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# Final Evaluation Report

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## Evaluation of the Language and Culture Facilitation Pilot Project

*FOR SENIORS RESIDING AT THE JEWISH SENIOR  
APARTMENT COMPLEX AND SENIORS IN THE  
COMMUNITY WHO SPEAK RUSSIAN AND YIDDISH*

January 2002

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## Executive Summary

An evaluation of the Language and Culture Facilitation Pilot Project was undertaken from January to September 2001. The purpose of the evaluation was to examine the impact of providing interpretive services to Jewish seniors while accessing health care services. Two sets of face-to-face interviews were conducted to examine changes in Jewish senior involvement with their health care needs and the impact of interpretive services on medical assessments, follow-up and intervention, and patient co-operation. As well, Jewish seniors and health care providers were asked to provide feedback about their experience with interpretive services, while accessing health care services, through a survey.

### *Findings*

- Request for interpretive services continued to expand during the evaluation phase of the Pilot Project. The number of interpretation contacts with Jewish seniors and health care providers increased from four per month in January 2001 to 30 per month (26 for providers) in October 2001. Type of health professionals contacted included physicians, public health nurses, home care nurses, social workers, occupational therapists, respiratory technicians, paramedics, dieticians, registered nurses and providers in the emergency department.
- In general, experience using a trained interpreter was reported to be positive and useful by seniors. Seniors were very comfortable and confident with the services provided, remarking how knowledgeable and accurate the interpreter was. Seniors reported feeling that they understood what the health professional was saying. They also felt that the health professional was able to understand their health issues, medication use and concerns. Ability to communicate with the health provider reduced anxiety during medical visits and increased the confidence of seniors during these visits.
- Providers reported that using a trained interpreter was a very useful and positive experience. Access to this type of service increased awareness of the Russian culture and lifestyle, made the appointment time more efficient and productive, and increased communication between the provider and client. As well, providers reported that clients were more accepting of the provider and that the seniors appeared to feel more comfortable with the interpreter present. Providers were able to explain their role to the seniors and what to expect on subsequent visits.
- Prior to the Pilot Project, interpretation was most frequently provided through family and or friends. A number of limitations were associated with family and or friends providing interpretation including: *Seniors were hesitant to ask family (too busy); untrained interpreters did not always interpret word for word; family and friends gave unsolicited advice to health professionals and to the client; confidentiality, and lack of understanding medical terminology.*

- Advantages of using a trained interpreter included: *Having a better understanding of the situation; reduced anxiety about appointments; information was accurate; more confidential; unbiased; seniors had a better understanding of the health system; providers increased their understanding of the Russian culture; and overall the length of appointments was decreased.*
- Suggested improvements included: *Increasing access (hours); increasing the number of interpreters ensuring that both genders are represented; ensure that introduction protocols are established prior to providing service; distributing a list of interpreters to health providers; and ensuring that interpreters have training in medical terminology*
- The findings of the evaluation indicate that real benefits are gained by providing interpretive services for seniors accessing health care services. Recommendations include:
  - 1) The Health Region should continue to facilitate the provision of interpreter services in health care;
  - 2) Further development of a communication document that outlines availability, service protocols, roles and responsibilities, contact and resource information that would be available for seniors (and other clients) and health providers;
  - 3) Expansion of this type of service to include other client groups; and
  - 4) Further evaluation of health outcomes on a larger sample size to look at health system benefits (*for example, reduced appointment time, improvements with medication use and compliance, impact on emergency department visits and admissions*) and client health benefits (*for example, improved management of health conditions, increased access to health care needs*).

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# Final Evaluation Report

## Evaluation of the Language and Culture Facilitation Pilot Project

### Background

The purpose of the *Evaluation of the Language and Culture Facilitation Pilot Project* is to facilitate informed decision making regarding access to health service options for Jewish seniors living in the Jewish Senior Apartment Complex as well as in the community. More specifically:

- To determine to what extent the Language and Culture Facilitation Pilot Project increases involvement of Jewish seniors with their health care needs through cultural and linguistic interpretation;
- To determine to what extent the Pilot Project increases direct involvement of health care professionals with initial assessment, follow-up and intervention through cultural and linguistic interpretation;
- To determine to what extent the Pilot Project fosters co-operation between Jewish seniors and health professionals; and
- To determine to what extent the Pilot Project increases the involvement of Jewish seniors in identifying and planning health supports.

TriAd Research Inc. was contracted to conduct the evaluation of the Language and Culture Facilitation Pilot Project. This report will present the findings of the evaluation collected through client, health care provider, and project member interviews. Surveys completed by health care providers and seniors accessing interpretive services provide additional information.

### Methodology

- 1) In the initial phase of the evaluation, document and literature reviews were conducted. This review was conducted prior to the development of interview guides and questionnaires to identify expected standards of service provided by interpreters, appropriate use of the interpreters by professional staff as well as potential barriers and benefits to accessing interpretive services in a health care setting.
- 2) Interview guides were developed for face to face interviews that were conducted with project team members [manager, coordinator and interpreter] as well as seniors and health professionals that had accessed the interpreter during the pilot project. Purposeful sampling was used to select those who were interviewed. The logic and power of purposeful sampling lies in selection of information-rich cases for in-depth study. Information rich cases are those

from which one can learn a great deal about issues of central importance, in this case the effects of providing interpretive service for seniors in the health care setting. Information rich cases include those individuals who are knowledgeable and have experience with service delivery provided through the pilot project.

Client [health professional and senior] questionnaires were developed to supplement the qualitative interviews. These questionnaires provide information from the largest possible sample of participants in the pilot project. These questionnaires were distributed from July to September, 2001.

- 3) Interviews were conducted in two phases. In the first phase of interviewing from May-June 2001, a total of eight interviews were completed. In addition to the project team, three seniors and two health professionals who had accessed the interpretive service provided through the pilot project were interviewed. These interviews provided an early assessment of the benefits and limitations of the pilot project so that changes could be addressed early. During the second phase of interviewing, September 2001, 12 interviews were completed with seniors and health care professionals. As well, the interpreter was interviewed a second time.

This report will present all of the data collected for the evaluation period of the pilot project.

## Literature Review

The literature regarding interpreters and health care service provision can be accessed through literature that addresses 'bilingual health communicators,' 'interpreters and health professionals,' nursing literature on cultural diversity and communication,' as well as 'translation studies'. This literature tends to discuss communication issues, barriers, and challenges. There are few evaluation studies or quantitative analyses. Gaps in the literature are evident, particularly with respect to different languages. For example, studies of Spanish interpreting and interaction are more plentiful than other languages, likely due to American recognition of the increasing number of Spanish immigrants. In addition to literature addressing interpretation and health care service delivery, there is a separate literature regarding refugees and their experiences. This literature review is limited to the literature that addresses interpreters, more generally, and, therefore, does not touch on specific challenges or barriers faced by refugees. Moreover, this review is not comprehensive and has been tailored to the particular needs and interests of the pilot project being evaluated.

The literature makes a clear distinction between 'interpretation' and 'translation'. Interpretation can be defined as, "the process of mediating a spoken or verbal interaction between people who speak different languages without adding, omitting, editorializing or distorting meaning" (Agger-Gupta, 2001). While interpretation involves spoken to spoken communication, translation involves written to written communication. This evaluation focuses on interpretation, rather than translation. Nevertheless, the literature on translation studies provides some insight into barriers and challenges regarding interpretation.

The literature on interpretive services in the health care field can be divided into several categories: (1) interpreter's role (2) style of interpretation (3) relationships among interpreter, client and provider (4) consequences of interpreter for health outcome/encounter (5) provision of interpretive services and (6) cultural diversity and language. Hatton and Webb (1993) suggest a similar combination of themes revealed in the literature: (1) selection (2) effectiveness (3) roles and (4) styles. The literature can also be categorized along

methodological lines according to its qualitative or quantitative nature. Most studies are qualitative and involve use of focus groups or semi-structured interviews to gather data.

### ***Interpreter's Role***

More recently, a group of Australian researchers has conducted a review of qualitative data regarding relationships and roles of interpreters and bilingual health communicators. They have published at least three articles. These researchers (Matthews, Johnson, Noble, Klinken, 2000) identify six key features to consider with regards to the roles of interpreters and bilingual communication facilitators:

- scope of language
- language proficiency
- nature of communication/interaction
- nature of contact and relationship
- client responsibilities
- relationship with other health care providers.

Their earlier work (Johnson et al, 1999) emphasized two main components of a bilingual health communication model: (1) language proficiency and (2) context within which language assistance was required. The above features were considered in developing the survey questionnaire for this evaluation. After the pilot project, these identified features may continue to provide useful categories to enhance understanding.

The framework of Matthews et al provides six features regarding interpreter roles. Other work examines the various roles, in addition to interpreting, that health care workers may have. These include roles as 'outreach workers' or 'cultural brokers' in community health settings. The literature regarding cultural brokers tends to focus on the cultural aspects and cultural service provision rather than interpretation, itself. Studies comparing interpreters and cultural brokers are lacking in the literature. One study (Kaufert and Koolage, 1984) of interpreters as cultural brokers examined the role conflicts in the job demands of Cree and Salteau interpreters in two hospitals in remote northern, Native Canadian communities. Kaufert and Koolage found that the interpreters had multiple roles including: (1) interpreters (2) 'culture-broker' informants (providing explanations of Native culture to administrators and health professionals) (3) culture-broker-biomedical interpreters (providing explanations of health to Native patients), and (4) patient advocates. This qualitative study included data collected from interviews with eight interpreters, and from participant observation. The pilot study showed that the main source of conflict in language interpretation roles resulted from "the failure of clinicians and administrators to recognize that the involvement of interpreters added a significant role to clinical encounters that directly influenced the overall social and cultural context of diagnosis and treatment...The interpreters often found it necessary to move beyond the direct translation of the concept to explain the function of an organ or describe a procedure in lay language" (Ibid:284).

In addition, Kaufert and Koolidge noted the conflict related to the power relationship between the medical professional and the interpreter. In light of this conflict, they recommended training opportunities for interpreters, and cautioned that credentialing of interpreters may involve inculcation of values that conflict with the organizational requirements of hospitals, for example. To deal with conflicting values, they further recommended the development of forums to address issues that cultural brokers may face.

### ***Style of Interpretation***

The role of the interpreter in the health care encounter is closely related to the issue of style of interpretation. Interpretation appears to be a simple task but researchers have found its layers of complexity to be confounding for both study and understanding (Matthews et al, 2000). As Hatton and Webb (1993:106) explain, “Bilingual staff often perceived themselves to be ‘interpreting’ although the situations they described did not support their claims to be interpreters, rather they were facilitating communication” (see also Johnson et al, 1999). There are two well-known articles that address style of interpretation. Vasquez and Javier (1991) suggest that the verbatim approach is best while Baker (1981) contends that interpreters functioned best somewhere between the verbatim and the independent approach. While Hatton and Webb (1993) referred to this issue, they did not directly address it in their findings. However, they did note the importance of establishing rapport with the client in their study of 22 registered nurses and 15 interpreters. Rapport points to a more independent approach.

Concerns about complex technical language are also evident in the literature. As Matthews et al (2000) explain, “The ability of health staff to translate complex technical language into language accessible to non-technical or lay persons is vital to successful communication” (Bourhis et al, 1989; Scott and Weiner, 1984; Swenson, 1984).

### ***Relationships among Interpreter, Client and Provider***

Another qualitative study (Hatton and Webb, 1993) noted 3 styles of interactions among interpreters, clients and health professionals. As the researchers explained, the “voice box” interpreter is one who simply acts as the client’s voice and does not assist, enable nor hinder or change the situation and the meaning of what is being said. The “excluder” excludes the client and may filter information between the client and the health professional. The “collaborator” collaborates with both the client and the health professional. According to the researchers, the collaborator model resulted in the most effective rapport with clients. Rapport facilitated client assessment and planning/delivery of services.

In Hatton’s earlier work (1992) she found that interpreters made judgments about what information to relay to either the client or the provider based on appraisal of the situation along four subdimensions: (1) task appraisal (2) client appraisal (3) provider appraisal (4) information appraisal. Task appraisal included categorizing of tasks into those that were “boring” and “best”; the second of which included the opportunity to learn about the client. Client appraisal involved appraising the capabilities and knowledge of clients, and then intervening based on this appraisal. Hatton found that interpreters had specific expectations of providers and providers were appraised based on whether or not they met the expectations. Information appraisal included consideration of its complexity. Underlying this study was a definition of ‘translators’ as, “more accurately, interpreters who appraise tasks, clients, providers and/or information, and they hold considerable power” (Hatton, 1992). This model and definition of an interpreter raise issues for consideration. In the future, the pilot project team will want to consider how the interpreters in the pilot appraise tasks, clients, providers and information, how this may change over time, and to what extent it affects the outcome of the pilot project.

The effects of interpreters on communication between the health professional and the client are also discussed in the literature. Phelan and Parkman (1995) explain that interpreters work toward being invisible but their presence can change dynamics. For example, their presence may make a patient more inhibited about interrupting or asking questions. They suggest that patients should be constantly encouraged to ask questions. This article also points to another concern of the literature, the best type of interpreter. Phelan and Parkman use the Audit Commission of the NHS distinctions: (1) bilingual health workers (2) trained interpreters (3) friends and relatives and (4) untrained volunteers. They conclude that trained interpreters are the “best option.”

### ***Consequences of Interpretation for the Health Outcome/Encounter***

In terms of the impact of the interpreter on the health outcome, Kravitz et al (2000) undertook a study of 285 Medicaid patients of which 112 were English-speaking, 111 were Russian-speaking and 62 were Spanish-speaking. The intent of the study was to evaluate the effect of language on visit time controlling for patient demographics and health status. The study found that the Spanish and Russian speakers took an additional 9.1 and 5.6 minutes of the physician's time, on average, per encounter. Kravitz et al hypothesized that, in addition to taking more time, physicians might compensate for their inability to take a precise history by ordering more laboratory tests or requiring specialty consultations. While they found no statistically significant differences regarding the number of tests, the researchers concluded that the Russian-speaking patients were nearly two times as likely as English-speaking patients to receive one or more specialty referrals ( $p < .003$ ). After reviewing additional literature, Kravitz et al (2000) noted that Russian patients may be more likely to complain of "red flag" symptoms such as chest pain or to request consultations more vociferously (see Smith, 1996; Brod and Heurtin-Roberts, 1992).

While Kravitz et al's study highlighted the effect of language on visit time, a study by Jackson et al (1997) examined the impact of medical interpretation on understanding. Jackson et al found that eighty-two percent of a sample of 34 Cambodian refugees who had been educated about hepatitis B through public health outreach did not understand the term used. The meaningless term involved translation of hepatitis B as 'rauk tlaam' or 'liver disease'. In contrast, all respondents understood terms that included symptoms but did not refer to diseased organs. The words chosen by the medical interpreters reflected "medical thinking" and "medical authority". Jackson et al emphasized the need for interpreters to choose between medical terminology focused on the liver and Khmer terminology that identified recognizable experiences and used Khmer health concepts. In this case, knowledge of medical terminology may have been a hindrance to communication. The need to weigh medical terminology and the terminology of the patient's language may be a challenge for the interpreter. Few studies exist addressing the use of medical terminology or noting the importance of knowledge of medical terms for interpreters in health care settings. One other exception is an early study that identified interpreter's lack of familiarity with biomedical terminology as a potential source of conflict (Bloom et al, 1966).

Another study dealing with the consequences of interpretation provision for the healthcare encounter addressed satisfaction with interpreters. It used a satisfaction survey to identify issues of importance to the client with regards to the use of interpreters in their health care interactions. The study examined satisfaction with Spanish interpreters in an ambulatory care setting. Over 90 percent of respondents rated accuracy, accessibility and respect for confidentiality as 'important' or 'very important' (Xuo and Fagan, 1999) The study also found that patients (94%) were more concerned than health professionals with the ability of the interpreter to assist them after the physician visit (Ibid.). This finding suggests an expanded role for the interpreter. It may be useful for administration to consider to what extent patients involved in the pilot or in future interpretation interactions may desire interpreter assistance after their visit to a physician or specialist. How comfortable will interpreters and health care professionals be with such interactions?

### ***Provision of Interpretive Services***

An area of recent interest in the literature is provision of interpretive services. As these services become more widely offered within health care organizations, attention to service delivery has resulted. The work of Agger-Gupta (2001) provided a broad review of the literature addressing intercultural communication and transcultural nursing, organizational diversity in healthcare settings, health implications of patient language, and health outcome disparities between English and non-English speaking patients. His research identified and described “theoretical models of the ways in which professional health care interpretation and culturally appropriate care were initially created and how front-line managers of interpreter services and their executives construct and depicted these services as legitimate and integral to their health care organization” (Ibid:1). Agger-Gupta’s interdisciplinary, qualitative, comparative, grounded-theory work involved interviews with 33 health professionals from 14 organizations in two provinces and four states regarding the development of interpretive services. From qualitative data, he developed a 4 stage model of interpretive service development including: (1) “making do” (2) “launch” (3) “normative growth and maturation” and (4) “culturally and linguistically appropriate health care”.

In addition to the usefulness of Agger-Gupta’s dissertation regarding the development of interpretive services, he also provides some information regarding the unique needs of the Calgary Health Region. As a consultant, he was involved in surveying 840 (42 percent response rate of 2005 staff surveyed) frontline staff. Fifty-five percent of the respondents agreed or strongly agreed that without an interpreter they did not have enough patient information to know what diagnostic tests to order while 48 percent agreed or strongly agreed that without a qualified interpreter present they were concerned about the validity of informed consent regarding treatment of non-English speaking patients (Agger-Gupta, 1998). These findings provide a background and basis for this study.

Agger-Gupta’s work is seminal; hence there are few, if any, studies that address the development of interpretive services. A related area of interest is the way interpretive service may be provided in the community. Few studies address this. There are some articles about language banks, but these tend not to be evaluative (Novak et al, 1983; Reis, 1998). Discussions of outreach workers or cultural brokers tend to focus on the outcomes of particular interventions, rather than the way service has been provided, or its effectiveness.

### ***Cultural Diversity and Language***

Finally, some of the literature regarding interpretation and translation in health care addresses the issue of cultural diversity in institutions. James (1998) argues that cultural interpretation is often provided by institutions that have done little more than add a service for clients from cultural minorities while leaving intact their service structures – structures that have historically viewed language and cultural differences as problems. There is a need to work within institutions where service providers and administrators understand language as a cultural, social and political instrument through which individuals articulate their identities, realities and understandings of their cultural contexts and service needs. This issue is relevant to the evaluation as the context within which the pilot occurs is always a concern of the evaluators.

The work of Fong and Gibbs (1995) who examined the development of cultural competence in human service organizational settings may also be relevant for the pilot project. While the article addresses the specific challenges posed for multicultural workers, many of their findings may be applicable to interpreters. Fong and Gibbs identify three main constraints to organizational change in the direction of cultural diversity and acceptance of multicultural workers: (1) being new (2) being different and (3) bureaucratic demands. They note that multicultural workers are especially vulnerable to exclusion, isolation and unfair workloads (Gutierrez, 1992; Seck et al, 1993). Moreover, Fong and Gibbs explain that pre-existing services, rules and procedures may not always be appropriate in serving cultural communities. They note that multicultural workers are often hired after an agency has

explored other alternatives and found them ineffective and therefore, the worker may experience the frustration of having an instant workload as well as the potential that their role is dead-ended at the service level. These concerns are important for the pilot project team to consider if they wish to retain high quality interpreters.

The work of Fong and Gibbs also points to considering the integration of multicultural workers, or, in this case, interpreters, within the larger organization. The authors make five recommendations: (1) Organizations should acknowledge their impetus for the desire to hire multicultural staff. (2) Initial tasks may involve developing outreach efforts to lay leaders in the community, creating linkages with other agencies, subcontracting etcetera. (3) Reaching new communities is not the sole responsibility of any one individual but the organization as a whole. (4) The agency should consider optimal ways to cluster culturally diverse staff to create a critical mass so they are no longer singled out as tokens in various units, also to avoid the opposite extreme of segregating them in one unit or one geographic area. (5) Agency administration and staff must share a clear understanding about the required level of skills and knowledge necessary to deliver effective services to the target population, ability to develop community ties and the need for language skills.

### ***Transferability of Evaluation Findings***

The limitations of this evaluation are related to the pilot project's use of one interpreter, and the focus on two ethnic groups, Jewish and Russian seniors. The literature appears to suggest that there may be cross-cultural differences in the acceptance of interpretive services. For example, Maltby (1998) found that Vietnamese women were not always happy with their interpreters. She pointed to their distrust of the translation, preferring to go without something rather than use an interpreter, and waiting for extended periods for the Vietnamese physician instead of short periods to use an interpreter in their health care encounter. As this evaluation report demonstrates, the Russian and Yiddish clients who took part in this pilot seem to be very open to the use of interpreters, as well as satisfied with the service. The extent to which this openness and satisfaction would be indicative of other ethnic groups, and clients is unknown. Moreover, because only one interpreter was used in this pilot project much of its success may hinge on the capabilities of that interpreter, rather than other factors.

Nevertheless, the limitations must not overshadow the potential contributions of the pilot project. The findings of this evaluation report including (1) literature review (2) articulation of key constructs to consider (3) thematic findings and (4) potential for empirical research in cost-benefit or cost-efficiency are programmatically applicable to other contexts. This last area is also a fruitful one for future research. There are few studies on cost-effectiveness or cost-benefit (Agger-Gupta, 2001). Other gaps in the literature include discussion of medical interpretation and patient consent, comparisons of cultural brokers, outreach workers and interpreters including their various role challenges, and implementation studies describing how interpretive services are provided and accessed.

# Evaluation Findings - Qualitative

## Qualitative results

This section presents the finding from qualitative interviews conducted with seniors, health professional and project team members.

### 1) Phase one - implementation

#### **A) Training**

The pilot project hired and trained an interpreter in January of 2001. Training included:

- Review of the video “How to communicate effectively through an interpreter”;
- Discussion of techniques of interpreting;
- Provision to the Interpreter of the “Standards of Health Care Interpreting” (draft) and Review of the Standards with Interpreter;
- Training of the Interpreter with respect to the health care system in Calgary, its structure and information about hospitals, training about medical terminology, etc.; and
- Ongoing assistance provided by the project team with regards to issues related to interpreting through Interpretive Services (Calgary Health Region).

#### **B) Protocol for access established**

Seniors were made aware of the interpretive service through Jewish Family Services. As well, seniors indicated that they saw a notice posted on the bulletin board in their complex (Jewish Seniors Apartment Complex).

The process for accessing the interpreter during the pilot project was:

- 1) Client telephoned project coordinator through Jewish Family Services
- 2) Coordinator contacted the interpreter; and
- 3) Interpreter contacted the seniors to arrange interpretation.

Depending on the situation, the interpreter would call the health professional on behalf of the senior to arrange/change an appointment time. As the pilot project progressed and relationships were established, health care professionals began calling the interpreter directly to arrange appointments with seniors for medical visits.

For seniors, the contact prior to their appointment was a telephone call from the interpreter. If there was time before the session the client and interpreter discussed “what was going on”. The home care nurse reported that she would arrange to meet the interpreter just prior to the appointment with the senior and both providers would arrive at the appointment together.

*“time before appointment very beneficial, help to identify what papers/documents are needed for the appointment” [provider]*

*“interpreter and the nurse normally come together....seldom have a chance to meet with interpreter (ahead of appointment)” [senior]*

## 2) Phase 2 – Interpretive Service for Seniors and Health Care Providers

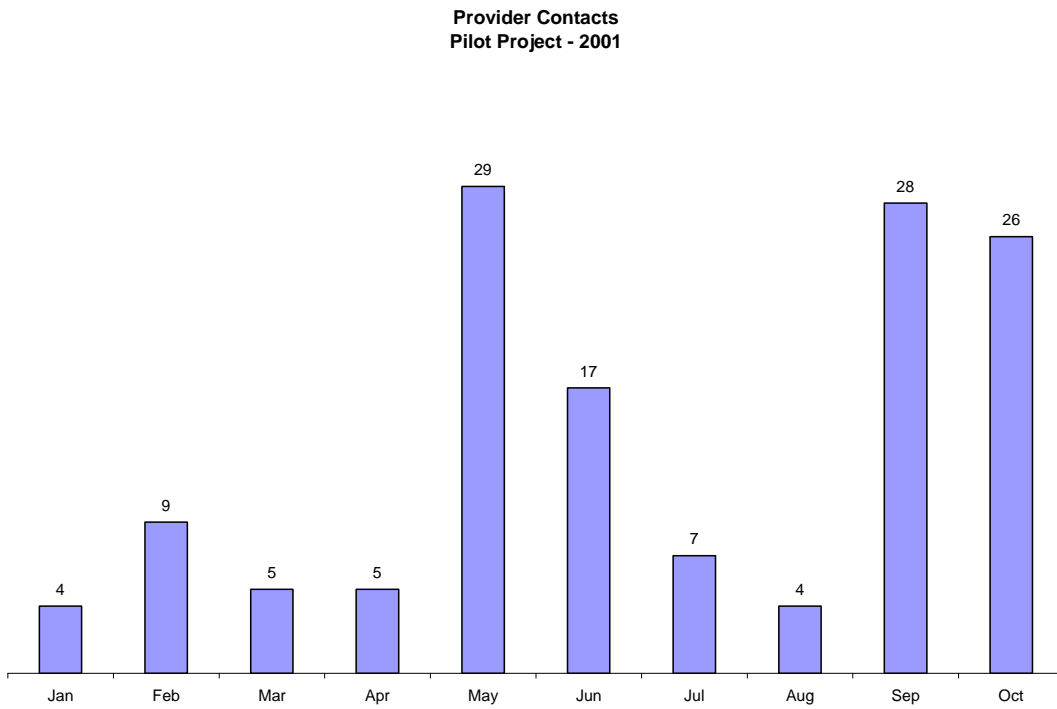
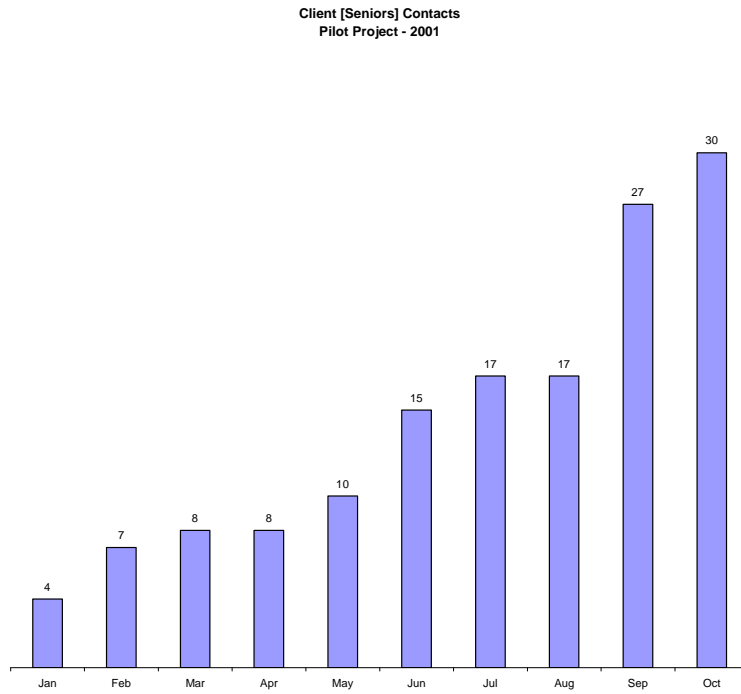
### A) Pilot Project Activity

Request for interpretive services continued to expand during the evaluation phase of this pilot project. Interpretations were provided while seniors were receiving services from, for example, the following health professionals:

- 1) Physician
- 2) Public health nurse
- 3) Home care nurse
- 4) Social worker
- 5) Occupational therapist
- 6) Respiratory technician
- 7) Paramedics
- 8) Dietician;
- 9) Registered Nurse; and
- 10) Providers in the emergency department, intensive care, and a cardiology unit.

Figures 1 and 2 illustrate increasing contact with seniors and health care professionals for the period of the pilot project evaluation.

**Figures 1 & 2: Number of interpreter contacts**



## B) Experience using interpreters - comparison

### **Interpretation provided prior to the pilot project**

Before the pilot project began, respondents reported using an interpreter on at least one occasion. However, the interpreter was typically a family member or a neighbour/friend of the senior. Sometimes *“I knew who they would allow me access...sometimes someone over the phone...”* [provider].

Prior to the pilot project family and friends of seniors were often the only option available to health care providers. Limitations associated with using family and friends to provide interpretation were:

- Seniors were hesitant to ask family. Seniors were apprehensive about calling family members because they felt like they were imposing on their children’s busy lives.

*“...my son is always busy..”* [senior]

*“...families are not able to take time off work to provide interpreting...because they are often financially responsible..”* [provider]

- Untrained interpreters [family/friends] may not always interpret word for word. Interpretation provided through family and friends was not verbatim. Seniors felt like family would *“not always tell them everything”*.

*“The person in the building was going on and on and the actual client would only say one word.”* [provider]

- Family and friends gave unsolicited advice to health professionals and or the client.

*“...I told [the senior] that they should .....”* [provider]

- Confidentiality. Participants indicated that interpretation by family or friends is not always optimal as the seniors’ situation may be sensitive and they may not want family or friends to know about it.

*“it’s a small community...family members don’t want other family members to know about their situation”* [interpreter]

- Lack of medical terminology and understanding of medical terms. This was identified as a limitation when family or friends interpreted, potentially resulting in misinformation and inappropriate use of, for example, medications. Lack of medical terminology may be a confounding factor for families and friends when attempting to interpret verbatim.

*“...not sure our daughter asked questions correctly..”* [senior]

## **Interpretation provided through the pilot project**

Throughout the evaluation period, all respondents reported that accessing the trained interpreter from the pilot project was a positive, useful experience. Seniors were very comfortable and confident with the services provided, remarking how knowledgeable and accurate the interpreter was. Seniors reported feeling that they understood what the health professional was saying. They also felt that the health professional was able to understand their health issues, medication use and concerns. Ability to communicate with the health providers reduced anxiety during medical visits and increased the confidence of seniors during these visits. Seniors participating in the pilot project often accessed the interpreter's services on more than one occasion.

Providers who were interviewed also reported that using a trained interpreter was a very useful, positive experience. Access to this type of service increased awareness of the Russian culture and lifestyle, made the appointment time more efficient and productive, and increased communication between the provider and client. As well, providers reported that clients were more accepting of the provider and that the seniors appeared to feel more comfortable with the interpreter present. Providers were able to explain their role to the seniors and what to expect on subsequent visits.

### **More specifically:**

- All seniors felt that by using a trained interpreter both the senior and the health professional had a better understanding of the situation. Seniors felt that the interpreter had a good understanding of their needs. Furthermore, seniors were more informed about their health thereby increasing their ability to make more informed decisions about their health.

*“..[the interpreter] understood everything...she could explain to the nurse all the previous medications I took...” [senior]*

*“...gave us [husband and wife] all the information we needed...we could ask questions and get answers ...we understood exactly the type of medications we needed to take....we felt the doctor understood...” [senior]*

*“...[the interpreter] understood everything...we have a common language” [senior]*

*“...definitely getting more information...even the ones that have minimal English...taking an interpreter made the difference...got more information..” [provider]*

*“...you are able to address issues that they would be unable to explain...or because the family is bias...you don't get the true story...” [provider]*

*“for example, a client was misusing medication because of limited English...I thought it was just that [the client] was stubborn...and it was because of poor language skills...[the client] was trying to remember everything by memory...[the client] was not able to read English or Russian....” [provider]*

*“helps with understanding medications...in expressing concerns to the doctor” [senior]*

*“easier to make decisions” [senior]*

*“explaining through drawing and writing is often not enough...” [provider]*

- Some seniors indicated that unless they had an emergency they would likely re-schedule an appointment if the interpreter was not available.

*“...without the interpreter there is no use going to [the] appointment..” [senior]*

- All participants [seniors and providers] felt comfortable with a trained interpreter.

*“..I felt completely comfortable..[the interpreter] has a good attitude and she cares” [senior]*

*“I feel more comfortable that all things have been addressed...I feel I’m doing a better job...I am able to conduct tests with [the interpreter] present that I couldn’t do before...” [provider]*

*“Now feel more comfortable and understand what is being communicated. (I) trust (the interpreter)...that (the interpreter) is able to express our concerns.” [senior]*

*“We see her often, she has become like a friend.” [senior]*

- Seniors have reduced anxiety about appointments

*“...(I) used to be nervous when the nurse came ....now I am quiet & calm...” [senior]*

*“...now I am able to understand” [senior]*

*“it makes the patient feel so much better and safer when they have someone who speaks their language...they know they are getting their views across to the [provider]....everybody is understanding” [provider]*

- All participants felt that the information exchanged was accurate.

*“I could ask questions...everything was explained to me and I am very satisfied” [senior]*

*“...made it so easy...I could get a sense of where the patient [e.g. with dementia] was.....instead of trying to guess and hoping that this is what [the patient] means” [provider]*

*“in order to meet the clients needs...because of the language barrier you can’t really do it without having someone ...the interpreter makes it possible for clear communication...word by word ...and them [senior] to understand it....the client doesn’t feel left out” [provider]*

- Having a trained interpreter is more confidential.

Seniors and providers did not have any concerns about confidentiality. Often confidentiality between the health professional and the interpreter were discussed early in their relationship.

*"...its private stuff...I don't discuss.....since I work here, I don't tell anyone anything.." [interpreter]*

- Trained interpreters are unbiased.

Health providers found the interpreter to be unbiased. This was particularly important when conducting sensitive assessments with seniors.

*"...for example, doing a mini mental with a family member....its very difficult for family members to be unbiased....[the interpreter] is interpreting exactly...[the interpreter] doesn't give [the senior] hints or clues.." [provider]*

- One of the participants indicated that they had a better understanding of the health system. For other participants this was less of a concern/issue than understanding the information exchanged between themselves and the health professional that they were accessing at a particular appointment.

*"..[the interpreter] helped me understand the system, though I don't know why I must wait so long for tests..." [senior]*

*"able to make conclusion...without the aid of the interpreter I wouldn't know about various services" [senior]*

*"understand better when the provider will come and for what reason" [senior]*

- Increased understanding of culture

Providers reported that using an interpreter increased their understanding of the Russian culture. Access to an interpreter increased the comfort level of entire families during sensitive situations (e.g. dying parent). In these situations, when family members may not want to discuss options and or wishes of their parent, access to an interpreter was helpful.

*"she helped us understand the Russian culture.....in my role [helping with death and dying] ...there are certain mannerisms... the way family react that are cultural as opposed to individual" [provider]*

*"...trying to find out the wishes of the individual.....one time the son just didn't want to talk to his father about it....many feel that they should be in the hospital [to die]...and that's just not possible anymore" [provider]*

- Understanding of medical terminology

Seniors and health providers reported that they found the pilot project interpreter to be very professional and possessed an excellent understanding of medical terminology.

*"I would see [the doctor] who speaks Yiddish and I speak some Yiddish....but some words are not familiar....with [the pilot project interpreter] it is much easier.... [the interpreter] explains everything in detail...I get more information and understand it..." [senior]*

*"I give [the interpreter] more detail than I would someone without a medical background...." [provider]*

- Length of appointment

Some providers indicated that initial appointments were longer, however, once both the provider and the interpreter had worked together a few times, appointments were actually faster than without a trained interpreter. Longer appointment times are in line with the literature. A recent study (Kravitz et al, 2000) found that use of interpreters was associated with increased physician time in a study of Russian, Spanish and English patients.

*"can get things done really quickly....I can find out what the reaction to medication is...what going on [with the senior]...." [provider]*

*"huge difference....you are able to process things more quickly..." [provider]*

### C) Would you recommend this service?

All of the participants interviewed would recommend this service to others and would continue to access the service if it continues to be available. None of the participants had any concerns about using a trained interpreter.

*"...most people I know speak poor or little English, with the interpreter they can understand the doctor..." [senior]*

*"(my) daughter works and is not always available..."*

*"...of course, it is necessary to communicate"*

*"...with an interpreter I feel much more secure...it has been a huge help....I understand my condition much better...before I simply did not understand [the home care nurse]....I now understand everything and [the interpreter] takes the time to make sure that I understand.." [senior]*

*"I can't say enough about the service" [provider]*

#### D) How could it be improved?

All of the participants felt that the service provided through the pilot project was “invaluable”. Improvements suggested include:

##### 1) Hours available/increasing access

Seniors commented that the project interpreter was not always available. Where possible, Seniors booked ahead and indicated that the interpreter was very flexible and accommodating. Emergency or unpredictable situations made it a challenge to respond to seniors and health professionals because of the limited number of hours the interpreter was available.

While the interpreter managed to accommodate most seniors, as the knowledge of and demand on the interpreter increases, the pilot project may not be able to accommodate the needs of this target group. Many seniors and providers requested that more hours be made available for interpretation.

*“need more time so that the interpreter isn’t always have to run off to another appointment” [senior]*

*“drop in hours....available in office to come by and ask questions” [senior]*

##### 2) Increase the number of interpreters/gender

Many providers and seniors recommended increasing this service so that accessibility would be enhanced. As well, providers suggested that access to interpreters of both genders was very important. Some situations require gender specific interpreters. The interpretation literature supports the providers’ suggestion. The setting, or social context has a bearing on the interactions involved (Hatton and Webb, 1993; Johnson et al, 1999), for example, discussion of sexually transmitted diseases or HIV-testing clinics. Discomfort with the topic of translation can complicate the interaction.

*“once I had a female patient and a male interpreter...I found that awkward because of the nature of the illness.....I was hesitant to ask some questions because of the male female role....especially with the culture....and the age different...a younger male and older female....” [provider—experience prior to pilot project]*

##### 3) Establish introduction protocols

To ensure clarity of the role of the interpreter a protocol around introduction to health care providers should be established. One health professional interviewed reported that they did not know who the interpreter was at the beginning of the appointment. A formal protocol should be established/clarified by the team with respect to expectations around introductions at the beginning of an appointment in cases where the health provider has not met with the interpreter at a previous appointment. This will be particularly important in emergency situations, so that

emergency staff understands the appropriateness of the interpreter's presence. Furthermore, providers indicated that it would be useful to know the background of the interpreter as part of their introduction at the beginning of an appointment.

This point was not an issue in the second phase of the evaluation. This was most likely due to better communication on the part of the interpreter and increased knowledge of the interpreter by providers accessing the service.

#### 4) Communication of resources

Providers indicated that it would be very helpful to have a resource list of interpreters that are available, their background, and hours available. This list should be distributed to all health professionals working with individuals and families from a variety of cultures.

#### 5) Training

Participants identified the importance of medical terminology when interpreting for health care providers. As well, additional training specifically about seniors, their psychological and physical concerns/issues is recommended for new interpreters. The need for training is emphasized in the literature. For example, Dodd (1983) recommended that interpreters be given a period of training at the start of their employment in interpreting techniques, medical language, colloquial or slang terms used in relation to health and disease and in the cross-cultural influences of the interpreter's work.

#### 6) Defining the Interpreter's Role

This pilot project has clearly been successful in providing interpretive services to the target group. Providers and clients are satisfied. However, the project team may want to move beyond initial satisfaction with service to consideration of service enhancement/improvement. While providers feel that the interpreter is correctly interpreting the information provided and clients feel the service is of a high quality in comparison to that provided by their families and friends, it is not clear what role the interpreter is playing. {Qualitative data suggest the clients believe the interpreter is translating "word for word" but as the literature explains this is rarely the case and may not be desirable. As Hatton (1992) notes, rather than "conduits", interpreters are "information processors." In her work, Hatton found that interpreters made judgments about what information to relay based on assessments along four subdimensions: (1) appraisal of tasks (2) appraisal of clients (3) appraisal of providers and (4) appraisal of information. As she explained, "In bilingual, bicultural settings, the work was secondary. Of primary importance was the interpretation of the social world that proceeded concomitantly with verbal translation." In the case of the interpreter used for this pilot project, there is an apparent connect with the social world of both the clients and the providers. The extent to which this experience is transferable to other interpretive services depends on a better understanding of that connect. The project team may wish to gather additional information regarding the pilot project interpreter including her appraisal of the four subdimensions noted above as well as reasons beyond providing verbatim translation that she has so satisfied her clients and the providers she interacts with. Possible reasons may include her knowledge, both cultural and medical, as well as her sharing a culture with her clients. The literature is also confounding on whether verbatim or independent interpretation is best. Vasquez and Javier (1991) recommend the verbatim

approach while Baker (1981) found that interpreters functioned best somewhere between verbatim and independent. Finding the right point on the continuum for the particular clients served may be a crucial part of the interpretive process.

#### 7) Integration of the Interpreter within the health system

This service has been demonstrated to be highly useful for both clients and providers. It is also likely to contribute to cost savings as length of appointment for physician visits appear to decrease after the initial visit. Moreover, if clients receive adequate medical care, cost savings are also likely to result as clients seek fewer unnecessary medical visits, need less emergency care and are more empowered to respond to their health needs. The Calgary Health Region should consider stable, consistent provision of this service and, if so, be prepared to inform potential clients of its availability. With the current, unstable nature of the service provision, clients may become less likely to access it to avoid building a relationship and rapport with something that may not exist in the months to come. Integration will require more than simply employing an interpreter. Considerations should be paid to issues raised above including number of interpreters, gender, language and full-time or part-time service. What will best meet client needs with adequate resources while expending the least resources possible?

## Quantitative Findings - Senior and Provider Survey

### Survey Results

The interpreter distributed the survey to all providers and seniors who accessed the service between August and September 2001 (see figures 1 & 2). For seniors, the survey was translated into Russian. Open-ended questions on the senior survey contained few responses and, therefore, will not be discussed in this report.

In total, 13 providers returned questionnaires (*where N is not equal to 13, questions were not completed*). As well, seven seniors returned a feedback form. One client did not complete the form correctly resulting in only six survey responses.

Providers and seniors were asked to provide feedback by indicating their agreement with each of the following statements, where 1=strongly disagree and 5=strongly agree.

SENIORS - Table of survey results [number of responses]

	N	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
It is easy to arrange an appointment with the interpreter	9	0	0	0	0	<b>9</b>
The interpreter treated me well in person	10	0	0	0	0	<b>10</b>
I felt comfortable with the interpreter	10	0	0	0	0	<b>10</b>
The interpreter listened to me	10	0	0	0	0	<b>10</b>
Instructions given by the interpreter were clear and understandable	10	0	0	0	0	<b>10</b>
My questions were always answered to my satisfaction	10	0	0	0	0	<b>10</b>
My needs and concerns were always dealt with	10	0	0	0	0	<b>10</b>
I understand that the interpreter should not give me advice in decisions that I make	10	1	0	0	0	<b>9</b>
I was able to get enough information to make a decision	10	0	0	0	0	<b>10</b>
Having an interpreter made it easier to access medical services	10	0	0	0	0	<b>10</b>
I understand that this service is confidential	10	0	0	0	0	<b>10</b>
I am satisfied with the service I receive here	10	0	0	0	0	<b>10</b>
I would use this service again	10	0	0	0	0	<b>10</b>

In addition seniors were asked "How long did it take to arrange this appointment with the interpreter?". All respondents indicated "same day".

PROVIDERS - Table of survey results [number of responses]

	N	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I felt comfortable with the interpreter	22	0	0	0	5	17
The interpreter listened to me	21	0	0	0	6	15
Instructions given by the interpreter were clear and understandable	18	0	0	0	6	12
My questions were always answered to my satisfaction	20	0	0	0	9	11
My needs and concerns were always dealt with	15	0	0	0	5	10
I am satisfied with the service I receive here	20	0	0	0	7	13
I would use this service again	21	0	0	0	6	15
The interpreter took too long interpreting what I said	22	15	7	0	0	0
I have a better understanding of the role of the interpreter	15	0	0	1	9	5
I was able to communicate effectively with my client	21	0	1	0	6	14
My client was able to make an informed decision	18	0	1	2	7	8
I have concerns about confidentiality	20	14	2	4	0	0

*Note: where "n" is less than 22, the respondent indicated "NA"*

Providers were asked if they *"Had ever used a trained interpreter before?"* Most of the providers (67%) who returned a questionnaire had NOT used an interpreter prior to the pilot project.

Findings from the survey were consistent with qualitative interviews conducted and indicated a very positive response from seniors and providers.

## Summary of Findings

Seniors were less anxious about their health care visits as a result of the interpretive service provided. They had increased comfort with and understanding of information exchanged between the provider and themselves allowing them to participate more actively in the visit, understand test results, understand medication needs and usage. As well, communication through an interpreter resulted in clear communication of provider roles and expectations for the current and subsequent (where applicable) visits. In addition, service was improved because of increased understanding of the Russian culture, lifestyle and family needs.

The pilot project demonstrated:

- 1) Increased involvement of seniors with their health needs;
- 2) Direct involvement of the health care provider with seniors accessing their service;
- 3) Cooperation of the senior with health care providers; and
- 4) Improved health care planning and the identification of health care needs for Jewish seniors.

## Recommendations

The success of this project is evident in the consistent responses from health care providers and seniors who accessed services between January and September 2001. Seniors and providers were very comfortable accessing the services of a trained interpreter.

### **Action Recommended – short term**

- 1) Continue support for this group of seniors.
- 2) Create a communication document that clearly outlines hours of availability and contact information for this interpreter, as well for other interpretive services that are available to health care providers.

### **Action Recommended – long term**

- 1) Expand hours where possible.
- 2) Expand the number of interpreters available (including variety of gender and language).
- 3) The Calgary Health Region should continue to facilitate the provision of interpretive services into health care services.
- 4) Further evaluation with a larger population to determine the health system benefits and outcomes (*for example, reduced appointment time, improvements with medication use and compliance, impact on emergency department visits and admissions*) and client health benefits and outcomes (*for example, improved management of health conditions, increased access to health care needs*).

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