BEST PRACTICES IN INTERPRETATION AND TRANSLATION SERVICES

Literature Review and Environmental Scan

INTERPRETATION & TRANSLATION SERVICES
August 2008

Alberta Health Services
Calgary Health Region

BEST PRACTICES IN INTERPRETATION AND TRANSLATION SERVICES LITERATURE REVIEW AND ENVIRONMENTAL SCAN

TABLE OF CONTENTS

ACKNOWLEDGEMENTS
GLOSSARY OF TERMS
EXECUTIVE SUMMARY

1.0 INTRODUCTION **1**
2.0 METHODS **2**
2.1 Literature Review 2
2.2 Environmental Scan 2
2.3 Criteria for Determining Best/Leading Practices 2
3.0 RATIONALE FOR AND MODELS OF INTERPRETATION AND TRANSLATION **3**
3.1 Rationale for Interpretation/Translation Services 3
Population Diversity 3
Outcomes of Linguistically-competent Health Care 4
Legal Implications 5
Labour Implications 5
3.2 Interpretation Models and Interpreter Roles 6
Interpretation Models 6
Interpreter Roles 8
4.0 BEST/LEADING PRACTICES IN INTERPRETATION / TRANSLATION SERVICES **9**
4.1 Standards of Practice and Codes of Ethics 9
4.2 Development and Implementation of Language Services 12
Organizational Support 13
Plans, Policies and Procedures 13
Needs Assessment 14
Centralized Coordination 14
Community Involvement 15
Regional, Provincial and National Networks 15
4.3 Human Resources 16
Language-Concordant Health Care Providers 16
Qualified Health Care Interpreters 17
4.4 Education and Training for Interpreters and Practitioners 18
Interpreter Training and Competency Protocols 18
Bilingual Health Care Workers as Interpreters 19
Practitioner Training in the Importance and Use of Interpretation Services 20
Practitioner Training in Working Effectively with Interpreters 21
4.5 Interpreter-Practitioner Collaboration 22
Increasing Practitioners' Confidence in the Quality of Interpretation 22
Balancing the Triad Relationship 22
Role Expectations in the Collaborative Relationship 23
4.6 Delivery of Interpretation Services 24
Identifying and Assessing Language Needs 24

Protocols for Requesting and Acquiring Interpretation Services 25
Adequate Supply of Interpreters 26
Cultivating 'Buy-in' of Practitioners 27
Ensuring Adequate Time for Interpretation Services 27
4.7 Interpreter Job Satisfaction 28
Role Conflict 28
Status Ambiguity 29
Difficult Assignments / Debriefing 30
4.8 Additional Language Services 30
Guidelines for Translation of Written Materials 30
Telephone and Video Interpretation 31
5.0 EVALUATION OF INTERPRETATION / TRANSLATION SERVICES 33
Resource Assessment 33
Service Delivery Assessment 33
Client Outcome Assessment 34
6.0 SUMMARY AND CONCLUSIONS 35
7.0 RECOMMENDATIONS FOR THE CALGARY HEALTH REGION 37

References 43

Appendix A: Tools for Language Services Assessment 50

Appendix B: Additional Resources 51

ACKNOWLEDGEMENTS

This literature review and environmental scan was prepared by Susanne Arnold, RN, BN and Jennifer de Peuter Chick, M.A. for Healthy Diverse Populations, Healthy Living, Calgary Health Region.

GLOSSARY OF TERMS[1]

Accredited Interpreter: "An interpreter who has passed the screening criteria of a particular organization and has been awarded a certain recognition or accreditation. An accredited interpreter is NOT necessarily a Certified Interpreter…" (Healthcare Interpretation Network, 2007: 9).

Ad Hoc Interpreter: An untrained person who is called upon to interpret, such as a family member interpreting for her parents, a bilingual staff member pulled away from other duties to interpret, or a self declared bilingual in a hospital waiting-room who volunteers to interpret. Also called a *chance interpreter* or *lay interpreter*.

Best practice: a process or methodology that has been proven to work well and produce good results, and is therefore recommended as a model.

Bilingual Provider: A health care professional with proficiency in more than one language, enabling the person to provide services directly to limited-English proficient patients in their non-English language.

Bilingual Worker / Employee: An employee, with proficiency in more than one language, who is often called upon to interpret for limited-English proficient patients, but who is usually not trained as a professional interpreter. "A high level of bilingualism is the minimum qualification for a competent interpreter but by itself does not ensure the ability to interpret" (Healthcare Interpretation Network, 2007: 9).

Certified Interpreter: "A professional interpreter who is certified as competent by a professional organization through rigorous testing based on appropriate and consistent criteria. Interpreters who have had limited training or have taken a screening test administered by an employing legal, health, interpreter or referral agency are NOT considered certified" (Healthcare Interpretation Network, 2007: 10).

Chance or Ad Hoc Interpretation: Refers to interpretation services performed in a health care setting by individuals who are not trained in the techniques of interpretation, such as family members, friends, strangers, and untrained medical and non-medical staff. The use of chance or ad hoc interpreters in the health

[1] Definitions are adapted from National Standard Guide for Community Interpreting Services (Healthcare Interpretation Network, 2007: 9-14) and California Health care Interpreters Association (2002: 64-77).

care setting is highly problematic and not recommended (Hsieh, 2006; Lehna, 2005; Flores, 2005; Green et al., 2005; Garcia et al., 2004).

Consecutive Interpreting: The *mode* of interpreting whereby the interpreter relays a message in a sequential manner after the speaker has paused or has completed a thought. In other words, the interpreter waits until the speaker has finished the utterance before rendering it in the other language.

Cultural Competency (in health care): A continuous process of seeking cultural sensitivity, knowledge and skills to work effectively with individuals and families from diverse cultural communities and with their culturally diverse providers.

Diversity Competency: The ability of individuals and systems to respond respectfully and effectively to people of all diverse backgrounds in a manner that recognizes, affirms, and values the differences, similarities and worth of individuals, families and communities and also protects and preserves the dignity of each (Calgary Health Region, 2008).

First-Person Interpreting: The use of the direct utterances of each speaker by the interpreter as though the interpreter was the voice of the person speaking in the language of the listener. For example, if the patient says, "My stomach hurts," the interpreter says (in the listener's language), "My stomach hurts," and not "She says her stomach hurts" (this would be in the *third person*).

Health Care Interpreting: Interpreting that takes place between a patient (or the patient and one or more family members) and a health care provider (doctor, nurse, lab technician) in settings across the health care continuum, including, but not limited to, doctor's offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations.

Health Care Interpreter: A health care interpreter is one who has 1) been trained in health care interpreting, 2) adheres to the professional code of ethics and protocols of health care interpreters, 3) is knowledgeable about medical terminology, and 4) can accurately and completely render communication from one language to another. Ideally, health care interpreters have been tested for their fluency in the languages in which they interpret and tested for their interpretation skills. A health care interpreter may include a bilingual or multilingual provider or medical staff.

Health Literacy: The term originally focused on an individual's ability to read and understand health information; the focus has recently expanded to include the ability of health systems and care providers to communicate in relevant and easy to understand ways. There are three levels of health literacy: 1) functional

literacy (the ability to read and write well enough for basic understanding); 2) interactive literacy (the ability to communicate effectively with others about health needs; and 3) critical literacy (the ability to critically appraise health information).

Interpreter: "A person who facilitates spoken language communication between two or more parties who do not share a common language by delivering, as faithfully as possible, the original message from source into target language" (Healthcare Interpretation Network, 2007: 12).

Interpreting: "The act of facilitating spoken language communication between two or more parties who do not share a common language by delivering, as faithfully as possible, the original message from source into target language" (Healthcare Interpretation Network, 2007: 11).

Limited English Proficiency (LEP): People with limited English proficiency (LEP) are those who cannot speak, read, write or understand English on a level that permits them to interact effectively with health care providers.

Medical Interpreting: This term is often used interchangeably with health care interpreting, but does not usually include interpreting in the broader continuum of health care – nursing homes, public health, population health, community and home care nursing, and social work, among others.

On-site Interpreting: Interpreting taking place within a specific facility or location. This term was used as an equivalent for the concept of "proximal," or *face-to-face interpreting.* Many organizations now have interpreters working as remote, telephonic interpreters for patient/provider interactions within their site or facility.

Remote Interpreting: Interpreting provided by an interpreter who is not in the presence of the speakers, e.g., interpreting via telephone or videoconferencing.

Signed Language: "Visual-spatial languages used by Deaf people. Signed Languages are natural languages with their own grammatical structures and lexicon" (Healthcare Interpretation Network, 2007: 13).

Simultaneous Interpreting: Converting a speaker or signer's message into another language while the speaker or signer continues to speak or sign.

Source Language: "Language from which translation or interpretation is carried out" (Healthcare Interpretation Network, 2007: 14).

Target Language: "Language into which translation or interpretation is carried out" (Healthcare Interpretation Network, 2007: 14).

Telephone (or Telephonic) Interpreting: Interpreting carried out with the interpreter connected by telephone to the principal parties, typically provided through a speakerphone or headsets.

Translation: The conversion of a written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language.

Translator: A person who converts written texts from one language into a text in a second language with an equivalent meaning, especially one who does so professionally.

Transparency / Transparent Interpreting: The idea that the interpreter keeps both parties in the interpreting session fully informed of what is happening, who is speaking, and what the interpreter is doing, is known as "transparency." Whenever interpreters intervene by voicing their own thoughts and not the interpreted words of one of the parties, it is critical that they ensure that a) the message is conveyed to all parties and b) everyone is aware that the messages is from the interpreter (for example, *"…the interpreter would like to say,…"*).

Video Conference Interpreting: Interpreting when one or more of the parties are not present in the same room, using a video camera to enable the parties to see and hear each other, including the interpreter, via a TV monitor.

EXECUTIVE SUMMARY

The purpose of this literature review and environmental scan was to identify best practices in interpretation and translation services and to identify ways in which the Calgary Health Region can continue to grow in this area. The literature review focused on articles published since 2001 and the environmental scan involved a review of gray literature and in-depth interviews with Managers of four interpretation and translation services programs.

The literature review examined the rationale for providing interpretation and translation services, including the increasing linguistic diversity of the Canadian population, the benefits of providing linguistically-competent health care, and the legal and labour implications of providing interpretation and translation services. The strengths and weaknesses of various interpretation models were summarized, and the various roles of the health care interpreter, as well as standards of practice and codes of ethics, were explored.

Best practices were then identified as they pertain to the development and implementation of interpretation and translation services, to human resource development and education, to the delivery of interpretation services (including the identification of need and protocols for requesting an interpreter), to written translation and telephone and video interpretation, and as they pertain to the evaluation of interpretation and translation services.

Best practices in the development and implementation of interpretation and translation services include effectively garnering organizational support and resources, implementing centralized coordination of services, developing formalized policies and procedures, encouraging community involvement, and participating in regional, provincial, national and international networks.

Best practices related to human resource development and education were found to include the recruitment and retention of language-concordant health care providers, the use of qualified health care interpreter services rather than ad hoc interpreters, and educating health care staff about the role of interpreters, methods of requesting an interpreter, and ways of working effectively with a health care interpreter. Understanding the effects of role conflict, status ambiguity and difficult assignments on interpreter job satisfaction and the influence of an interpreter on the practitioner-patient relationship were also emphasized.

With respect to the delivery of services, best practices were identified as they pertain to the methods used to determine the need for an interpreter, protocols

for requesting an interpreter, and the allowance of adequate appointment time for interpretation.

Guidelines for the translation of written materials and best practices concerning the use of telephone and video interpretation were also explored, as were recommended components of evaluations of interpretation and translation services, including resource, service delivery, and patient outcome assessments.

The report concludes that the Calgary Health Region is an exemplar of many best practices in health care interpretation and translation; the Region has developed a formalized, centrally administered interpretation service, participates in information-sharing networks, conducts regular needs assessments, liaisons with diverse communities to promote interpretation services; and has established standards for interpreter qualifications. As the Region strives to become a model organization for best practices in interpretation and translation services, it is recommended that the Region continue to monitor the literature for developments in best practices, continue to monitor and evaluate the strengths and challenges of its Interpretation and Translation Services, and enhance its capacity to share 'lessons learned' with the broader health care community. It is also recommended that the Region examine existing relationships with populations utilizing (and under-utilizing) interpretation services and consider how these relationships might be better used as a mechanism for distributing information about interpretation services and for soliciting feedback about ease of access and the quality of interpreted encounters. Additional steps might be taken to raise awareness among staff members of the Interpretation and Translation Services program, to ensure staff members are skilled in identifying the need for interpretation and translation services and are familiar with the procedures for arranging for an interpreter, and to increase awareness of the risks associated with relying upon untrained (e.g. ad hoc) interpreters. The Region could further explore factors influencing the job satisfaction of interpreters, including for example the communication skills of practitioners, status ambiguity and perceived lack of recognition for their contribution to the health care team, role conflict, and difficult assignments. Finally, it is recommended that the Region continue to utilize the data garnered from the extensive evaluation undertaken in 2007, and continue to pursue annual assessments, in order to identify and respond to challenges arising in the areas of resources, service delivery, client outcomes, and interpreter job satisfaction.

1.0 INTRODUCTION

> Despite formidable advances in medical technology, good communication remains the cornerstone of the practice of medicine. Indeed, over the past decade there has been a resurgence of interest in the dialogue between patients and their health care providers – so-called "narrative medicine" – an acknowledgement of the belief among medical practitioners that even today, almost 90% of the diagnosis still resides in the story the patient tells (Carter-Pokras et al., 2004: SP34).

The Calgary Health Region strives to be a model organization for diversity competency, demonstrating best or leading practices in all areas of diversity competency including linguistic / language competency. To this end, the Region has developed and implemented formalized Interpretation and Translation Services. To ensure services remain optimally effective, the Region has commissioned a review of the literature and environmental scan to identify the most current best / leading practices in interpretation and translation services, and to identify ways in which the Region can grow in this area.

In this report we first present the methods used to generate and review the literature and to garner interview data (Section 2.0), and then examine the rationale for the provision of interpretation and translation services and review models and roles of the health care interpreter (Section 3.0). In Section 4.0 we review best or leading practices in health care interpretation and translation and examine issues affecting interpreter job satisfaction. Section 5.0 provides a review of best practices in program evaluation, and Section 6.0 provides a summary of the main findings and conclusions. The paper concludes with a series of recommendations for the Calgary Health Region (Section 7.0).

2.0 METHODS

2.1 Literature Review

The literature review was prepared with computer-assisted database searches (EMB Reviews – Cochrane; EMBASE Review; CINAHL; Ovid Medline; Health Source; Health STAR; PubMed Restricted; Web of Science; Academic Search Premier; IBSS; Social Services Abstracts; Social Works Abstracts Plus; SocINDEX; Sociological Collection; Linguistics and Language Behavior) with key words "linguistic competency or competencies, linguistic liaison, interpreter, interpreter services, interpretation, language mediator, language mediation, translation, translator." These terms were combined with "family practice, delivery of health care, health services, evidence based, best practice," using wild card and MeSH headings, to identify North American and international articles published between 2001 and 2008.

2.2 Environmental Scan

The environmental scan included a review of non-refereed ('gray') literature identified through Internet search engines (Google and Google Scholar) with a particular focus on organizations exemplifying 'best' or 'leading' promises in interpretation / translation services. Telephone interviews were also conducted with Managers of four interpretation and translation services programs. Notes were taken during the interviews. Participants were not compensated for their involvement.

2.3 Criteria for Determining Best/Leading Practices

A recent review of the literature lead Jacobs et al. (2006a) to conclude that at present, there is a significant lack of published literature providing guidance in interpretation and translation services in health care. Specifically, there is little empirical evidence to guide language services in selecting the most effective language interventions, a lack of standardized, tested and validated instruments to assess the qualifications of interpreters/translators, and little guidance on how best to establish, implement and evaluate interpretation/translation services. The present review of scholarly and grey literature similarly identified little empirical evidence that would support the designation of particular practices as 'best' or 'leading.'

Rather than rely exclusively on evidence-based outcomes, then, the current review also included practices considered to exemplify best or leading practices in interpretation and translation services when they were:

- Identified as 'promising' through systematic reviews of published literature; or
- Recommended by multiple reliable sources; or
- Included as components of health care interpreting and translation standards and/or codes of ethics.

3.0 RATIONALE FOR AND MODELS OF INTERPRETATION AND TRANSLATION

In this section we examine the rationale for providing interpretation and translation services, including the increasing linguistic diversity of the Canadian population, the benefits of providing linguistically-competent health care, and the legal and labour implications of providing interpretation and translation services. We then consider the strengths and weaknesses of various interpretation models and the various roles of the health care interpreter, and conclude the section with a review of standards of practice and codes of ethics for health care interpreters.

3.1 Rationale for Interpretation / Translation Services

Population Diversity

Canadian health care systems are striving to become linguistically-competent in response to the increasing diversity of the Canadian population. According to the 2006 Census, 19.8% of the national population is comprised of foreign-born people, the highest proportion in 75 years; between 2001 and 2006, Canada's foreign-born population increased by 13.6%, compared to an increase in the Canadian-born population of just 3.3% (Statistics Canada, 2007a). The majority of newcomers to Canada are of Asian descent (58.3%), followed by European (16.1%; Ibid.). Nearly three-quarters of newcomers report a first language other than English or French (70.2%), with 18.6% reporting Chinese languages; 6.6% Italian; 5.9% Punjabi; 5.8% Spanish; 5.4% German; 4.8% Tagalog; and 4.7% Arabic (Ibid.).

The 2006 Census found that a growing proportion of newcomers to Canada are settling in smaller metropolitan areas (16.5% settled in Calgary, Ottawa-Gatineau, Edmonton, Winnipeg, Hamilton and London, compared to 14.3% in 2001), and in 2006, 5.2% and 2.9% of newcomers made their home in Calgary and Edmonton, respectively (Ibid.).

The population served by the Calgary Health Region, currently exceeding 1.2 million, is increasingly culturally and linguistically diverse (Calgary Health Region, 2008). Increased immigration from non-European countries (such as China, India, Philippines, Pakistan and Korea) and the high proportion of immigrants unable to

effectively communicate in either official language requires the Region to continue to monitor and further develop health care services that are culturally and linguistically appropriate (Ibid.).

> The demand in the Calgary Health Region for interpretation and translation services is high and continues to grow. In 2007, approximately 10,000 face-to-face interpretations were conducted (1700 more than the previous year) and 8000 telephone interpretations. The program is anticipating 12,000 face-to-face interpretations in 2008. An overall average increase of 27% of total interpretations per year has been noted since 2004/05.
>
> *Interpretation and Translation Services, Calgary Health Region*

Outcomes of Linguistically-Competent Health Care

It is well documented that language barriers negatively affect access to and quality of health care. Persons with limited English language proficiency (LEP) are less likely to seek health and mental health care and less likely to receive needed services when they do seek care; more often have poor understanding of diagnoses, treatment, and prescribed medications; are less likely to use preventive services and health promotion and health education materials; and report lower levels of satisfaction with care (Pippens et al., 2007; Sentell, Shumway and Snowden, 2007; Jacobs et al., 2006b; Brach, Fraser and Paez, 2005; Flores, 2005; Lehna, 2005; Mullins et al., 2005; Bowen, 2004).

Effective language services can significantly enhance access to and quality of health care. A recent review of evidence lead Karliner et al. (2007) to conclude that professional health care interpretation reduces errors, and improves patient comprehension, service utilization, clinical outcomes, and satisfaction with care. A similar review conducted by Flores (2005) confirmed that qualified interpretation is associated with increased rates of preventive screening, and Bernstein et al. (2002) found that LEP patients with access to qualified interpreters had appropriately longer hospital stays (controlling for illness type) and received more services and referrals than LEP patients needing but not having access to interpretation services (see also Ngo-Metzger et al., 2007; Morales et al., 2006; Green et al., 2005; Enslein et al., 2002).

Legal Implications

Health care organizations are increasingly cognizant of the legal implications of providing (and not providing) linguistically appropriate services. While the provision of interpretation services is not legislated in Canada (with the exception of providing signed language interpretation), federal and state laws in the U.S. now require linguistically-competent health care services, and in this country, health care services have a duty to accommodate individual needs to prevent undue hardship (e.g., by ensuring health care practices do not have a negative effect on an individual as a result of their race, colour, ancestry or

place of origin; Calgary Health Region, 2002). In light of this duty, and in light of the likelihood that the provision of linguistically-competent health care services may soon become a legal requirement in Canada, health care organizations are perhaps more aware than ever of the importance of providing adequate and appropriate linguistic services (Blake, 2003).

Labour Implications

Health care organizations are also enhancing efforts to formalize their language services in response to the challenges associated with the use of unionized employees as volunteer interpreters. Not only are there legal, contractual and ethical implications of having unionized employees provide services outside their job description, but by providing volunteer interpretation services, employees are also providing a service that is within the job description of other unionized employees (the job classification of Health Care Interpreter; Calgary Health Region, 2002). Administrative and budget difficulties also result when employees provide services in areas outside of those for which they were hired (Ibid.).

The rationale provided above (including the increasing linguistic diversity of the Canadian population, growing awareness of the negative health outcomes of linguistically-incompetent health care, movement toward the provision of interpretation services as a legal requirement, and challenges associated with the use of unionized health care employees as volunteer interpreters) highlight the importance (and timeliness) of identifying best or leading practices in the development and delivery of health care interpretation and translation services. A number of best or leading practices were identified through the literature review and interviews with program Managers, and are presented in the following pages. First, however, we present an overview of the circumstances in which the use of interpretation and translation services is appropriate, the strengths and weaknesses of various interpretation models, and the role of the health care interpreter as message converter, message clarifier, cultural clarifier, and patient advocate.

3.2 Interpretation Models and Interpreter Roles

Interpretation Models

In addition to the employment of language-concordant health care providers, addressed in a later section (see Section 4.3), interpretation services are meant to increase access to and quality of health care for LEP patients and are employed when there is incongruence between the languages spoken by the health care provider and the patient; when the patient demonstrates limited understanding due to language in-proficiency; and when cultural norms prohibit the patient from speaking directly with the health care provider (Enslein et al., 2002). Models of interpretation services include the dedicated interpreter model,

in which interpretation services are provided by facility- or community-based individuals who are trained in health care interpreting specifically; the community interpreter model, in which interpretation is provided by paid or volunteer community interpreters who are trained in interpretation but typically not trained in health care interpreting and who serve the broader community; and the bilingual clinical and non-clinical staff model, in which staff members participate in a health care encounter as interpreters (and not as practitioners). Interpreters may be employed by the health care organization or hired on contract, and may be regionally-coordinated or coordinated by individual health care facilities (Bowen, 2004). Additional services include telephonic interpretation and/or video conference interpretation as well as the translation of written materials.

The National Council on Interpreting in Health Care (NCIHC, 2002a) reviewed the benefits and limitations of relying upon bilingual clinical and non-clinical staff members for the provision of interpretation, and the benefits and limitations of interpretation services provided by qualified health care interpreters. Advantages of interpretation provided by bilingual clinical staff members (e.g., where bilingual physicians or nurses provide interpretation services for patients seen by other providers) include staff members' availability and knowledge of health care concepts and terminology. However, clinical staff members seldom have formal training in interpretation and are thus likely to be unaware of ethical issues and interpreting techniques, and may not be familiar with medical concepts and terminology in other languages. Interpretation provided by clinical staff members may also lead to role ambiguity, in that the patient may not know whether the interpreter is acting as interpreter or as health professional. NCIHC concluded that this model is effective and appropriate only when the staff member asked to interpret can meet the same criteria as qualified health care interpreters (including demonstrated linguistic proficiency, training in health care interpreting ethics and techniques, interpreting competency, and participation in continuing education for interpreters).

The bilingual non-clinical staff model involves the provision of interpretation services by non-clinical staff members (e.g., receptionists, medical assistants, janitorial and food services staff; NCIHC, 2002a). Again, non-clinical staff may be readily available to interpret, but drawbacks include the potential negative impact on the functioning of the institution (as staff members are pulled away from regular job duties), lack of interpreter training, lack of knowledge of health care issues and vocabulary in either language, and dissatisfaction of colleagues who must cover for the absent worker. This model is recommended only when

staff members are trained and assessed as interpreters and only with the support of managers and staff[2].

> The Calgary Health Region uses the dedicated interpreter model. The Region employs 45-48 certified health care interpreters to provide in-person and over-the-phone interpretation throughout the Region, 12 hours a day in 21 languages. The interpreters are staff members, either full-time or part-time, and only a few are employed on a casual basis.
>
> In addition to these interpreters, the Region contracts an external service to provide over-the-phone medical interpretation 24/7 in 170 languages. To access the telephone interpretation service, a Regional employee makes the initial contact on behalf of the client.
>
> Services are scheduled through trained dispatch clerks and the service is overseen by a program manager.
>
> *Interpretation and Translation Services, Calgary Health Region*

The dedicated interpreter model involves the provision of interpretation services by qualified health care interpreters who are either employed by the organization or hired on contract (NCIHC, 2002a). Qualified interpreters are costly, but provide a higher quality of interpretation, have a clear role in the patient-provider-interpreter encounter (minimizing role ambiguity), are able to focus on the task of interpretation, and are more likely to participate in continuing education to keep abreast of interpretation ethics and techniques. Because of the costs associated with having qualified interpreters on staff, some organizations adopt an agency model, wherein language agencies dispatch interpreters on demand.

Telephonic interpretation is often used to supplement in-person interpretation services. Challenges include the exclusion of non-verbal communication, the reduced ability of telephone interpreters to act as cultural brokers or mediators, and logistical problems associated with accessing telephones in various clinical situations (NCIHC, 2002a).

Interpreter Roles

The California Healthcare Interpreters Association (2002) identifies four roles of the interpreter: message converter (relating the meaning of all message without additions, deletions or changes in meaning); message clarifier (interpreter is alert for possible words or concepts that might lead to misunderstanding and identifies and assists in clarifying possible sources of confusion for the patient/provider); cultural clarifier (interpreter is alert to cultural words or concepts that might lead to misunderstanding and acts to identify and assist the

[2] Some organizations have implemented an "Interpreter for a Day" program wherein bilingual staff spend one day per week acting only as interpreters; other organizations have implemented pay differentials for bilingual staff (NCIHC, 2002).

parties to clarify culturally-specific ideas); and patient advocate (interpreter actively supports change in the interest of patient health and well-being; see also Dysart-Gale, 2007). The extent to which interpreters practice each of these roles varies and depends in part on the interpreter's personal understanding of ethical guidelines and the expectations of patients, practitioners and the health care organization. Interpreter roles and related ethical considerations are discussed throughout this report.

Having presented the rationale for the provision of interpretation and translation services and reviewed various interpretation models and interpreter roles, we turn now to examine best or leading practices in health care interpretation and translation services, identified through a review of scholarly and grey literature and interviews with interpretation and translation services Managers.

4.0 BEST / LEADING PRACTICES IN INTERPRETATION / TRANSLATION SERVICES

Coordinated language services informed by best practices effectively reduce access barriers to and improve the quality of health care services for persons with limited English proficiency (LEP; Vandervort and Melkus, 2003). Best practices provide direction in the development, coordination, promotion and assessment of language services and the development of protocols for interpreter and translator qualifications and screening, and provide guidance with respect to the provision of interpretation services by bilingual staff members, community volunteers, and patients' family members or friends. Best practices also provide guidance on such controversial issues as whether interpreters should strive to be a neutral 'conduit' of information, or engage in cultural mediation, circumstances under which interpreters should act as patient advocates, and the extent to which interpreters can and should promote the well-being of the client and foster the client-provider relationship (Dysart-Gale, 2007; Bancroft, 2005; Vandervort and Melkus, 2003).

At the Calgary Health Region, interpreters and translators adhere to practice guidelines on a number of levels. First, they follow Regional standards of practice, to which they are introduced at staff orientation. They also sign confidentiality agreements upon hiring, and are informed about issues related to confidentiality and the Freedom of Information and Protection of Privacy Act during training. In addition, most Regional interpreters are graduates of Bow Valley College Certified Health Care Interpreter Program, which itself follows professional standards of practice.

On a national/international level, standards for certified health care interpreters are being developed and the Calgary Health Region maintains connections with the groups involved in developing these standards.

Interpretation and Translation Services, Calgary Health Region

We begin this section with a review of standards of practice and codes of ethics in health care interpreting. We then present best or leading practices in the development and implementation of interpretation and translation services, and in the areas of human resources, education and training, relationships and collaborations in the interpreted health care encounter, and the delivery of interpretation services. We conclude the section with a brief review of best practices in written translation, telephone interpretation, and video interpretation.

4.1 Standards of Practice and Codes of Ethics

Standards of practice and codes of ethics provide the health care interpreting profession with guidelines for training, practice and in some countries, licensure (Hsieh, 2006). National standards for Canadian healthcare interpreters have not yet been developed, though numerous authors (e.g., Bowen, 2004; Sasso, 2004; Vandervort and Melkus, 2003) as well as the Canadian government have called for their development[3]. National standards for Community Interpreting more generally, however, have been published (see *National Standard Guide for Community Interpreting Services*, Healthcare Interpretation Network, 2007), and serve as a useful guide for healthcare interpreters. In the U.S., the National Council on Interpreting in Health Care (NCIHC) published the first national standards for use in American health care interpreting (Bancroft, 2005; NCIHC, 2005). The 32 standards, developed through an environmental scan on international best practices and standards[4], are grouped into nine categories, each corresponding to an ethical principle[5]. According to the Standards, interpreters should adhere to the following principles[6]:

> **Accuracy**: to ensure all exchange of information is conveyed accurately and completely, without adding, omitting, or substituting;
>
> **Confidentiality**: interpreters must not disclose information outside the treating team, except with the patient's consent or if required by law;

[3] Some health care organizations have developed practice guidelines and/or codes of ethics for their own programs; see for example Winnipeg Regional Health Authority's "Code of Ethics and Standards of Practice for Health Interpreters," Language Access, June 2008.

[4] See *The Interpreter's World Tour: An Environmental Scan of Standards and Practices for Interpreters* (Bancroft, 2005).

[5] The NCIHC review of the international literature on standards and ethics in medical interpreting found that professional medical interpretation is highly advanced in Australia, which has a detailed Code of Ethics and Code of Practice as well as a national accreditation authority. The UK is leading the way in medical interpretation in Europe, with a national registry of medical interpreters, a National Center for Languages, and detailed standards of practice.

[6] Codes of ethics (including those of the Massachusetts Medical Interpreters Association, the International Medical Interpreters Association, and the National Council on Interpreting in Health Care) generally address the following nine areas as well.

Impartiality: interpreters must operate in a neutral, objective way and refrain from projecting personal views through words or gestures[7];

Respect: interpreters acknowledge the inherent dignity of all parties and treat all with respect;

Cultural Awareness: interpreters strive to understand the cultures associated with the languages he or she interprets, including biomedical culture;

Role Boundaries: interpreters limit professional activities and personal involvement to the role defined for the position of interpreter;

Professionalism: interpreters uphold public trust and carry out duties in accordance to professional guidelines[8];

Professional Development: interpreters continue to develop and improve language and cultural knowledge and interpreting skills and performance; and

Advocacy: interpreters act or speak on behalf of the clients for fairness in treatment and equal rights.

The extent to which health care interpreters can and should adhere to the ethical principles of impartiality and role boundaries is currently debated. Gregg and Saha (2007) articulate the conceptual underpinnings of this debate with a discussion of language as 'langue' and 'parole.' As 'langue,' language is a 'shared system of grammar and words;' understood as such, the quality of interpretation may be gauged by the extent to which the interpreted words match the intended words. As 'parole,' language is a 'symbolic resource' employed by speakers to make sense of their world and to convey their place in it; understood this way, the quality of interpretation is gauged by the interpreter's ability to deliver messages that reflect the cultural and social milieus out of which

> Interpreter programs often provide guidelines on the role of the interpreter. Some encourage interpreters to limit their role to language interpretation and ensure health care staff are aware of this strict role boundary, while others recognize a need for cultural interpretation in their patient population and are working toward enhancing awareness among staff of the potential for interpreters to utilize their cultural knowledge and perform cultural brokerage as well as language interpretation.
>
> *Anonymous Language Services Program Manager*

[7] Notably, codes of ethics refer to impartiality as 'refraining from counseling, advising or projecting personal involvement' (Bancroft, 2005). The extent to which and the circumstances under which it is considered acceptable for interpreters to 'counsel' or 'advise' is currently debated.

[8] Codes of ethics provide a more detailed description of professionalism: 'disclosure of conflicts of interest and refraining from accepting assignments when professional skills or relationships with the client or health care provider affect impartiality; refraining from accepting/requesting additional fees for services, gifts, and gratuities' (Bancroft, 2005).

the words, and their meaning, arose. The authors suggest that the dual nature of language be considered in weighing the ethics of interpretation.

The lived experience of health care interpreters further challenges the ethical 'ideal' of the interpreter as a conduit of messages. In practice, interpreters vary in the extent to which they adhere to the principle of neutrality and the practice of rigid role-boundaries. Interview research conducted by Dysart-Gale (2007) revealed that some health care interpreters strive to adhere to the conduit or transmission-based model, and consider deviating from interpreting messages verbatim as a violation of ethical principles and as potential malpractice, while others are comfortable deviating from their role as conduit, recognizing that at times there is a need to mediate messages (for example when the intended message is highly inappropriate or offensive in the target culture), clarify cultural meanings, and act as cultural broker or patient advocate. In practice, Dysart-Gale found interpreters to often move between roles, transmitting messages verbatim at some points and acting as mediator, clarifier or cultural broker/patient advocate at others, and found that patients and practitioners may also impose multiple and at times conflicting role expectations. In response, Dysart-Gale encourages interpreters to examine their personal values, beliefs and abilities, acknowledge the fluidity of their roles, and reconcile discrepancies or ethical conflicts as they arise through open communication with clients and practitioners. The Manager of Winnipeg Regional Health Authority's Language Access program, interviewed for the present study, suggested that interpreter staff meetings can provide an opportunity for the examination of personal, program, and patient expectations as well.

4.2 Development and Implementation of Language Services

Best practices in the development and implementation of language services include garnering organizational support, developing formalized policies and procedures, assessing need, centralizing coordination of services, engaging the community, and participating in broader networks. Each is discussed in this section.

> Interpretation and Translation at the Calgary Health Region has evolved over the years to better meet the needs of an ever-expanding diverse population. Changes include hiring dedicated booking clerks, hiring more interpreters, providing interpretation in more languages and implementing procedural changes to increase efficiency and reduce error.
>
> *Interpretation and Translation Services, Calgary Health Region*

Organizational Support

The development and implementation of appropriate and effective language services requires health care organizations to recognize that language assistance is essential to the provision of quality health care and that as such, language services should not be approached as 'add-on' services but should be considered inherent to the provision of safe and acceptable care (Wu et al., 2007; Brach, Fraser and Paez, 2005). Organizational support is required for the provision of adequate infrastructure, and the development and implementation of a coordinated service plan and of accountability mechanisms, each of which are considered essential features of successful language services (Brach, Fraser and Paez, 2005; Bowen, 2004). Language services that have been successful in garnering organizational support report that effective means of doing so include connecting language services with one of the driving issues of the organization, such as patient safety or quality of care, and soliciting support from high-level and influential administrators (Wu et al., 2007).

> Corporate support for interpretation services in a large hospital was demonstrated when an official Corporate Directive was implemented for the use of trained interpreters. Services had been operating informally for four years prior, but the Directive has been instrumental in the ability of the program to garner resources for staffing and to implement a budget for telephone interpretation.
>
> *Anonymous Language Services Program Manager*

Interviews with interpretation and translation services program Managers revealed the importance of cultivating champions as a means of garnering organizational support for interpreter services as well. When implementing interpretation services at a new site, for example, Language Access (Winnipeg Regional Health Authority) purposefully identifies and recruits one or two key individual in the site to champion the services. This has proven effective in raising awareness and increasing staff buy-in.

> An exemplary language plan, developed by the Asian Pacific Health Care Venture, includes strategies for meeting identified needs as well as language service protocols, interpreter job descriptions, and training modules for bilingual staff members.
>
> *Youdelman and Perkins (2005)*

Plans, Policies and Procedures

In addition to garnering organizational support, successful language services develop coordinated plans, policies and procedures for service delivery. The Massachusetts Department of Public Health (2004) best practice guidelines recommend service plans include comprehensive written policies and procedures that provide formalized methods for publicizing patients' right to interpretation services and methods of accessing those services; identifying and assessing the language needs of patients; determining how interpreters are

contacted and their services arranged; guiding staff in deciding the most appropriate interpretation service(s) to use; and assuring proper documentation of the LEP patient encounter (including whether interpretation services were

> To stay on top of language trends, the Calgary Health Region maintains informal networks with the communities served, monitors census and demographic data and communicates with the refugee health program in Calgary. In addition, the Region continually monitors requests for in-person interpretation services and receives regular reports on usage of the contracted telephone interpretation services.
>
> *Interpretation and Translation Services, Calgary Health Region*

used or refused). Policies should also be in place with respect to the translation of written materials, training and continuing education requirements or recommendations for interpreters, periodic assessment of interpreters, and ongoing program monitoring and evaluation processes.

Needs Assessment

Language services programs require the capacity to conduct systematic needs assessments, including access to data on the prevalence of LEP individuals and the languages spoken in the communities served, with assessments made during program implementation and on a regular basis thereafter (Brach, Fraser and Paez, 2005; Carter-Pokras et al., 2004). Managers of interpretation and translation services programs interviewed for the present report indicated that census data, including population distribution statistics provided by the City or municipality, are used to identify emerging trends. Language data collected during the patient registration process, as well as interpreter usage data, further provide a basis for ongoing needs assessment. Settlement agencies are also consulted to identify immigration trends and corresponding interpretation needs; for example, during the implementation of Winnipeg Regional Health Authority's Language Access program, an email was distributed to key individuals in organizations serving diverse populations to get a feel for the language needs of their clientele. This informal assessment helped inform the selection and recruitment of interpreters. The interviews also revealed, however, that staying 'one step ahead' of emergent language needs can be challenging, particularly when interpreters are hired as staff members and not as temporary contract workers.

> Fraser Health reports that BC Immigration announces when large refugee/immigrant groups are expected to arrive in the province. When such announcements are made in a timely fashion, the Language Services Program Manager is able to recruit interpreters to meet the anticipated demand.
>
> *Language Services Program, Fraser Health*

Centralized Coordination

Language services are most effective and efficient when they are centrally administered (Youdelman and Perkins, 2005; Sasso, 2004). In a review of interpretation services offered by Canadian health care organizations, Tang (1999) for example found that programs that were centrally administered had the most efficient methods of patient intake and interpreter dispatch, and were better able to monitor standards of service and provide ongoing training. Centralization was found particularly beneficial to smaller institutions, as it allowed the sharing of resources and administrative costs.

Community Involvement

> Language Access took a collaborative approach to designing their services by developing a Regional Language Barriers Committee with representation from the four language constituencies in Canada (immigrant and refugee, Aboriginal, French, and Sign Language).
>
> *Language Access, Winnipeg Regional Health Authority*

Language services are most effective when developed and implemented in consultation or partnership with representatives of the populations served, such as community agencies serving immigrant groups and ethnocultural minorities (Wu et al., 2007). Importantly, the linkages formed through community collaboration can help the health care organization identify and become more responsive to the unique language needs of the communities served. Collaborations also facilitate the sharing of translated materials and community resources, including trained community interpreters (Tang, 1999), and can help raise awareness in those communities of the availability of interpretation services and the roles of interpreters (Cornes and Napier, 2005).

Community involvement is important during program implementation, but can also help ensure interpretation services are meeting community needs on an ongoing basis. Interviews revealed that interpretation and translation services program Managers have frequent contact with immigrant-serving agencies, and interpreters are often members of, and involved with, diverse language communities.

Regional, Provincial or National Networks

While language services are largely the responsibility of individual health care organizations in Canada and the U.S., regional, provincial and national networks of language services have been shown to improve the quality of language services in health care settings. Partida (2007) describes such networks as commonplace in Australia, citing for example the Australian Translating and Interpreting Service (a national call centre offering more than 1,500 interpreters speaking in excess of 120 languages and dialects), and argues that broadly

coordinated efforts are more effective and efficient in developing, implementing and monitoring language services in health care:

> Health care organizations borrow and replicate untested solutions and programs and struggle to grow trained interpreters. There is no valid reason that health care organizations should independently develop, from scratch, the resources needed to improve language access for LEP patients. Lack of coordinated efforts is wasteful and contributes to wide variations in quality of interpretation and, ultimately, in quality of care and health outcomes. Eliminating language barriers in health care requires a calibrated and focused effort to develop response capacity across the nation. Attending to language barriers at the provider level is essential, but working only at this level leaves communication gaps that undermine the benefits of these investments (349).

A number of best practices in the development and implementation of language services have been discussed, including the importance of garnering support for the premise that interpretation and translation services are a prerequisite of quality health care, of developing formalized policies and procedures, of conducting community needs assessment and developing programs according to identified needs, and of central coordination, community participation, and networking. Best practices pertaining to human resources, including the recruitment and retention of language-concordant practitioners and qualified health care interpreters, and the education and training of interpreters and those who work with interpreters are considered next.

> During the development of Language Services Program, the Manager networked with individuals in other health facilities for knowledge-sharing with respect to the logistics of program implementation. Networking was considered vital to this process.
>
> *Language Services Program, Fraser Health*

4.3 Human Resources

Language-Concordant Health Care Providers

A key component to language services is the recruitment and retention of a bilingual workforce (Brach, Fraser and Paez, 2005; Carter-Pokras et al., 2004). While the literature cautions against relying upon bilingual staff members as interpreters (unless trained and assessed as interpreters; Lehna, 2005; Youdelman and Perkins, 2005; Elderkin-Thompson, Silver and Waitzkin, 2001), there is evidence that LEP patients with language-concordant physicians are more satisfied with their care than are LEP patients with qualified interpreters and language-discordant practitioners (Ngo-Metzger et al., 2007; Flores, 2005; Fernandez et al., 2004). Though more research is needed, it is thought that lower satisfaction may be a function of language barriers that remain, despite the provision of services

by qualified interpreters, and of the dynamics that are present in interpreted encounters (the impact of the interpreter's presence in medical encounters is explored in greater detail in Section 4.5).

Qualified Health Care Interpreters

Successful (and ethical) language services utilize qualified health care interpreters to supplement the bilingual workforce. According to the literature, qualified health care interpreters are fluent in the target language, are trained in ethical standards and interpreting techniques, are knowledgeable in ethnic/cultural customs, and provide a level of professionalism and a quality of interpretation that is not achieved when working with 'ad hoc' or 'chance' interpreters, such as family members, friends, untrained medical and non-medical staff, and strangers (Hsieh, 2006; Lehna, 2005; Garcia et al., 2004).

More specifically, the National Standard Guide for Community Interpreting Services (Healthcare Interpretation Network, 2007) recommends interpreters demonstrate interpreting competence, linguistic competence, research and technical competence, and strong interpersonal skills. Interpreters should have active listening skills, good memory retention skills, be able to take notes during the interpretation assignment (to ensure accuracy of the information given), and be able to mentally transpose and verbalize into the target language. Interpreters should "have an in depth knowledge and understanding of his/her working languages and the required range of language registers" and "have knowledge of subject areas and relevant terminology" (Healthcare Interpretation Network, 2007:15), and should have "the ability to efficiently acquire the additional linguistics and specialized knowledge necessary to interpret in specialized cases" (Ibid.: 16). Finally, interpreters should have strong communication skills; be polite, respectful and tactful; be able to relate well to people; and have good judgment (Ibid.).

Almost all of the interpreters for the Calgary Health Region are recruited from the Bow Valley College Certified Health Care Interpreter Program. All of these students have had practicum placements at the Calgary Health Region. Through the program, they are specifically trained to interpret information between health care providers and their patients and clients Before hiring, candidates are tested for proficiency in their own language as well as English. Once on staff, interpreters are tested for proficiency periodically.

Interpretation and Translation Services, Calgary Health Region

The importance of ensuring the availability of trained health care interpreters cannot be overemphasized. Flores (2005) conducted a systematic review to assess the impact of interpretation services on quality of care, and found that ad hoc or chance interpreters misinterpret or omit up to half of all physicians' questions, tend to avoid embarrassing topics, are more likely to commit errors, and have a higher risk of not mentioning the side effects of medication (see also

> Winnipeg Regional Health Authority hired a project coordinator to develop a communications / education strategy for health care providers. A resource package was developed, including a Power Point presentation. Requests for interpreter services have recently tripled, which is attributed in large part to increased awareness of the services.
>
> *Language Access, Winnipeg Regional Health Authority*

Laws et al., 2004); ad hoc interpreters are also more likely to control or influence, rather than facilitate, the patient-practitioner interaction (Lehna, 2005), and reliance upon ad hoc interpreters has been cited as being "associated with the worst quality of care" (Tocher and Larson, 1998: 510, cited in Calgary Health Region, 2002).

It is notable that there remains a tendency among health care professionals to use ad hoc or chance interpreters, with research participants most often citing issues of convenience and cost as reasons for doing so (Gadon, Balch and Jacobs, 2007), but also citing mistrust and time constraints as reason (Lee, Lansbury and Sullivan, 2005). In response, the literature recommends practitioners garner a better understanding of the implications of relying upon untrained interpreters (e.g., through continuing education, discussed below) and make use of available resources intended to facilitate the use of qualified interpreter services (such as toolkits produced by the California Academy of Family Physicians, the American Medical Association, and the Health Resources Educational Trust; Gadon, Balch and Jacobs, 2007; Lee, Lansbury and Sullivan, 2005).

> Language Access made a deliberate decision to hire interpreters as employees, rather than on contract, to enable the provision of training and professional development. Monthly staff meetings include a professional development component, with such topics as interpreting in challenging settings (e.g. cancer care setting) and legal and ethical considerations. Interpreters are also provided with an orientation to sites that may pose challenging interpretation encounters, such as Women's Health Centre where clients require interpretation during abortion-related visits.
>
> *Language Access, Winnipeg Regional Health Authority*

4.4 Education and Training for Interpreters and Practitioners

Interpreter Training and Competency Protocols

In the absence of a national accreditation body for health care interpreters, the onus rests with the health care organization to establish standards for the minimum required qualifications of interpreters (McGlynn, 2007; Green et al., 2005; Laws et al., 2004). To facilitate this process, the Massachusetts Department of Public Health (2004) best practice guidelines suggest following the standards

for core skills, knowledge and ethical understanding endorsed by the National Council on Interpretation in Health Care:

> **Core skills** include language proficiency, accuracy and completeness of interpretations, ability to manage the flow of communication between patient and staff/provider, and the ability to serve as a cultural broker, as necessary;
>
> **Core knowledge** includes understanding of medical terminology and concepts in English and interpreted languages, knowledge of specific cultural concepts and of biomedical culture, and understanding 'untranslatable words;'
>
> **Ethical understanding** includes knowledge of the ethics of confidentiality, accuracy, completeness, conveying cultural frameworks, non-judgmental attitudes about the content interpreted, client self-determination, attitude toward clients (trust and respect), acceptance of assignments (and disclosing conflicts of interest), compensation, self-evaluation (representing their qualifications accurately and completely), ethical violations (withdrawing from encounters perceived to violate the code of ethics), and professionalism.

The interviews with Managers of interpretation and translation services programs, conducted for the present report, indicated that health care interpreters are also encouraged to participate in professional development opportunities on a regular basis. Professional development may be offered by the interpreter services program or by an outside agency. In sites where interpreters are hired as employees, professional development is often provided by the employer. Programs utilizing interpreters hired on contract, on the other hand, usually do not have the capacity (e.g. authority) to provide additional training, and in such cases interpreters are informed of and encouraged to attend external learning opportunities.

> The Calgary Health Region holds staff meetings for the Interpretation and Translation staff every four to six weeks and provides three to five in-services each year, which are specific to interpretation and translation. In addition, the interpreters attend general Regional staff training on a range of topics, such as mental health, end of life issues and genetic counselling.
>
> *Interpretation and Translation Services, Calgary Health Region*

Bilingual Health care Workers as Interpreters

Standards should also be in place for assessing the qualifications of bilingual staff and practitioners asked to interpret. Moreno et al. (2007) describe a Language Competency Assessment Test used in a large California health care system. The

test is administered by a private agency, includes written and oral components, and measures language comprehension, communication skills, and knowledge of medical terminology. Staff and practitioners who pass the test at the medical level are permitted to interpret in medical encounters, while those who pass only at the basic level are permitted to interpret in non-clinical encounters (e.g., scheduling appointments).

> Bilingual and multilingual staff members at the Calgary Health Region undergo language proficiency testing (oral and reading) before they are approved by the Region to perform their duties in the language for which they have been tested. Testing is done with the assistance of Regional interpreters or the telephone interpretation service. Ensuring the staff members are skilled in their first language helps to ensure quality control for interpretation.
>
> *Interpretation and Translation Services, Calgary Health Region*

Practitioner Training in the Importance and Use of Interpreter Services

There is ample evidence that practitioners are less likely to use interpretation services when they do not fully understand the presence and implications of language barriers, when they believe their own second-language skills are sufficient, or when they believe that working with ad hoc interpreters (e.g., family, friends) is adequate (Lee, Sullivan and Lansbury, 2006; Brach, Fraser and Paez, 2005; Gerrish, Chau and Birks, 2004; Bischoff et al., 2003).

> The use of 'ad hoc' interpreters is observed mainly among younger, newer staff members. Formal education curricula are considered inadequate for providing training in the cultural dimensions of health care, and hospital orientation for new staff members tends to be information-intensive and not ideal for cultivating an understanding of the importance of using trained health care interpreters. Older and more senior staff members, on the other hand, have learned through experience with diverse clientele the importance of using interpreters.
>
> *Anonymous Language Services Program Manager*

Interviews with interpretation services program Managers, conducted for the present report, also revealed that the risks of not using qualified health care

> Like other interpretation services programs, Fraser Health Language Services Program has increased the convenience of requesting an interpreter by using a single telephone number to place requests. They also provide cards, available to all staff, which provide instructions on how to request an interpreter.
>
> *Language Services Program, Fraser Health*

interpreter services are not always well understood. According to the Manager of Winnipeg Regional Health Authority's Language Access program, Dr. Sarah Bowen analyzed the Winnipeg Regional Health Authority Integrated Risk Management Framework to identify the impact of language barriers on the risks, and found that of 154 high level risks, 43 contained evidence of the impact of language barriers. Winnipeg Regional Health Authority is working on a draft Interpreter Services Policy

which will highlight instances where health care providers must request the services of trained health care interpreters (e.g. when obtaining informed consent or discussing a diagnosis).

Health care staff members are also less likely to use interpretation services when they have difficulty identifying patients' need for interpretation (Kazzi and Cooper, 2003); for example, patients may be identified by staff members as LEP, but may be perceived by staff as speaking English well enough to 'get by' (Schenker et al., 2007)[9].

> One of the hospitals in Capital Health has made a deliberate effort to keep the paperwork for requesting an interpreter to a minimum. A simplified request form was developed to keep the process simple and the time required minimal.
>
> *Anonymous Language Services Program Manager*

Finally, practitioners and staff are more likely to rely on ad hoc interpreters when they are not fully aware of the processes and procedures for requesting the services of qualified interpreters (Ibid.).

> The Calgary Health Region promotes the interpretation service to staff through a brief session in their orientation (2.5 to 3 minutes) and on an ongoing basis through tabletop displays, print material and stickers on telephone handsets. While awareness of the service has increased, it is thought that the majority of staff members are still unaware of the service.
>
> Interpretation and Translation Services, Calgary Health Region

Educating staff and practitioners in the benefits of qualified health care interpretation services has been demonstrated to increase the likelihood that their services will be employed (Karliner, Perez-Stable and Gildengorin, 2004). Continuing education is most effective when it includes information on the impact of language barriers on patient care, the negative outcomes of relying upon untrained or ad hoc interpreters, protocols and procedures for accessing / requesting interpreters, and ways of working effectively with interpreters (Chen, Youdelman and Brooks, 2007; Gany et al., 2007; Hunt and de Voogd, 2007; Hsieh, 2006; Nailon, 2006). The most effective method of raising awareness among practitioners, however, is through their involvement in the design and implementation of language services (Wu et al., 2007).

Practitioner Training for Working Effectively with Interpreters

Interpreters cite the communication skills of practitioners as a main barrier to effective interpretation. The tendency of practitioners to speak rapidly and without pause, and to present complex information and use medical jargon, is cited as particularly problematic (Abbe et al., 2006). LEP patients also report

[9] Assessment tools for identifying the need for interpretation services are discussed in Section 4.6.

difficulty comprehending complex information and medical jargon (Ibid). In response, the literature recommends continuing education for practitioners that would emphasize the importance of speaking slowly, of providing longer and more frequent pauses for interpretation, and of avoiding the use of complex medical concepts and jargon (Rosenberg, Leanza and Seller, 2007).

> One of the greatest challenges for the Calgary Health Region Interpretation and Translation Service is to get health care practitioners and clients to realize they need a professional interpreter and cannot rely just on family members or any staff member that speaks the non-English language. With family members and non-certified staff, there are no controls for confidentiality or interpretation quality. With certified health care interpreters, confidentiality is assured and quality controls are in place.
>
> *Interpretation and Translation Services, Calgary Health Region*

Interpreters also cite practitioners' lack of cultural knowledge as negatively affecting the quality of interpreted encounters; in a study conducted by Abbe et al. (2006), 82% of interpreters felt the physicians with whom they worked did not sufficiently understand the cultural beliefs, values, norms and practices of LEP patients. Interpreters interviewed by Hudelson (2005) reported frequently observing discrepancies between the patients' and physicians' ideas about illness (observing that patients may try to hide or minimize symptoms of illnesses that are highly stigmatized in their cultural communities), expectations of the clinical encounter (e.g. patients may arrive late as is customary in their culture), and communication styles (e.g. patients may be unfamiliar and uncomfortable with Western medical questioning styles). Both communication skills and cultural knowledge may be developed through continuing education opportunities.

> Some staff are resistant to using the telephone interpretation service because they think the interpretation will be better if they can see the interpreter in person and read body language. There are also concerns among some staff about confidentiality issues if interpretation is provided over the telephone.
>
> *Interpretation and Translation Services, Calgary Health Region*

The literature review and environmental scan present a strong case for the use of qualified health care interpreter services and the importance of educating health care staff in the risks associated with relying on ad hoc or chance interpreters. Educating health care staff to work effectively with interpreters is equally important. It is also necessary to understand the dynamics of the patient-interpreter-practitioner relationship, discussed in the next section.

4.5 Interpreter – Practitioner Collaboration

Increasing Practitioners' Confidence in the Quality of Interpretation

A common experience of practitioners, and a potential contributing factor in their reluctance to use health care interpreter services, is the practitioner's

inability to know whether their interpreted messages have been effectively conveyed, both in terms of accuracy and emphasis (Nailon, 2006; Cioffi, 2003). Abbe et al. (2006) surveyed pediatric oncologists and found that one-third cited this uncertainty as the most salient reason for their reluctance to use interpreter services. The literature suggests practitioners' confidence in the interpreted encounter may be enhanced when practitioners become at least somewhat

In order to enhance patient understanding of and comfort with the interpreter role, Winnipeg Regional Health Authority (WRHA) interpreters are trained to introduce themselves and their function prior to interpreting, and WRHA has produced a document entitled "Key Points in Interpreter Introduction," specifying the content of the introduction. Interpreters are required to state their name, who they represent (WRHA Language Access Interpretation Services), their role (to deliver messages as faithfully as possible); and that they will interpret with accuracy and fidelity (everything said will be interpreted). Interpreters further discuss confidentiality and impartiality (the interpreter is there to interpret for both parties), clarify that they practice 'first person' interpreting (parties to speak directly to each other), and explain that they will be using note-taking as a memory aid and that notes will be destroyed at the end of the session. Finally, interpreters indicate that it may be necessary to clarify something that is not clearly understood, and request permission from the patient/client/resident to interpret.

Language Access, Winnipeg Regional Health Authority

fluid in the target language, when they work consistently with the same interpreter, when interpreters have the medical background required to accurately transmit the messages, and when practitioners simplify their explanations and avoid using jargon (Houston and Cowley, 2003).

Balancing the Triad Relationship

The introduction of an interpreter to a health care encounter unavoidably influences the patient-practitioner relationship. The quality of rapport and the potential for relationship-building between the patient and practitioner is sometimes felt to be compromised by the presence of an interpreter (Rosenberg, Leanza and Seller, 2007; Aranguri, Davidson and Ramirez, 2006; Cornes and Napier, 2005; Fatahi et al., 2005; Miller et al., 2005). The triadic relationship is also potentially disconcerting for the LEP patient (Greenhalgh, Robb and Scambler, 2006; Blake, 2003). Research conducted by Green et al. (2005) found that LEP patients using interpreter services were more likely than LEP patients with language-concordant physicians to withhold questions about their health care, particularly when discussing sensitive issues. While further research is needed to fully understand and assess the impact of the triadic relationship on health outcomes, it is useful for practitioners and interpreters to be aware of the dynamics, and to develop, as they are able, methods of enhancing the practitioner-patient relationship and enhancing patient comfort. For example, interpreters can refrain from engaging in side conversations with the practitioner, which may cause the patient to perceive the interpreter and practitioner as 'teaming up' in a negative fashion (Laws et al., 2004).

Role Expectations in the Collaborative Relationship

It is not uncommon for interpreters and practitioners to have different expectations of the interpreter's role. As mentioned, interpreters vary in the extent to which they self-identify as conduits of messages, cultural clarifiers, and cultural brokers and patient advocates; similar variance is found among practitioners (Rosenberg, Leanza and Seller, 2007; Hsieh, 2006). The most commonly cited method for addressing role ambiguity (and role conflict) is through effective communication, wherein interpreters and practitioners discuss and clarify role expectations including, for example, whether interpreters are expected to alert patients and practitioners to misunderstandings or explain cultural references and meanings (Rosenberg, Leanza and Seller, 2007; Hsieh, 2006). The literature also suggests interpreters and practitioners meet, as time permits, before the interpreted encounter, to ensure both parties have a shared understanding of the goals of the consultation and to discuss linguistic and cultural issues that may affect the quality of the consultation (Cornes and Napier, 2005; Lee, Lansbury and Sullivan, 2005).

We have seen, then, that increasing confidence in the quality of the interpreted health care encounter, developing rapport in an interpreted encounter, and balancing role expectations and demands are essential to providing quality health care. We now turn to consider best practices in the delivery of interpretation services.

> While acknowledging the importance of raising awareness of interpretation services in the community, it is equally important to ensure that sufficient capacity is in place before advertising too broadly. Winnipeg Regional Health Authority has developed a detailed strategy for implementing a public awareness campaign, but is withholding the campaign until they have developed sufficient capacity to meet the increased demand that greater public awareness will generate. The present focus is on raising awareness among health care providers.
>
> *Language Access, Winnipeg Regional Health Authority*

4.6 Delivery of Interpretation Services

Best practices in the delivery of interpretation services pertain to identifying and assessing patient language needs, protocols for requesting an interpreter, interpreter availability and timely delivery of interpretation services, and ensuring adequate appointment time.

> At present one tertiary hospital in Winnipeg Regional Health Authority uses an electronic patient record with language fields. At this site, admitting staff are provided with training and a carefully drafted script for asking about language needs. The script is currently undergoing evaluation (including community feedback), and when finalized, will be available to other health care organizations as an example of 'promising practice' in identifying language needs during the intake and patient registration process.
>
> *Language Access, Winnipeg Regional Health Authority*

Identifying and Assessing Language Needs

Best practices in the identification and assessment of language needs include having effective procedures in place that enable patients with language needs to easily self-identify as requiring language services. Increasing the likelihood that patients will self-identify requires the organization to employ (and monitor) practices that facilitate awareness-building of clients, including awareness that interpretation services are available and ways of accessing those services (Sentell, Shumway and Snowden, 2007; Sasso, 2004). Common methods of

> The North DeKalb Health Clinic and L.A. Care Health Plan introduce language services at the first point of contact by using "I Speak" cards and posters at the front desk; the signs list the languages spoken in the service area and enable the client to point to the language they speak. Once language preference is identified, it is noted in the patient file, or a brightly colored sticker is affixed to the medical record to identify the language needs and whether interpretation services have been accepted or declined, allowing for any health care worker to readily identify the language needs of particular patients.
>
> *L.A. Care Health Plan, cited in Youdelman and Perkins (2005)*

informing LEP patients of language-service availability include the posting of multi-lingual signage at all points of entry to the health care facility, and advertising the availability of services (and access protocols) in community newspapers and through community outreach workers (Chandrika et al., 2007; Bowen, 2004; Massachusetts Department of Public Health, 2004; Kazzi and Cooper, 2003). Some organizations provide LEP patients with wallet-size cards identifying the language in which interpretation services are required, carried by patients and presented at subsequent visits, while others facilitate self-identification by having bilingual staff members wear colour-coded badges identifying the languages they speak; when approached by a LEP patient, the staff member can direct them to interpretation services (Kazzi and Cooper, 2003).

The Calgary Health Region increased its interpretation service reliability by switching the dispatch role from clerks who had numerous other responsibilities to dedicated dispatch clerks who underwent extensive training. Complaints about the program went from approximately one a week to one every three or four months.

Interpretation and Translation Services, Calgary Health Region

The identification of language needs is also the responsibility of health care staff, and in some programs, is the primary mode of identification. The Massachusetts Department of Public Health (2004) best practice guidelines for hospital-based interpretation services recommend that during intake, staff members ask LEP patients whether they speak a language other than English at home. If the answer is affirmative, patients should then be asked "How well do you speak English." If the patient answers anything other than "very well," the patient should be considered to benefit from interpretation services in their preferred language. The use of open-ended questions is believed to create a less pressured situation and thus minimize the risk that the patient will provide a misleading response.

Various assessment tools are also available, which effectively reduce the burden on staff and practitioners to make a determination of language needs, and include the Basic English Skills Test, the Short Test of Functional Health Literacy Assessment, and the Need for Interpreter Risk Factor Assessment (see Downey and Zun, 2007; Enslein et al., 2002).

As interpretation services are implemented in various sites in the Winnipeg Regional Health Authority, the sites are provided with a package that includes signage and other materials providing information on the services, including protocols for requesting an interpreter.

Language Access, Winnipeg Regional Health Authority

Once identified, the need for interpretation services should be documented in the patient's file for future reference (Carter-Pokras et al., 2004)[10]. If interpretation services are dispatched, details of the service should be documented (including the name of the interpreter and the language interpreted), and if interpretation is declined, the reason for the decline should be noted (Massachusetts Department of Public Health, 2004).

Protocols for Requesting and Acquiring Interpretation Services

Health care providers are more likely to request interpretation services when methods of doing so are simplified and well understood, and the literature

[10] In the U.S., the Joint Commission implemented a new accreditation standard in January, 2006 requiring the patient's language and communication needs to be entered in the patient's record (Chandrika et al., 2007).

recommends developing and raising awareness about protocols for requesting services. In order to simplify request protocols, Winnipeg Regional Health Authority's Language Access program implemented a fax request service; using fax, requests for interpreters can be made in a matter of minutes, compared to phone calls placed after hours to central dispatch which can take up to 20 minutes.

Protocols for requesting interpretation services should include providing as much information about the situation as possible to the interpreter. As stated in the Massachusetts Department of Public Health (2004) best practice guidelines, interpreters should not accept assignments for which they are not qualified. In practice, however, interpreters often receive little information about the assignment, which can impair their ability to gauge their suitability (Cornes and Napier, 2005). It is recommended that interpreters be provided with sufficient information prior to accepting the assignment so that careful consideration can be given to any reasons the interpreter should decline (Ibid.).

> The Calgary Health Region promotes the benefits of the service and attempts to increase confidence about reliability, quality and confidentially, through staff presentations and table top displays. It plans to get the displays into every unit in the Region.
>
> In the broader community, the service is promoted indirectly by networking with community groups and by publishing articles about health issues in language newspapers, e.g., Chinese, Arabic and Korean.
>
> *Interpretation and Translation Services, Calgary Health Region*

Adequate Supply of Interpreters and Timely Delivery of Services

Identifying the need for language services, and having simplified and well-known protocols for requesting an interpreter are best practices, but have limited effectiveness if the health care organization does not have access to a sufficient supply of qualified interpreters available in a timely manner (Davidson et al., 2007; Aries, 2004; Kazzi and Cooper, 2003). Asked to identify the most salient barrier to using interpreter services, nurses and midwives interviewed by Cioffi (2003) cited the lack of interpreters able to accommodate the languages spoken by patients, and the unavailability of interpreters during the night and on weekends. The literature recommends health care organizations examine their ability to provide interpretation services at all times of day, in a timely manner, and that accommodate the languages of the clients served.

> When appointments are booked in advance in hospitals in the Fraser Health Region, the family physician usually notifies the hospital that an interpreter will be required. Advance notice helps the Language Services Program make the necessary arrangements. In addition, Language Line phones are available in all Emergency Departments to accommodate the need for interpreter services on short notice.
>
> *Language Services Program, Fraser Health*

The timely delivery of interpretation services may be enhanced by linking patient registration systems to interpreter scheduling systems. In an effort to improve the delivery of language services in American hospitals, Regenstein (2007) spoke with representatives of hospitals exemplifying promising practices in interpretation services. One of the promising practices to reduce patient wait times was the linking of patient registration systems to interpreter scheduling systems. Because interpretation services was aware of the need for language services upon patient registration, the service coordinator was able to respond quickly, reducing wait times for interpreters, and was better able to anticipate the upcoming need for interpretation resources. Another promising practice was to dedicate interpreters to high-volume locations. Regenstein also found that relying on bilingual staff members to interpret resulted in longer wait times, and the delays very often resulted in having family members or friends interpret.

Fraser Health has found it useful to bring an interpreter into a hospital for regular hours, five days per week, to allow staff members to become familiar with the interpreter and their services; staff members soon come to realize the value of the services, and begin to request interpretation services in additional languages and show an eagerness to learn about the full range of language services available.

Language Services Program, Fraser Health

Finally, many interpretation programs rely on external agencies and telephone interpretation services to provide interpretation in languages less common to the populations served and during nighttime and weekend hours. Interviews with Managers of interpretation and translation services programs conducted for the present report revealed that telephone interpretation is also utilized when interpretation is required on short-notice, as is often the case in Emergency Departments.

While many departments and programs recognize the importance of using trained health care interpreters, and while many will not see a patient without an interpreter, it can be challenging to cultivate interpreter utilization in smaller hospitals, particularly in communities not highly characterized by language diversity.

Language Services Program, Fraser Health

Cultivating 'Buy-in' of Practitioners

Without the 'buy-in' of health care practitioners, even the most well-designed interpreter program will not meet the needs of LEP patients. Evaluations of interpretation programs developed under the Hablamos Juntos initiative in the U.S. revealed that interpreters often struggled to integrate themselves into, and find acceptance within, the health care team. This was attributed to lack of attention, in the development of the programs, to cultivating the support of practitioners:

> Unfortunately, most of the project leaders realized too late in the intervention period that they had not sufficiently communicated to physicians the rationale for the adoption of interpreter programs. None provided training to physicians on how to work with interpreters (Wu et al., 2007: 353).

Practitioner support may be enhanced through education, with the use of simplified procedures for identifying language needs and requesting an interpreter, involving practitioners in the planning and implementation of interpretation services, and "cultivating physician champions to foster behavior change" (Ibid.: 353). Moreover, ensuring an adequate supply of interpreters available in a timely fashion will reduce negative experiences for both LEP patients and practitioners. With adequate supply and simplified protocols, practitioners are more likely to include interpretation services as routine practice; once part of routine practice, practitioners are less likely to be satisfied with the quality of care they provide without interpreters (Regenstein, 2007).

A challenge for the Calgary Health Region interpreters occurs when health care appointments take place later than scheduled. The Regional policy is that interpreters stay at the appointment location for the period of time for which they are booked (interpreter sessions are scheduled for a minimum of 45 minutes). If the appointment is not completed during that time, the interpreters leave that location so they are punctual for their next appointment.

The Region is considering printing cards explaining this policy for interpreters to give to the receptionist on site. This will allow health care providers the opportunity to juggle their schedule, if possible, to allow the interpretation to take place before the interpreter must leave.

Interpretation and Translation Services, Calgary Health Region

Ensure Adequate Time for Interpretation Services

Research has shown that a lack of time during interpreted medical consultations is a major barrier to effective service provision (Greenhalgh, Robb and Scambler, 2006), as well as a source of stress for interpreters, as they attempt to respect the practitioners' time while ensuring enough time is available to ensure the patients' understanding (Hsieh, 2006; Fatahi et al., 2005). In response, the literature recommends as a best practice that practitioners be aware of the additional time required when interpretation services are employed, and schedule longer appointments when it is known that interpretation services will be used (Hunt and de Voogd, 2007; Carl and Partridge, 2004; Herndon and Joyce, 2004). To facilitate this process, some health care organizations have computerized systems that enable an interpreter to be automatically scheduled when patients with identified interpretation service needs schedule appointments (Massachusetts Department of Public Health, 2004).

In addition to the many aspects of program delivery that may be enhanced through best or leading practices, discussed above, becoming competent in the

provision of interpretation and translation services requires health care organizations be mindful of factors influencing interpreter job satisfaction. These factors, including role conflict and status ambiguity, are discussed in the following section.

4.7 Interpreter Job Satisfaction

The success of interpretation services in the health care setting depends in part on the job satisfaction of interpreters. Three main sources of dissatisfaction experienced by interpreters, according to the literature and interviews, are role conflict, status ambiguity, and difficult assignments.

Role Conflict

Research has found role conflict to be one of the main barriers to job satisfaction among medical interpreters (Rosenberg, Seller and Leanza, 2008). Specifically, interpreters often experience competing expectations from their professional role, the health care practitioner, and the patient. While codes of ethics suggest interpreters should remain neutral / objective conduits of messages, practitioners, patients and interpreters' personal beliefs and values may require interpreters to act as message clarifiers and/or patient advocates. Dohan and Levintova (2007) illustrate this role conflict with findings from their research with interpreters serving Russian-speaking cancer patients in San Francisco. In Russian culture, because cancer treatment is perceived as ineffectual, it is considered inappropriate to tell a patient they have cancer (for fear of diminishing hope). Culturally-informed Russian interpreters who understand this perspective reportedly struggle with the ethical dilemma of whether to translate the physician's diagnosis word-for-word, or whether to rephrase the diagnoses (e.g., substituting 'cancer' with 'tumor,' perceived in Russian culture to be less fatal). Interpreters in the study suggested physicians be educated in Russian culture and be encouraged to permit 'culturally-sensitive' interpretation.

> When interpreters at the Calgary Health Region experience role conflict, they are asked notify the program they are unable to do the interpretation and arrange for another interpreter to be scheduled. A situation in which role conflict might occur is when interpreter who was sexually assaulted in the past is asked to interpret for a sexual assault victim in an emergency department.
>
> *Interpretation and Translation Services, Calgary Health Region*

In addition, Hsieh (2006) recommends interpreters examine their role conflict, as well as their beliefs, self-expectations and experiences, and on this basis, choose their roles and strive to identify role boundaries internally, but also by communicating their preferences and expectations with practitioners and patients. Because interpreters are likely to move between the roles of 'conduit' and clarifier and/or advocate during the course of an encounter, Hsieh also

> Interpreters at the Calgary Health Region are members of the Health Sciences Association of Alberta labour union. While the Region is contract compliant, there has been dissatisfaction over what some interpreters perceive to be a low pay scale relative to interpretation positions in private industry and relative to other diversity positions within the Region that require broader responsibilities, e.g., diversity liaisons.
>
> *Interpretation and Translation Services, Calgary Health Region*

recommends that interpreters advise practitioners and patients when they are changing roles.

Status Ambiguity

A second main source of job dissatisfaction among medical interpreters stems from a perceived lack of recognition for their contribution to the health care system. A lack of recognition may be conveyed by a practitioner's failure to communicate effectively with an interpreter, or a practitioner's failure to enhance the interpretive process by avoiding the use of medical jargon or speaking slowly with adequate pauses (Fatahi et al., 2005), but it may also be conveyed by systemic processes of the health care setting. For example, interpreters are paid for interpreting, but are normally not compensated for their additional services as cultural broker, liaison or advocate, leading the interpreter to perceive that these services are not valued by the organization (Rosenberg, Seller and Leanza, 2008). The lack of dedicated space to place their belongings, receive mail or make telephone calls can further lead interpreters to feel marginalized in the health care system (Rosenberg, Seller and Leanza, 2008; Hsieh, 2006). Status ambiguity and role confusion is compounded by the practice of having interpreters share space with clients prior to the consultation (e.g. in waiting rooms), as clients may engage the interpreter in conversation and in doing so, may disclose privileged information or feel they do not need to repeat the information in the presence of the practitioner (Hsieh, 2006; Fatahi et al., 2005). In response, the literature recommends health care organizations examine their policies and expectations, to ensure that they have realistic expectations of interpreters and appropriate means to accomplish them (Hsieh, 2006).

Interviewees also suggested that status ambiguity may be due in part to a lack of professional designation of health care interpreters. While interpretation programs reportedly recognize the need for professionalization of interpreters,

> The Calgary Health Region uses a standardized translation process to ensure accuracy and readability level of all translated documents, including health information, medical history and immunization records. This process, which is currently under review, involves first translation the information from one language to the other, then back translating into the first language. The purpose of the current process review is to identify other ways of translation that better allow the writer's unique voice to be heard while still ensuring accuracy.
>
> *Interpretation and Translation Services, Calgary Health Region*

interpreters themselves, as a group, do not appear to be moving in this direction[11].

Difficult Assignments / Debriefing

While not identified as a best practice in the literature, interview data revealed the importance of providing support to interpreters when given difficult assignments. Managers stressed the importance of speaking with interpreters about their experiences before and after difficult assignments, and of requesting that the interpreter be involved in debriefing sessions.

Before turning to best practices in the evaluation and assessment of interpretation and translation services, it is useful to review the literature on guidelines for the translation of written materials, and the literature on telephone and video interpretation. Neither topic has generated a large body of literature, but a summary of findings is provided below.

> Translation requests at the Calgary Health Region undergo a prioritization process as more requests for translation are received than can be accommodated.
>
> *Interpretation and Translation Services, Calgary Health Region*

4.8 Additional Language Services

Guidelines for Translation of Written Materials

In addition to interpretation services, language services in health care settings include the translation of written materials, such as consent forms, intake and other administrative forms, advanced directives, financial and programmatic application materials, medication labels and discharge instructions (Carter-Pokras et al., 2004; Massachusetts Department of Public Health, 2004).

According to the literature, translated materials should be linguistically comprehensible, but also accessible by the intended reader (Colina and Sykes, 2004; Dunckley et al., 2003). To enhance accessibility, the translation of written materials should take into account the level of health literacy of consumers (Carl and Partridge, 2004; Dunckley et al., 2003); it should not be assumed that health care consumers have sufficient literacy skills in their first language to read and comprehend complex medical information. The Massachusetts Department of Public Health (2004) best practice guidelines recommend translated materials use simple language, and recommend developing a centralized, easily accessible source for standardized, validated texts for signage and vital documents in a variety of languages. Dunckley et al. (2003) also note the

[11] Signed Language Interpreters, in contrast, are represented nationally by the Association of Visual Language Interpreters of Canada (Healthcare Interpretation Network, 2007).

importance of validity, recommending translation accomplish cultural equivalency (rather than word-for-word translation) to ensure the translated material conveys the intended message. Finally, translation services should be performed by qualified translators and the health care organization should ensure that translators meet a minimum standard of skills and competencies.

Telephone and Video Interpretation

Telephone interpretation is often used as a substitute for in-person interpretation when on-site interpreters cannot accommodate the languages spoken by LEP patients and when on-site interpreters are not available. Guidelines for the use of telephone interpretation services are provided by Herndon and Joyce (2004), and include ensuring the interpreter is situated in a private setting and equipped with a speaker phone; ensuring all parties are reminded of the confidentiality of the encounter prior to beginning; and having the practitioner describe the setting for the interpreter (e.g., examination room with patient who is six months pregnant). The authors further suggest practitioners develop a list of questions they wish to ask and the information they would like the interpreter to garner prior to the encounter to enhance the 'flow' of the interpreted encounter.

The Calgary Health Region is able to provide telephone interpretation a) 24/7 through a contract service, b) when language interpretation is available through the staff interpreters.

Interpretation through video is not available yet but may be a possibility in the future through the use of laptop computers.

Interpretation and Translation Services, Calgary Health Region

Video interpretation is becoming increasingly popular as a means of overcoming the inadequacies of telephone interpretation (such as the inability to read non-verbal cues). While best practices in video interpretation are not well documented in the literature, the criteria used by Holy Name Hospital in the U.S. in selecting their video interpretation service may serve as a guide (Hirsch and Marano, 2007). Specifically, Holy Name selected a video interpretation service that was available on demand (24/7), that was easy to use and provided high quality picture and sound, that used encrypted transmission, provided medically trained interpreters, was cost effective, and offered staff training. The hospital reports that the greatest benefit of using video interpretation is the rapid availability of interpretation services; because their language needs are met immediately, patients and their families feel their needs are respected. The next goal of Holy Name is to implement video interpretation on-demand in every patient room using existing in-room television monitors, and to make video interpretation available to paramedics and EMTs at accident or disaster scenes.

Summary

The literature review and interviews revealed a number of best or leading practices in the development, implementation and delivery of language services, in the areas of human resources, education and training, and with respect to managing the interpreted encounter and enhancing interpreter job satisfaction. One of the key recommendations in the literature concerns the evaluation and assessment of interpretation and translation services, to which we turn now.

5.0 EVALUATION OF INTERPRETATION / TRANSLATION SERVICES

The literature recommends as a best practice the annual evaluation or assessment of interpretation and translation services, including assessments of resources, service delivery, and client outcomes (Bowen, 2004; Massachusetts Department of Public Health, 2004). Each area for assessment is discussed below, and a sample of available assessment tools is provided in Appendix B.

> The interpretation service of the Calgary Health Region underwent an extensive evaluation in 2007. The evaluation involved focus groups, in-person interviews and telephone surveys with patients and staff and a review of the program data base. The evaluation identified a set of recommendations for improvement that will help to guide future planning.
>
> *Interpretation and Translation Services, Calgary Health Region*

Resource Assessment

Annual assessments should include a review of the resources available for the development and implementation of interpretation and translation services, and should include procedures for identifying additional resources that are needed to address any gaps in service, as well as the steps that could be taken to obtain and utilize those additional resources (Massachusetts Department of Health, 2004).

Service Delivery Assessment

> The value of an interpretation and translation service is difficult to assess but can be inferred from this example in the Calgary Health Region:
>
> A cancer patient arrived in Calgary with the results of her comprehensive diagnosis workup. The medical records, however, came from a tumour clinic in Beijing. The 10-page medical document was translated by an interpreter, reviewed by a medical doctor, and provided to the patient's treatment team in Calgary. The translation process saved the Region the cost of repeating the tests and spared the patient the ordeal of undergoing the tests a second time.
>
> *Interpretation and Translation Services, Calgary Health Region*

Annual assessments should document and evaluate the procedures used to identify and track the language needs of health care consumers, and should examine utilization data to evaluate the provision of services, including the frequency of use, the types of interpreters utilized, and the circumstances or conditions in which interpreter services are used (Chandrika et al., 2007). More specifically, evaluations should identify whether charts are flagged to indicate the patients' need for interpretation services, whether patients are receiving interpretation services when required (and how this is known), how long it takes,

on average, for an interpreter to arrive, and how often the medical encounter takes place without an interpreter (and why; Carter-Pokras et al., 2004). Interpreter qualifications and employee knowledge of existing policies and procedures should further be examined, as should grievance procedures for patients, including provisions for patients who feel they have not been provided with adequate interpretation services (Hsieh, 2006; Bowen, 2004; Massachusetts Department of Public Health, 2004). Assessments should also identify the types of information that is being translated in the health care setting, into which languages, and by whom (Massachusetts Department of Health, 2004). Gaps in service and short-comings of service delivery should be identified and response strategies developed (Carter-Pokras et al., 2004; Massachusetts Department of Health, 2004).

Client Outcome Assessment

Assessments should solicit and respond to feedback from users (patients/providers) and interpreters, including satisfaction measures (Regenstein, 2007; Massachusetts Department of Public Health, 2004). Assessments should solicit patient and provider views on the ease of accessing interpretation services, including their perceptions of interpreter response time, cancellation rates, and simplicity of the required paperwork and required documentation (Regenstein, 2007).

> While implementing their interpretation services, Language Access conducted a parallel evaluation. The purpose of the concurrent evaluation was to enable the program to adjust to feedback during the implementation process.
>
> *Language Access, Winnipeg Regional Health Authority*

In summary, becoming competent in language services requires health care organizations not only develop and implement programs that are informed by best or leading practices, but requires also the ability and commitment of the organization to monitor the delivery of such services and their impact.

6.0 SUMMARY AND CONCLUSIONS

The Calgary Health Region strives to be a model organization for the delivery of culturally competent health care. Growing diversity in the linguistic composition of Canadian society, growing awareness of the negative health outcomes of linguistic incompetence, and legal and labour implications of not providing qualified interpretation and translation services together make an exploration of best and leading practices in language-related services a timely endeavor.

Scholarly literature dating from 2001 to present, combined with interviews with Managers of exemplary interpretation and translation service programs, have provided a solid understanding of the various models of interpretation and roles of the health care interpreter, and have illuminated a plethora of what are considered to be best or leading practices in interpretation and translation services.

While our understanding of exemplary practices borrows from standards of practice and codes of ethics of the health care interpreting profession, the literature on such standards and codes also heightened our awareness of some of the ethical dilemmas facing health care interpreters, including the extent to which interpreters can and should adhere to the principle of neutrality and the challenges associated with negotiating multiple and sometimes conflicting roles.

The literature review and interviews have also enhanced our understanding of some of the key ingredients for developing and implementing strong interpretation and translation services programs, including the organizational view that interpretation and translation services are essential for quality health care, the dedication of sufficient program resources, the development of formalized policies and procedures, systematic evaluation of the language needs of the communities served, centralized coordination of services, community involvement, and participation in broader interpretation and translation services networks.

Best practices related to human resource development were identified, including the recruitment and retention of bilingual and multilingual staff members, the use of qualified health care interpreter services, and educating staff members about the role of health care interpreters. Issues related to enhancing practitioners' confidence in the quality of interpreted encounters, and to the dynamics that emerge between patients, interpreters and practitioners were explored and best practices identified.

Service delivery issues were also explored, with best practices emerging with respect to how clients with language needs are identified and how clients are made aware of interpretation and translation services. Best practices in protocols for requesting and acquiring an interpreter were identified, as were methods of enhancing the likelihood that practitioners will utilize qualified health care interpreters even when using the services of a family member or friend to interpret for example is more convenient. The literature on health care interpreter job satisfaction was consulted, and the findings provided insight into role conflict, status ambiguity and difficult assignments as main sources of job dissatisfaction.

The best practice section of the report concluded with a look at the evaluation and assessment of interpreter and translation services. Annual, systematic assessments of resources, service delivery, and client outcomes were recommended in the literature and interviews.

In the next section of the report, we identify areas in which the Calgary Health Region exemplifies best practices in interpretation and translation services, and consider ways in which the Region may continue to grow.

7.0 RECOMMENDATIONS FOR THE CALGARY HEALTH REGION

The Calgary Health Region is an exemplar of many best practices in health care interpretation and translation. These include:

- Dedication to the principle that language services are inherent to the provision of safe and acceptable care with the use of the dedicated interpreter model (employing nearly 50 certified health care interpreters);
- Development of a formalized, centrally administered interpretation service;
- Participating in broader networks for information sharing and to keep abreast of developments in provincial, national and international standards of practice for health care interpreters;
- Conducting regular assessments of the need for interpretation services in the communities served including identification of the different languages spoken and the volume of interpreted encounters conducted and anticipated;
- Liaising with communities to promote interpretation services and to garner feedback for program improvement;
- Establishing standards for the minimum required qualifications of interpreters and providing in-services specific to interpretation and translation to ensure interpreters keep abreast of developments in interpreter skills and knowledge; and
- Establishing standards for assessing the qualifications of bilingual and multilingual staff and practitioners asked to interpret;

As immigration rates in Canada continue to rise, the demand for interpretation and translation services in the health system will increase. Based on this literature review and environmental scan, the following recommendations about Interpretation and Translation Services can be made for the Calgary Health Region as the Region strives to adhere to, and become a model for, best practices:

- While networking is an effective method of keeping up-to-date on advances in interpretation standards of practice, it is also recommended that the Region consider monitoring best practices through periodic scans of the literature. A brief annual scan for example would serve to keep the present literature review up-to-date, thereby ensuring its continued usefulness;
- The Region might consider publishing information about Interpretation and Translation Services as a means of sharing best practices with the broader health care community, locally as well as provincially, nationally and internationally;
- Periodic reviews of and adjustments to policies and procedures for service delivery (including formalized methods of publicizing patients' rights to

interpreter services and methods of accessing services; identifying and assessing patients' need for services; guiding staff in the use of language services; and ensuring proper documentation of the interpreted encounter); for human resources (including continuing education requirements of interpreters and staff and period assessments of interpreters); and for ongoing program monitoring and evaluation are recommended;

- Language services are most effective when developed and implemented in consultation with representatives of the population served. It is recommended that the Region examine existing relationships with populations utilizing (and under-utilizing) interpretation services and consider how these relationships might be better used as a mechanism for distributing information about interpretation services and for soliciting feedback about ease of access and the quality of interpreted encounters. The extent to which existing and potential relationships might be used as a means of distributing information about the importance of using qualified health care interpreter services (as opposed to family members or friends), how to access interpreter services, the role of interpreters, and feedback mechanisms should also be examined and where necessary, strengthened;
- The Region should continue to provide in-services for interpreters, should keep abreast of developments in continuing education in interpretation (e.g. by networking with other organizations and scanning websites related to interpretation for new issues/topics/courses), and should solicit and respond to the learning needs of interpreters employed by the Region;
- It is critical that patients be aware of the availability of interpretation services and how to access them. Methods currently used to communicate this information should be examined for their exhaustiveness (e.g., are multilingual signs posted at all points of entry in every health care facility?) and their effectiveness (e.g. is the information presented in simple language). The Region might consider practices used by other organizations and described in this review, such as having bilingual and multilingual staff members wear badges identifying the languages they speak who can provide LEP patients with information on how to arrange for an interpreter. The likelihood that patients will become aware of interpretation services and methods of accessing them is greatest when all staff members are equipped with this information. It is therefore recommended that additional steps be taken to raise awareness among all staff members;
- One of the greatest challenges facing interpretation services is reluctance on behalf of health care providers to utilize the services. Barriers identified in the literature include lack of awareness about the risks of relying upon

untrained interpreters, unfamiliarity with procedures for arranging for an interpreter, mistrust of the quality of interpretation or concerns about confidentiality, and failure to identify the need for interpretation.

- This study did not identify any formalized methods of educating staff in the Region about the risks of relying upon untrained interpreters. In addition to print materials, it is recommended that staff members have the opportunity to attend an information/learning session about the importance of using qualified health care interpreter services for quality health care;
- Though the extent to which staff members are aware of the procedures for arranging for an interpreter in the Region is unknown, this research identified the perception that the majority of staff are unaware of the availability of interpreter services and likely unaware of the procedures for arranging for an interpreter. It is recommended that steps be taken to educate all staff members about the services available and procedures for accessing them. It may be the case that the current 2-3 minute overview provided during staff orientation is insufficient, and the Region might consider dedicating more time to this topic. Ongoing reminders may also be necessary, given the vast amount of information new staff must absorb during orientation. The use of tabletop displays in every unit in the Region holds promise, and the Region should continue to identify alternative methods of communicating information about interpretation services;
- There is anecdotal evidence that some staff members in the Region are reluctant to use telephone interpreters because of concerns about the quality of interpretation (e.g. not being able to read the body language of the interpreter) and concerns about confidentiality. Because utilization is highly contingent on perceptions of quality, it is recommended the Region review available guidelines for the use of telephone interpretation services, such as those provided by Herndon and Joyce (2004), which include for example ensuring that the interpreter is situated in a private setting and equipped with a speaker phone, and ensuring all parties are reminded of the confidentiality of the encounter prior to beginning. As a further remedy to the limitations of telephone interpretation it is recommended the Region continue to explore the use of video interpretation.
- The extent to which staff members in the Region successfully identify or fail to identify the interpretation needs of clients is not known. Because utilization of interpretation services is contingent in large upon the ability for staff members to identify and respond to interpretation needs, it is recommended that the Region review

current methods of needs identification and develop and implement additional or more formalized methods as necessary. Questions to consider include: Does the Region have formal protocols for identifying language needs during early stages of patient contact (e.g. are interpretation needs assessed at intake)? Are there formal methods for recording interpretation needs and outcomes (in patient files for example)? Standardized protocols will enable the Region to track cases in which interpretation is provided, and cases where interpretation is requested but not provided (e.g. refused). Emerging trends (e.g. higher than average refusal or unmet needs in a particular unit) can then be investigated and addressed (e.g. through increased education on protocols for requesting an interpreter or methods of identifying the need for interpretation).
    - Finally, practitioners are more likely to use interpretation services when doing so is convenient. The Region might consider soliciting feedback from practitioners to identify (real and perceived) inconveniences and take measures to increase convenience.
- While this study did not garner information on the job satisfaction of interpreters employed by the Region, the literature identified a number of issues affecting job satisfaction of health care interpreters generally. These include ineffective communication skills of practitioners, status ambiguity and perceived lack of recognition for their contribution to the health care team, role conflict, and difficult assignments.
    - Qualities of practitioner communication negatively affecting the quality of interpretation include rapid speech and the use of medical jargon. It is recommended that practitioners be educated on the importance of speaking slowing and avoiding jargon and that interpreters consider reminding practitioners of the preferred communication style prior to beginning the interpreted encounter.
    - It is important that the role of the interpreter in the health care system be acknowledged and educating all staff members in the Region about the importance of interpretation is a recommended first step. Additional measures may include providing interpreters with dedicated space (e.g. a place to receive phone calls and space to leave personal items) and providing interpreters with separate waiting spaces (see Section 4.7).
    - Interpreters often experience competing expectations from their professional role, the health care practitioner, and the client. Educating health care providers and clients about the role of the interpreter is an important first step, but interpreters should also be provided with opportunities to network with fellow interpreters for the sharing of experiences and of strategies for coping with role

conflict. Role conflict and methods of dealing with competing expectations should also be topics included in continuing education for interpreters.
    - Efforts should continue to be made to provide interpreters with opportunities to discuss difficult assignments before and after the assignment and should be encouraged to be invited to (and to attend) debriefing sessions when available.
- Finally, it is recommended that the Region continue to utilize the data garnered from the extensive evaluation undertaken in 2007 to strengthen the delivery of interpretation services. In addition, the literature recommends conducting annual evaluations for the purpose of identifying and responding to challenges arising in terms of resources, service delivery, and client outcomes. The Region should ensure that annual assessments solicit and respond to feedback from users (both patients and staff), including their views on procedures used for the identification of the need for interpretation services, the ease of accessing interpretation services, and the experience of the interpreted encounter itself. Interpreters should also be consulted to identify issues related to job performance and job satisfaction.

REFERENCES

Abbe, Marisa, Christian Simon, Anne Angiolillo, Kathy Ruccione and Eric D. Kodish. 2006. A survey of language barriers from the perspective of pediatric oncologists, interpreters, and parents. **Pediatric Blood and Cancer**. Vol. 47: 819-24.

Aranguri, Cesar, Brad Davidson and Robert Ramirez. 2006. Patterns of communication through interpreters: A detailed sociolinguistic analysis. **Journal of General Internal Medicine**. Vol. 21(6): 623-29.

Aries, Nancy R. 2004. Managing diversity: The differing perspectives of managers, line workers, and patients. **Health Care Manager Review**. Vol. 29(3): 172-80.

Bancroft, Marjory. 2005. **The Interpreter's World Tour: An Environmental Scan of Standards of Practice for Interpreters**. National Council on Interpreting in Health Care.

Bernstein, J., E. Bernstein, Dave A. Hardt, T. James, J. Linden, P. Mitchell, T. Oishi and C. Safi. 2002. Trained medical interpreters in the emergency department: Effects on services, subsequent chargers, and follow-up. **Journal of Immigrant Health**. Vol. 4(4): 171-77.

Bischoff, Alexander, Thomas V. Perneger, Patrick A. Bovier, Louis Loutan and Hans Stalder. 2003. Improving communication between physicians and patients who speak a foreign language. **British Journal of General Practice**. Vol. 53: 541-46.

Blake, Caminee. 2003. Ethical considerations in working with culturally diverse populations: The essential role of professional interpreters. **CPA Bulletin**. June: 21-23.

Bowen, Sarah. 2004. **Language Barriers within the Winnipeg Regional Health Authority: Evidence and Implications**.

Brach, C., I. Fraser and K. Paez. 2005. Crossing the language chasm: An in-depth analysis of what language-assistance programs look like in practice. **Health Affairs**. Vol. 24(2): 424-34.

Calgary Health Region. 2008. **Regional Diversity Directional Document, 2008-2012**.

Calgary Health Region, Diversity Services. 2002. **Business Case for Centralized Regional In-House Interpretation and Translation Services Initiative**.

California Healthcare Interpreters Association. 2002. **California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles & Intervention**.

Carl, J. and M.R. Partridge. 2004. Crosscultural communication in those with airway diseases. **Chronic Respiratory Disease**. Vol. 1: 153-60.

Carter-Pokras, Olivia, Marla J.F. O'Neill, Vasana Cheanvechai, Mikhail Menis, Tao Fan, and Angelo Solera. 2004. Providing linguistically appropriate services to persons with limited English proficiency: A needs and resources investigation. **American Journal of Managed Care**, Special Issue. Vol. 10: SP29-SP36.

Chandrika, Divi, Richard G. Koss, Stephen P. Schmaltz and Jerod M. Loeb. 2007. Language proficiency and adverse events in US hospitals: A pilot study. **International Journal for Quality in Health Care**. Vol. 19(2): 60-67.

Chen, Alice, Mara K. Youdelman and Jamie Brooks. 2007. The legal framework for access in health care settings: Title VI and beyond. **Journal of General Internal Medicine**. Vol. 22(Suppl2): 362-67.

Cioffi, Jane. 2003. Communicating with culturally and linguistically diverse patients in an acute care setting: Nurses' experiences. **International Journal of Nursing Studies**. Vol. 40: 299-306.

Colina, Sonia and Julie Sykes. 2004. Educating parents in the Spanish-speaking community: A look at translated educational materials. **Bilingual Research Journal**. Vol. 28(3): 299-318.

Cornes, Andy and Jemina Napier. 2005. Challenges of mental health interpreting when working with deaf patients. **Australian Psychiatry**. Vol. 13(4): 403-08.

Davidson, Natasha, Sue Skull, Hanny Calache, Donna Chesters and Jane Chalmers. 2007. Equitable access to dental care for an at-risk group: A review of services for Australian refugees. **Australian and New Zealand Journal of Public Health**. Vol. 31(1): 73-80.

Dohan, Daniel and Marva Levintova. 2007. Barriers beyond words: Cancer, culture and translation in a community of Russian speakers. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 300-05.

Downey, La Vonne A. and Leslie Zun. 2007. Testing of a verbal assessment tool of English proficiency for use in the health care setting. **Journal of the National Medical Association**. Vol. 99(7): 795-98.

Dunckley, Maria, Rhidian Hughes, Julia Addington-Hall and Irene J. Higginson. 2003. Language translation of outcome measurement tools: Views of health professionals. **International Journal of Palliative Nursing**. Vol. 2(9): 49-55.

Dysart-Gale, Deborah. 2007. Clinicians and medical interpreters: Negotiating culturally appropriate care for patients with limited English ability. **Family and Community Health**. Vol. 30(3): 237-46.

Elderkin-Thompson, Virgina, Roxane Cohen Silver and Howard Waitzkin. 2001. When nurses double as interpreters: A study of Spanish speaking patients in a US primary care setting. **Social Science & Medicine**. Vol. 52: 1343-58.

Enslein, J., T. Tripp-Reimer, Choi E. Kelley and L. McCarty. 2002. Evidence-based protocol: Interpreter facilitation for individuals with limited English proficiency. **Journal of Geront. Nursing**. Vol. 28(7): 5-13.

Fatahi, Nabi, Bengt Mattsson, Jasaf Hasanpoor and Carola Skott. 2005. Interpreters' experiences of general practitioner – patient encounters. **Scandinavian Journal of Primary Health Care**. Vol. 23: 159-63.

Fernandez, Alicia, Dean Schilinger, Kevin Grumbach, Anne Rosenthal, Anita L. Stewart, Frances Wang and Eliseo J. Perez-Stable. 2004. Physician language ability and cultural competence: An exploratory study of communication with Spanish-speaking patients. **Journal of General Internal Medicine**. Vol. 19: 167-74.

Flores, Glenn. 2005. The impact of medical interpreter services on the quality of health care: A systematic review. **Medical Care Research and Review**. Vol. 62(3): 255-99.

Gadon, Margaret, George I. Balch and Elizabeth A. Jacobs. 2007. Caring for patients with limited English proficiency: The perspectives of small group practitioners. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 341-46.

Gany, Francesca, Jennifer Leng, Ephriam Shapiro, et al. 2007. Patient satisfaction with different interpreting methods: A randomized controlled trial. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 312-18.

Garcia, Estevan A., Lonnie C. Roy, Pamela J. Okada, Sebrina D. Perkins and Robert A. Wiebe. 2004. A comparison of the influence of hospital-trained, ad hoc, and telephone interpreters on perceived satisfaction of limited English-proficient parents presenting to a pediatric emergency department. **Pediatric Emergency Care**. Vol. 20(6): 373-78.

Gerrish, Kate, Ruby Chau and Elizabeth Birks. 2004. Bridging the language barrier: The use of interpreters in primary care nursing. **Health and Social Care in the Community**. Vol. 12(5): 407-13.

Green, Alexander R., Quyen Ngo-Metzger, Anna T. R. Legedza, Michael P. Massagli, Russell S. Phillips and Lisa I. Iezzoni. 2005. Interpreter services, language concordance, and health care quality: Experiences of Asian Americans with limited English proficiency. **J. Gen. Intern. Med**. Vol. 20: 1050-56.

Greenhalgh, T., N. Robb and G. Scambler. 2006. Communicative and strategic action in interpreted consultations in primary health care. **Social Science & Medicine**. Vol. 63: 1170-87.

Gregg, Jessica and Somnath Saha. 2007. Communicative competence: A framework for understanding language barriers in health care. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 368-70.

Healthcare Interpretation Network. 2007. **National Standard Guide for Community Interpreting Services**. Available online from: http://healthcareinterpretation.homestead.com/National_Standard_Guide_for_Community_Interpreting_Services.v2..pdf

Herndon, Emily and Linda Joyce. 2004. Getting the most from language interpreters: Communicating with patients who have limited English proficiency requires more than simply "finding someone who speaks their language." **Family Practice Management**. Vol. 11(6): 37-40.

Houston, Anna M. and Sarah Cowley. 2003. Health needs assessment in the health visiting service and the impact on the ethnic community. **International Journal of Nursing Studies**. Vol. 40: 85-94.

Hirsch, Jonathan and Frank Marano. 2007. Better patient care through video interpretation. **Health Management Technology**. Vol. 28(3): 30-31; 37.

Hsieh, Elaine. 2006. Conflicts in how interpreters manager their roles in provider-patient interactions. **Social Science & Medicine**. Vol. 62: 721-30.

Hudelson, Patricia. 2005. Improving patient-provider communication: Insights from interpreters. **Family Practice**. Vol. 22: 311-16.

Hunt, Linda M. and Katherine B. de Voogd. 2007. Are good intentions good enough? Informed consent without trained interpreters. **Society of General Internal Medicine**. Vol. 22: 598-605.

International Medical Interpreters Association. 2006. **Code of Ethics**. Retrieved online February 4, 2008 from: http://www.mmia.org/standards/CodeofEthics.asp

Jacobs, Elizabeth, Alice H.M. Chen, Leah S. Karliner, Niels Agger-Gupta and Sunita Mutha. 2006a. The need for more research on language barriers in health care: A proposed research agenda. **The Milbank Quarterly**. Vol. 84(1): 111-33.

Jacobs, Elizabeth, D.S. Shepard, J.A. Suaya and E.L. Stone. 2006b. Overcoming language barriers in health care: Costs and benefits of interpreter services. **American Journal of Public Health**. Vol. 94(5): 866-69.

Karliner, Leah S., Elizabeth A. Jacobs, Alice H.M. Chen, and Sunita Mutha. 2007. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. **Health Research and Educational Trust**. Vol. 42(2): 727-54.

Karliner, Leah S., Eliseo J. Perez-Stable and Ginny Gildengorin. 2004. The language divide: The importance of training in the use of interpreters for outpatient practice. **Journal of General Internal Medicine**. Vol. 19: 175-83.

Kazzi, G. Bonacruz and C. Cooper. 2003. Barriers to the use of interpreters in emergency room pediatric consultations. **Journal of Pediatric Child Health**. Vol. 39: 259-63.

Laws, M.B., R. Heckscher, S.J. Mayo, W. Li and I.B. Wilson. 2004. A new method for evaluating the quality of medical interpretation. **Med Care**. Vol. 42: 71-80.

Lee, Teresa Sze-Mun, Gerard Sullivan and Gwenda Lansbury. 2006. Physiotherapists' communication strategies with clients from culturally diverse backgrounds. **Advances in Physiotherapy**. Vol. 8: 168-74.

Lee, Teresa S., Gwenda Lansbury and Gerard Sullivan. 2005. Health care interpreters: A physiotherapy perspective. **Australian Journal of Physiotherapy**. Vol. 51: 161-65.

Lehna, Carlee. 2005. Interpreter services in pediatric nursing. **Pediatric Nursing**. Vol. 31(4): 292-97.

Massachusetts Department of Public Health. 2004. **Best Practice Recommendations for Hospital-based Interpreter Services**. Office of Minority Health.

Massachusetts Medical Interpreters Association. Code of Ethics. Retrieved online Feb. 4, 2008 from: http://www.mass.gov/dph/omh/interp/mmia_code_ethics.pdf

Miller, Kenneth E., Zoe L. Martell, Linda Pazdirek, Melissa Caruth and Diana Lopez. 2005. The role of interpreters in psychotherapy with refugees: An exploratory study. **American Journal of Orthopsychiatry**. Vol. 75(1): 27-39.

Morales, Leo S., Marc Elliott, Robert Weech-Maldonado and Ron D. Hays. 2006. The impact of interpreters on parents' experiences with ambulatory care for their children. **Med Care Res Rev**. Vol. 63(1): 110-28.

Moreno, Maria R., Regina Otero-Sabogal and Jeffrey Newman. 2007. Assessing dual-role staff-interpreter linguistic competency in an integrated health care system. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 331-32.

Mullins, C. Daniel, Lis Blatt, Confidence M. Gbarayor, Hui-Wen Keri Yang and Claudia Baquet. 2005. Health disparities: A barrier to high-quality care. **American Journal of Health-systems Pharmacy**. Vol. 62(15): 1973-82.

Nailon, Regina E. 2006. Nurses' concerns and practices with using interpreters in the care of Latino patients in the emergency department. **Journal of Transcultural Nursing**. Vol. 17(2): 119-28.

National Council on Interpreting in Health Care (NCIHC). 2005. **National Standards for Practice of Interpreters in Health Care**.

National Council on Interpreting in Health Care (NCIHC). 2004. **A National Code of Ethics for Interpreters in Health Care**. Retrieved online Feb. 4, 2008 from: http://data.memberclicks.com/site/ncihc/NCIHC%20National%20Code%20of%20Ethics.pdf

National Council on Interpreting in Health Care (NCIHC). 2002a. **Models for the Provision of Language Access in Health Care Settings**. Bruce Downing and Cynthia E. Roat. The National Council on Interpreting in Health Care Working Papers Series.

Ngo-Metzger, Quven, Dara H. Sorkin, Russell S. Phillips, Sheldon Greenfield, Michael P. Massagli, Brian Clarridge and Sherrie H. Kaplan. 2007. Providing high-quality care for limited English proficient patients: The importance of language concordance and interpreter use. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 324-30.

Partida, Yolanda. 2007. Addressing language barriers: Building response capacity for a changing nation. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 347-49.

Pippins, Jennifer R., Margarita Alegria and Jennifer S. Haas. 2007. Association between language proficiency and the quality of primary care among a national sample of insured Latinos. **Medical Care**. Vol. 45(11): 1020-25.

Regenstein, Marsha. 2007. Measuring and improving the quality of hospital language services: Insights from the Speaking Together Collaborative. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 356-59.

Rosenberg, Ellen, Robbyn Seller and Yvan Leanza. 2008. Through interpreters' eyes: Comparing roles of professional and family interpreters. **Patient Education and Counseling**. Vol. 70: 87-93.

Rosenberg, Ellen, Yvan Leanza and Robbyn Seller. 2007. Doctor-patient communication in primary care with an interpreter: Physician perceptions of professional and family interpreters. **Patient Education and Counseling**. Vol. 67: 286-92.

Sasso, Angela. 2004. **Achieving Equal Access in Health Care**. Prepared for The Affiliation of Multicultural Service Agencies and Societies.

Schenker, Yael, Frances Wang, Sarah Jane Selig, Rita Ng and Alicia Fernandez. 2007. The impact of language barriers on documentation of informed consent at a hospital with on-site interpreter services. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 294-99.

Sentell, Tetine, Martha Shumway and Lonni Snowden. 2007. Access to mental health treatment by English language proficiency and race/ethnicity. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 289-93.

Tang, S.Y.S. 1999. Interpreter services in health care: Policy recommendations for health care agencies. **Journal of Nursing Administration**. Vol. 29(6): 23-29.

Vandervort, Elisa Brettler and Gail D'Eramo Melkus. 2003. Linguistic services in ambulatory clinics. **Journal of Transcultural Nursing**. Vol. 14(4): 358-66.

Winnipeg Regional Health Authority. 2008. Code **of Ethics and Standards of Practice for Health Interpreters**. Language Access. June.

Wu, Shinyi, M. Susan Ridgely, Jose J. Escarce and Leo S. Morales. 2007. Language access services for Latinos with limited English proficiency: Lessons learned from Hablamos Juntos. **Journal of General Internal Medicine**. Vol. 22(Suppl 2): 350-55.

Youdelman, Mara and Jane Perkins. 2005. **Providing Language Services in Small Health Care Provider Settings: Examples from the Field**. National Health Law Program Field Report. April.

APPENDIX A: TOOLS FOR LANGUAGE SERVICES ASSESSMENT

Organizational Evaluation of Linguistic Access Tool

The National Council on Interpreting in Health Care (NCIHC) has developed an Organizational Evaluation of Linguistic Access tool that can be employed to help identify the strengths and limitations of existing linguistic services, including risks to the organization, cost drivers, qualitative issues in care delivery, the impact on care outcomes, regulatory compliance issues across ethnic patient populations, and provide a better understanding of ethnic community needs and of internal and external resource availability and allocation. The tool enables an evaluation of the organization as a whole, by addressing the multilingual needs of the patient (e.g. evaluating community demographics and demographics of the patient population receiving care), the organization's approach and commitment toward cultural diversity in terms of organizational structures (e.g., organizational leadership, policies on cultural and linguistic competencies, training, performance appraisals, quality assurance criteria, language tracking, protocols for accessing interpreters, interpreter protocols, hiring and training, and ethno-cultural community involvement), and the way staff and physicians interact with LEP patients on the 'front lines.' It also enables the assessment of bilingually provided services, face-to-face interpreting, telephonic interpreting, external interpretation agencies, and translation services.

Speaking Together

In 2006, the Robert Wood Johnson Foundation launched the Speaking Together: National Language Service Network as an initiative to improve the quality and availability of language services in American hospitals (Regenstein, 2007). Recognizing that few hospitals track data on service supply and demand, Speaking Together developed five performance measures (based on the six domains of quality identified by the Institute of Medicine: safety, timeliness, efficiency, effectiveness, equity and patient-centredness) that hospitals could use to monitor and evaluate their language services. The performance measures, which could be employed to evaluate health care languages in this country, include:

- The percent of patients who have been screened for their preferred spoken language;
- The percent of LEP patients receiving initial assessment and discharge instructions from assessed and trained interpreters or from bilingual providers assessed for language proficiency;
- The percent of encounters where the patient wait time for an interpreter is 15 minutes or less;
- The percent of time interpreters spend providing medical interpretation in clinical encounters with patients; and
- The percent of encounters interpreters wait less than 10 minutes to provide interpretation services to provider and patient.

APPENDIX B: ADDITIONAL RESOURCES

The **California Healthcare Interpreting Association** developed "California Standards for Healthcare Interpreters Ethical Principles, Protocols, and Guidance on Roles & Intervention." Website: http://chia.ws/pages/resources_publications.php

Centers for Medicare & Medicaid Services, Baltimore: CMS. Providing Oral Linguistic Services: A Guide for Managed Care Plans; II. Planning Culturally and Linguistically Appropriate Services: A Guide For Managed Care Plans; III. Best Practices for Culturally and Linguistically Appropriate Services in Managed Care Last modified February 4, 2003. Website: http://www.cms.gov/healthplans/quality/project03.asp

The **County of Los Angeles**, Department of Health Services has produced a card with the message "point to your language; an interpreter will be called" in 23 languages, given to clients with limited English proficiency. For an example, see website: http://www.lni.wa.gov/KingCounty/LanguageIDCard.pdf

The **Maryland Department of Labor, Licensing and Regulation** (DLLR), office of Equal Opportunity And Program Equity established a policy on communicating with individuals with Limited English Proficiency (LEP), and interpretation / translation services (June, 2003). The policy provided specific guidance and instructions for obtaining and providing timely, quality language translation/interpreter services for clients, applicants for program services, applicants for employment, and other DLLR customers. Website: www.dllr.state.md.us/wdplan/attachk.doc

The **Massachusetts Medical Interpreter's Association** provides the Medical Interpreting Standards of Practice. Website: www.mmia.org.

National Center for Cultural Competence Center for Child and Human Development. Georgetown University, A Definition Of Linguistic Competence. Website: http://www11.georgetown.edu/research/gucchd/nccc/documents/Definition%20of%20Linguistic%20Competence.pdf