

Midwives unable to overcome language barriers in prenatal care

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ABSTRACT

BACKGROUND: the present study aims to explore to what extent midwives experience barriers in providing information about prenatal screening for Down syndrome to women from diverse ethnic backgrounds, and to assess their competences to overcome these barriers.

METHODS: midwives from 24 Dutch midwifery practices in Rotterdam completed a structured web-based questionnaire (n=57). Data were obtained on perceived ethnic-related differences and barriers in providing information on prenatal screening, preparedness to provide cultural competent care, and the use of translated materials and professional translators. A group interview was conducted to further explore the results emerging from the questionnaire (n=23).

RESULTS: almost all midwives (95%) experienced barriers in informing women from non-Western ethnic backgrounds about prenatal screening. Midwives especially felt incompetent to provide information to pregnant women that hardly speak and understand Dutch. In total 58% of the midwives reported that they never used translated information materials and 88% never used professional interpreters in providing information on prenatal screening. The main reasons for this underutilization were unawareness of the availability of translated materials and unfamiliarity with the use of professional interpreters.

CONCLUSIONS: although language barriers were reported to be the main difficulty in providing cultural competent care to patients from diverse ethnic backgrounds, only a minority of the midwives used translated materials or professional interpreters. In order to enable all pregnant women to make an informed decision whether or not to participate in prenatal screening, midwives' competences to address language barriers should be increased.

Key words: Language barriers, Cultural competence, Prenatal screening, Professional interpreters

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INTRODUCTION

Health care professionals in today's multicultural societies are increasingly

confronted with patients from different ethnic and cultural backgrounds. This diversity has implications for health care systems and the professionals working in various fields of health

care. Cultural differences for example often lead to a poor mutual understanding between patients and providers and low compliance to medical treatment (1, 2). Not only the cultural background, but also the social context that patients live in is of importance in health care. Patients from ethnic minority groups often have a lower income and experience more stress and less control in their lives (3). Moreover, due to language barriers and low health literacy, patients from ethnic minority groups often face great difficulties in understanding health information, communicating their health problems, participating in decision-making and navigating the health care system (4-8). These issues have led to a movement towards cultural competence in health care to prevent further increase in ethnic disparities in health and health care (9). Cultural competence has been described as the ability of health care organisations to meet the needs of diverse populations and the ability of the health care professional to bridge cultural differences to build an effective relationship with a patient (10). Cultural competence interventions at clinical level have been described as efforts to enhance health care professionals' knowledge of the relationship between socio-cultural factors, health beliefs and behaviours, and to equip health care professionals with the tools and skills to manage these factors appropriately (9).

Midwives in Rotterdam, the second largest city in the Netherlands, have a patient population that merely consists of pregnant women from non-Dutch ethnic background, most of them originating from non-Western countries such as Africa, Turkey, and Caribbean countries (Surinam, the Dutch Antilles and Aruba). Since 2007, midwives are legally obliged to offer all pregnant women information about the options for prenatal screening for Down syndrome at the booking visit (11-13). Our previous study among pregnant women in Rotterdam showed that those from Dutch, Turkish and Caribbean (Surinamese) ethnic background (n=270) reported that the midwife is the prime source of information about prenatal screening for Down syndrome (14). The goal to inform pregnant women and their partners about prenatal screening is to enable them to make an informed decision whether or not to participate in prenatal screening, which is hardly reached among ethnic minority groups in various countries (15, 16). The information on prenatal screening is difficult to convey and the decision-making process generally is very complex. Our previous study showed that only

5% of the women from Turkish background and 26% of women from Caribbean background made an informed decision whether or not to participate in prenatal screening for Down syndrome, compared to 71% of the women from Dutch ethnic background. These ethnic differences could to a large extent be attributed to differences in educational level and language barriers (14, 17). The present study aims to explore to what extent midwives experience barriers in providing information about prenatal screening for Down syndrome to women from diverse ethnic backgrounds, and to assess their competences to overcome these barriers.

METHODS

Population and data collection

The study population consisted of midwives from midwifery practices that were part of the *Verloskundige Kring*, the local society of midwives in Rotterdam, the Netherlands. This society consists of 24 independent practices with about 85 midwives working in partnership in each practice. Practically all midwifery practices (>95%) in the geographical area of Rotterdam are part of this society. In July 2008, representatives of the practices received information about the study and were asked whether they would participate in the study. After permission, all midwives were invited to participate in the study via an e-mail letter, including a link to the web-based questionnaire. If necessary, up to five e-mail reminders were sent to each midwife, supported by telephone calls to the midwifery practices.

To further explore some of the results emerging from the web-based questionnaire, the chairwoman of the society of midwives was contacted to organize a group interview at one of the meetings of the local society of midwives. The group interview was lead by the researcher (MF). A question route was developed on the basis of the findings from the questionnaire. The discussion was audio-taped and later summarised and categorized per topic.

Measures

Background characteristics of the midwives were measured by multiple-choice items. Religiosity was measured by the question whether or not the

midwife counted herself among a certain religion. Ethnic background (Western or non-Western) was assessed by country of birth of the midwife and her parents, which is in accordance with the definition applied by Statistics Netherlands: i.e. someone is considered to be of non-Western ethnic origin when at least one of her parents was born in Turkey or countries in Africa, South America or Asia. Someone is considered to be of Western ethnic origin when at least one of her parents was born in Europe (excl. Turkey), North America, Oceania, Indonesia or Japan (18). Attitude towards routinely offering prenatal screening to all pregnant women was measured by one item on a scale from 1 ('totally against') to 5 ('totally in favour').

Ethnic-related differences in the provision of information were assessed by twelve items. Two dichotomous items assessed whether midwives always offer information women regardless their ethnic background and age and explored reasons for not offering information by two open ended questions. Ten items assessed to what extent midwives offer information to: non-Western women who hardly speak Dutch versus those who have no language barriers; non-Western women who are religious versus those who are not religious; non-Western women who have a low versus high educational level; Dutch women who are religious versus not religious; and Dutch women who have a low versus high educational level. Cronbach's alpha of these 10 items was 0.86.

Barriers in providing information to women from non-Western ethnic backgrounds were measured by the question how often midwives experienced specific barriers in providing information about prenatal screening to women from non-Western ethnic backgrounds. Response options ranged from 1 ("never") to 4 ("always"). A second multiple-choice item with multiple answers was provided to assess the reasons for these barriers.

Preparedness to provide cultural competent care was assessed by three items on how prepared midwives believed themselves to be in providing information to women from different cultural backgrounds, women who hardly speak and understand Dutch, and those whose religious beliefs influence the decision-making process. Responses were measured on a scale ranging from 1 ("very unprepared") to 5 ("very well prepared"). These items were adapted from a previous study on preparedness in cross-cultural care (19).

The use of translated written materials and professional interpreters was measured by two

items on the extent of using translated written materials and professional interpreters in case of language barriers. The items were rated on a scale ranging from 1 ("never") to 4 ("always"). Reasons for not always using translations and interpreters were measured by two multiple-choice items with multiple answers and further explored in a group interview that was held at the meeting of the local society of midwives (this was attended by 23 midwives).

Analyses

Descriptive statistics were used to summarise background characteristics of the population, provision of information to Dutch women and women from non-Western ethnic backgrounds, and the use of translated written materials and professional interpreters.

Univariate analysis of variance (ANOVA) was used to test differences in mean experience of barriers and mean cultural competence between religious and non-religious midwives, midwives with Dutch and non-Western ethnic backgrounds, midwives with a higher or lower number of non-Western clients, and midwives with a positive, neutral or negative attitude towards routinely offering prenatal screening. Differences in the use of translated materials and professional interpreters were tested by chi-square tests.

RESULTS

Response and background characteristics of the population

All 24 midwifery practices of the local society of midwives participated in the study, which constitutes about 95% of the midwifery practices in the Rotterdam area. A total of 73 midwives were sent an invitation by e-mail: 57 midwives, from all 24 practices, actually filled in the web-based questionnaire (response rate 78%). In total 23 midwives, from 19 midwifery practices, participated in the group discussion. Table 1 presents their background characteristics.

Ethnic-related differences in the provision of information

Fifty midwives (88%) reported that they always offer information about prenatal screening

TABLE 1

| CHARACTERISTICS OF THE MIDWIVES (N=57) | | |
|---|-------------|----------|
| | MEAN (SD) | N (%) |
| AGE (IN YEARS) | 38.5 (10.8) | |
| SEX | | |
| Male | | 0 (0) |
| Female | | 57 (100) |
| RELIGIOUS | | |
| Yes | | 35 (61) |
| No | | 22 (39) |
| ETHNICITY | | |
| Western | | 48 (84) |
| Non-Western | | 9 (16) |
| WORKING PRACTICE | | |
| Solo practice | | 2 (3) |
| Group practice | | 55 (97) |
| YEARS OF EXPERIENCE | 12.8 (8.8) | |
| NUMBER OF BOOKING VISITS PER WEEK | | |
| <5 | | 24 (42) |
| 5-10 | | 29 (51) |
| >10 | | 4 (7) |
| NUMBER OF NON-WESTERN COUNSELEES | | |
| Minority | | 18 (32) |
| Half | | 19 (33) |
| Majority | | 20 (35) |
| ATTITUDE TOWARDS ROUTINELY OFFERING PRENATAL SCREENING | | |
| Positive | | 39 (68) |
| Neutral | | 12 (21) |
| Negative | | 6 (11) |

to every pregnant woman regardless of their ethnic background, language skills, religious beliefs, age or educational level. Seven midwives (12%) reported that they do not always offer information when women hardly understand and speak Dutch. Three of them also reported that they generally offer information to less than half of the religious women, regardless of their ethnic background.

In total, 46 midwives (81%) reported no ethnic-related differences in providing information. Nine midwives (16%) reported to give less and two midwives (3%) reported to give more information about choices and consequences of prenatal screening to non-Western than to Dutch women. One of them reported to give more information but less advice on participation to non-Western women.

None of the other midwives reported any differences in giving direct advice or a personal opinion on whether or not to participate in prenatal screening.

Difficulties in informing women from non-Western backgrounds and cultural competence

Table 2 shows that almost all midwives (95%) experienced barriers in informing women from non-Western ethnic backgrounds about prenatal screening. Lack of translated materials, lack of time during the booking visit, and the generally lower educational level of the women were the most frequently mentioned reasons for these difficulties. No significant differences in mean experience of barriers were found regarding religion, ethnic

TABLE 2

| BARRIERS IN INFORMING WOMEN FROM NON-WESTERN ETHNIC BACKGROUNDS, AS REPORTED BY THE MIDWIVES (N=57) | |
|---|---------|
| | N (%) |
| EXPERIENCES BARRIERS | |
| Never | 3 (5) |
| Sometimes | 39 (69) |
| Often | 15 (26) |
| Always | 0 (0) |
| REASONS FOR EXPERIENCING BARRIERS* | |
| Lack of translated materials | 29 (53) |
| Lack of time during booking visit | 15 (27) |
| Generally lower educational level | 12 (22) |
| Socio-economic problems | 9 (16) |

*Multiple answers were possible

TABLE 3

| MIDWIVES' PREPAREDNESS TO INFORM PREGNANT WOMEN ABOUT PRENATAL SCREENING (SCALE 1-5) | | | | | | | | | | | |
|--|-----------------|--|-------------------------|-------------------------|-------------------------|--------------------------------|-------------------------|-------------------------|--------------------------------|------------------|------------------|
| PREPAREDNESS TO INFORM PREGNANT WOMEN.. | TOTAL MEAN (SD) | MEAN PREPAREDNESS BY BACKGROUND CHARACTERISTICS (95% CI) | | | | | | | | | |
| | | RELIGIOUS | | ETHNIC BACKGROUND | | NUMBER OF NON-WESTERN PATIENTS | | | ATTITUDE TOWARDS ROUTINE OFFER | | |
| | | YES (N=35) | NO (N=22) | WESTERN (N=48) | NON-WESTERN (N=9) | MINORITY (N=18) | HALF (N=19) | MAJORITY (N=20) | POSITIVE (N=39) | NEUTRAL (N=12) | NEGATIVE (N=6) |
| ..from a different cultural background | 4.27 (0.52) | 4.36 (4.19-4.54) | 4.14 (3.89-4.38) | 4.24 (4.08-4.39) | 4.44 (4.04-4.85) | 4.17 (3.98-4.36) | 4.28 (3.99-4.56) | 4.37 (4.08-4.66) | 4.26 (4.10-4.43) | 4.36 (3.91-4.82) | 4.17 (3.74-4.60) |
| ..who hardly understand and speak Dutch | 3.13 (0.90) | 3.32 (3.02-3.63) | 2.82 (2.44-3.20) | 3.02 (2.76-3.28) | 3.67 (3.12-4.21) | 3.06 (2.62-3.49) | 3.00 (2.52-3.48) | 3.32 (2.92-371) | 3.14 (2.83-3.43) | 3.27 (2.67-3.88) | 2.83 (2.04-3.62) |
| ..whose religion influences their decision | 4.21 (0.65) | 4.29 (4.07-4.51) | 4.09 (3.79-4.39) | 4.19 (3.99-4.39) | 4.33 (3.95-4.72) | 4.06 (3.79-4.32) | 4.05 (3.71-4.39) | 4.53 (4.23-4.82) | 4.28 (4.10-4.46) | 4.28 (3.40-4.60) | 4.17 (3.38-4.96) |

Significant differences in preparedness between midwives ($p < 0.05$)

background, number of non-Western clients, and attitude towards routinely offering prenatal screening.

In general, midwives felt prepared to inform women with other cultural backgrounds and women whose religious beliefs influence their decision on

screening participation. However, they felt less prepared to inform women who hardly understand and speak Dutch (Table 3). Religious midwives and non-Western midwives felt more prepared to inform women who hardly understand and speak Dutch than non-religious or Western midwives.

TABLE 4

| USE OF TRANSLATED WRITTEN MATERIAL AND PROFESSIONAL INTERPRETERS IN THE PRESENCE OF LANGUAGE BARRIERS, AS REPORTED BY THE MIDWIVES (N=57) | |
|---|---------|
| | N (%) |
| WRITTEN MATERIALS* | |
| Never uses translated materials | 33 (58) |
| Sometimes uses translated materials | 13 (23) |
| Mostly uses translated materials | 7 (12) |
| Always uses translated materials | 3 (5) |
| PROFESSIONAL INTERPRETERS | |
| Never uses professional interpreters | 50 (88) |
| Sometimes uses professional translators | 7 (12) |

*One missing value on the use of written materials

Use of translated written materials and professional interpreters

Table 4 shows that 46 midwives (81%) reported that they never or sometimes use translated written materials when they are confronted with language barriers. Only 10 midwives (17%) reported that they mostly or always use translated materials. Most important reason for never or sometimes using translated materials was that these are not present in the midwifery practice, reported by 54% of the midwives. Other reported reasons were that translated materials are not easily available during the booking visits and that it is often forgotten to use translated materials, each reported by 11% of the midwives.

None of the midwives reported that they always or often use professional interpreters in case of language barriers, 50 midwives (88%) reported that they never and 7 midwives (12%) reported that they sometimes use professional interpreters. The most reported reason for not using professional interpreters was that midwives do not know beforehand whether there is a language problem, reported by 54% of them. Other reasons were that it takes too much time to call in an interpreter, reported by 39%, and that midwives do not know beforehand which language clients prefer, reported by 21% of the midwives. Moreover, 14% of them reported that they had no reason for not using an interpreter. No significant differences in the use of translated materials or professional interpreters were found between various groups of midwives.

Results group interview

The group interview at the local society of midwives was especially aimed at exploring why midwives hardly used any translated materials or interpreters. Midwives explained that they only have Dutch-language booklets about prenatal screening for Down syndrome. Most midwives acknowledged the potential benefit of translated materials, but did not seem to know where to find these materials. Some midwives explained that they often download translated booklets from the website of a regional primary health care centre for prenatal screening. Only a few knew that translated version of national materials could be downloaded as well. Unfamiliarity also seemed to be the most important reason for not using professional interpreters. Only two midwives mentioned that they have experience with professional interpreters and were in fact very positive about it. The majority had neither positive nor negative experiences.

In response to the question how the most important language barriers can be resolved, midwives mentioned that when the pregnant woman calls to make an appointment for the booking visit it is feasible to ask her whether a professional translator is needed. Midwives recognized that overcoming language barriers would indeed improve the provision of information about prenatal screening and seemed to be open for interventions such as the use of professional interpreters. The website for translated materials and telephone numbers of interpreter services were immediately included in the minutes of the meeting and were later distributed to all members of the local society.

DISCUSSION

Most midwives reported no differences in the provision of information about prenatal screening for Down syndrome to women from different ethnic backgrounds. However, when pregnant women from non-Western ethnic backgrounds hardly speak and understand Dutch, midwives do not always offer information and feel less prepared to inform these women about prenatal screening. Although language barriers were reported to be the main difficulty in informing pregnant women, a minority of midwives reported to use translated materials and professional interpreters in the provision of information about prenatal screening.

The findings in this study are in accordance with the reports of the 270 pregnant women that participated in our previous study and were recruited from the same practices. Turkish and Surinamese women without language problems were 3.7 times more likely to have received information about prenatal screening than those who reported problems with speaking, reading and understanding Dutch (odds ratio 3.7, 95% CI 1.19-11.26) (14).

Other studies in the field of prenatal care also identified problems of translations as one of the sources of communication problems between genetic counsellors and pregnant women from Mexican origin (20). Multiple communication problems were described in the use of untrained or no interpreters in prenatal genetic clinics in Texas (21). Language differences are also reported as a barrier to quality in healthcare organizations in general, such as the ability to understand symptoms and treating diseases among outpatient clinicians and lower rates of informed consent among hospitalized patients in the USA (5-8). Moreover, studies among physicians in the Netherlands and the USA showed that clients from an ethnic minority with a language barrier are less likely to receive empathic responses and involvement in the decision-making process and are more likely to have problems in understanding a medical situation (22-24).

Our finding that midwives often do not use professional interpreters is in accordance with international studies among other health care professionals. Physicians in the USA reported lack of time, lack of access to medical interpreters and written materials in other languages as barriers in delivering cross-cultural care (25). In-depth interviews among physicians showed that they found it easier to "get by" without interpreters

and communicate through gestures, using limited second language skills, or relying on histories obtained by other physicians (26). Although midwives reported no barriers in providing information to pregnant women from other cultural and religious backgrounds, it is questionable to what extent this perceived competence reflect their actual competence or rather is a reflection of unaware incompetence. Midwives in the Netherlands usually have no training in cultural competence. Although the need to address cultural and ethnic diversity issues in medical education has been widely acknowledged, educational objectives are hardly implemented in the curriculum (27).

As far as we know this is the first study on differences and difficulties that midwives experience in providing information about prenatal screening for Down syndrome to women from diverse ethnic backgrounds. Although the underuse of professional interpreters and translated information are reported before in clinical practice, it was unknown how and to what extent midwives are dealing with language barriers in providing the complicated information about prenatal screening. Moreover, this study indicates that more action should be undertaken to implement scientific results in interventions to deal with language barriers in the diverse settings of health care. The strength of this study is that we further explored the findings from our questionnaire by a group interview and were therefore able to gain more insight into reasons for the underuse of translated written material and professional interpreters, and formulate specific interventions. Despite that almost all midwifery practices in the area of Rotterdam participated in the study, the small sample size could be considered a limitation of this study. Another limitation is that the data are self-reported, and we do not know the factual behaviour of the midwives. Nevertheless, this study indicates that the care for people from ethnic minorities still not come up to the mark, creating the potential for inequalities in current policy and practice. Despite abundant literature documenting language barriers in patient provider communication and evidence-based effective solutions to overcome these, implementation into practice seems to be lacking.

CONCLUSIONS

Although language barriers were reported to be the main difficulty in providing cultural competent care to patients from diverse ethnic

backgrounds, only a minority of the midwives used translated materials or professional interpreters. Since midwives' provision of information is essential to enable all pregnant women to make an informed decision whether or not to participate in prenatal screening for Down syndrome, interventions and further research should aim at increasing midwives' competences to address language barriers. Observational studies are needed to investigate the quality of information provision at process level and link midwives activities to pregnant women's understanding and informed decision-making. Interventions should aim at increasing awareness among midwives of the availability of and access to translated materials. The availability of national translated materials should be much more promoted among midwives and other health care professionals. To increase the use of professional interpreters, midwives and other health care professionals should know how to implement the use of professional interpreters in their daily practice. This not only implies that

they know where to find interpreters, but also how they have to work with them. Systematic cultural competency training should therefore enclose a part of the curriculum of (future) health care professionals in the Netherlands. Such cultural competency training should also provide health care professionals with knowledge, tools and skills to better understand and manage socio-cultural issues.

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