room to interpret. This endangers the patients' privacy.

3.1.2. Refusing care or help

'There was a refugee, a pregnant woman. She could not find anyone to interpret for her. She ended up having a miscarriage [because her symptoms were not discussed adequately or in a timely manner].'

Patient representative, Amersfoort

Most sounding boards indicated that many patients experience suboptimal care or support, or that it is entirely refused because they do not have sufficient proficiency in the Dutch language.

Patient representatives in all of the sounding boards were able to give multiple examples of situations, ranging from dental care to psychiatric care, in which patients were sent away from appointments because they did not have sufficient proficiency in the Dutch language and had not brought an adult family member or friend to interpret. Sometimes patients are told they are not allowed to come unless they bring someone to interpret for them. In extreme cases, not using an interpreter can lead to unnecessary damage to health or even death.

Patients who receive no care or support sometimes repeatedly return because their symptoms are not resolved. When the language barrier is not adequately navigated, they do not understand what is wrong with them or what they need to do to resolve their symptoms. They return out of desperation

and lack of understanding, and have no intention whatsoever of being the ‘annoying patient’. Nevertheless, repeated returns can lead to frustration among health or social care professionals, which does not benefit the relationship between the professional and the patient.

Some patients and patient representatives experience discrimination from health or social care professionals due to stigma and prejudice. When it is assumed that a patient does not speak the Dutch language sufficiently, lacks the education or skills, is not sufficiently articulate or is not aware of the patient’s rights, the care experienced is more negative than when a patient does speak the language, is aware of the patient’s rights and is not afraid to ask about them.

‘I’m not just a daughter, but also an interpreter, a psychologist, a general practitioner, ...’

Patient representative, Helmond

3.1.3. Strain on adult family members and friends

All sounding boards indicate that interpreting, or having to interpret, puts a strain on the family member or friend who often has to do this repeatedly and in different contexts.

Almost all of the patient representatives who participated in the sounding boards are adult family members or friends that have had to interpret. Adult family members and friends also experience various difficulties. They often do this because they see it as an obligation to their parents, family members or community. However, in many cases it is seen as a burden, which does not always benefit the relationship between the patient and their adult family member or friend. Especially with sensitive topics, the adult family member or friend might even develop (psychological) issues. Patient representatives therefore consider it unacceptable for minors to be used as interpreters.

Although patient representatives recognise the importance of communicating all of the information adequately, some admit that they do not always relay everything. The most important reasons they mention for not interpreting everything are:

1. Family members and friends may feel embarrassed to act as interpreters, when taboo topics are being discussed.
2. In the case of bad news, family members and friends want to protect the patient.
3. Not all of the adult family members and friends are proficient enough in Dutch, the patient’s language, or in ‘medical language’ to be able to interpret everything.
4. In some cases, for example when a patient says something unpleasant to or about the health or social care professional, family members and friends may want to protect the professional and the relationship.

Sometimes there is no shame or taboo between the patient and the adult family member or friend, and they are able to interpret well and to discuss everything with and in the presence of the patient. However, this should not be assumed in advance. Patient representatives generally indicate that an adult family member or friend is usually willing to accompany the patient, but that this is mainly for (emotional) support. Adult family members or friends cannot be expected to interpret, unless this is explicitly the wish or preference of the patient and the adult family member or friend.

3.2. Wishes and needs

3.2.1. Knowledge and trust

In most of the sounding boards, patients expressed the need for more knowledge and trust, which serves as a basis for the relation and communication between the health or social care professional and the patient.

Patients notice that they lack knowledge about their own bodies, illnesses, the Dutch healthcare system, and their rights as patients There is a strong need for education by experts and professionals. Patient representatives notice that patients are willing to believe everything a professional interpreter or 'someone in a white coat' tells them, whereas they do not believe information shared by an adult family member or friend as easily.

> **'Of course, people should learn the Dutch language, but in sensitive situations, people still tend to shut down.'**
>
> Patient representative, Helmond

All patient representatives have expressed that it is mainly a matter of trust: trust between a health or social care professional and a patient, and trust between the professional interpreter/ adult family member or friend and the patient. A lack of trust can be a reason for turning down the help of a professional interpreter and instead deciding to go with an adult family member or friend. Therefore, in every sounding board it was stressed that it is important to ask the patient which language barrier solution they prefer.

3.2.2. Types of language support

All of the sounding boards have expressed that it would be ideal for the patient to have sufficient proficiency in the Dutch language, but that is not always feasible. Therefore, certain types of language support are needed.

Patients would like to be proficient in the Dutch language, so they can share their story freely. A health or social care professional who can speak to them in their native language is a good alternative for them. The patient representatives acknowledge that these solutions are not feasible for most patients who experience a language barrier. The best alternative they mention is the strong need for a professional interpreter or a cultural mediator. They understand that hiring a professional interpreter is not always possible, for example in cases of emergency, but they demonstrate a strong desire to be informed about this type of language support. Other types of language support, such as translation apps or an adult family member or friends who interpret, do not always provide sufficient support, although they can sometimes be useful. A professional interpreter can also help to increase the patient's autonomy and independence.

4. Module 1: Identifying a language barrier

4.1. Key question

How can health and social care professionals and support staff identify a language barrier and its extent and whether this negatively impacts the quality of care and support?

4.2. Recommendations:

1. Check if the patient's record or their referral letter mentions which language(s) the patient speaks and whether language support is needed.
2. If there is no information available about the languages they speak and their potential need for language support, ask the patient open-ended questions in Dutch or a common language to identify a potential language barrier. Have this conversation before or at the start of the appointment. If a family member or friend made the appointment, direct these questions to them instead.
3. In the case of a potential language barrier, determine whether language support is needed based on the type of conversation you are expecting to have.
4. When there is a language barrier, write down in the patient's record which languages they speak and the language support that might be needed. In consultation with your patient, also provide this information when transferring or referring your client.

4.3. Foundation

Before language support can be offered, it is important to identify whether there is a language barrier that could hinder the healthcare and support. Here follows a chronological explanation about why, when, how, and by whom this is determined.

Each section is based on scientific literature, previous recommendations and reports supplemented by the insights of the focus groups and reviewed based on the expertise of the guideline working group.

4.3.1. Why is it important to identify if there is a language barrier?

To determine the most suitable type of language support, it is important to first identify whether there is a language barrier or not. This might sound simple, but that is not always the case.

In many cases, both health or social care professionals (45,62–64) and patients (65) misjudge their own language proficiency. Because of this, health or social care professionals might over or underestimate the patient's language proficiency.

In some cases, patients claim to understand Dutch very well, when, in reality, they will demonstrate socially desirable behaviour and nod along to what the health or social care professional says. Sometimes, health or social care professionals who speak with their patient in a (limited) common language, assume the adult family member or friend is adequately conveying information. In reality, the family member's or friend's proficiency in the common language might not be sufficient.

Finally, there have been cases in which it was falsely assumed that patients did not have sufficient proficiency in Dutch or another common language and language support was used, even though it turned out to be unnecessary, because the patients were able to speak for themselves well enough.

Therefore, it is essential to establish whether there is a language barrier, so that the most suitable type of language support can be determined. This way, health risks and incidents caused by the language barrier can be prevented, which enables much better healthcare and support.

4.3.2. Who is responsible for identifying the language barrier and its extent?

According to the Dutch Healthcare Quality, Complaints and Disputes Act (WKKGZ), healthcare providers are responsible for offering proper healthcare. According to the Dutch Medical Treatment Agreement Act (WGBO), healthcare professionals are responsible for informing the patients, obtaining informed consent and establishing shared decision-making. Patients are expected to do their best to inform their healthcare professional(s) well.

If proper healthcare cannot be guaranteed due to a language barrier, it is the responsibility of health or social care professionals and support staff to pursue the most suitable type of language support (3–6, 66). In some cases, a patient's life can depend on clear communication. It is beneficial for those involved in the care process to be aware of the need for language support beforehand. Therefore, it is important to make agreements with other health or social care professionals and support staff about how a language barrier is identified and which type of language support is used in which situation and which way.

4.3.3. At what point can a language barrier and its extent be identified?

From the focus groups it became clear that a language barrier and its extent should ideally be identified before the first conversation or appointment. If needed, language support can then be arranged beforehand by support staff and extra time can be allotted for the conversation or appointment. If a language barrier or its extent is unknown or was not determined correctly, it is possible to identify the language barrier during the conversation or appointment and determine whether language support is needed. Ideally, this is identified at the beginning of the conversation or appointment. The ways in which a language barrier and its extent can be identified, are explained below (see paragraph 4.3.4).

In current practice, a professional interpreter usually only gets involved in later appointments between a patient and a health or social care professional (18). This has been confirmed by the focus groups of health or social care professionals and patient representatives. When you figure out during or after a conversation that you did not understand each other well enough and so, you decide to use a professional interpreter for future appointments, a lot of time has been wasted unnecessarily. Ideally, you would identify a language barrier and its extent as early as possible.

4.3.4. How do you identify a language barrier and its extent?

There are three distinct levels of language barrier (65). These levels are:

1. **No language barrier or a minimal language barrier.** This is the case for patients who speak and understand Dutch perfectly in everyday situations. In general, these particular patients speak Dutch relatively fluently and they can describe clearly which problems they are experiencing. In most cases, these patients need either no language support or only minimal language support. It is, however, important to remember that these patients might not know

certain difficult words or medical terms, because these words are not common in everyday situations. Additionally, it might be difficult to find the right words in emotional situations, especially in a language that is not their native one. In certain situations, additional language support might still be needed for this group of patients.

2. **A minor to moderate language barrier.** This is the case when a patient speaks some Dutch, but not fluently. This could be someone who only knows some common Dutch words and phrases or someone who recently passed their civic integration exam and already understands some simple Dutch phrases. This group of patients in particular has a wide range of language proficiencies, and so, it is important to determine how significant the language barrier actually is. Then you can determine whether language support is needed and if so, what type.

3. **A significant language barrier.** This is the case when a patient speaks little to no Dutch. These patients might start speaking their native language instead of speaking Dutch, might clearly struggle to respond in Dutch or may have already brought someone to interpret or translate for them (34). Patients who speak little to no Dutch will always need language support, but the extent of the required support is dependent on the situation.

In scientific literature, two different methods are described that health or social care professionals can use to identify whether a language barrier is significant enough to require language support. In general, these methods can be divided into two approaches: self-assessment by the patient and a verbal evaluation by the health or social care professional. The focus groups made up of health and social care professionals, patient representatives, and professional interpreters/ cultural mediators further demonstrate that support staff, such as assistants and receptionists, can also play a role in identifying the extent of the language barrier.

Self-assessment by the patient

The first approach in identifying a language barrier and its extent is to let the patient self-assess. For example, the patient can complete a short questionnaire before the conversation or during the patient intake, or you can verbally ask simple questions at the beginning of the conversation. To evaluate someone's language proficiency, communication skills, and healthcare literacy, as well as finding out their preferred language, the following questions can be asked:

- Self-assessed language proficiency: 'How well do you speak Dutch?'
- Self-assessed communication skills: 'How well are you able to explain the issue to a health or social care professional?'
- Self-assessed health literacy: 'How well can you understand spoken or written information about your health from health or social care professionals?'
- Self-assessed preferred language: 'In which language would you prefer to receive care/help?'

These questions can, for example, be introduced as follows: 'In order to help you properly, it is important for me to know how well you speak and understand Dutch, and what I can do to support you with this. That is why I am asking you a few questions.'

The sample questions above clearly demonstrate that identifying the extent of a language barrier is about more than just language proficiency. Research has shown that simply asking for a person's preferred language is not sufficient in determining whether, or not, a professional interpreter is needed (68). In general, it is recommended to first consider how a patient answers questions regarding language proficiency, communication skills, and health literacy. If the patient answers these questions with 'very good', there is likely little to no language barrier. If the patient answers the questions with 'very bad', 'good' or something in between, there is likely a minor to significant language barrier. The

next step is then to ask the patient what their preferred language is. This approach seems to be the most accurate way to identify a language barrier and its extent (67).

Though identifying a language barrier can be somewhat standardised by posing these kinds of questions, there has also been some criticism regarding the effectiveness of self-assessment by patients. For example, when health or social care professionals ask the questions themselves, patients might give socially desirable answers about their language proficiency. Patients might also be ashamed to admit that there is a language barrier or a need for language support (36), or that they do not understand such questions well enough (35). This makes it difficult for the health or social care professional to assess the language barrier and its extent.

Verbal evaluation by the health or social care professional

The second approach to identifying a language barrier and its extent is through verbal evaluation by having the health or social care professional ask open-ended questions in a conversation. This way health or social care professionals can themselves assess whether the patient understands their questions and whether they have understood the patient's answers. This can, for example, be based on the following questions (69):

- 'Can you tell me where you are?'
  - If someone has a hard time understanding the question or answering it in Dutch, continue with the next question. If this is not the case, the person likely requires little to no language support. 'I need some extra information. Could you tell me more about e.g. previous hospitalisations, medical disorders and treatments?'
  - If you, as a health or social care professional have a hard time understanding the answer, continue with the next question. If this is not the case, the person likely requires little to no language support
- 'Do you need a professional interpreter?'
  - If so, then get the process going. If not, then make a clear note in their record why not.

Regarding the last point about using a professional in interpreter, the focus groups of health or social care professionals stressed the importance of informing the patient of the purpose of the conversation, the expected effects the language barrier will have on the communication, and the reason why it is necessary or preferable to hire a professional interpreter. According to health or social care professionals, an approach like this contributes to mutual understanding and trust. A more direct approach for a health or social care professional to guide patients in this direction is by explaining to them why it would be difficult to help them without the help of a professional interpreter. During all focus groups it was stressed that it is important to identify a language barrier and its extent as early as possible. Introductory appointments between the health or social care professional and the patient could play an important role in that regard.

Moreover, health or social care professionals stated that they do not always have enough time to question the patient about a possible language barrier and its extent. The best case scenario is that a professional interpreter would be present at all initial consultations, so that the patient can express in their own language right away whether the help of a professional interpreter will be needed in future consultations. Even if an adult family member or friend is accompanying the patient, a professional interpreter might be better at assessing the need for a professional interpreter in the future or whether the family member or friend is able to interpret adequately.

When asking these questions, keep in mind that patients might be ashamed of not being able to speak the language. This could lead to an even bigger language barrier, or to the patient seeking out care or support later than needed out of embarrassment, or to the patient being too afraid to ask for the language support that they require (36). Therefore, it can be useful to not only ask open-ended

questions, but also to keep in mind the other factors that could indicate a significant language barrier (see below).

Assessment by support staff

During all focus groups it was stressed that it is important to identify a language barrier and its extent as early as possible. If the patient's record or referral letter does not give a clear indication of which type of language support they need, this can be assessed during a consultation. Support staff could ask the patient over the phone to assess whether there will be a language barrier that could negatively impact the conversation and, if so, which type of language support would be the most suitable. If a family member or friend is calling to make an appointment on behalf of the patient, this could also indicate a language barrier and a possible need for language support. In such situations, support staff can, for example, hire a professional interpreter or arrange for a translation device in advance.

Factors that may indicate a language barrier

There is a language barrier, significant or otherwise, if a patient:

- primarily speaks a language other than Dutch (35);
- clearly has trouble responding in Dutch (35);
- has brought someone along to interpret or translate (35);
- has someone else call to make an appointment;
- shows a lot of hesitation, confusion or discomfort before answering;
- is very quiet or passive or only nods their head.

Please note that these are factors that *could* indicate a language barrier, but this does not mean that every patient these factors apply to is actually experiencing a language barrier. In any case, it is important to always have an open conversation with the patient and to discuss their personal preferences.

4.4. Considerations

All in all, it is important to accurately identify a language barrier and its extent without delay. This way the most suitable type of language support can be determined and used, and extra time for a appointment can be scheduled in advance.

The guideline working group concluded that identifying a language barrier without delay can prevent patients from having to come back several times because they did not understand certain information along with preventing other negative effects of a language barrier. Whether it is the patient themselves indicating they need a professional interpreter or another type of language support, or the health or social care professional determining that the patient needs language support: identifying that language could form a barrier may be cost-effective and improve equal care for non-Dutch speaking patients.

Identifying whether or not a language barrier is present does not cost money, but it does cost time. If a language barrier and its extent have been identified correctly, this could help save time and money, for example, because the most suitable type of language support could be used immediately. Therefore, the working group considers it reasonable to identify a language barrier without delay, assess what kind of language support is needed to navigate the language barrier and assessing which type(s) of support is the most suitable. In practice, it might become clear early on that someone is fluent in a language or not at all, but it is important to be wary of possibly under or overestimating a patient's language proficiency (62).

It is more difficult to assess whether there is a language barrier when it comes to patients that speak Dutch, but not fluently enough. In such situations, it can be more difficult to determine whether language support is needed and, if so, to what extent. Therefore, it is essential to frequently evaluate whether to provide language support or not, for example when the language barrier is minor. Or whether the chosen type of language support, such as a translation device, is effective enough to adequately communicate with the patient during the conversation in the short-term, or the entire treatment or support process in the long-term.

Sometimes their health or support needs may seem simple, or the patient appears to be communicating perfectly fine, but over time, more complex issues come to light, revealing the limitations of the patient in adequately speaking or understanding the language. This can apply to emotionally charged subjects, such as the patient wanting to talk about difficult or shocking experiences, trust issues, cultural differences or poor healthcare literacy.

During a long-term treatment or support process the patient may become more fluent in the Dutch language and may have built up a social network that helps them to learn the language. Their language proficiency may also worsen, due to dementia or aphasia, for example. If this is the case, assess if a specific type of language support is needed to navigate the language barrier. The way in which communication goals can be evaluated are discussed in Module 3.

4.4.1. Identifying language barriers prior to an appointment

It is important to identify a language barrier and its extent prior to an appointment wherever possible. Support staff who are in direct contact with a patient when planning an appointment, can increase the possibility of identifying a language barrier.

An adult family member or friend calling on behalf of a patient, or a patient clearly having a hard time understanding the staff member could be signs that language support is needed. Support staff could also ask the patient or adult family member or friend some simple questions to quickly determine whether language support is necessary, which can then be arranged prior to the appointment.

If this leads to a language barrier being identified, it is advisable to book extra time before the appointment or even plan a double appointment.

4.4.2. Identifying language barriers at the start of an appointment

If it is not possible to identify a language barrier prior to a conversation or appointment, e.g. in case of emergency or because the patient turns up unannounced, it is important to do so at the start of an appointment, so that quick arrangements can be made, if necessary.

By writing down the type of language support the patient might need in their record afterwards, this type of support can then immediately be considered for follow-up appointments or when referring or transferring the patient. This helps to plan ahead with professional interpreters and therefore make this type of language support more accessible. General practitioners seem to play an especially central role in this process, due to their coordinating role as a primary healthcare provider (70).

4.4.3. Reporting a language barrier in the patient's record

Asking and processing the language(s) that someone speaks is generally not regarded as processing sensitive personal data. Sometimes this is the case, for example if the person's language gives an

indication of their ethnicity or their political or religious views. In this case, the processing of this data can be privacy sensitive. However, because this data is crucial for providing preventive and/or good medical care, much like the medical data reported in the patient's record, this data is allowed to be processed. This is an exception to the General Data Protection Regulation (GDPR) and the GDPR Implementation Act. It is important that the data is handled with care, and processed and shared appropriately.

5. Module 2: Choosing the most suitable type(s) of language support

5.1. Key question

How can health and social care professionals, patients, and patients' family and friends determine which types of language support are the most suitable to assist communication? And who decides which type of language support is used?

5.2. Recommendations:

1. When there is a potential language barrier, determine together with your patient which type(s) of language support is/are the most suitable. Base this on the type of conversation you are expecting to have and the feasibility:
    a. Communicate in Dutch, or if that is not possible, in another common language with the patient if the communication is sufficient for the expected subject matter of the conversation.
    b. If you are expecting this conversation to be about a complex, sensitive or impactful topic, hire a professional interpreter or transfer the patient to an equivalent health or social care professional who speaks the patient's native language. Preferably also do this during the initial consultation.
    c. Consider letting an adult family member or friend act as an interpreter for the patient if the expected conversation will be relatively simple. Make sure that the family member or friend is over the age of eighteen. An adult family member or friend should only be allowed to act as an interpreter if both them and the patient consent to doing so, if they trust one another, and if the family member or friend speaks both languages well.
    d. If the patient has adequate literacy and technology skills, consider using digital tools for an appointment when the expected subject matter of the conversation is relatively simple, or use it to support other types of language support. It is best to use a digital tool with sentences that have already been translated. Only use a unencrypted translation app to translate single words or simple sentences and never share personal information.
    e. Also offer material in simplified Dutch or in another language when this is beneficial for patients who do not necessarily experience a language barrier. Only provide material in a language the patient, or family member or friend understands well.
    f. Use nonverbal communication such as gestures, images, drawings and communication cards to support other types of language support.
    g. Do not allow someone who is not the patient's family member, friend, or health or social care professional to act as an interpreter outside of emergency situations where no other types of language support are available.

2. When a patient does not consent to using a professional interpreter or to transferring to another health or social care professional who speaks the patient's native language, ask for the reason. Reiterate why you think this type of language support is necessary. If the patient still does not consent, write this down in their record with their reason.

3. Consider offering the patient other types of language support when the communication goals are not being achieved.

    a. Consider involving a professional interpreter ad hoc over the phone, meaning not booked in advance, when it appears the communication goals are not being achieved during the appointment. If that is not possible, consider scheduling a new appointment with a professional interpreter present.
    b. Consider transferring or referring the patient to a health or social care professional who speaks the patient's native language if the communication goals are not being achieved with a professional interpreter.
    c. Consider involving a cultural mediator if the communication goals are not being achieved with a professional interpreter and if it is not possible to transfer or refer the patient to a health or social care professional who speaks the patient's native language.

5.3. Foundation

If a language barrier is negatively impacting the communication between the health or social care professional and the patient, it is important to provide the most suitable type of language support. There are various options, but not all of them are suitable for every conversation.

Below, you will find more information about the current scientific proof regarding the effectiveness of each type of language support from the systematic review (1). Afterwards, we will take a look at what health or social care professionals and patient representatives think about this, based on the insights of the focus groups. In addition to the scientific proof, other sources have been added, such as grey literature (e.g. international reports or guidelines), and the expertise of the guideline working group members.

5.3.1. (Limited) common language

Systematic review

If the patient and health or social care professional are able to communicate in Dutch or another common language, then speaking a common language can lead to a similar understanding of the shared information as when a professional interpreter is used (71).

Scientific literature also shows that, in general, communication improves when speaking a common language; patients ask more questions, the patient and health or social care professional discuss multiple topics, and patients are more satisfied with the communication and their care (13,71) than when a professional interpreter is used.

When a health or social care professional and a patient speak in a (limited) common language, be that limited or not, instead of using a professional interpreter, the duration of the conversation stays the same (13,71,72).

Focus groups

According to the focus groups, especially the patient representatives, patients prefer to communicate in a common language with the health or social care professional. However, learning a new language is difficult and takes time, as explained in previous sections. Therefore, many cases will require additional or alternative language support.

Additional sources

A language barrier and its extent can be identified by asking the patients several open-ended questions (see Module 1) (67,68). This automatically gives an indication as to whether they speak a common language. The smaller the language barrier, the better the patient and health or social care professional can communicate in a common language, and the more often a conversation can be conducted in Dutch.

However, having to speak in a language that is not the patient's native language increases the risk of miscommunication (73) and makes them feel anxious about having a conversation about their health – especially when it comes to mental or emotional health (74).

The ability to communicate effectively in Dutch as a (limited) common language depends on the language proficiency of the health or social care professional and the patient, as well as on the type of conversation and the patient's care needs.

Additional information from the guideline working group

During conversations with the guideline working group, it was stated that, in some situations, having a conversation using only the vocabulary both the patient and the health or social care professional know, can already be helpful. An important factor to take into consideration is the fact that no other party, that might have other interests or is not directly available, has to be involved in the conversation.

However, the guideline working group did stress the importance and difficulty of estimating someone's language proficiency: some people may seem fluent in Dutch, but in practice, do not understand much.
(See Module 1).

5.3.2. Healthcare professional that speaks the patient's native language

Systematic review

When patients are able to communicate with a health or social care professional in their native language, terms like 'partnership' and 'facilitation' are mentioned more often, as opposed to conversations where a professional interpreter or a (limited) common language is used (72). Furthermore, conversations between health or social care professionals and patients with the same native language generally tend to be shorter than conversations in which a professional interpreter is used (72).

Focus groups

According to the focus groups made up of health and social care professionals, in some situations, it can already be helpful to have a health or social care professional who speaks the patient's native language facilitate the first conversation, so that the patient feels more comfortable with the organisation that the professional works for.

Health and social care professionals state that, ideally, every organisation would have employees that speak multiple languages. Patient representatives think that finding a health or social care professional who speaks the patient's native language is generally the best and most agreeable way to navigate a language barrier. They state that speaking the same language essentially has the same effect and that, by definition, no health or social care professional from the patient's country has to be found. Nevertheless, a health or social care professional that speaks the patient's native language and the help of a professional interpreter are considered equal types of language support.

Additional sources

According to an international guideline, asking a health or social care professional who speaks the patient's native language for help is considered the best way to navigate the language barrier (75), even more so than using a professional interpreter.

Additional information from the guideline working group

Following the patient representatives and an international guideline, the guideline working group considers a health or social care professional that speaks the patient's native language to be the best type of language support when navigating a language barrier. However, the guideline working group did state that this is not always feasible, for example because there are not many multilingual health or social care professionals available. So, if a patient wanted to make use of this type of language support, they may have to travel long distances.

5.3.3. Professional interpreter

Systematic review

Scientific literature states that, unlike in a situation in which there is no interpreter present, using a professional interpreter leads to a better quality of life for patients (76), the health or social care professional inviting the patient to ask questions more often (77), and to the health or social care professional understanding the patient better (77).

In comparison to an adult family member or friend or an ad hoc interpreter, using a professional interpreter leads to better understanding of the shared information (78), including diagnoses (79), and a higher patient satisfaction (78). Conversations in which there is a language barrier take longer, but this could be prevented by using a professional interpreter (80).

Unlike a situation in which there is no interpreter present, using a professional interpreter can also prevent healthcare costs and poor-quality care (80,81). Unlike situations in which there is no interpreter present, using a professional interpreter leads to a shorter stay in the emergency department, but to a longer stay in another hospital department (76,82,83). However, it is unclear what this means for the quality of care, and what exactly causes a longer or shorter stay.

Results regarding re-hospitalisation are mixed: some studies show that it does not matter whether a professional interpreter is used (82,83), whereas other studies show that there are less re-hospitalisations when a professional interpreter is used (76).

When using a professional interpreter, it is also relevant to make a distinction between the three different ways in which they can be present nowadays: present in person, over the phone or by video call.

Scientific literature has shown that professional interpreters who are present in person or by video call generally bring better results than telephone interpreters. Interpreters who are present in person or by video call scored similarly on patient satisfaction (84) and understanding (85), but the remote video interpreter is rated better than a physically present professional interpreter (86).

Both interpreters who are present in person and by video call lead to a better understanding of the patient (78) and higher patient satisfaction (78) compared to telephone interpreters. Telephone interpreters and video remote interpreters do not differ in terms of the duration of the interpretation (79), professional interpreting skills (85), technical difficulties (85) and on the quality of the interpretation (79).

Regarding delays in the communication, different studies have shown different results: some state that using a telephone interpreter leads to more delays (79), while other studies did not find any differences (85). A video call with a professional interpreter is more expensive than a telephone interpreter (79).

Focus groups

During the focus groups, both health or social care professionals and patient representatives have stated that, in most situations, they prefer to use a professional interpreter during a conversation. It is advisable to hire them in advance, for example by support staff, to save time during the conversation itself.

Especially during conversation in which the patient's culture influences what can and cannot be discussed, such as conversations involving shame or certain taboos, patient representatives believe it is sufficient to only use a professional interpreter – and no other type of language support. Within mental health care, professional interpreters are considered a necessity, but it is also recognised that professional interpreters cannot always adequately convey the emotion of a speaker, especially over the phone.

Generally speaking, health or social care professionals agree with scientific literature recommends, namely that professional interpreters who are present in person or by video call are better options than a telephone interpreter, especially when nonverbal communication is important. Nevertheless, hiring a telephone interpreter is sometimes the best option, for example when a patient does not trust a professional interpreter, has had bad experiences in the past, or when the patient comes from a small community and might know the professional interpreter personally, which could affect their privacy. The fact that names are not disclosed and that they do not see each other, a safe distance could be created between the patient and professional interpreter and could protect their anonymity.

Additional sources

International guidelines (75,87–90) and systematic reviews (91–93) generally consider professional interpreters as the golden standard for adequately navigating language barriers. It is important to not just assume that someone who only speaks the language to a certain extent does not need or want a professional interpreter (75).

Dutch reports from 2016 (18) and 2022 (33) have shown that the non-use of professional interpreters, where necessary, can lead to a reduction in quality, unequal access and increased use of healthcare services. In approximately 16% of the healthcare conversations, a professional interpreter is required (18). Depending on the type of conversation, care needs or patient's circumstances, in different situations, other types of language support may be sufficient. Therefore, in certain sectors like Dutch Association of Mental Health and Addiction Care (GGZ) and Youth Healthcare (JGZ), there may be a bigger general need for the use of professional interpreters than in other sectors (18,33).

In 43% of cases where a professional interpreter is deemed necessary in order to provide proper healthcare or support, such as during technically complex treatments, or when discussing taboo or emotionally charged topics, health or social care professionals never use one, and in 29% of cases, they rarely use one in (33). Only one in three patients who need help from a professional interpreter, actually receive it (18). This may be due to a lack of funding, the administrative burdens, or a lack of time and awareness among health and social care professionals concerning the reason why using a professional interpreter is necessary and is a possibility (18,33).

However, health and social care professionals think that using a professional interpreter will pay off in the long run, such as increased health benefits for the patient or timesaving results for health or social care professionals, because the care or support can be organised more efficiently. In doing so, health

or social care professionals attach a certain worth to their professional autonomy and their ability to assess whether a professional interpreter is needed. In this regard, 'it is likely that a health or social care professional will not often use a professional interpreter unnecessarily, because of the extra time and effort it takes to do so' (33) – so using a professional interpreter is practically always justified (18).

Additional information from the guideline working group

The guideline working group states that, following international guidelines, professional interpreters are considered the golden standard for adequately navigating language barriers and fit the general expectations and needs of patients. However, the guideline working group stresses that professional interpreters can only be used with the patient's consent.

If the patient refuses the use of a professional interpreter, even when the health or social care professional thinks a professional interpreter is needed in order to provide proper healthcare, that could lead to a dilemma and, in some situations, a conflict between the health or social care professional interpreter and the patient. In such situations, it is up to the health or social care professional to ask the patient why they do not want to use a professional interpreter, and to again inform them why this type of language support is considered necessary. It may also be helpful for the health or social care professional to explain the role of the professional interpreter: namely, the role of an impartial and neutral interpreter with a duty of confidentiality.

In some situations, a professional interpreter may be refused due to the influence of an adult family member or friend being present. If this happens, it could be worth finding out whether it might be possible to speak to the patient without their adult family member or friend present or whether the use of a professional interpreter is advisable regardless. If the patient once again refuses a professional interpreter, it is then up to the health or social care professional to note this in the patient's record and, if possible, accompanied with the reason for refusal.

The way in which the professional interpreter is present, in person, over the phone or by video call, is not relevant in this case, as long as the interpreter is present when needed. If the professional interpreter is visibly present, particularly in person or by video call, it might be important consider whether the interpreter fits the patient's ethnicity, gender, and age group. In certain situations, such as situations involving shame, privacy, or security issues, it can be inconvenient for a professional interpreter to be physically present. In other cases, such as conversations in which bad news is shared, it can be advisable for a professional interpreter to be present in person.

5.3.4. Adult family member or friend who interprets

Systematic review

Limited scientific literature shows that adult family members and friends interpreting in certain situations, such as patient surgery outcomes (94), can lead to similar quality assessments as when a professional interpreter is used.

Focus groups

Focus groups including health or social care professionals agree, they state that an adult family member or friend interpreting can be helpful in some situations and can share additional contextual information that the patient may not mention themselves. However, there is a lot of uncertainty regarding the interpretation: what is interpreted, what is not, and how is it done? Minors should never be used as interpreters.

Moreover, health or social care professionals stated that adult family members and friends might also negatively impact the conversation, for example if they are in conflict with the patient. Take for example: Situations involving Veilig Thuis or suspicions of assault. Lastly, it is not advisable for an

adult family member or friend to interpret if the conversation takes an unexpected turn for the patient, imagine a patient with simple eye problems turns out to have an STD.

During the focus groups, patients or patient representatives stated that they sometimes feel like they are left with no choice other than to bring an adult family member or friend to interpret for them. This sometimes forces them to beg people to come along to a consultation, or otherwise no type of language support is used. In such situations, it is the adult family member or friend who has time that comes along.

However, not all patients trust adult family members or friends, because, for example it is a woman or because they only trust people 'in white coats'. The patient, adult family member or friend may also feel embarrassed to talk about certain sensitive topics. Nevertheless, it is considered a better option to bring someone who is familiar with the patient's situation, such as the medication they take.

This is where support staff comes in, to ask questions about this when making an appointment. Questions like: 'We would like for you to bring someone you trust. Is that possible and are you okay with that? If yes, is this person able to interpret for you? Are you okay with that too?'

Additional sources

A Dutch report from 2016 demonstrated that, in practice, an adult family member or friend interpreting is the most used type of language support when navigating a language barrier but is not always sufficient (18). International guidelines and systematic reviews generally advise against having untrained adult family members and friends interpret during a conversation (75,91,92).

It is not advisable because the adult family member or friend is not a 'neutral' interpreter, but someone who also has their own role in the communication (44,95) and only interprets parts of what the patient or health or social care professional says (96). In some cases, it can be helpful for an adult family member or friend to share contextual information that the patient does not mention themselves or to represent the patient's interests (44,97).

The patient assumes their adult family member or friend will represent their best interests and therefore trusts the adult family member or friend they brought along more than they trust a professional interpreter (97). However, health or social care professionals should never expect the patient to bring their own interpreter to the conversation (75).

Additional information from the guideline working group

When assessing whether it is suitable for an adult family member or friend to interpret, it is important to not just assess the effects the conversation has on the patient, but also on the adult family member or friend themselves. The interpreting adult family member or friend could experience negative effects too, such as psychological issues or the feeling of being overwhelmed. Therefore, the guideline working group thinks it is never acceptable to use a minor as an interpreter.

Another factor that should be considered, is the fact that an adult family member or friend may consciously or unconsciously influence the patient with their translation. Therefore, the guideline working group advises against using an adult family member or friend as an interpreter during complex, sensitive, or impactful conversations.

Furthermore, they recommend only letting an adult family member or friend interpret if they have a trusting relationship with the patient, speak both languages adequately and only when both the patient and the adult family member or friend consent to it.

5.3.5. Digital tools

Systematic review

Literature regarding digital tools currently distinguishes between two types of tools: free translation applications in which you can enter or record words and sentences freely and have them translated, such as Google Translate or SayHi, and domain-specific digital tools containing specific pre-translated sentences.

Free translation apps can generally translate simple sentences as well as a human translator, but they make more translation errors in more complex sentences (98,99). This explains why, when comparing free translation apps to domain-specific pre-translated tools, the latter better helps patients understand information, is a better means of support in speaking with, and in replying to health or social care professionals, and leads to a higher satisfaction among both patients and health or social care professionals(100,101).

Literature contains no information about using tools that rely on artificial intelligence, such as ChatGPT.

Focus groups

All focus groups have already shown that especially free translation app are, in particular, already being used a lot in practice, and in paramedical fields. In relatively simple situations, such as making an appointment, translating a single word, making small talk on the go with a patient, or discussing the menu with a hospitalised patient, the focus groups considered digital tools to be very helpful in navigating language barriers without needing another type of language support.

In more complex situations, using only digital tools is not enough, but they can be used as an additional type of language support.

Health or social care professionals stress that translations are not as reliable in every language, especially when it comes to non-Western languages, free translation apps are not of high quality. When using digital tools, it is stressed that it is important to keep in mind that not all patients have sufficient digital skills or reading proficiency. In some situations, recording sentences or listening to translations can offer a satisfactory solution.

Another factor that should be considered according to the focus groups, is that digital tools cannot translate nonverbal emotions and are not able to detect confusion or misunderstandings, in a case where the translation might be incorrect.

Additional sources

Additional literature primarily stresses the limitations of digital tools. It turns out that digital tools mainly function best for English or Western European languages, because a lot of language models in, for example, artificial intelligence are based on the English language (102,103). A recent Dutch report (34) found that it is inadvisable to use digital tools during emotional, heavy, complex or intense conversations. However, these tools do offer options for simple conversations about practicalities or acute situations in which there is no time to wait for a professional interpreter. Digital tools can be helpful when the patient is fairly proficient in Dutch and only has trouble understanding specific medical terms.

Even though it is pleasant to have a range of free, diverse digital tools whenever one is needed, health or social care professionals are rather reluctant to use them, as they are not sure whether the patient's privacy and a high quality of translation can be ensured or not(34). Privacy-wise, health or social care professionals are generally worried about the safety of free translation apps. The report

(34) has shown that; the quality of translations produced by digital tools should be improved first, that clearer information is needed, and that translation apps can only be on a wider scale if privacy guidelines are put into place, on an organisational level.

The report recommends making it easier to gain access to digital tools within organisations, for example by granting access to phones, tablets, computers and translation apps. The use of personal devices, such as mobile phones, is discouraged. In addition, the report recommends for organisations, professions, and working branches to select digital tools of which translation quality and privacy safeguarding are known. Furthermore, an overview demonstrating the situations in which digital tools are suitable types of language support, including an instruction on how to use these tools. This approach allows health or social care professionals to receive more support when using digital tools (34).

However, some sources also state that using digital tools is not problematic, as long as no personal data is entered that can be traced back to a patient or health or social care professional (104,105).

Additional information from the guideline working group

The guideline working group is positive about using digital tools for short and simple interactions. As soon as conversations get more complicated, digital tools become less suitable, according to the working group, because nuances are more difficult to convey. For this reason, the guideline working group mostly advises for the use of digital tools to support other types of language support.

However, there are some concerns about third-party commercial applications that are being used to communicate sensitive information, as it is often unknown what happens to this information. This is why it is not advisable to share confidential information, such as names or personal data that can be traced back to the patient, when using digital tools, unless you are sure the privacy of the patient and the health or social care professional is protected.

Additionally, in accordance with the recommendations of the aforementioned Dutch report (34), the guideline working group advises against using your own phone or that of the patient, but to use a work phone, where possible.

5.3.6. Translated material

Systematic review

There is little research that proves the efficacy of translated material as a type of language support in itself. One study found that sending a reminder letter in a patient's native language did not lead to a change in the number of appointments for a preventive mammogram than a reminder letter in English (106). In this instance, the reminder itself might be more important than the language in which it is written.

Focus groups

Based on the focus groups made up of health or social care professionals, it appears that translated material is often seen as an important complement to other types of language support during appointments. Health or social care professionals often provide the patient with information in their native language, for example by translating information from thuisarts.nl with Google Translate.

However, the focus groups made up of patient representatives shared their concerns about the fact that not every patient can read or write and that not everyone has someone in their environment who can help them with that. Videos in the patient's native language might be the solution, in some cases.

Additional sources

Whenever there is material available in the patient's native language, international studies and guidelines suggest offering them to the patient (35,89,90). Preferably, it should be provided in a patient-friendly way, using simple words and short sentences or bullet points, without any medical jargon and be translated by a certified translator. Additionally, you can ask a professional interpreter to write down instructions for the patient, so they can read them at home.

Additional information from the guideline working group

The guideline working group indicates that the information provision for non-Dutch speakers on the websites of Dutch hospitals is often insufficient, mostly because it is not available in different languages.

5.3.7. Communicating with nonverbal communication

Systematic review

Based on the literature, it is not possible to draw conclusions about the effectiveness of communicating with nonverbal communication compared to other types of language support.

Focus groups

The focus groups made up of health or social care professionals mentioned that, in some cases, for example, while waiting for a professional interpreter, miming using the hands and feet was already quite helpful. This might be the case for physiotherapists who demonstrate a particular exercise, after which the patient mimics them.

The focus groups made up of patient representatives talk about how hands, feet, and gestures can aid communication, and that patients often try to make the best of the limited available resources. However, sometimes a patient is denied because the language barrier cannot be solved, such as instances in which a health or social care professional refuses to hire a professional interpreter or if there is no adult family member or friend present to act as an interpreter.

Additional sources

According to earlier studies, guidelines and reports (18,88,107,108), it is often the case, in practice, that patients and health and social care professionals exclusively communicate in nonverbal communication, even when a professional interpreter is necessary. This may be due to the fact that patients do not want to be a burden to their health or social care professional or because they do not trust a professional interpreter (107). However, nonverbal communication is never seen as an adequate solution for navigating a language barrier in any of the sources.

Additional information from the guideline working group

Although the guideline working group acknowledges that nonverbal communication is always possible, it is not always sufficient when providing proper healthcare and support. The guideline working group therefore advises against the use of nonverbal communication as a type of language support.

5.3.8. A person brought in ad hoc as an interpreter

Systematic review

Someone who is brought in as an ad hoc interpreter generally interprets less consistently and less comprehensively than a professional interpreter (72). The possibility of inaccurate interpretations is higher with an ad hoc interpreter, compared to a professional interpreter who is physically present or engaged by video call (86). Moreover, an ad hoc interpreter makes more clinically significant errors in the interpretation than a professional interpreter who is physically present (86).

Focus groups

Focus groups made up of health or social care professionals demonstrated that, particularly in unplanned situations in which the patient does not bring an adult family member or friend to interpret, they make use of what they have at their disposal. Sometimes that is a person, such as a colleague, who is brought in to interpret ad hoc.

During the focus groups, patient representatives have stated that for relatively simple cases, such as scheduling appointments, volunteers who are available to interpret at that time may be used. Using a person who is brought in to interpret ad hoc is perceived as better than nothing, but is far from ideal.

Currently, situations are being reported in which patients have approached people 'on the street' or in the waiting room until they have found someone able to interpret on an ad hoc basis. These 'sudden interpreters' do not have a duty of confidentiality and lack the knowledge and patient involvement that adult family members or friends who interpret may have.

Additional sources

The use of an untrained person who is brought in to interpret ad hoc is discouraged in international guidelines and systematic reviews (75,91,92). As multilingual health or social care professionals are often asked to interpret ad hoc, another guideline recommends training them so they can act as professional interpreters (89).

Additional information from the guideline working group

The guideline working group considers it fundamentally undesirable to use an untrained person ad hoc as an interpreter, particularly when other, better alternatives are available.

5.3.9. Cultural mediator

Systematic review

No evidence has been found in the scientific literature regarding the effectiveness of a cultural mediator in navigating the language barrier compared to other types of language support.

Focus groups

The focus groups made up of health or social care professionals have demonstrated that the role of a cultural mediator in the (para)medical domain is hardly known. Some health or social care professionals, especially the ones working in hospitals, occasionally ask spiritual counsellors for assistance during additional conversations, such as treatment decision-making. In social care, the added value of a cultural mediator is recognised, especially during complex conversations, such as conflict situations. Some patient representatives have also stated that, ideally, educators in the immigrants' own language and culture (VETC-ers in Dutch), whose work is comparable to that of cultural mediators, should ideally be used. VETC-ers and cultural mediators do not only translate the language, but also mediate between cultures, which can have a positive effect.

Health or social care professionals indicate that, in practice, they generally prioritise navigating the language barrier over the cultural barrier. It is important to note that navigating the language barrier is often sufficient in ensuring adequate communication and in the discussion of cultural differences. It helps for the health or social care professional to have adequate intercultural communication skills.

The focus groups made up of professional interpreters and cultural mediators demonstrated that, currently, there are no professional norms, guidelines, or registrations for cultural mediators, unlike for professional interpreters. This causes a lot of uncertainty regarding the role of a cultural mediator. In practice, cultural mediators are also used as interpreters even though they are often untrained. Nevertheless, both professional interpreters and cultural mediators believe that cultural mediators can

be of added value in identifying and navigating (recurring) communication issues. Professional interpreters have sworn to always translate neutrally, impartially, and faithfully, but cultural mediators have more freedom and can help explain culture-specific expressions.

Additional sources

Literature (89,90,109) recommends respecting the culture of the patient and their family. It emphasises the importance of training the intercultural competences and skills of health and social care professionals (89), but in some situations, a cultural mediator may also offer a solution. A report by the World Health Organisation (WHO) from 2019 (20) has shown that cultural mediators can play several roles: they can support the communication, navigate sociocultural barriers, offer psychosocial support, and improve the therapeutic relationship between the health or social care professional and the patient.

The lack of adequate training and professional standards from cultural mediators can result in a significant threshold when it comes to using cultural mediators. Within the Netherlands, Pharos, the Dutch Centre of Expertise on Health Disparities actively devotes itself to improving the work of cultural mediators (110). Moreover, youth care organisation Nidos uses cultural mediators when assisting young refugees (111).

Additional information from the guideline working group

The guideline working group members believe that cultural mediators add value, but they are worried about how feasible this is. As phrased in the title of this guideline, they primarily want to focus on adequately navigating language barriers. Due to the lack of professional standards and the fact that cultural mediators are not generally trained like professional interpreters, it cannot be confirmed whether cultural mediators can navigate a language barrier. Nevertheless, they recognise that language barriers and cultural barriers are often closely related. If a health or social care professional does not have the required intercultural competences to adequately handle a barrier of this kind, a cultural mediator could also offer support, but only in addition to a professional interpreter.

5.4. Considerations

When choosing one or several types of language support, it is important to discuss these with the patient. The patient's wishes and preferences are key in providing proper healthcare. The health or social care professional can express their own preferences based on the recommendations mentioned in this guideline and explain them to the patient. If the patient does not consent, it is important to note this in their record and make a collective decision about which type of language support fits best. Here follows a consideration for each type of language support, based on their health effects, feasibility, acceptability, equality and cost-effectiveness. (see also the Evidence-to-decision table in attachment 4).

5.4.1. (Limited) common language

Given the positive health effects of communicating in a (limited) common language, this type of language support will contribute to the reduction of health disparities. This type of language support also takes no additional time or money. Therefore, this type of language support is generally feasible, acceptable and cost-effective.

However, it is important to carefully assess whether the patient is actually able to adequately convey their story in the common language, and whether the health or social care professional is able to adequately convey the information needed in the common language, as well as to verify whether the patient has understood the information correctly.

If the health or social care professional and the patient are able to communicate adequately in the common language, this type of language support can be used. Speaking slowly and using simple words is helpful.

If, during the conversation or process, it turns out that the common language is not effective enough, for example because the patient reverts to their native language or because the health or social care professional notices that information is being conveyed inadequately in the common language, it is important to consider using another type of language support, preferably a professional interpreter.

Keep in mind that a common language, such as English, is not acceptable in every situation, such as with complex conversations or care. In such cases, the conversation usually gets emotionally loaded quickly and a lot of medical jargon is used, which makes it hard to go into enough depth if the common language proficiency is too limited.

5.4.2. Healthcare professional that speaks the patient's native language

A health or social care professional speaking the patient's native language generally has positive health effects for the patient. This type of language support contributes to a reduction in health disparities between patients with and without a language barrier, especially if the health or social care professional and patient are not able to adequately communicate in Dutch or another common language.

Furthermore, a health or social care professional who speaks the patient's native language can also remove cultural barriers, which helps reduce health disparities. This makes this type of language support recommendable. However, it becomes less recommendable if the health or social care professional who speaks the patient's native language is in the same community as the patient and has to discuss sensitive topics with the patient.

Access to health and social care professionals who speak the patient's native language is, among other things, decided by the availability of health and social care professionals who speak a certain language, their willingness to provide patients with care in their own language and their willingness to be able to be traceable based on the languages they speak. In order to share information about these languages, the health or social care professional needs to consent. It is important that the data is handled with care, and processed and shared appropriately. Asking and processing the language(s) that someone speaks is generally not regarded as processing sensitive personal data. Sometimes this is the case, for example if the person's language gives an indication of their ethnicity or their political or religious views. Therefore, this should be considered when collecting and sharing data of the health and social care professionals.

The feasibility of this type of language support is generally low, because there are relatively little health or social care professionals with foreign backgrounds available, or because they are not available in the patient's area, which makes them unreachable.

In many situations, it will not be necessary to refer the patient to a health or social care professional who speaks the patient's native language, because the language barrier can be navigated by using a different type of language support, such as a professional interpreter or another common language. A referral could mean the patient has to wait longer to receive care or support, has to travel farther, or is otherwise subject to higher costs or increased inconvenience.

Therefore, it is important to arrange a possible referral with the patient. Especially recurrent communication issues, which can be caused by cultural differences, can be a reason to discuss a possible referral.

5.4.3. Professional interpreter

Using a professional interpreter, in person or by video call, is acceptable, improves equal access to care for non-Dutch speaking patients and has virtually only positive health effects. Even though using a professional interpreter is the ideal type of language support for a lot of health or social care professionals and patients, it is not always feasible. Sometimes, immediate action needs to be taken, due to an emergency situation or a lack of time to find and prepare a professional interpreter.

In order to make the use of a professional interpreter more feasible, planning care or support and engaging the professional interpreter in advance is helpful. This is where the support staff comes in. When making an appointment, one can, for example, ask the patient whether they need a professional interpreter and if so, in what language. This way, it can be determined whether a professional interpreter can be booked in advance.

It is important to not only assess the feasibility, but also the cost-effectiveness of using a professional interpreter, as using a professional interpreter is relatively expensive. During complex, sensitive or impactful conversations, it is important that emotions and nuances are conveyed adequately. In such cases, the guideline working group does not recommend using other types of language support, other than a health or social care professional speaking the patient's native language.

The working group draws the same conclusion for the initial consultations: the benefits of using an interpreter outweigh the costs. If trust is built and the patient's care needs, other health issues, and background are determined during the initial consultation, the health or social care professional may eventually gain more time to provide care and support to the patient. Moreover, by taking time to work with a professional interpreter during the initial consultation, patients will better understand what is wrong and not have to come back more often.

In other relatively simple situations, such as small talk and scheduling follow-up appointments, relatively small health benefits can be achieved. In such situations other, cheaper, or free types of language support are sufficient.

An interpreter who is present in person costs more than an interpreter who is present over the phone or by video call, but has an added value in a situation like this, and so may be considered. Examples in which an in-person interpreter may be preferred include situations in which the interpreter needs to see exactly what someone is doing or pointing at, situations in which the patient does not feel comfortable working with a telephone interpreter, and situations which involve conversations held by multiple people, such as group-based information sessions. If a health or social care professional or patient has explicit concerns about the patient's privacy, despite the interpreter's duty of confidentiality, it is preferable that they hire an interpreter over the phone. In such a case, it is also recommended to not mention the patient's name. Such situations can occur if a patient comes from a small community, whose language is spoken by only a small percentage of people in the Netherlands.

Sometimes the patient prefers using a professional interpreter of the same gender or of a similar background. In such a case, the guidance mentioned in KNMG's viewpoints regarding the freedom to choose a doctor (112) is as follows: 'Organisations will only try to fulfil requests for a health or social care professional of a certain sex if the patient specifies this while making the appointment. However, in an emergency, the patient will have much more limited options, and may even have no options at all.'

A patient always retains the right to refuse the use of a professional interpreter. If a patient does so, the reason of refusal has to be reported in the patient's record, if possible. The preference for a

professional interpreter of the same gender mainly applies to interpreters who are present in person or by video call. The focus groups have shown that this is less relevant when interpreting over the phone, since the lack of visual communication creates more distance and privacy.

5.4.4. Adult family member or friend who interprets

Generally speaking, it is important to primarily consider the patient's adult family members and friends to be their support and a possible conversation partner, just like in conversations without a language barrier. This particularly applies to conversations in which the patient is a minor accompanied by their parent, guardian or sibling.

However, using an adult family member or friend as an interpreter is not feasible for every patient, as not everyone has a social network of people who speak both Dutch and the patient's native language adequately. Therefore, the patient cannot be asked or demanded to bring an adult family member or friend to interpret for them.

Given the limited positive effects of using an adult family member or friend as an interpreter, and the unclear quality of the translation, this type of language support does not always contribute to reducing health disparities either.

Generally speaking, it is only acceptable to use an adult family member or friend as an interpreter during simple conversations, emergency situations without access to a better alternative, or if both the patient and the adult family member or friend prefer this type of language support.

If a patient or an adult family member or friend comes along with the intention to interpret, it is important to first assess whether the family member or friend is over the age of eighteen. Make sure minors never interpret, given the negative impact this could have on them, such as short-term and long-term psychological issues. And for the potential negative impact on the conversation quality. If the family member or friend is of legal age, so over the age of eighteen, it is important to assess whether they are willing and able to interpret.

In some situations, an adult family member or friend may interpret alongside a professional interpreter during the initial consultation. The professional interpreter can then assess whether the adult family member or friend is able to interpret during future appointments. Furthermore, it is important to assess the relationship between the patient and the adult family member or friend. For example, it would be unacceptable to have an employer interpret for a migrant worker about a topic that relates to their work, or to have a family member or friend interpret in the case of domestic violence committed by that family member.

It is advisable to directly assess with the patient, without interference of an adult family member or friend, whether they actually consent to having this person interpret for them. This question can be asked using means such as digital tools or a professional telephone interpreter. If this assessment is made due to suspicions of a possible conflict between the patient and the family member or friend, it is advisable to do so without the family member or friend present.

When using an adult family member or friend as an interpreter, it is important to keep in mind that this type of language support may be preferable for the patient, but aggravating for the adult family member or friend. It is advisable to ask the adult family member or friend whether they feel willing and able to interpret, especially if they frequently interpret for the patient.

It might be helpful to mention the conversation topic at the start and to check whether both the patient and the adult family member or friend still feel comfortable with their role as an interpreter during the conversation.

5.4.5. Digital tools

Using digital tools as a type of language support is feasible and cost-effective in many cases, given the fact that a lot of tools are available for free and are quickly developed to be of better quality. This especially applies to English and other Western European languages. In some situations, this happens because the patient brings a phone with a translation application to the appointment.

The feasibility and acceptability of digital tools depend on the digital skills of both the health or social care professional and the patient, the level of language proficiency, the patient's reading and writing ability, and the type of conversation. If a patient has poor digital or reading skills, this type of language support cannot always be used, and could even help increase health disparities.

Furthermore, it is important to keep in mind that no personal data is entered into a digital tool, given there is not enough insight into the extent to which the privacy of the patient or the health or social care professional is safeguarded.

Health or social care professionals are recommended to follow the policy regarding the use of digital tools their employer or professional association has drawn up (113). It is advisable for organisations or institutes to clearly establish which digital tools are allowed and preferred.

It is also important to assess the acceptability of digital tools as a type of language support. For simple situations, in which short and clear sentences can be used, it is acceptable to use a free translation application. In some situations, such as emergency care or when preparing a conversation, digital tools with fixed pre-translated sentences can contribute to reducing health disparities.

However, for complex, sensitive or impactful conversations, it is unadvisable to use digital tools, because the translations are currently not of good enough quality. The translation quality is lower for rare language pairs, such as Dutch–Tigrinya, than for common language pairs, such as Dutch–English.

Even if the translation quality and data protection of digital tools will be reliable enough in the future, it is still important to take the patient's language proficiency into account, as it affects the acceptability of this type of language support.

5.4.6. Translated material

Translated material can have positive health effects, provided that the patient is able to read and write. If the patient cannot read, it is important to check whether there is someone who can read for them. If the patient is able to read, translated material has significant potential when it comes to sharing information in advance and afterwards. For the patient, it may be useful to prepare themselves for a certain conversation or to be able to read the information again later.

If the patient is able to read, handing them translated material is an acceptable type of language support that contributes to reducing health disparities, provided that the same approach would be used for a Dutch-speaking patient. When assessing whether translated material on its own is an adequate form of language support by itself, it is important to think about whether it can also be used

for a patient without a language barrier. If this is not the case, the translated material for patients with a language barrier is only sufficient when used with another type of language support.

This is more feasible if there is already translated material available or if the information is relatively simple to translate using digital tools. If there is no translated material available and digital tools cannot translate the information adequately, it is less feasible.

5.4.7. Nonverbal communication

This type of language support is feasible and free, but is rarely considered acceptable on its own, unless there is no other option. There is no information available about the health effects of this type of language support, and the extent to which it contributes to reducing health disparities is not known. Keep in mind that gestures can have different meanings and connotations in different cultures, and that a lot of patients do not know their own body well. Therefore, a drawing of a certain body part such as a stomach may not be enough to indicate where the organ is located in the body or what could be wrong with it.

For patients who speak Dutch or another common language and know the human body well enough, this type of language support can be effective. In all other situations, it can be used in addition to other types of language support.

5.4.8. A person brought in ad hoc as an interpreter

Using a person as an ad hoc interpreter is usually not feasible, as it is often difficult to find someone to interpret last minute. Moreover, this type of language support generally does not lead to reduced health disparities, as the translation is often not of an acceptable quality. On top of that, a person brought in ad hoc as an interpreter has no duty of confidentiality to follow with regards to the patient. Therefore, this type of language support is generally not considered acceptable.

However, in some situations, such as emergency situations, bringing in an ad hoc interpreter is considered a better option than having no language support at all.

5.4.9. Cultural mediator

The health effects of using a cultural mediator are still unclear. Even though using a cultural mediator is generally considered acceptable and can contribute to reducing health disparities between patients who experience a language barrier and those who do not, there is little information about the feasibility and cost-effectiveness of this type of language support. Furthermore, there may be hesitations about its acceptability, especially since cultural mediators have no duty of confidentiality and no official framework to follow.

However, Pharos and youth care organisation Nidos do have information available about cultural mediators on their websites (110,111). Nidos educates cultural mediators and Pharos educates key persons. As of now, cultural mediators are mostly volunteers and play the role of educator and connector. At Nidos, the cultural mediators are paid (110).

6. Module 3: Evaluating the performance of communication goals

6.1. Key question

How can health and social care professionals assess whether the communication goals are being achieved when there is a language barrier?

6.2. Recommendations:

1. Ask the patient to explain in their own words what you have discussed. Do this at multiple points during the conversation, most importantly, at the end. The best way to do this is the teach-back method. Write down in the patient's record if chosen type(s) of language support are sufficient.

6.3. Foundation

Once it has been determined which type(s) of language support will be used, it is important to check whether the communication goals are being achieved. Here follows an explanation as to why, when, how and by whom the achievement of these goals can be evaluated. Each section is based on scientific literature, previous recommendations and reports, which were supplemented by the insights of the focus groups and reviewed based on the expertise of the guideline working group.

6.3.1. Why is it important to evaluate communication goals?

Every conversation has a goal, and communication is only effective when that goal is achieved. Effective communication has various positive effects, such as higher patient satisfaction, better quality of care, and improved physical and mental health (114). That is why it is important to evaluate communication goals, that is, whether or not the goals of the conversation have been achieved.

The literature distinguishes six communication goals (115):

1. **Building a relationship:** Respect, trust, and a solid, harmonious relationship between patient and healthcare professional are the foundation of a therapeutic relationship. Building a good and effective relationship is therefore an important communication goal.
2. **Collecting information:** Health and social care professionals need information about the symptoms, experiences and expectations of their patient. This helps them make a diagnose, interpret symptoms, and draw up a suitable treatment plan. Gathering information is therefore a communication goal.
3. **Giving information:** Health and social care professionals are obligated to inform their patient. This can be necessary in order to explain health issues or solutions, to support the patient in their decision-making or to reduce their anxiety. Adequately informing the patient is therefore a communication goal.
4. **Decision-making:** Informed and shared decision-making are central principles in healthcare. The patient needs information about the pros and cons of different treatment options and needs support in choosing which of their values to prioritise. Facilitating decision-making that is based on information and preferences is therefore a communication goal.

5. **Encouraging a healthy lifestyle:** In many cases, the goal is for the patient to improve their lifestyle. This may help them prevent illnesses or other issues, and improve or retain good health and well-being. Encouraging a healthy and suitable lifestyle is therefore a communication goal.
6. **Reacting to emotions:** Healthcare questions are often accompanied by strong emotions. A patient may feel scared, angry, powerless, or sad. It is important for health and social care professionals to recognise certain emotions and respond to them, for example by soothing the patient or ensuring their emotions do not negatively impact other communication goals. Responding to emotions, which includes supporting the patient and referring them somewhere else, if necessary, is an important communication goal.

6.3.2. Who is responsible for evaluating communication goals?

During all focus groups, it was stated that the health or social care professional is responsible for evaluating the communication goals. This is no different from the responsibility of the health or social care professional to identify a language barrier and the extent of it and to choose the most fitting type of language support.

During the focus groups, it was stressed that assessing whether the patient and health or social care professional understood each other, is separate from dealing with language barriers. Even in conversations without a language barrier, it is important to assess understanding, so adjustments can be made in time if necessary.

In case of a language barrier, it is even more important to assess the understanding, so that the type and level of language support can be adjusted in time if necessary.

6.3.3. When can communication goals be evaluated?

During the focus groups, it was stated that evaluating the communication goals is mainly supposed to take place at the end of a conversation or appointment.

However, short breaks to evaluate the communication goals can also be built into the conversation. By evaluating earlier on, like at the start of the conversation, adjustments can be made more quickly.

This enables language support to be used even earlier or, if necessary, to hire a professional interpreter right away instead of having to make a separate appointment, even though this may be useful in some cases.

The way in which communication goals can be evaluated, is elaborated on below (paragraph 6.3.4). Both methods can be used both during and after a conversation or appointment.

In addition to the methods described below, some health and social care professionals in the focus groups indicated that they would prefer to schedule a follow-up appointment with a patient to check whether they understood and applied all of the information correctly. This can, if necessary, be done in the presence of a professional interpreter. In some cases, the evaluation of the communication goals could also take place after a conversation or appointment.

6.3.4. How do you evaluate communication goals?

Teach-back method

Both the scientific literature and the additional focus groups point to a single, unanimous answer to the question of how health and social care professionals can assess whether communication goals have been achieved: the teach-back method

When applying the teach-back method, the patient is asked to summarise, in their own words, what has been discussed. This may relate to how the patient should use their medication or which exercises can be done at home.

When using the teach-back method, it is important to keep in mind how the question is phrased. Firstly, it is important to ask open-ended questions. Secondly, it is important that the questions do not give the patient the impression that they are being tested. A question such as ‘Can you tell me what you understood?’ may make the patient feel insecure or angry. Patients are often afraid of being ‘judged’ by the health or social care professional on how they understood the information (116,117). That is why it is advisable to ask the teach-back question in a way that makes the health or social care professional seem more vulnerable. A classic example of the teach-back method is:

- ‘I want to make sure I explained everything clearly. What will you tell or do at home?’

The teach-back method results in a range of positive outcomes, such as higher satisfaction, better therapeutic compliance, improved self-care, higher quality of life, better understanding, reduced anxiety, fewer re-hospitalisations and more happiness (118,119).

The *Ask Me 3* technique

Another way of evaluating whether the communication goals have been achieved is the Ask Me 3 technique (120,121). This technique involves a patient answering three questions at the end of a conversation or appointment, which are:

1. ‘What is my health issue?’
2. ‘What should I do about it?’
3. ‘Why is it important that I do so?’

This technique can be applied by the health or social care professional, by explicitly asking these questions at the end of the conversation. Additionally, the health or social care professional can use this technique to summarise the most important conclusions or to check whether all relevant information has been effectively communicated to the patient (122).

The Ask Me 3 technique has several positive characteristics. It actively involves the patient in their own care, and helps them better understand the treatment and care provided. This can build trust between the patient and the health or social care professional (123).

Research has shown that the Ask Me 3 technique has positive effects in conversations where there is no language barrier. The method improves understanding, increases patient satisfaction, stimulates therapeutic compliance, and enhances the quality of life (118,124–127).

It also contributes to effective communication and a solid relationship with the health or social care professional (128). For non-Dutch speaking patients, the Ask Me 3 technique leads to more knowledge and better self-care (129).

6.4. Considerations

Both the teach-back method and the Ask Me 3 technique are strategies with very little debate about their effectiveness. For almost all types of conversations in health and social care, the teach-back method is feasible, accessible, and cost-effective, and leads to more equality for all patients, regardless of the extent of the language barrier.

Using both methods takes time, but even a single or a few brief questions can contribute to positive health outcomes. There are no costs attached to these methods.

7. Distribution and implementation

This chapter describes the actions that the Dutch Patients' Federation and other organisations involved in developing the guideline can take to distribute this guideline, the preconditions for its implementation, and advice for stakeholders who contribute to proper healthcare and who support people with a language barrier.

Due to the broad scope of the guideline, the diversity of potential users, and the different types of care, this chapter does not include a detailed implementation plan. The development of implementation plans is the responsibility of the professional associations and patient organisations. In that process, it would be advisable for them to learn from and coordinate with each other.

7.1. Distribution

The Dutch Patients' Federation and other organisation involved in this guideline will distribute the guideline and a practical summary among professional associations and national health and social care organisations, as soon as the authorisation process with the relevant professional associations has been completed.

National organisations are asked to distribute the guideline among its members. Professional associations that have not taken part in the project will also be invited to authorise the guideline.

Target audiences for the distribution of the guideline and corresponding materials:

- The participating and other relevant professional associations and patient organisations.
- Organisations of patients, informal caregivers, refugees and immigrants, and interpreter organisations.
- Professional health and social care associations.
- Educational institutes for health and social care professionals.
- Dutch Ministry of Health, Welfare and Sport, and Dutch Ministry of Justice and Security.
- Zorgverzekeraars Nederland (the main health insurance organisation in the Netherlands).
- The Association of Netherlands Municipalities (VNG) and the organisation of managers and directors in social care (DIVOSA).
- ZonMw, National Health Care Institute, Dutch Healthcare Authority, Health and Youth Care Inspectorate, Dutch Central Disciplinary Tribunal for Health Care and Dutch Association of Supervisory Directors in Healthcare and Welfare.
- Dutch Guidelines Network and coordinating quality organisations, such as the Quality Alliance Mental Health (AKWA GGZ) and SKILZ.
- Knowledge institutions, including Pharos, Movisie, the Netherlands Youth Institute, and the Trimbos Institute.

It will be discussed with the involved professional associations when the guideline can be widely distributed.

The development of a version of the guideline for patients and adult family members and friends is unfortunately not possible within the scope of the current project. The Dutch Foundation for Intercultural Care, which is the patient organisation who has contributed to the development of the guideline, will develop material for patients, family members and friends, and other key persons.

7.2. Implementation

To ensure that the health and social care professionals, patients and adult family members and friends can follow the recommendations, it is important that a number of preconditions are in place. In Modules 1, 2 and 3, specific preconditions for the different types of language support have already been identified, based on the substantiation, the focus groups and the considerations of the guideline working group. In this chapter, we elaborate on the preconditions of three central themes 1) Broad awareness and education, 2) Extra time needed to be able to provide proper healthcare and 3) Access to the different types of language support.

7.2.1. Broad awareness and education

During the focus groups, participants of the guideline working group emphasised the importance of addressing language barriers in health and social care in education and refresher training courses. Health and social care professionals indicated that this currently receives little attention and that they lack knowledge and skills in working with interpreters and other types of language support. Scientific literature confirms that it is important for future health and social care professionals to learn how to communicate effectively when a professional interpreter is used (130).

In 2022, researchers from the management consulting firm Berenschot, working on behalf of the Dutch Ministry of Health, Welfare and Sport, concluded when researching the use of interpreters in health and social care that all sectors should pay more attention to navigating language barriers and intercultural communication between health and social care professionals (33). Respondents also indicated that health and social care professionals need training in intercultural communication and the ability to assess whether the patient understands everything.

The guideline working group stresses that awareness is not only needed among health and social care professionals and patients, but that a broader awareness is also needed among support staff, managers and administrators, because providing proper healthcare when there is a language barrier requires collective effort.

For broad awareness and education, the following is needed:

- Availability of visual material that are both emotionally and intellectually appealing, so stakeholders can contribute to raising awareness among health and social care professionals, patients, adult family members and friends, support staff, managers, policy makers, and administrators.
- Sharing good practices, like the improvement of work processes that contribute to effectively navigating language barriers.
- Practical materials for recognising and identifying language barriers and the responsibilities of health and social care professionals, organisations, patients and adult family members and friends.
- Sharing this guideline and practical material via social media, newsletters, specialist journals, and a central platform.
- Incorporating education on how to navigate language barriers in the core curriculum of healthcare studies.
- Health and social care-specific training, refresher courses, testing and registration for interpreters.
- Making information about navigating language barriers accessible.

7.2.2. Organisation of care: time

In order to provide proper healthcare and support, health and social care professionals often need more time for conversations where a language barrier is present than for conversations without a language barrier. Besides the time needed for the communication, it takes extra time to assess if there is a language barrier and to what extent, which type of language support is needed, and to arrange this support. Moreover, more time is needed to check whether the patient and the health or social care professional have understood each other correctly.

Effectively navigating the language barrier also saves time. Respondents in Berenschot research (32) expect the use of a professional interpreter to pay off, regarding both the effectiveness of healthcare (health gain) and the efficiency of care (time savings for health and social care professionals). The guideline working group and participants of the focus groups also emphasise that the use of interpreters saves time.

Using translation apps and adult family members and friends as interpreters takes less time for health and social care professionals than using professional interpreters. To make sure that health and social care professionals use a professional interpreter when necessary, there is a precondition in place that gives them enough time to process requests properly.

Regarding the available time, the following is needed:

- Health and social care professionals and support staff have the option to reserve extra time for conversations in which professional interpreters, translation apps, adult family members or friends, or other types of language support are needed in order to provide proper healthcare.
- Arrangements are made regarding efficiently requesting a professional interpreter, planning appointments and consultations with health and social care professionals who speak the patient's native language, and arranging digital tools.

7.2.3. Organisation of care: access to types of language support

Professional interpreter

Berenschot researchers (32) concluded in 2022 that many health and social care professionals experience issues when using professional interpreters, which causes them to use an interpreter less often than they consider necessary. Forty-three per cent (43%) of health and social care respondents stated that they never use a professional interpreter when needed, whereas ten per cent (10%) stated that they often or always use an interpreter if needed. The following reasons for not using a professional interpreter were mentioned: a lack of funding, a lack of information about the options to hire a professional interpreter, the time it takes to use a professional interpreter, and a lack of knowledge around navigating language and cultural barriers.

On 27 November 2023, the Dutch Ministry of Health, Welfare and Sport wrote a letter to the Dutch House of Representatives giving clarity on their policy: 'Good and appropriate care begins with clear communication. Therefore, it is important to structurally arrange the use of professional interpreters in situations in which they are necessary.' The Dutch Ministry of Health, Welfare and Sports bases this statement on the viewpoint the National Health Care Institute communicated in 2020 regarding the use of interpreters: 'According to the Dutch Healthcare Quality, Complaints and Disputes Act (WKKGZ) and the Medical Treatment Agreement Act (WGBO), health and social care professionals must provide proper healthcare by acting in accordance to the responsibilities at a professional standard. Providing high-quality care implies that the health or social care professional and the patient are able to communicate adequately in a language they both understand' (22).

This viewpoint on the use and funding of interpreters was part of a report the National Health Care Institute wrote regarding interpreters in mental health care. In 2024, the National Health Care Institute confirmed on paper to the project group that the viewpoint regarding the funding of interpreters is more widely applicable to all care within the scope of the Health Insurance Act (see attachment 5).

As regards content, the government policy is now clear, but the funding of interpreters has only been arranged in a part of the sectors. The last few years, regulations have been drawn up for the Dutch Association of Mental Health and Addiction Care (GGZ) for patients of legal age and for first-line birth care. Based on these regulations, the costs for interpreters can be declared to health insurers. The Dutch Ministry of Health, Welfare and Sport has filed a request to the Dutch Healthcare Authority for an advisory opinion regarding the funding for GP care (Letter to the House of Representatives, December, 2024). They also requested research about whether the solution for GP care could also be effective for other first-line care. Regarding specialist medical care, the Dutch Healthcare Authority (NZa) states that the costs for interpreters have been incorporated in the rates (Letter to the House of Representatives, November, 2023). All care and support for which municipalities are responsible (the Child and Youth Act, Social Support Act (Wmo), Public Health Act (Wpg)) municipalities are responsible for the costs, according to the Dutch Ministry of Health, Welfare and Sport and the aforementioned letter to the House of Representatives. Regarding the Long-Term Care Act, the Ministry states that there are no signs that the lack of funding forms a threshold for using an interpreter (Letter to the House of Representatives, November, 2023).

For the effective use of professional interpreters, the following is needed:

- Structural funding for interpreters, so that all health and social care professionals can use an interpreter for all patient groups, when necessary, to provide proper healthcare.
- Information on how funding is arranged and how professional interpreters can be used is available and accessible to all health and social care professionals.
- Information on language barriers, the need for language support, the types of support required, and functional illiteracy can be easily and quickly identified and recorded in digital records.
- Professional interpreters with expertise in health and social care are available and can be deployed in line with the needs in health and social care.
- Practical solutions for arranging professional interpreters (e.g. through support staff) should be shared and implemented.

Accessible information for health and social care professionals about the access to interpreters can be found on the website www.zoschakeltueentolkin.nl.

Health and social care professionals who speak the patient's native language

Using health and social care professionals who speak the patient's native language depends on their availability and how easily they can be found.

For the effective use of health and social care professionals who speak the patient's native language, the following is needed:

- Within healthcare organisations, it is known which health and social care professionals speak which languages and what care they can provide in those languages.
- There are agreements about how and when patients can be transferred or accepted from other healthcare providers.
- Accessible overviews are available of health and social care professionals who provide care and support, both for individual and group care.

Examples of initiatives that contribute to the ability to find health and social care professionals who speak the patient's native language and have the same cultural background:

- National overview of intercultural mental health care and social support.
- AlloMedics
- Multilingual Speech Therapy Foundation Netherlands

Adult family member or friend who interprets

For adult family members and friends to interpret effectively, it is important that:

- Health and social care professionals have practical information about how to ask whether the patient and the adult family member or friend agree to have said adult family member or friend to interpret, how they can work with adult family member or friends who act as interpreters and what to do when it is not appropriate for the adult family member or friend to interpret.
- There is information available for patients and their family members and friends about this guideline, when interpretation by a relative is or is not desirable, what other types of language support are available, and how the adult family member or friend can contribute to proper healthcare.

Digital tools

In late 2023, research bureau EQUALIS researched the use of digital tools when navigating a language barriers in health or social care on behalf of the Dutch Ministry of Health, Welfare and Sport (33). The researchers concluded: 'The use of digital tools to navigate language barriers in health and social care is currently still limited, even though these tools can have a positive impact on the quality of care.' The researchers stated that health and social care professionals only know about a small part of the digital tools available, and that the quality is often considered to be insufficient, especially due to a lack of clarity regarding privacy.

The focus groups have shown that health and social care professionals often use translation apps like Google Translate as a supporting tool during simple conversations. Given the current shortcomings regarding privacy, the guideline working group has concluded that digital tools are only suitable for simple conversations and as a means of support for other conversations.

For the effective use of digital tools, it is important that:

- Digital tools are available that provide high-quality spoken and written translations, specifically made for health and social care, safeguarding the privacy of patients, health and social care professionals and healthcare providers.
- It is clear and accessible to all those involved which digital tools they can use and what the quality and security of these tools are.
- Health and social care professionals are trained in the use of digital tools, in accordance with the European legislation.

Translated materials

Translated materials, materials in simplified Dutch, and visual support are crucial in order to provide care and support to people who are not fluent in Dutch. These materials are essential for effective communication. EQUALIS research has shown that many health and social care professionals are unfamiliar with the materials and platforms available. In order to improve the shareability, it is

advisable to make materials available online and to digitally share them with patients and their adult family members and friends (131).

For the effective use of translated materials, it is important that:

- Good, reliable and up-to-date databases are set up in which health and social care professionals, patients and adult family members and friends can find translated materials.
- There is a clear policy in place regarding the use of translation apps to translate websites and materials, and that health and social care professionals, patients and adult family members and friends can monitor the way translations were made.

Some places where you can find translated and accessible materials:

- Pharos' knowledge bank, the most well-known platform according to EQUALIS' research (33).
- The overview of translated materials, made by GGD GHOR Nederland.
- The Language Tool for Birth Care, made by Kennisnet Geboortezorg.
- Health-tech company Inforium BV uses AI-translated materials.

Cultural mediators

The work of cultural mediators is relatively unknown in the Netherlands. In other countries they have a bigger role in health and social care. The World Health Organisation has reported about the role of cultural mediators and the scientific proof regarding their influence on health and social care. However, during the systematic review (1) of this guideline, no research studies were found regarding the correlation between cultural mediators, healthcare and language barriers. Because 'cultural mediator' is not a regulated profession in the Netherlands, only a recommendation regarding the use of a cultural mediator when there is a language barrier was drawn up.

Focus group participants and members of the guideline working group believe that using cultural mediators has added value.

For the effective use of cultural mediators, it is important that:

- Official frameworks are established for the use of cultural mediators.
- Health and social care professionals know what cultural mediators are and what they can and cannot contribute within health and social care.

7.3. Financial impact of implementing the guideline

A thorough analysis of the financial consequences of implementing this guideline was not feasible for this project, as only a very limited amount of data is available about the costs and benefits of the different types of language support. Among other reasons, this is because the funding for interpreters is arranged differently in each sector (see paragraph 7.1.3). Additionally, the utilisation of different types of language support will be influenced by developments that are hard to predict, such as: the extent to which this guideline will be implemented, the funding for interpreters in all the different healthcare sectors, the increases in quality and reliability of digital tools, the increase in the amount of new asylum seekers and immigrants, and a possible modification of the required language proficiency for integration.

About research on the costs and benefits of the use of professional interpreters:

- On behalf of the Dutch Ministry of Health, Welfare and Sport, research agency Regioplan did a cost-benefit analysis in 2009 for GP care and the Dutch Association of Mental Health and Addiction Care(132). The researchers determined that it was not possible to give an insight into a large portion of the quantitative and qualitative benefits.
- Based on a review of international research of cost-benefit analyses for the use of professional interpreters, it was concluded that only a limited amount of cost-benefit analyses have been done, that these involved only a few types of care, that these research studies worked with different outcome measures, and that it is not feasible to accurately calculate the quantitative and qualitative benefits for patients, the healthcare system and society(133).
- The data needed to perform a proper cost-benefit analyses is not yet being collected. A minimal requirement for this would be a uniform way to register in a patient's record whether there is a language barrier and what type of language support was used. However, this data is not yet being registered in a uniform way.

7.4. Advice for stakeholders

Commitment is needed on every level of health and social care to make sure that health and social care professionals can provide proper healthcare whenever a language barrier occurs.

General advice for stakeholders:

- Create awareness of the impact of language barriers and the responsibilities of health and social care professionals and healthcare providers to provide proper healthcare in case of a language barrier. Take this into account when stimulating shared decision-making.
- Promote the spread and implementation of this guideline and effectively integrate it to navigate language barriers in workflows.
- Develop a toolbox with concise, practical materials in collaboration with people from the field. Incorporate links to websites with materials and information about how funding for interpreters is arranged.
- Arrange education with accreditation about navigating language barriers and working with interpreters and make this a fixed part of basic training.
- Select which digital tools can be used with other stakeholders' input, and be transparent about quality, privacy and the proper use. Considering the fast developments in technology, make sure to update this regularly.
- Stimulate the development of communication cards, visual materials, materials in simple Dutch and translated materials.
- Develop a national platform with information and materials about navigating language barriers in health and social care.
- Consider whether the guideline can be expanded to include communication with people who are deaf or hard of hearing.

7.5. Advice per group of stakeholders

7.5.1. Professional associations and scientific associations of health and social care professionals

- Authorise the guideline, distribute it among members, and promote its implementation. Promote the development of practical materials for health and social care professionals.
- Assess whether specific suggestions in this guideline are needed for certain professionals, such as caregivers, or for certain conditions, such as dementia or aphasia.
- Stimulate and evaluate the implementation of the guideline and corresponding materials.
- Advocate for structural solutions for the funding of interpreters.
- Call for standardised registration options in patient records and standards for transfer letters (in ZorgDomein, for example) for information about language barriers, such as preferred language(s) and language support.
- Consider referring to the guideline Navigating language barriers in health or social care in new guidelines, quality standards or in revisions.
- Refer to the digital tools that can be used.

7.5.2. Providers of care and support

- Draw up a policy for navigating language barriers and make it widely known, for example through guidelines for health and social care professionals, managers, support staff, chain partners, patients, and adult family members and friends.
- Ensure that health and social care professionals can allocate sufficient time for conversations where there is a language barrier.
- Offer training to health and social care professionals in navigating language barriers and working with an interpreter.
- For organisations where funding for interpreters has not yet been arranged, budget sufficient resources for the use of interpreters and make agreements with health insurers or municipalities.
- Advocate for structural solutions for the funding of interpreters.
- Ensure that health and social care professionals reflect the diversity of the population, so that care providers who speak the patient's language can be used.
- Identify which languages staff members are proficient in and whether they are willing to provide care in other languages. Share this information within the organisation and, where applicable, more broadly, so that it becomes clear in which languages care can be provided.

7.5.3. Patient organisations and informal care organisations

- Develop and share materials for patients, their family members and friends, and others to inform them about and provide guidance on navigating language barriers.
- Identify the experiences of members with insufficient proficiency in the Dutch language regarding healthcare.
- Translate information for patients in the most commonly spoken languages.
- Advocate with stakeholders for structural funding and access to interpreters for health and social care professionals.

7.5.4. Professional associations

- Advocate for structural solutions for the funding of interpreters in health and social care.
- Advocate for the inclusion of fields for preferred language, language barrier, and used language support in digital records and templates for transfer letters.
- Create an overview of digital tools that can be used and keep it up-to-date.
- Develop a guideline for members about the implementation of the guideline.

7.5.5. Health insurers

- Contribute to efficient and congruous funding for interpreters and to the efficient procurement of interpreter services.
- Stimulate the development of guidelines for the procurement and monitoring of interpreter services.
- Research how to efficiently organise referrals of patients to a health or social care professional who speaks the patient's native language.
- Stimulate innovation in digital tools to navigate language barriers, as this contributes to the accessibility and quality of care and can help reduce costs.
- Inform staff members and customers about the guideline, the policy and the funding of interpreters.
- Investigate options for providing additional time for patient contact where language barriers exist.

7.5.6. Ministry of Health, Welfare and Sport

- Ensure that the funding for the use of interpreters for all health and social care professionals is structurally arranged.
- Contribute to improving the quality of interpreting in health and social care by encouraging the field to develop frameworks, accreditation, and registration for interpreters with domain-specific knowledge and skills.
- Develop a policy to stimulate the use of health and social care professionals who speak the patient's native language.
- Stimulate the field to develop a policy and guidance for the use of digital tools. Stimulate research to the usability, effectiveness, and implementation of digital tools.
- Explore, based on current practice, the needs and possibilities for the allocation of extra time necessary for health and social care professionals to provide proper healthcare when there is a language barrier.

7.5.7. Municipalities

- Make agreements on the use and funding of interpreters for care and support within the scope of the Child and Youth Act, Social Support Act and the Public Health Act, with in-house services (neighbourhood team, GGD) and with contracted healthcare providers.
- Inform health and social care professionals, policy advisors and administrators about the policy for the use of interpreters in health and social care.

7.5.8. Association of Dutch Municipalities

- Inform municipalities about the national policy on navigating language barriers in health and social care, as well as this guideline.

- Contribute to efficient and congruous funding for interpreters and to the efficient procurement of interpreter services.

7.5.9. National Health Care Institute

- Ensure that this guideline will be included in the Register of Quality Standards.
- Offer clarity about the frameworks for the use of professional interpreters for all domains in care and social support.
- Address navigating language barriers and the use of interpreters in reports and policies aimed at reducing health disparities, shared decision-making, and appropriate care.

7.5.10. Dutch Healthcare Authority

- Contribute to efficient and congruous funding for interpreters and to the efficient procurement of interpreter services. In doing so, consider the impact on the quality and availability of interpreters, as well as simple, consistent, and sustainable access to interpreters. Involve organisations of health and social care professionals, patients and interpreters.
- Develop guidance on the procurement and monitoring of interpreter services for the different types of funding, together with stakeholders.
- Include access to interpreters in supervisor tasks.

7.5.11. Inspection for health and social care

- Inform inspectors and policy advisors about the guideline.
- Consider including whether providers have a policy regarding the use of interpreters and digital tools in the testing framework.
- Be alert to document and report bottlenecks and incidents related to language barriers and the use of interpreters.

7.5.12. Professional associations of interpreters

- Advocate for structural solutions for the funding of interpreters in health and social care.
- Develop frameworks, educational requirements, accreditation and registration for interpreters in health and social care, together with stakeholders.

7.5.13. Provision of education and refresher courses for health and social care professionals

- Include navigating language barriers and working with interpreters in education and refresher courses for health and social care professionals.
- Develop refresher courses regarding navigating language barriers and offer opportunities to practice working with digital tools, professional interpreters, and adult family members and friends who interpret.

7.5.14. Provision of education and refresher courses for interpreters

- Collaborate with other organisations and stakeholders to develop domain-specific specialisations for professional interpreters in health and social care, as these sectors require

different knowledge and skills from those needed for interpreting in other contexts, such as the legal domain.

7.5.15. Organisations for accreditation and registration of interpreters

- Develop a professional framework, accreditation and registration for interpreters in health and social care, together with other stakeholders.

7.5.16. Knowledge institutions (including Pharos, Movisie, the Netherlands Youth Institute, the Trimbos Institute and Vilans)

- Include navigating language barriers in research, policy reports, meetings, training programmes, and communications.
- Collaborate with stakeholders, such as professional associations and insurers, to develop an overview of which digital tools can be used, for what purposes, and for what reasons. Due to the rapid developments, it is important to ensure that this overview remains up-to-date.
- Collaborate with stakeholders to consider which materials can be made available in other languages and facilitate access to these materials for health and social care professionals and patients.

7.5.17. Local and regional cooperations, like obstetric care networks (VSVs) and regional support organisations for healthcare (ROSes) and general practitioners (RHOs)

- Discuss the practice and policy for navigating language barriers with chain partners.

7.5.18. Developers of digital tools

- Develop digital tools of high quality and security for navigating language barriers in health and social care.

7.5.19. Developers of digital records and templates for referrals

- In consultation with stakeholders, include options for preferred language, language proficiency, and language support used in digital records and transfer letter templates.

7.6. Indicators and monitoring

The Dutch Patients' Federation will maintain a record of organisations that have authorised the guideline, provided administrative support, or issued a No Objection Certificate. A year after finishing this project, the Dutch Patients' Federation will approach these organisations to assess their experiences with the implementation of this guideline and to discuss the steps needed to further advance its long-term implementation.

7.6.1. Indicators for implementing the guideline

Indicators that can be used to monitor the implementation of the guideline:

- Number of professional associations that have authorised the guideline, provided administrative support, or issued a No Objection Certificate.
- Number of professional associations and healthcare providers that introduce the guideline to health and social care professionals and patients.
- Percentage of health and social care professionals, patients, adult family members and friends and managers that are familiar with the guideline (based on research).
- Number of guidelines and quality standards that refer to the guideline.

7.6.2. Indicators for implementing types of language support

Indicators that could be used to monitor the use of different types of language support, thereby providing an indication of the implementation of the guideline:

- Cost for the use of interpreters, based on the information of insurers (such as the Dutch Association of Mental Health and Addiction Care 18+ and first-line birth care via the Dutch Healthcare Authority), funds for GP practices in deprived neighbourhoods and interpreter services (such as Global Talk, Acolad).
- Percentage of health and social care professionals who use professional interpreters when needed (based on research – compare with the research from Berenschot (32)).
- Percentage of health and social care professionals who use digital tools in comparison with the research from EQUALIS in 2023 (33).
- Language proficiency and need for language support in digital records.

8. Knowledge gaps

In this general guideline, we provide recommendations based on the integration of information from various scientific sources and an assessment of the feasibility and acceptability of different types of language support. However, there are still gaps in knowledge in certain areas. These knowledge gaps are explained below.

8.1. Awareness and behavioural change

In Module 1, we provide recommendations to health and social care professionals and support staff on how to assess the presence and extent of a language barrier. These recommendations are based on findings from scientific literature (not part of the systematic review (1)), earlier recommendations and reports, and insights from the focus groups, and are assessed based on the expertise of the guideline working group. However, we do not have concrete information on how health and social care professionals can act in practice to assess a language barrier.

> **Knowledge gap 1:** Research is needed into how health and social care professionals, patients and adult family members and friends can be supported in assessing a language barrier, making practical choices between different types of language support, increasing the awareness of the effectiveness of these types and recognising signals that indicate when upgrading to a more efficient solution is needed, for example, scaling up from an adult family member or friend who interprets to a professional interpreter.

In Module 2 of this guideline, we provide recommendations to health and social care professionals on how they can determine which type(s) of language support are most suitable for supporting communication. These recommendations are based on the findings from the systematic review (1), the focus groups and additional sources, such as grey literature and international reports, and the expertise of the guideline working group.

Despite our current insight on when certain types of language support are more suitable, many health and social care professionals as well as other involved parties, such as managers and policy advisors, have stated that either they are not aware of the importance of navigating a language barrier or that they have a negative attitude towards or little intention of actively navigating a language barrier.

This may result in patients continuing to rely on an adult family member or friend to interpret, or even in care or support being denied. However, we do not have concrete information on how health and social care professionals and other parties can be convinced to change their behaviour regarding navigating language barriers.

> **Knowledge gap 2:** Research is needed into the ways to motivate health and social care professionals and other parties to invest in behavioural change regarding navigating language barriers. Topics to research regarding language barriers are awareness, attitudes, intentions and negative factors. These factors are important predictors of behaviour and behavioural change.

The focus groups and the experiences of the guideline working group have shown that patients and adult family members and friends are often not sufficiently aware of the importance of navigating a language barrier. They also have limited knowledge of aspects such as the Dutch healthcare system, or hold different expectations of care and support. However, we do not have concrete information on what is needed to increase awareness among patients and adult family members and friends.

Knowledge gap 3: Research is needed into how patients, family members, and friends can be better informed about topics such as the Dutch healthcare system. It is important to consider the needs and preferences of patients and adult family members and friends regarding both the content and type of information.

8.2. Use and effectiveness of types of language support

As stated previously, Module 2 contains recommendations on different types of language support. However, much remains unknown about certain aspects of the different types of language support.

Knowledge gap 4: Research is needed into the use and effectiveness of different types of language support, both in social care and across a wider range of healthcare settings. At this point in time, we have not been able to identify scientific literature on social care for this guideline. There is plenty of scientific literature available on healthcare, but it is limited in the number of different healthcare settings covered. This can limit the applicability of some considerations.

Knowledge gap 5: Research is needed into relatively new types of language support, such as the effectiveness of cultural mediators and digital language support, including artificial intelligence. For digital language support, it is important to specifically examine how quality and reliability can be improved more rapidly.

Knowledge gap 6: Research is needed into the cost-effectiveness of different types of language support. Although some scientific publications on cost-effectiveness are available, these studies have not been conducted in the Netherlands.

8.3. Outcomes

The foundation of Module 2 contains findings from scientific literature regarding different outcomes, such as quality of life, patient satisfaction and the quality of translations. However, information about certain outcomes is missing that either the guideline working group considers relevant or that is important due to recent developments in the Dutch healthcare system.

Knowledge gap 7: Research is needed into how developments regarding language barriers can be incorporated into the broader context of shared decision-making and appropriate care. Shared decision-making is a cornerstone of patient-oriented and appropriate care. Scientific literature shows that patients with a migration background generally like to be involved in decisions regarding their care.

Knowledge gap 8: Research is needed into the specific relationship between language barriers and low healthcare literacy. This requires paying attention to the ways we can avoid making assumptions about a patient's wishes or skills, such as the assumption that 'elderly patients or patients with poor healthcare literacy are not willing or able to work with digital tools.'

Knowledge gap 9: Research is needed into the broader number of outcome measures regarding the navigation of language barriers. Ordered from most to least relevant, the guideline working group considered the following outcomes to be relevant, despite not occurring in any scientific literature: cost-effectiveness, the number of examinations/ diagnostics, the amount/ severity of side effects, therapeutic compliance, the chosen

alternative for a type of language support and the availability/ accessibility of certain types of language support.

Knowledge gap 10: Research is needed into how to monitor errors and incidents caused by language barriers that are insufficiently navigated.

8.4. Knowledge about implementation

In order to sustainably integrate this general guideline into daily practice, there are a few preconditions in place. However, we do not have information about certain preconditions regarding the implementation of this guideline.

Knowledge gap 11: Research is needed into effective strategies for the implementation of the general guideline.

Knowledge gap 12: Research is needed into the funding of language support to gain more insight into situations, contexts, and fields in which a lack of funding hinders the use of professional interpreters.

Knowledge gap 13: Research is needed into how the navigation of language barriers can be better implemented into education and refresher training courses. This is a broad issue, ranging from the education and refresher trainings for social workers and medical specialists, to the education of professional interpreters and cultural mediators.

9. Methodology

9.1. General background information

This general guideline was developed by the multidisciplinary guideline working group in cooperation with the Dutch Patients' Federation, researchers of the University of Amsterdam, a guideline methodologist of Amsterdam UMC, and an independent chairman. The development of this guideline was made possible by the funding of ZonMw (the Quality of Care programme, project number 05160122130002) and the Dutch Patients' Federation. The content of this guideline was not influenced by any viewpoints of ZonMw.

9.2. Composition of the working group and sounding boards

In 2022, a multidisciplinary project group and guideline working group were established. The project group was in charge of the research and gave proposals to the guideline working group to discuss. Each of the three patient representatives in the guideline working group established a sounding board in their local area. Before every guideline working group meeting, they asked their sounding board for input and reactions to the analyses of bottlenecks and draft recommendations, so they could be well-prepared to contribute to the guideline working group.

9.2.1. Guideline working group

The aim of the guideline working group was to:

- analyse and prioritise the bottlenecks collected in practice and deduced from scientific literature;
- establish key questions and select the most relevant questions for a goal-oriented and systematic review;
- establish the recommendations for every key question.

In order to do this, they made use of their own knowledge, experience and practice. The organisations that were primarily involved were invited to delegate authorised representatives to the guideline working group. The guideline working group consisted of the following people:

Authorised representatives on behalf of professional associations:

- Fatiha Abdessadki, on behalf of the Dutch Nurses' Association (V&VN)
- Mujtaba Al Hadi, on behalf of the Royal Dutch Pharmacists Association (KNMP)
- Namam Ali, on behalf of the Dutch Association of Internal Medicine (NIV)
    - Member of the commission for diversity & inclusion of the Dutch Young Internist Group (JNIV)
    - Assisted by Dr Olivier Richel, senior specialist supervisor at NIV
- Leonie Fassaert, on behalf of the Dutch Society for Surgery (NVvH)
    - Assisted by Roel Bakx, paediatric surgeon at Amsterdam UMC and chairman of the NVvH guidelines commission
- Rima Fessahaye, on behalf of the Dutch Association of Social Workers (BPSW)
- Wahiba Fissoune, on behalf of the Royal Dutch Association of Midwives (KNOV)
- Petra de Jong, on behalf of the Association of Public Health Physicians (KAMG)
- Tom Kieffer, on behalf of the Dutch Society for Obstetrics and Gynaecology (NVOG)
- Heleen Koppelaar, on behalf of the Dutch Association of Psychologists (NIP)

- Peggy van der Lans, on behalf of the Dutch Society for Obstetrics and Gynaecology (NVOG)
- Carla Loman, on behalf of Royal Dutch Association of Midwives (KNOV)
- Sylvia Mennink, on behalf of the Dutch College of General Practitioners (NHG)
- Mariëlle Moonen, on behalf of the Order of Registered Interpreters and Translators (ORT&V)
- Hanneke Raven, on behalf of the Dutch Society for Psychiatry (NVvP)

Authorised patient representatives on behalf of patient organisations:

- Samira Laaboudi, on behalf of the Dutch Foundation for Intercultural Care (SGAN)
- Nazlı Lale-Kahraman, on behalf of the Dutch Foundation for Intercultural Care (SGAN)
- Esma Sabaz, on behalf of the Dutch Foundation for Intercultural Care (SGAN)

Representative on behalf of Pharos:

- Elize Smal, Dutch Centre of Expertise on Health Disparities Pharos (since February 2025)
- Anke van Dam, Dutch Centre of Expertise on Health Disparities Pharos (since 1 December 2023)
- Heleen Koudijs, Dutch Centre of Expertise on Health Disparities Pharos (from 1 January to 1 December 2023)
- Maarten Dekker, Dutch Centre of Expertise on Health Disparities Pharos (until 1 January 2023)

Based on additional expertise:

- Yordi Lassooy-Tekle, independent professional interpreter and cultural mediator

9.2.2. Project group

The project group consisted of the following members:

- Simone Goosen (project leader), initiator and campaign manager ‘Tolken terug in de zorg, alstublieft’, policy advisor and epidemiologist, on behalf of the Dutch Patients’ Federation
- Jako Burgers (chairman of the guideline working group, in a personal capacity), general practitioner, strategic healthcare advisor at the Dutch College of General Practitioners (NHG), Endowed Professor in Health and Personalised Care in Guidelines at Maastricht University, in a personal capacity.
- Aja Al-Waely, project support officer, Master’s student Care Management, on behalf of the Dutch Patients' Federation
- Miranda Langendam, assistant professor and researcher, epidemiologist and guideline methodologist, on behalf of Amsterdam UMC
- Barbara Schouten, associate professor, Amsterdam Center for Health Communication (ACHC), Amsterdam School of Communication Research (ASCoR), on behalf of the University of Amsterdam
- Nida Gizem Yilmaz, assistant professor, Amsterdam Center for Health Communication (ACHC), Amsterdam School of Communication Research (ASCoR), on behalf of the University of Amsterdam
- Liza van Lent, postdoctoral researcher, Amsterdam Center for Health Communication (ACHC), Amsterdam School of Communication Research (ASCoR), on behalf of the University of Amsterdam

9.2.3. Sounding boards

The following names have, among others, participated in the sounding boards:

- Nora Yaacoubi, outreach support assistant
- Majid Mohaved, civic integration consultant
- Nasrin Fazelpoor, intercultural social worker, family system and parenting support
- Naima Jabri, social worker
- K. Amhaouech, nurse
- Fatima Tanejjart, caregiver
- S. Boudriz, experienced caregiver
- A. El Alili, lecturer and interpreter
- Chaïmae El Addouti, manager of a health care institution
- Layla Boudriz, caregiver
- Fatiha Azzarfane, caregiver in individual healthcare
- Aziza, patient expert
- Soubiha, client/patient
- Malika El Houriria
- Fatima Oubenqaasou

Other participants prefer not to be named.

9.2.4. Other experts who reviewed this guideline

- Evert Bloemen, non-practicing doctor, worked as a senior advisor at Dutch Centre of Expertise on Health Disparities Pharos until 2022
- Markus Oei, ENT specialist, chairman of the Dutch foundation for reliable sources (Stichting Betrouwbare Bron)

9.2.5. Other contributors

The following people have supported the scientific research:

- Stefano Giani, information specialist, University Library, University of Amsterdam
- Lotte Mikkers, junior lecturer in Communication Science, University of Amsterdam
- Marieke Boschma, junior lecturer in Communication Science, University of Amsterdam
- Mirthe Zonneveld, research Master’s student in Communication Science, University of Amsterdam
- Emma di Modica, Master’s student in Communication Science, University of Amsterdam
- Jeremy Casper, undergraduate student in Communication Science, University of Amsterdam

The text was revised by Laura Jansma.

The text was translated by Marlijn Bennink, Saar Bontrup, Anaïs van Gestel and Thijn Truijen from Zuyd Vertalingen, of Zuyd University of Applied Sciences. The translation was revised by Rachel Brouder and Sarah Guckian.

9.3. Declarations of interest

The declarations of interest of the guideline working group members are available on request at the Dutch Patients' Federation, taal@patientenfederatie.nl.

9.4. Authorised parties

The Dutch Patients' Federation will keep track of and share a list of parties that have authorised the guideline, have issued a No Objection Certificate or have given administrative approval.

9.5. Publication date

Follows after the authorisation phase.

9.6. Process information about the development of the guideline

9.6.1. Establishment of the project

In 2019, the Johannes Wier Foundation for Healthcare and Human Rights made a public appeal to the Quality Board of the National Health Care Institute. The appeal was signed by more than 200 professional and interest organisations and experts. In this appeal, the Quality Board was asked to prioritise the development of a guideline for navigating language barriers in health and social care. The Quality Board, the National Health Care Institute and the Dutch Ministry of Health, Welfare and Sport supported this appeal, and ZonMw provided funding for the development of the guideline.

The Johannes Wier Foundation and the Dutch Patients' Federation discussed with stakeholders what organisation could lead the project. Due to its broad scope, it was decided that the Dutch Patients' Federation would lead the project. This organisation invited a patient organisation, a professional association for health and social care professionals, and the Order of Registered Interpreters and Translators to be part of the project and the guideline working group. The Dutch Patients' Federation was chosen based on their involvement in the Quality Board's appeal, the federation's participation in a stakeholder support meeting in 2020, and the broad representation of health and social care professionals. Dutch Centre of Expertise on Health Disparities Pharos was also invited.

In order to develop this evidence-based general guideline, the AQUA guidelines were followed (29). The process consisted of three phases: the preparation, development and closing phase. The content of the three phases is elaborated on below.

9.6.2. Preparation phase

The preparation phase started out by setting up the project group and the guideline working group. These groups consisted of relevant professional associations and organisations of healthcare users, so health and social care professionals, patients, clients and methodological experts would be able to contribute to every phase of the guideline's development.

Subsequently, the aim, target audience, scope, and methodology of the general guideline were broadly outlined during the preparation phase. It was also established what would be done during the development and closing phase. In addition, an overview was developed of existing national and international guidelines, as well as the experienced bottlenecks related to navigating language barriers and the various types of language support. The overview of types of language support was

based on a scientific publication (134) and unpublished scientific work conducted by the Department of Communication Science at the University of Amsterdam.

Before the working group started developing the guideline, the financial and other interests of the members of the project group and the guideline working group were documented through declarations of interest completed by all members.

9.6.3. Development phase

The development phase consisted of three parts:

1. Bottleneck analysis and the formulation of key questions
2. Systematic summary of knowledge and qualitative research
3. Developing the concept of the general guideline

Bottleneck analysis and formulating key questions

The results of the preparation phase, in particular the identified bottlenecks, were presented to the target audience of the general guideline during an invitational conference. The aim was to define the target audience, processes, and instruments for the general guideline more precisely, and to further supplement or refine the identified bottlenecks. The updated list of bottlenecks was presented to the guideline working group so that the identified bottlenecks could be prioritised. The project team formulated key and background questions based on the prioritisation of the identified bottlenecks. These questions were also presented to the guideline working group for prioritisation and approval. The outcomes of these steps determined the focus of the systematic summary of knowledge and the qualitative research.

Ultimately, the following three key questions were formulated, as addressed in Modules 1 to 3 of this general guideline:

1. How can health and social care professionals and support staff identify a language barrier and its extent and whether this negatively impacts the quality of care and support? (Module 1)
2. How can health and social care professionals, patients, and patients' family and friends determine which types of language support are the most suitable to assist communication? And who decides which type of language support is used? (Module 2)
3. How can health and social care professionals assess whether the communication goals are being achieved when there is a language barrier? (Module 3)

In addition, seven background questions were asked. The project group used the term 'background questions' as a working title. Answers to the background questions were incorporated throughout the guideline as informational background or supplementary content, including in the considerations. The background questions were:

- Which circumstances affect the language barrier?
- Which topics are avoided or unaddressed when a language barrier is present?
- Which contexts and situations could affect privacy, and which type(s) of language support is/are most suitable in these cases?
- Which knowledge, skills and attitude do those involved need to apply the specific type(s) of language support?
- What are the legal, professional, and ethical responsibilities of those involved regarding communication in the case of a language barrier in different contexts and situations?
- Which situations, preconditions and practical points have consequences for the feasibility and achievability of certain types of language support?

- What is needed in the education of health and social care professionals and professional interpreters to sufficiently prepare them for navigating language barriers in the medical and social context?

Systematic summary of knowledge and qualitative research

This general guideline is based on scientific evidence. This means that scientific research has played an important role in the development of it. During the prioritisation of the key questions by the guideline working group, it was determined that key question 2, concerning the determination of the type(s) of language support, forms the core of the guideline. Therefore, a search strategy was developed for this key question in collaboration with an information specialist from the University of Amsterdam, and a qualitative study was designed. The systematic review (1) was carried out based on the search strategy. The qualitative research consisted of focus groups with health and social care professionals, patients and patient representatives, professional interpreters and cultural mediators.

Based on the search strategy for key question 2, a general search strategy was formulated for key questions 1 and 3, as well as for the background questions, in collaboration with an information specialist from the University of Amsterdam. However, instead of conducting an exhaustive systematic review for all these questions, the focus was primarily placed on the availability of other (systematic or exploratory) reviews, due to the more exploratory and generally informative nature of these questions. This was supplemented with information and publications from non-scientific sources, such as grey literature, as well as the experiences and best practices of the members of the guideline working group.

Systematic review for key question 2

For the systematic review (1) in key question 2, the following PICO was applied:

- **Population;** All patients who experience a language barrier with a health or social care professional.
- **Intervention:** The types of language support that were applied before, during or after the conversation in health and social care.
- **Control group:** The types of language support that can be compared to the usual care received without language support or with each other.
- **Outcome:** The most important findings are divided into patient related, health or social care professional related and health system related outcomes. This system of categorisation was inspired by De Haes and Bensing's framework (2009) on endpoints in medical communication (115).

The search strategy was conducted in the following databases: PsycINFO, MEDLINE, Embase, CINAHL, Cochrane Library, Linguistics & Language Behavior Abstracts, Communication & Mass Media Complete, SocINDEX and Web of Science. The initial search strategy was formulated by PsycINFO and adjusted for the other databases.

Scientific publications were included in the data collection if they:

1. Were published in or after 2013;
2. Were original empirical studies;
3. Were written in English;
4. Compared the effects of the application of at least one form of language support with no language support or the application of another form of language support in health or social care;
5. Were quantitative in nature.

After removing duplicates, the search strategy resulted in 2,495 scientific publications. First, titles and abstracts were screened to determine whether a publication might be relevant for full screening. As a result of the screening process, 139 publications were reviewed in full to assess whether they met the inclusion criteria. Ultimately, 22 publications were included in the data extraction.

For these 22 publications, the ‘risk of bias’ and the quality of the evidence were assessed. To do this, the GRADE method (135) was applied.. GRADE was also used to make a ‘Summary of the findings’ table in which all of the findings were explained. Information about the study design, the population, the context, the researched types of language support, measurement moments, and the results from the 22 publications was included. The entire process was completed by two members of the project group.

The studies’ ‘risk of bias’ was acceptable. The GRADE scores however, were marked ‘very low’. This means that we have little certainty about the direction and extent of the effects.

These low scores were largely due to the fact that there were only two 'Randomised Clinical Trials (RCTs)' in the review (1). RCTs were generally seen as the ‘strongest form of evidence’. Therefore, most studies contained relatively weak evidence.

Moreover, even after grouping the outcomes (patient, health or social care professional, and system or context-related outcomes), there was sometimes only one or simply a few studies per comparison. This sometimes led us to downgrade the GRADE scores, for example because the outcomes were too imprecise (e.g., due to a small number of patients) or because the studies were inconsistent (i.e., the results varied).

A protocol describing the methodology for the systematic review was previously registered in the online database PROSPERO (136) and as a part of the whole project in the Open Science Foundation (OSF) (137). The scientific publication of this literature review has since been published with open access in *Patient Education and Counseling* (1).

Literature review for the remaining questions
Due to the more exploratory and generally informative character of these questions, the focus when formulating an overarching search strategy was on earlier, systematic or exploratory literature reviews and meta-analyses about language barriers. The search strategy featured two components, ‘language barrier’ and ‘review’, along with other related terms.

The initial search strategy was formulated for PsycINFO and Linguistics & Language Behavior Abstracts, and produced 384 results. They were then reviewed by two independent reviewers to determine which previous reviews/ meta-analyses might be relevant when answering the research questions.

Ultimately, 49 articles were identified as potentially being relevant and were used as a foundation for the current guideline, as much as possible.

Focus groups
The systematic review (1) showed that several topics had not yet been studied or had only been studied only to a limited extent. No studies were found on the effectiveness of various types of language support in social care, and relatively little is known about newer types of language support, such as cultural mediators and digital tools.

To gain an understanding of the potential to attribute of the results to other domains and to explore practical considerations in greater depth for health or social care professionals, patients, their

representatives, and professional interpreters/ cultural mediators, a total of eight focus groups were conducted: four groups with twenty health or social care professionals in total (two in medical and paramedical domains and two in the social domain); three groups involving sixteen patient representatives in total; and one involving seven professional interpreters and cultural mediators in total.

The focus groups were semi-structured, allowing space for both pre-prepared questions and for a discussion of topics that emerged during the conversations. These focus groups provided an important opportunity to pay more attention to key questions 1 and 3, for which no systematic literature review was conducted.

The focus groups were structured in three parts, those being:

1. **The ideal situation:** Ideally, how is a language barrier determined? Which combinations of language support are used and why? How can communication goals be evaluated to determine whether or not they have been achieved?
2. **Considerations and advice** What is current practice? What can be done to align the ideal scenario with current practice? What is feasible, and what is not?
3. **Format of the guideline**: What is needed in terms of the format and content of the guideline?

Participants of focus groups involving health or social care professionals and professional interpreters and cultural mediators were found through the project group's networks and via email or LinkedIn messages. Participants of focus groups involving patient representatives were found through the official patient representatives who were involved in the development of the general guideline.

These mandated patient representatives established a total of three sounding boards: one in Amersfoort, one in Amsterdam, and one in Helmond. In total, there were sixteen patient representatives on these sounding boards. All of them participated in the focus groups organised in respective cities.

Data collection took place between 14 February 2024 and 2 April 2024. Each focus group lasted 1.5 hours. The focus groups were recorded and transcribed. A codebook was developed in order to analyse the focus groups.

A protocol describing the methodology per focus group was previously registered as part of the whole project in OSF (137). A scientific publication about the focus groups is currently being prepared.

Developing the concept of the general guideline

After completion of the systematic summary of evidence and the qualitative study, the findings were summarised and shared with the guideline working group. The guideline working group was asked to think of specific advice, considerations and their wording.

During an in-person meeting, all input from the guideline working group was collected, after which the project group processed the information to make an updated list of recommendations. The input of the guideline working group was the deciding factor in determining the feasibility, quality, parity and cost-effectiveness of various types of language support and approaches.

All recommendations were incorporated into a first draft of the guideline, which was then resubmitted to the guideline working group. They were able to provide feedback on the full document, including the recommendations, both in writing and orally during an online meeting. After processing the feedback, the project group made final adjustments and prepared the guideline for commentary.

9.6.4. Closing phase

In late June 2024, a meeting was held with representatives from professional and patient organisations and those from interpreter organisations to endorse and discuss the implementation of the guideline. In mid-December, the guideline was presented to the members of the working group for approval.

In the closing phase, the general guideline was submitted for commentary, which took place between July and August 2024. Those directly involved, professional and patient organisations, experts, and stakeholders, including the Health and Youth Care Inspectorate, the Dutch Ministry of Health, Welfare and Sport, and the Dutch Association of Hospitals, were invited to provide comments on the draft guideline. The general guideline was adjusted based on the comments received and a finalised version was produced.

In addition to updating the general guideline, the project group also developed a plan to spread and implement the guideline. This plan included, but was not limited to, an overview of knowledge gaps, a proposal of an evaluation model for the general guideline, and recommendations for stakeholders regarding its implementation.

In January 2025, a meeting was organised with the members of the working group, policy advisors, and administrators of the involved organisations. During this meeting, participants provided input on implementation in small groups.

This process was initiated to ensure that the final guideline would be endorsed by the professional organisations and patient organisations directly involved in its development.

Finally, the process of project completion and accountability was carried out through a final report, a financial report, and an audit. The author will conduct this process in consultation with the project group.

10. Attachments

Attachment 1 Definitions and descriptions of terms

Types of language support

Communicating through a (limited) common language	Communicating through a language that both the health or social care professional and the patient speak to a certain extent. The extent to which speaking Dutch or another common language is possible, depends on the language proficiency of the patient and the health or social care professional, particularly in relation to the type of conversation. People who speak a language at an A2 or pre-intermediate level, such as people who have just passed their civic integration exam, can talk about simple symptoms, such as pain or an itch, in Dutch, but do not know more complex terms. They therefore require support to discuss these terms. The more important it is that someone can naturally share their story, the higher the language proficiency needs to be in order to communicate efficiently in a limited common language.
Cultural mediator (also: culture coach, key person,and in some cases: spiritual caregiver) (41)	Someone who facilitates communication between people who speak different languages and come from different cultural backgrounds. Cultural mediators provide information about culture-related values, lifestyles, beliefs, assumptions, and socio-cultural norms. They do so by clarifying culture-specific expressions and concepts that could cause misunderstandings. 'Cultural mediator' is not a registered profession in the Netherlands. This means that there is no standardised Code of Conduct and that cultural mediators do not fall under a legal, professional framework. They also do not need to take any language tests. Some cultural mediators are also sworn interpreters, and they can fulfil both roles in consultation with the consent of both the patient and the health or social care professional.
Digital tools	All digital or online programmes and applications used to navigate language barriers, both during a conversation and in surrounding moments. Digital tools are being used to translate instantaneously, unlike, for example, translated material. Some examples of digital tools are applications with domain-specific pre-translated sentences, free translation applications, in which you can enter or record whatever you want, and other forms of artificial intelligence that are not primarily intended as a translation application, but can be used as one.
Adult family member or friend who interprets or translates (21,42–44)	These can be the patient's relatives, friends or acquaintances that are being asked to interpret before or during the conversation. They will either join the conversation in person or attend over the phone. They act as the patient's representative or trusted person. They have no duty of confidentiality, do not work according to professional standards and are not bound to a professional code of conduct.
Nonverbal communication (also known as 'getting by') (45)	Communication that does not involve language, such as the use of hand gestures or drawings.

A person brought in ad hoc as an interpreter (46)	These are people that are asked ad hoc to act as an interpreter for the conversation. This could be anyone: another health or social care professional, a different staff member, or even a patient in the waiting room. They have no duty of confidentiality, do not work according to professional standards and are not bound to a professional code of conduct. **Please note:** in interpretation, the term 'ad hoc' refers to an interpreter service that was not booked in advance.
Interpreter (or: professional interpreter) (21,47–51)	An interpreter is a professional who has completed an accredited interpreter degree programme and/or passed the required exams regarding their language proficiency, interpreting skills and attitude. They also have to meet the requirements regarding annual refresher courses. Interpreters speak the language in which they interpret to at least B2 or C1 level, which is the highest level tested (see the description of language proficiency). An interpreter is impartial and neutral during the conversation, and is not allowed to add or omit information, and only mediates on a linguistic level, unless otherwise agreed upon beforehand. An interpreter is expected to accurately convey the intentions of both the health or social care professional and the patient. Interpreters that are registered with the Register of Sworn Interpreters and Translators (RBTV) must meet the quality and integrity requirements, including the legally established duty of confidentiality.
Translated material (52)	All types of written material that have been translated from Dutch into another language. This can be in printed or in digital form.
Health or social care professional that speaks the patient's native language	In the case of a language barrier, a health or social care professional may refer or transfer a patient to another health or social care professional who speaks the patient's native language. The health or social care professional that speaks the patient's native language has the same competencies and can provide the same care or support as the health or social care professional that has transferred or referred the patient. **Please note:** getting a fellow health or social care professional involved to interpret does not fall under the category of 'Health or social care professional that speaks the patient's native language', but under 'A person brought in ad hoc as an interpreter'.

Conversation types

Complex conversation (53,54)	A conversation can be complex for various reasons. It is up to the health or social care professional to decide if a conversation is complex, or is expected to be. When making that decision, consideration may be given to whether one or several of the following points apply: • The patient's health or support needs are unclear. • Several somatic, mental and/or social issues occur simultaneously. • The patient is possibly suffering from mental/ behavioural problems or anger/ aggression issues. • Detailed or complex information is being requested or shared. • Difficult decisions regarding treatment or referral are being made.

	• There is a lack of clarity surrounding the effects of the treatment or the other options available. • The patient or their representative has explicitly been asked for informed consent regarding a treatment. • The patient considers participating in a clinical trial.
Simple conversation	In this guideline, a conversation can be considered simple when it is not complex, sensitive or impactful. It is up to the health or social care professional to decide if a conversation is simple, or is expected to be.
Sensitive conversation	A conversation can be considered sensitive by the patient and/or family member or friend. Some examples of subjects a lot of people consider sensitive are sexuality, domestic violence, conflict, cancer, mental health, and the end of one's life. Some topics can be sensitive for one patient, but not for another. It is up to the health or social care professional to decide if a conversation is sensitive, or is expected to be.
Impactful conversation	A conversation is impactful when the outcome could have serious consequences to the patient and/or the adult family member or friend. These include breaking bad news, conversations that are about a surgery or heavy treatment or filing a report, for example to Veilig Thuis. It is up to the health or social care professional to decide if a conversation is impactful, or is expected to be.

General terms

Communication goals (115)	This includes building rapport with the patient, gathering information, providing information, practicing informed and shared decision-making, encouraging a healthy lifestyle, and reacting to emotions.
Communicatively vulnerable context (138)	This is the case when people experience other issues outside of a language barrier, that may complicate communication. These issues might include hearing difficulties, speech difficulties, such as vocal or articulation problems, linguistic difficulties, such as semantic impairments, or cognitive communication disorders, due to brain injury, for example.
Cultural barrier	A communication barrier that arises because two or more people have a different cultural background and do not sufficiently understand each other.
Health literacy (139)	One's ability to obtain, understand, assess, and use information when making health-related decisions. Elders, functionally illiterate people, and those with a migration background often have lower health literacy than others. In daily life, people with lower health literacy might struggle with: • taking medicine in the correct way; • navigating a hospital; • digital skills (internet searching); • understanding letters and emails; • understanding pamphlets, websites, and package leaflets; • having conversations with health or social care professionals; • understanding explanations and applying advice.
Functional illiteracy (139)	Being 'functionally illiterate' means that you do not have a good understanding of the languages which you speak. This group of people might struggle with reading, writing and/or doing maths. Many non-Dutch speakers are able to communicate in their native language perfectly fine. However, in some cases, people are also functionally illiterate in their

	native language. People who are illiterate cannot read or write because they were never taught how.
Long-term care (140,141)	Care or aid for people who require care over an extended period of time. This involves the elderly, those with chronic illnesses, disabled people or those with long-term mental illnesses. Long-term care is distinguished from curative care, which is focused on recovery and therefore distinct, and also often shorter in duration. Long-term care is partly covered by nursing homes, care homes, assisted living facilities, institutions and small-scale residential facilities.
Appropriate care (142)	Appropriate care adds value to people's lives and that incorporates the following important principles: people-focused, tenable, and sustainable. Appropriate care is established together with the patient and should place the patient at the centre, be value-driven, apply the right care in the right place, and focus on health rather than illness.
Patient, also known as client or care recipient (55)	Depending on the context, the term 'patient' refers to the client, care recipient, the patient's/ client's legal representative or to a person or citizen.
Shared decision-making (143,144)	Shared decision-making is a process in which a patient and health or social care professional discuss which type of treatment, care, or aid is most suitable. The most appropriate care depends on what matters most to someone. Shared decision-making happens in one or more conversation(s) in which the patient and health or social care professional discuss all possible options and how they might influence one's life.
Social care (56)	The sector that implements the Child and Youth Act, the Social Support Act and, in part, the Public Health Act. Municipalities and social organisations work together on health, well-being, and safety, with the aim of promoting a comprehensive approach to health and support and enabling the full participation of citizens.
Language barrier	A communication barrier that arises when two or more people do not share sufficient proficiency in the same language.
Language proficiency levels (145–149)	The level at which people understand and are able to use a language. Language proficiency levels can also be used to measure the difficulty of a text, be it written or spoken. The Council of Europe categorises proficiency into six different language proficiency levels: A1, A2, B1, B2, C1 and C2. **Beginner (A1):** At this level, people understand familiar words and very basic sentences, for example in announcements, pamphlets and brochures. They can also use the language, for example to introduce themselves, ask basic questions or explain where someone lives. They are often able to have simple conversations, as long as their conversation partner speaks slowly and clearly. When discussing very simple topics at a slow pace, such as planning an appointment, with the help of some nonverbal communication or a translation app A1 level should be sufficient. However, in most cases, those at this level will need additional language support. **Pre-intermediate (A2):** At this level, people can understand very short, simple texts and sentences. Usually, these are sentences and common expressions that discuss everyday topics. This might include reading personal letters that are relatively short and use easy vocabulary, relaying basic personal or familial information and interacting with staff in the supermarket. They can find specific and obvious information in everyday

	texts, such as pamphlets, menus, advertisements and timetables. People who have passed their civic integration exam have at least A2 level (situation in 2024). When discussing basic issues, such as headaches, a patient with A2 level should be able to manage perfectly fine, with the help of some nonverbal communication or a translation app if needed. For more complex subjects, these people will need additional language support. **Intermediate (B1):** At this level, people understand texts and conversations that use common words and cover familiar topics, such as work, school, and hobbies. If the conversation or text is on a topic they know a lot about, because,for example, it pertains to their job or their interests, they are able to use more difficult words. In personal letters or conversations, they can understand and describe wants and feelings well. 80% of Dutch people have at least this level of proficiency of Dutch, which is why it is recommended to write texts at this level. For most conversation topics, intermediate speakers are able to communicate effectively without, or with limited, language support, as long as the health or social care professional does not use complicated words. For complex topics, language support might still be beneficial in order to translate difficult terms, for example. **Upper-intermediate (B2):** At this level, people can understand articles, reports, and conversations about their own interests and area of expertise. They are able to talk about this fluently and without preparation and their conversation partners do not have to wait on them. The same goes for texts and conversations about contemporary, abstract, or concrete problems, their own opinions, and pros and cons. They can often also read contemporary literary prose. For complex or impactful topics, such as shared decision-making, it is recommended that the patient speaks Dutch on at least a B2 level. **Advanced (C1):** At this level, people can understand long, complex texts and conversations. This is the highest language proficiency level that you can achieve relatively easily through foreign language education. They understand both factual and literary texts and conversations, even if they are about a topic they are not an expert in. Sometimes they might have to reread certain passages. They can easily manage on their own in social, academic, and professional situations. They even have stylistic preferences, such as mixing up short and long sentences. Patients with a C1 level can generally manage on their own without any language support or a similar amount of support to a native speaker. **Proficiency (C2, native speaker):** At this level, people have no trouble understanding what they are reading or hearing. They can summarise information from a variety of sources, both written and oral, reconstruct arguments and write a proper report about their findings. They can express themselves fluently, accurately, and without preparation. C2 speakers can distinguish nuances in information, even in more complex situations.
Taboo subject (150)	A sensitive topic that is not discussed or is not allowed to be discussed for personal or cultural reasons. Certain subjects might be considered taboo for one patient but not for another. In certain cultures, cancer is a taboo topic, while others consider mental illnesses to be taboo.

Teach-back method (57)	A technique health and social care professionals can use to check whether or not the patient has understood the message is to ask the patient to explain in their own words what was just discussed
Healthcare (58–61)	The core of the healthcare sector consists of all providers of care focused on cure-based or long-term care and nursing. In financial terms, this mainly refers to care that is funded through the standard health insurance or the Exceptional Medical Expenses Act (AWBZ). In addition, sectors such as Youth Care, childcare, boarding institutions including asylum seekers' centres, socio-cultural work, elderly welfare, social support services, and occupational health and safety services also fall under healthcare (Statistics Netherlands, CBS) **Preventive care:** Care provided by caregivers, volunteers and family. Population-based preventive care provided by the Municipal Health Service (GGD) and youth health care also fall under preventive care. **Primary care:** Care individuals can access without a referral. This can be treatment from the GP, health or social care professional, dentist, physiotherapist, pharmacist, social worker, obstetrician, and district nurse. **Secondary care:** If primary care is insufficient and specialist care is required, health or social care professionals refer patients to secondary care. A referral from primary care is required for secondary care treatment. Secondary care includes hospital, mental health, and specialised youth care. **Tertiary care** When highly specialised care is needed for both mental and somatic health problems, patients are referred to institutions providing specialist care. This is called tertiary care.

Attachment 2 Summary systematic review

Explanation (also see paragraph 11.6.3)

For the systematic review (key question 2) the following PICO was applied:

- **P**opulation: All patients with whom a health or social care professional has experienced a language barrier.
- **I**ntervention: Strategies applied before, during, or after the health and social care consultation, with the aim of reducing the language barriers.
- **C**ontrol group: Strategies can be compared to usual care without strategies or with each other.
- **O**utcome: The most important findings are divided into patient related, health or social care professional related and health system related outcomes. This system of categorisation was inspired by De Haes and Bensing's framework (2009) on endpoints in medical communication (115).

The search strategy was conducted in the data bases: PsycINFO, MEDLINE, Embase, CINAHL, Cochrane Library, Linguistics & Language Behavior Abstracts, Communication & Mass Media Complete, SocINDEX and Web of Science. The initial search strategy was formulated by PsycINFO and adjusted for the other databases. Scientific publications were included in the data collection if they: (1) were published in or after 2013, (2) were original empirical studies, (3) were written in English, (4) compared the effects of at least one form of language support with no language support or the application of another form of language support on at least one outcome within health or social care, and (5) are quantitative in nature.

After removing duplicates, the search strategy resulted in 2,495 scientific publications. First, titles and abstracts were screened to determine whether a publication might be relevant for full screening. As a result of the screening process, 139 publications were reviewed in full to assess whether they met the inclusion criteria. Ultimately, 22 publications were included in the data extraction (13,71,72,76–86,94,98–101,106,151,152).

For these 22 publications, the 'risk of bias' and the quality of the evidence were assessed. To do this, the GRADE method (135) was applied. GRADE was also used to make a 'Summary of the findings' table in which all of the findings were explained. Information about the study design, the population, the context, the researched strategies, measurement moments, and the results from the 22 publications was included. The entire process was completed by two members of the project group.

The studies' 'risk of bias' was acceptable. All GRADE scores, however, were marked 'very low'. This means that we have little certainty about the direction and extent of the effects. These low scores were largely due to the fact that there were only two 'Randomised Clinical Trials (RCTs)' in the review. RCTS were generally seen as the 'strongest form of evidence'. Therefore, most studies contained relatively weak evidence. Moreover, even after grouping the outcomes (patient, health or social care professional, and system or context-related outcomes), there was sometimes only one or simply a few studies per comparison. This sometimes led us to downgrade the GRADE scores, for example because the outcomes were too imprecise (e.g., due to a small number of patients) or because the studies were inconsistent (i.e., the results varied).

A protocol describing the methodology for the systematic review was previously registered in the online database PROSPERO (136) and as part of the whole project in Open Science Foundation (OSF) (137). A scientific publication about this literature review is currently being prepared.

Summary of the results per comparison

Outcome	Description of results	GRADE
Comparison 1: Professional interpreter versus no professional interpreter		
Patient-related outcomes (76)	In a general inpatient rehabilitation setting, patients who received a professional interpreter during their admission (compared to those who did not) had a significantly higher Functional Independence Measure (FIM) gain (27.7±16.2 vs. 20.4±8.7; t(83)=-2.59, p=0.01).	⊕◯◯◯ Very low
Provider-related outcomes (77)	At a paediatric emergency department, the use of professional interpretation (compared to none) was associated with 7.1-fold increased odds of containing complete discharge education content, and with a 6.1-fold increased odds of a high-quality assessment of caregiver understanding (e.g., teach-back or invitation to ask questions).	⊕◯◯◯ Very low
Context-related outcomes (76,80–83)	For inpatient settings, the use of a professional interpreter (compared to not) was associated with a significantly longer length of stay (IRR=2.2, p<.001, (82); OR=1.3 and OR=1.41, (83); p=.008, (76)). For acute/ emergency care, the use of a professional interpreter (compared to not) was associated with a significantly shorter length of stay (IRR=0.58, [0.46-0.74], p<.0001; (82)), and better quality of care (i.e., defect-free stroke care was 73.9% versus 61.5% respectively, p=.04, (81)). For emergency departments and inpatient wards, there was no association between professional interpreter use and readmission rates (82,83). In primary care, using a professional interpreter (compared to none) could possibly save healthcare costs, reduce consultation length, and improve quality of care (80).	⊕◯◯◯ Very low
Comparison 2: Professional interpreter versus ad hoc/ informal interpreter		
Patient-related outcomes (78)	Caregivers (e.g., parents) of general paediatrics inpatients (78) more often (p=.01) reported to be completely aided in their understanding of their child's medical condition when they used a professional interpreter (i.e., video 100%, or live 93%) compared to an informal interpreter (e.g., medical student 56%, or family member 71%).	⊕◯◯◯ Very low
Provider-related outcomes	N/A	N/A
Context-related outcomes (86,94)	In primary care visits (86), patient-rated quality of interpretation was significantly higher for professional video-conferencing interpretation (M=4.0, p<.05) compared to in-person professional interpretation (M=3.4) and to ad hoc interpretation (M=3.4). The odds of inaccurate interpretation were higher for ad hoc interpretation (54%, p<.001) compared to in-person professional interpretation (16%) and to video professional interpretation (16%). The odds of moderately/ highly clinically significant errors did not differ significantly between ad hoc (8%), in-person professional (3%) and professional videoconferencing (7%). An adjusted model showed that the odds of inaccurate interpretation were significantly lower for professional in-person and video-conferencing versus ad hoc interpretation. Routine post-discharge surveillance of patient outcomes after knee/ hip surgery (94), showed that the assessments (e.g. of satisfaction, success, complications) made by informal interpreters (e.g. family or carers) versus those made by professional interpreters (i.e. in a cross-over study with a second follow-up call within 2 weeks) had substantial to excellent inter-rater agreement. Only one outcome resulted in a slightly higher score when the first call was made with a professional healthcare interpreter.	⊕◯◯◯ Very low
Comparison 3: Interpreter modalities (in-person versus video versus telephone)		
Patient-related outcomes (78,79,84)	In the context of paediatrics, video and in-person interpretation led to better parent comprehension than telephone interpreters (i.e., 100% video and 93% in-person, vs. 50-58% telephone, p=.01 (78), 75% video vs. 60% telephone, p=.03 (79)). Similarly, parents were more satisfied with iPad/ video interpretation (86%) compared to telephone interpretation (38%, p=.005 (78)). Patients at a travel and immigrant health clinic also most often rated videoconferencing as much better (82%) than telephone interpreting, whereas videoconferencing was mainly rated the same (58%) as in-person interpreting (84).	⊕◯◯◯ Very low
Provider-related outcomes (84,85)	The communication behaviour of providers did not differ significantly between video and telephone interpretation (85). Providers were more likely to be satisfied with video interpretation compared to telephone interpretation (85), and rated this generally as much better (88%) than telephone interpretation (84). Providers rated in-person interpretation as the same (54%) or much better (40%) than video interpretation (84).	⊕◯◯◯ Very low
Context-related outcomes (79,85,86)	At a paediatric emergency department (79), mean charges per patient for video interpretation were twice those for telephone interpretation ($61 vs $31, P<.001), but the ED charges did not differ significantly between the groups, nor did the duration in minutes of remote interpretation. In terms of translation quality, there were generally no significant differences between the rated quality of telephone and video interpreters (79,85). Still, parents at an ED reported more lapses in telephone interpretation, though overall levels were low (8% telephone vs. 2% video, p=.04, (79)). For primary care visits, patient-rated quality of interpretation was higher for videoconferencing compared to in-person interpreters (M=4.0 vs. M=3.4, p<.05, (86)), but the odds of significant errors did not differ significantly.	⊕◯◯◯ Very low
Comparison 4: Digital translation tools (versus each other, or versus human interpreter/ translator)		
Patient-related outcomes (100,101)	For emergency medical services (EMS; (100)), 86-92% of LEP individuals reported that QuickSpeak (i.e., an EMS domain-specific fixed-sentence tool) compared to Google Translate more often helped them to	⊕◯◯◯ Very low

	understand EMS personnel's questions (86-92% vs. 25-29%), to respond or speak to EMS personnel (75-79% vs. 25-43%), and to facilitate communication with EMS personnel (79-100% vs. 14-42%). In the context of nursing and allied health for older people (101), patients rated the overall ease of use of CALD Assist, TalkToMe, and Google Translate as moderate (median 4,5-5,0; range 0-10), with TalkToMe and Google Translate receiving higher ratings. Satisfaction with these apps was high (median 3,5-4,0; range 0-5). However, satisfaction was highest for CALD Assist and TalkToMe, which both contained preset health phrases.	
Provider-related outcomes (100,101)	EMS personnel (100) stated that QuickSpeak helped them to get the information needed more often than Google Translate (76% versus 59%), and that it helped them with communication more often (94% versus 59%). Besides, the usability of QuickSpeak (M=65.3, SD=13.7) was rated significantly higher (p=.04) than that of Google Translate (M=48.4, SD=25.6). In the context of nursing and allied health for older people (101), healthcare staff perceived the overall ease of use of CALD Assist (M=9.0, 7-10), TalkToMe (M=8.0, 1-10) and Google Translate (M=7.5, 4-10) as high. Satisfaction with CALD Assist (M=4.0, 3-5), Google Translate (M=3.5, 2-5), and TalkToMe (M=3.0, 2-4) was also high. In both cases, CALD Assist (which contained preset health phrases) received the highest ratings.	⊕◯◯◯ Very low
Context-related outcomes (98,99,152)	In terms of translation quality, iTranslate (98) was generally similarly accurate (i.e. in terms of fluency, adequacy, meaning, and severity) to human translators on simple sentences. However, iTranslate made more errors when translating difficult sentences. Similarly, messages translated by Google Translate were generally understood equally well as those translated by a professional interpreter (99), with the exception of determining the status of symptoms, for which clinicians' responses were more often correct, and they were more confident in responding when a professional interpreter translated the messages. In the evaluation of free iPad-compatible language translation apps (152), CALD Assist and TalkToMe (both containing preset phrases and related specifically to healthcare) were considered most suitable by clinical researchers. Google Translate, Microsoft Translator, MediBabble Translator, Universal Doctor Speaker, Canopy Speak, SayHi Translate, TripLingo, and Naver Papago Translate were considered to have low suitability.	⊕◯◯◯ Very low
Comparison 5: Interpreter versus Shared (second) language between patient and provider		
Patient-related outcomes (13,71,72)	There were no significant differences in number of attempts by diabetes patients in primary care to check their understanding between interpreted and same-language consultations (71). When a shared (second) language is used compared to an interpreter, patients generally talked more in general as well as about a diversity of topics. Patients with cancer (72) used five times as many partnership/ facilitation statements in (Spanish or English) same-language consultations compared to professionally interpreted consultations (M=14.9 and M=15.1 versus M=3.82, resp.). Besides, in same-language consultations compared to professionally interpreted consultations, patients in radiation oncology (13) produced more words (p<.001), asked more open- and closed-ended questions (p=.01), and used more statements on history telling (p<.001) and unprompted speech (p<.001). Similarly, diabetes patients in primary care (71) talked more about medical issues unrelated to diabetes (p=.023), their own ideas about the workings of their bodies or of health and illness (p<.001), and they were less involved in evaluation and information about diabetes-related clinical parameters p<.001). In terms of satisfaction, radiation oncology patients (13) were more satisfied with same-language compared to professionally interpreted consultations, for instance with their care in general (p=.007), with technical quality (p=.005), interpersonal manner (p=.004), communication (p=.018), time spend (p=.028), with their physician in general (p<.001), with accessibility (p=.056), and physician empathy (p<.001).	⊕◯◯◯ Very low
Provider-related outcomes (13,71,72,77)	Regarding providers' communication, using an interpreter compared to having a shared (second) language showed mixed results. Compared to interpreted consultations, the frequency of provider statements in same-language consultations related to: … psychosocial/ lifestyle information were higher (72) … positive talk were higher (72) … emotional talk/ feelings were higher ((72); p=.037, (71)) … partnering/ activation were higher ((72); p<.001, (13)) … humour were higher (p=.005, (71)) … patients' lifeworld were higher (p<.001, (71)) … (mis)understanding did not differ significantly (71) … number of questions did not differ significantly (71) … health education did not differ significantly in two studies (13,71), but led to a higher increased odds of containing complete discharge information in another (77) … history verification were higher (p=.01, (13))	⊕◯◯◯ Very low
Context-related outcomes (13,71,72)	Consultation length did not differ significantly between interpreted and same-language consultations (13,71,72)	⊕◯◯◯ Very low

Comparison 6: Other (preparatory materials)		
Patient-related outcomes (151)	In comparing an ACP (in full) directive in patients' mother tongue (only) with the ACP directive AND the online PREPARE program (i.e., a multilingual, patient-directed, interactive, online ACP program) for Spanish-speaking primary care patients (≥55 years with ≥2 chronic/ serious illnesses), there were no adverse events, depression and anxiety scores at 12-months did not differ, nor did patients' ease-of-use and satisfaction. Only patients' ACP engagement was higher in the PREPARE arm (p<.001).	⊕◯◯◯ Very low
Provider-related outcomes (151)	In comparing an ACP directive in patients' mother tongue (only) with the ACP directive AND the online PREPARE program, the increase in ACP documentation by the provider was higher in the PREPARE arm (98.1% vs. 89.5%).	⊕◯◯◯ Very low
Context-related outcomes (106)	Women (50-75 years) due for their 2-yearly screening mammography who received a reminder letter in their native language (i.e., Italian or Arabic) compared to English (i.e., usual care), did not differ significantly in booking a screening appointment within 14 days (37.4% versus 38.9%). Women who were under-screened (i.e., ≥27 months since last screening) who received a reminder telephone call in their native language compared to no phone call (i.e., usual care), significantly more often booked a screening appointment within 14 days (64.2% versus 6%).	⊕◯◯◯ Very low

Attachment 3 Summary of the focus groups

Health and social care professionals from medical and paramedical domains.

Ideal situation

Ideally, health and social care professionals know which languages the patient speaks, and how well they speak them, before the conversation, and whether there is a language barrier that makes it difficult to provide proper healthcare. Health and social care professionals tend to prefer having a professional interpreter, who has been arranged in advance, present during the conversation or an app that guarantees an accurate translation in many languages. Ideally,
the patient will also know how the Dutch healthcare system works. It may be helpful to assign a case manager to the patient, who will serve as the point of contact for both the patient (e.g. when scheduling appointments) and the health or social care professional (to relay information to the patient).

Current practice

An ideal situation can be difficult or sometimes even impossible to achieve due to limited time and high costs. Currently, efforts are being made to find ways to overcome the language barrier, and health and social care professionals identify and use various approaches to achieve this.

- Health and social care professionals often use digital tools such as Google Translate and SayHi. For relatively simple conversations, these approaches can often be especially effective.
- Colleagues who speak certain languages are asked to interpret or, if necessary, take over the patient's care. Sometimes it helps if even the first conversation is between a patient and a health or social care professional who speaks the patient's native language.
- A patient can bring an adult family member or friend to interpret, which does occur in some situations and can work well, although questions remain regarding the extent to which information is translated accurately. Generally, health and social care professionals agree unanimously that they do not want to use children as interpreters, although in a very limited number of situations some participants still consider this acceptable if no other solution is available at the time, for example, if a child is picking up medication for a parent. A conversation may take a different turn than anticipated, which can be challenging when an adult family member or friend is acting as the interpreter.
- Health and social care professionals feel it is possible to use in-consultation strategies in combination with providing translated materials, like using Google Translate to translate information from thuisarts.nl and giving it to patients to take home. This could also apply to visual aids. It is important that the patient can read or brings someone with them who can.
- The teach-back method can be used to check whether everything has been explained clearly. Adult family members and friends can also provide input on what has and has not been properly understood.
- Health and social care professionals do not know the 'cultural mediator'. However, they do sometimes use a spiritual counsellor in supplemental conversations, where the counsellor discusses certain choices with the patient. Health and social care professionals also see the added value in this. The cultural mediator is mainly seen as useful in situations where a summary rather than a literal translation is sufficient and where differences in healthcare systems can be better explained. The cultural mediator is also useful as they can respond more flexibly and proactively than a professional interpreter, who provides a literal translation.

Considerations and advice

- Therefore, it is important to not only ask whether someone speaks a language, but also whether they can read and write in that language. It is helpful to record this in the patient record.

- It can help to visualise the information, for example by asking the patient to send a photo, which is a word that is generally well understood regardless of language, but also by providing tools such as communication cards, instructional videos, or demonstrating actions (e.g. in physiotherapy).
- It is often preferable to see someone in person instead of speaking to them over the phone.
- In some consultations, a professional interpreter is required, for example in consultations involving advice or discussions about treatment. This also applies to certain topics, such as palliative care/ end-of-life care, or sensitive subjects. In psychiatry, it is preferable that the interpreter be physically present. Since nonverbal communication is so important, using an adult family member or friend as an interpreter or relying on other strategies is not sufficient in these cases.
- In fact, all cases involving a language barrier require additional time for the consultation. It may help to explore ways to make unplanned care more predictable, for example by seeing the patient at the end of the consultation session or the following day and arranging a professional interpreter for that specific time, or to use waiting time for other purposes, for example by seeing other patients until the interpreter becomes available, using the extra time for assessments, or managing with 'getting by'.
- It is helpful when health or social care professionals have more time, when the quality of the interpreter is satisfactory, when patients can be given written information to take home, and when multiple health or social care professionals within an organisation speak different languages.
- If a patient uses certain terms, it is helpful to use the same words, for example, if a patient refers to a form as a 'paper,' it can help to use that term as well.
- The wishes and needs of the patient are the most important.

Format of the guideline

- Concise, straightforward, and practical.
- A brief summary and a flowchart are useful, along with more extensive online versions that provide additional up-to-date explanations.
- General advice for how to handle specific conversations, like sensitive topics, is also quite useful.
- It helps to provide a summary card and/or training for assistants, particularly in terms of planning and organisation.
- Health or social care professionals, including assistants, can best be reached through professional associations.

Social care professional

Ideal situation

One cannot be denied care or treatment due to lack of language skills. The patient's support questions, needs, and preferences come first, and it is important that health and social care professionals have the option to involve professional interpreters to ensure high quality communication and confidentiality, preferably someone who is also able to interpret cultural context.

Current practice, considerations and advice

- In some situations, overcoming the language barrier is not sufficient, as there may also be a cultural barrier (e.g. a 'culture shock' experienced by someone who has only recently arrived in the country and is not yet familiar with the healthcare system).
- The more complex the situation (e.g. conflict situations, formal decisions/ orders, etc.), the more preferable it is to involve a cultural mediator.
- It is important to clearly understand someone's expectations and situation in advance.

- After treatment, it may be helpful to have someone who was not involved in the treatment and preferably speaks the patient's language to check how satisfied the patient was with the care and consultation.
- There may be situations in which the patient has a preference, or where the situation is so complex (e.g. a breach of trust) that the use of a professional interpreter is not appropriate. In those situations, it might be helpful to use a telephone interpreter, avoid mentioning names, and to use an interpreter from a different location or area in order to create distance and therefore a more comfortable situation for the patient.
- In some cases, it can be helpful if an adult family member or friend is present to provide additional context that the patient may have forgotten to mention. In other cases, it is not desirable for patients to bring an adult family member or friend to the consultation, for example when the patient is a minor the burden should not be placed on them, or in cases of domestic violence where the adult family member or friend cannot be trusted to interpret everything accurately.
- These groups often manage to use a professional interpreter, and sometimes even a preferred interpreter.
- Limited interpreter availability makes it more difficult to achieve an ideal situation.
- Limited funding and differences between municipalities, where some provide reimbursement and others do not, as well as differences between youth and adult care, where funding is provided either through municipalities or health insurance, make it more difficult to achieve an ideal situation.
- It creates challenges when interpreters/ interpretation services are accessible in different ways, and can sometimes make arranging an interpreter time-consuming.
- Digital tools can be a solution for simple conversations, such as scheduling an appointment, or for conversations via Whatsapp. During the conversation itself, however, especially when discussing more difficult subjects, this is not an option.
- The same applies to the informal interpreter.
- Situations in which a professional interpreter is essential include Veilig Thuis cases and group settings, where it is also necessary for the interpreter to be physically present.
- When working with an interpreter, half of your allotted minutes, such as those reimbursed by the health insurer, are spent on interpretation.
- Preferences or wishes of the patient are the most important.

Format of the guideline

- Decision tree/ flow chart
- Easy and well-organised what is best to apply in a given situation
- As visual as possible, such as pictograms
- Include more information on the back, about conversation techniques, for example
- It is also important to clearly communicate the severity of language barriers at the policy level
- A single telephone line for arranging an interpreter that is available at all times.
- A matrix showing, for example, which topics are sensitive for which cultures

Patient representatives

Ideal situation

Ideally, the extent of a language barrier should be identified before the first appointment. This is an important job for receptionists and assistants. While scheduling an appointment, these staff members should ask a patient what languages they speak and whether they need a professional interpreter present or whether it might be possible for them to bring along an adult family member or friend to interpret. Receptionists or assistants can remain alert to this, when someone calls on behalf of the patient to schedule an appointment.

It would be best if, during the conversation, there is a health or social care professional present who speaks the patient's native language. It is considered sufficient if the health or social care professional speaks the same language as the patient/client, sharing a country of origin is not as important. However, the use of a health or social care professional who speaks the patient's native language is not feasible in all cases. This translation option is therefore seen as equally effective to a professional interpreter. Ideally, patients would want professional interpreters in all cases. Men prefer male interpreters and women female interpreters. In the case of a telephone interpreter, however, gender does not matter for some patients. Lastly, an educator in the immigrants' own language and culture (VETC-er in Dutch), which is similar to a cultural mediator, is highly desirable.
Situations in which patient representatives believe a professional interpreter is needed include initial consultations/ conversations, discussions about treatment, mental health, or sensitive/ taboo topics, such as 'feminine topics', Veilig Thuis situations, addiction or cancer.

Ideally, at the end of the conversation, the health or social care professional would ask the patient to explain what has been discussed and whether or not they have understood everything.

Current practice, considerations and needs
In current practice, assigning a health or social care professional who speaks the patient's native language is not often feasible, and professional interpreters or VETC-ers are generally not engaged. Patients and their representatives indicate that they have no choice and, by default, bring an adult family member or friend, because otherwise no other option is offered by the health or social care professional. As a result, there is no time to consider options. Generally, 'whoever has the time' is the one who accompanies the patient to the appointment to interpret. In some cases, this means that the patient has to beg multiple people to come with them to interpret. Most patients are not comfortable bringing an adult family member or friend along, and adult family members or friends themselves often prefer not to come to appointments because of their busy schedules, for example. Sometimes, the adult family member or friend acting as an interpreter are not trusted, because, for example, the interpreter is a woman or because trust is placed only in those who 'wear a white coat,' such as doctors.

Other points mentioned included:

- Patients and their representatives indicated that they do not believe that health or social care professionals are unwilling to engage an interpreter in all cases, but that it would help if they offered to arrange an interpreter and, if necessary, schedule a longer follow-up appointment to accommodate this.
- Sometimes a combination of an adult family member or friend and a professional interpreter is used and has been known to be helpful.
- When an adult family member or friend is involved, it is important to remember that the patient and the adult family member or friend do not always fully understand each other. Such as a grandchild not having sufficient proficiency in the language of their grandmother or grandfather.
- It is often preferable if the person accompanying the patient, such as an adult family member or friend, is familiar with the patient's situation, and, for example, their medication use. However, even in such cases, adult family members or friends should not be relied upon, and so professional interpreters are needed.
- For relatively simple matters, such as scheduling an appointment, it is also acceptable to use an ad hoc interpreter or to use a digital tool.
- For important matters, it is not acceptable to use an ad hoc interpreter. This could affect the privacy of the patient.
- Digital tools are also not sufficient in important matters, due their superficial nature and errors in translation. Many patients, particularly older patients, have limited digital skills.

- Google Translate is not a suitable solution for languages such as Arabic, which have may different dialects.
- Patients generally prefer to receive written information in their own language, but it is also important to remember that there are patients, such as older people, who are not able to read or write. A recorded message would work better for them.
- Communicating through gestures/ sign language should never be the sole solution for navigating a language barrier, but it can be helpful.

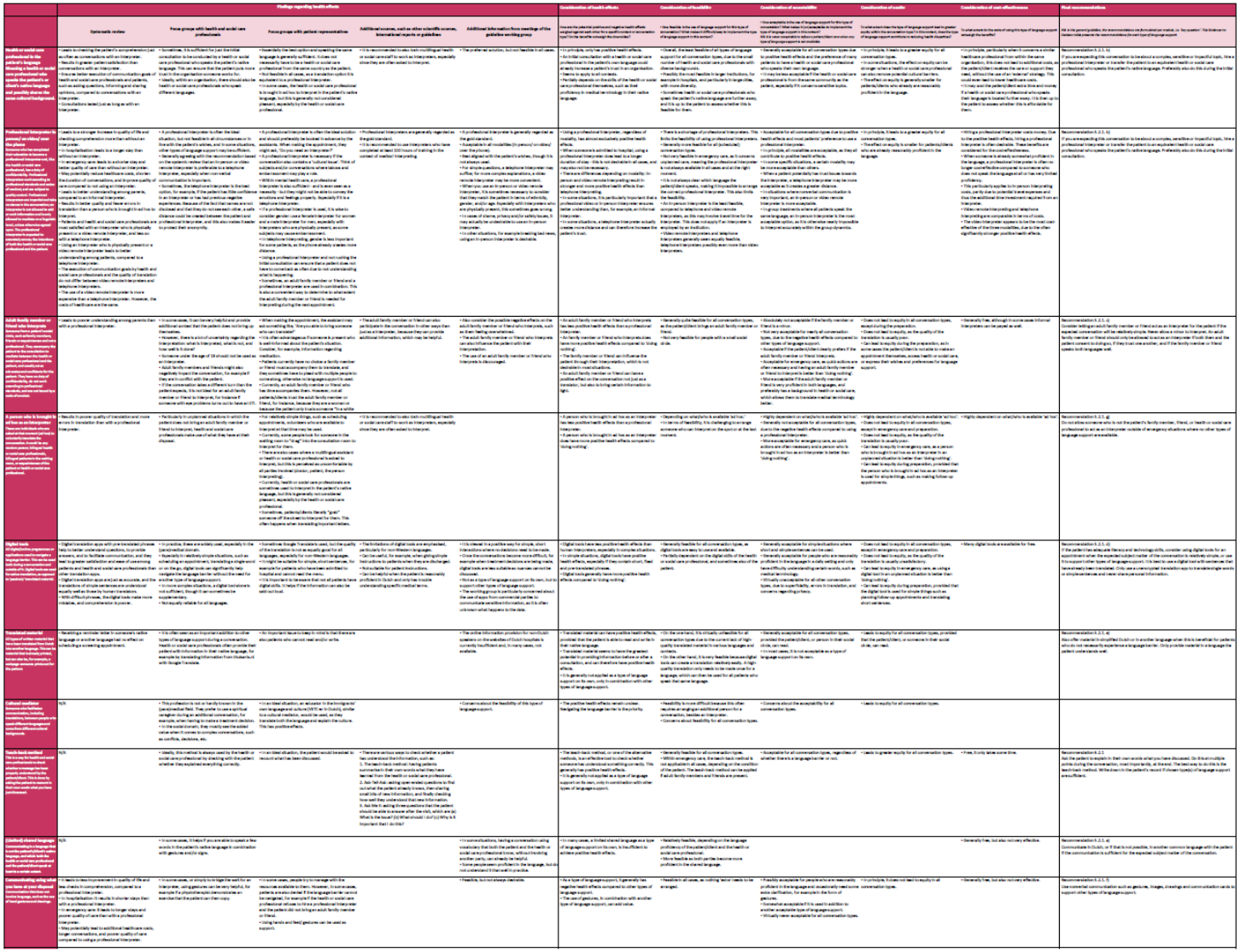
Format of the guideline

- Concise and to the point.
- Simple words.
- Pocket-size written cards are useful because they can be carried in wallets.
- Decision tree/ flow chart, in which non-essential information can be omitted.
- In multiple languages.
- Sometimes it is also helpful to provide educational videos. It is generally helpful to include a patient/ client education section in the guideline. This can be about the professional interpreter's duty of confidentiality.

Attachment 4 Evidence-to-decision table

See next page.

Evidence-to-decision (zoom in on the details)



Attachment 5 Mail National Health Care Institute about the funding of interpreters [original e-mail in Dutch]

From: [redacted]@zinl.nl>

Sent Thursday, 11 January 2024, 14:25

To: Goosen | Patient federation; Linda Daniels | Patient federation

CC [redacted]

Subject: Language barriers in health and social care

Dear Simone and Linda,

On 17 October 2023, a meeting took place between the Patient Federation and the National Health Care Institute on the progress of the language barriers in health and social care project. During that meeting you reiterated your request for an official statement by the National Health Care Institute about the scope of our indication from 2020 (Position Interpretation Services for Non-Dutch Speakers in the Mental Health Care Sector).

Our position states that an interpretation service that insured persons are entitled to in the context of the Health Insurance Act (Zvw). This should answer the posed question.

However, that does not indicate that the cost of an interpreter cannot be financed by the Zvw. According to the Dutch Healthcare Quality, Complaints and Disputes Act (WKKGZ) and the Medical Treatment Agreement Act (WGBO), health and social care professionals must provide proper healthcare by acting in accordance to their responsibilities resulting from the professional standard. Providing proper care implies that the health or social care professional and the patient are able to communicate adequately in a language they both understand. If hiring a professional interpreter is necessary to provide proper healthcare, the necessary costs shall be taken into account in regards to funding.

However, this is not a matter of solely clarifying details, but a matter of funding, which falls under the jurisdiction of the NZa. For example, a temporary arrangement has now been put in place for interpreter services in maternity care and GP care. The quality standard being developed by parties serves an important role in this process. The basic principle of funding is that healthcare and the associated services are being funded through the relevant healthcare laws. In order to link the domain with funding possibilities, it is important that the Quality Standard clearly defines in which situations, and in which care sectors, a professional interpreter is needed.

I trust that this offers a sufficient reply to your request for a statement regarding the scope of the 2020 clarification.

Kind regards,

[redacted]

[redacted]

[redacted]

.....

Team Pakket en Kwaliteit

Sector Care
National Health Care Institute
Willem Dudokhof 1 | 1112 ZA | Diemen
Postbus 320 | 1110 AH | Diemen

.....

[redacted]
http://www.zorginstituutnederland.nl

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Proper healthcare is ensured
Not more than is needed and not less than is necessary

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