Health Care Interpreter Services: A literature review

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Health care interpreter services in Canada: A literature review

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Introduction

The effects of language and communication in service delivery are increasingly of concern to practitioners as well as policy makers who are concerned with the quality and accessibility of primary health care in Canada (see for example Bowen, 2001b; Romanow, 2002). While there are only a small number of reports on potential language barriers in the Canadian health care system per se, several reports illustrate that difficulties based on language barriers are a reality in the every-day lives of many people in Canada (e.g., Heneman, 1994; Mesa, 1997). That is, although the Canadian health care system is committed to the removal of financial barriers to health care, issues of language access to health care have prevailed in Canada (Bowen, 2001b; Tang, 1999). There are many communities who are less than proficient in either French and/or English and who continue to experience language barriers in health care. These communities include First Nations and Inuit communities, deaf communities, speakers of official languages who live as a minority in a given region, as well as immigrants and refugees (Bowen, 2001b; Crammond, 2002).

According to the latest Census information, 446,290 individuals in Canada speak neither French nor English and about 10% of the entire population speaks a language other than English and French at home (Bowen, 2001b; Statistics Canada, 2001). Although not all immigrants and refugees necessarily encounter language barriers to the same degree in Canada, the literature suggests that those with less than proficient English language skills are particularly affected by the language barriers encountered in the health care system (Bowen, 2001b; Crammond, 2002; Elderkin-Thompson, Silver, & Waitzkin, 2001; Romanow, 2002). This finding is significant in that the number of immigrants and refugees from non-English speaking countries steadily increases and thereby challenges institutions in their provision of accessible services (Poss & Ranger, 1995; Romanow, 2002; Tang, 1999). The foreign-born population in Canada, according to Census data, has reached 18.4%; with higher proportions in metropolitan areas, such as in Toronto (43.7%) (Statistics Canada, 2001). While this is not to say that all immigrants lack complete language proficiency in either official languages, the proportion of immigrants from diverse ethno-culturally backgrounds in metropolitan areas and the increasing diversity of the Canadian population has raised concerns about the ability of the health care system to meet the needs of those with limited English or French language proficiency (Crammond, 2002; Gagnon, 2002; Poss & Ranger, 1995). Using the Longitudinal Survey of Immigrants to Canada, Tsui (2003), for example, found that 3.5% of the total sample reported language as the main difficulty when attempting to access health care in Canada. Similarly, Gagnon (2000) found that Canada is moderately responsive to the health needs of newcomers, and suggests providing interpreter services as part of a strategy to improve on the responsiveness of the health care system to this population. Indeed, studies and reports repeatedly point to the need of addressing language barriers and propose interpreter services as a response to this need.

At the front lines, interpreter services are frequently provided to mediate the language barriers experienced by immigrants and refugees with limited language proficiency in English or French (Bowen, 2001b; Crammond, 2002; Gagnon, 2002). While there is an overall consensus that some form of interpretation is necessary in the delivery of quality health care services to those with limited language proficiency, there is a wide range of interpreter practices and service models in Canada today (Bowen, 2001b; Tang, 1999). Part of the inconsistency around the use and impact of interpreter services in health care comes from the lack of standardization of interpreter services in Canada. Whereas legislation in New Zealand, Australia, and some states such as California and Massachusetts in the United States mandate the provision of extensive interpreter services to those who need it (Gagnon, 2002; Herndon & Joyce, 2004; Keers-Sanchez, 2003), there is to date no specific legislation or court decision acting as a precedent that requires institutions and other health

care service providers to make interpretation available for patients with less than proficient English or French language proficiency in Canada (Bowen, 2001b; Crammond, 2002).

The Deaf community in Canada, on the other hand, has had considerable success in ensuring that sign language interpretation is provided in health care encounters (Crammond, 2002). Based on existing legislation under the Canadian Charter of Rights and Freedoms, two deaf individuals from British Columbia succeeded in arguing that failure to be provided with interpreter services constitutes discrimination on the basis of disability. There have been no precedent setting cases, however, that would guarantee the right to interpreter services in health care for immigrants, refugees, and others who are not proficient in English or French (Crammond, 2002). What is more striking is that the right to interpreter services in health care has not been secured despite the Canada Health Act. The Canada Health Act was developed to guarantee the universal provision of medical services and coverage to all Canadians (Bowen, 2001b; Crammond, 2002; Gagnon, 2002). The notion of accessibility has been a core concept in the development of the Act, which aimed to equalize health discrepancies by equalizing access to health care services (Bowen, 2001b; Romanow, 2002).

Great differences in health status and degree of accessibility to services prevail in Canada (Bowen, 2001b; Gagnon, 2002; Romanow, 2002). Bowen (2001b) suggests that part of the problem lies with the definition of 'universal access' within the Canada Health Act. In the absence of an explicit definition, 'access' tends to be interpreted as a matter of financial resources rather than language barriers (Bowen, 2001b). This may partly account for the regional and provincial variations in health care service provision and the lack of enforceable legislation that would guarantee language access to all Canadians (Bowen, 2001b; Crammond, 2002; Gagnon, 2002). Having said that, this is not to say that interpreter services are never provided to those with limited English or French language proficiency in Canada. There is in fact increasing interest in language access issues and some institutions are attempting to respond to this issue. The government of British Columbia, for example, has developed a policy framework document consisting of guidelines for health providers on the topic of meeting the needs of those experiencing barriers to health care access (Tang, 1999). Similarly, an extensive report by the Commission on the Future of Health Care in Canada published in 2002 identified language barriers as part of ensuring access and ensuring quality in health care (Romanow, 2002).

Nevertheless, inconsistencies across the literature with respect to effectiveness and efficiency, costs, outcomes, impact of interpreter services in health care, as well as best practices, interpreter roles, types of interpretation, and practice models seem to mirror and contribute to the variety of institutional responses to language barriers and access issues in health care. In an effort to provide an overview of the critical issues related to interpreter services in primary health care encounters and settings, a variety of research study reports, community reports, government reports and scholarly literature have been reviewed for this paper. For the purpose of providing a concise snapshot of interpreter services in health care, the review will be limited to spoken language interpretation rather than translations, sign language, or other non-verbal forms of interpretation. While the focus of the review is on interpreter services in primary health care in the Canadian context, literature from the United States, the United Kingdom, and Switzerland have also been included because of the scarcity of Canadian literature and demographic population similarities. Although comparability and generalizations are limited given the specific contexts and populations in each country (Bowen, 2001b), the balance of Canadian and international literature provides an opportunity for contrast and comparison that can be helpful in addressing potential shortcomings of interpreter services in the Canadian context.

Language barriers in health care encounters

Generally, Canadian and international literature on language access issues emphasize that clear communication, including language, is key to accessible quality health care (Bischoff, Tonnerre, Moser & Loutan, 2000; California Health Care Interpreters Association, 2002; Gerrish, Chau, Sobowale, & Birks, 2004; Greenbaum & Flores, 2005; Jacobs, Shepard, Suaya, & Stone, 2004; Karliner, Perez-Stable, & Gildengorin, 2004; Torres, 2000). Ineffective or inadequate communication between patient and service providers is seen as a language barrier that affects primarily those who do not share the same language as the service provider (Bischoff, Bovier, Isah, Gariazo, Eytan, & Loutan, 2003; California Health Care Interpreters Association, 2002; Gerrish et al., 2004). Anne-Marie Mesa (1997) specifies that the patient must understand if he/she is to participate in decisions affecting him/her and follow the service plan proposed. While most of the literature does not explicitly place the burden of language proficiency on the shoulders of the patient, many discussions center on improving health care access and outcomes by striving for a common language between service providers and patients. In this view, language barriers arise because the patient and health care provider do not share the same language (Bischoff et al., 2003; Bolton, 2002; Gerrish et al., 2004; Tang, 1999). This concern is particularly illustrated in some of the American literature which proposes to train service providers in the language of the population served as a response to the problem of language barriers (as cited by Collins, Gullette, & Schnepf, 2004; Flores, 2005). Collins and colleagues (2004) found that service providers attempted to minimize language barriers in some hospital emergency departments by teaching Spanish to their staff. It should be noted, however, that the majority of immigrants to the United States come from Spanish-speaking communities, and that 60% of those speaking a home language other than English in the United States speak Spanish fluently (Flores, 2005). Promoting Spanish language instruction among service providers who then act as on-site interpreters may therefore seem like a viable solution. In the Canadian context, however, training service providers in all possible languages according to Canada's linguistically diverse population may be too costly and unrealistic.

Bolton (2002), Keers-Sanchez (2003), Rivadeneyra and colleagues (2000), Torres (2000), and others suggest that the issue at hand is not merely the lack of a common language, but actually the potential of cross-cultural miscommunication between individuals from linguistically and culturally differing backgrounds. In their accounts, culture becomes an important component of the language barriers experienced by immigrants and refugees when accessing health care. The concern is not that the patient or the service provider may not understand factual information, but that the information may be misunderstood because of unfamiliar verbal cues, cultural undertones or symbolic codes found in a given language (Bolton, 2002; Elderkin-Thompson et al., 2001). Bolton (2002) argues that effective communication demands more than just linguistic ability, particularly in a therapeutic relationship. According to Bolton (2002) language itself is inadequate because it requires a large amount of interpreting. In other words, meaning is derived not only from the content of words but also through a process of deciphering the intentions behind words, the tone and intonations used, as well as evasions and silences. These aspects of communication are culturally shaped (Bolton, 2002) and must therefore be properly interpreted by the physician as well as the patient (Hornberger, Itakura, & Wilson, 1997; Labun, 1999). Labun (1999) points out that interpretation must include a cultural as well as a linguistic component. As such, a great proportion of the literature attempts to address the issue of culture as part of the discussion of language and access to health care. Elderkin-Thompson and colleagues (2001), for instance, explain that language includes aspects that are culturally defined. In other words, there may be miscommunication between patients and service providers given that "the perception and interpretation of somatic sensations are frequently defined by cultural idioms" (Elderkin-Thompson et al., 2001, p.1344).

Recognizing that language barriers do not cease to exist simply because an individual has learned English, Bowen (2001b) argues that language barriers experienced by new immigrants and refugees

be seen as a minority issue rather than merely a newcomer issue. In other words, although many immigrants need language and communication assistance throughout their lives, language access to health care is treated as a settlement issue, rather than a health care issue in Canada (Bowen, 2001b). Bowen (2001b) explains that as a minority issue, language barriers in health care reveal inherent, societal barriers, whereas conceptualizing language barriers as a newcomer issues implies a time-limited issue that is overcome once the individual learns English or French. It is no surprise then that the overwhelming majority of the reviewed literature does not expand their discussions of language barriers and interpretative services health care beyond the scope of temporary immigrant and settlement related issues. Apart from Bowen (2001b), Bolton (2002) briefly mentions that the language barrier between a patient and physician cannot be explored in complete isolation from immigration, stigma, shame, poverty, and loss. Tang (1999) also briefly acknowledges that other dimensions, such as age, gender, and class influence communication whereby sharing a common language does not guarantee effective communication between the patient and health care service providers.

Without identifying the exact mechanisms or ways whereby language barriers tend to affect primary health care, the reviewed literature confirms that there are negative consequences for patients as well as service providers and the health care system when language barriers are encountered in primary health care. In fact, the majority of existing research study reports and literature concentrates on the adverse effects that inadequate communication due to language related issues can have on the quality of care and ultimately on the patient's health outcomes. In discussing the impact of language barriers on the therapeutic relationship between psychiatrists and patients, Bolton (2002) describes three main areas that are affected by the lack of or inadequate communication. According to Bolton (2002), the practitioner's tasks of establishing trust, understanding the patient's problem, and attempt to make a difference are challenged when the patient and practitioner do not share the same language. Another American study has found that more extensive diagnostic testing were done and more conservative treatments were prescribed by physicians when language barriers existed in the medical encounter (Greenbaum & Flores, 2005).

Other adverse effects that tend to arise from language barriers and subsequent communication difficulties in health care include risk of medical errors (Ku & Flores, 2005), misdiagnosis or inappropriate treatment (Bernstein et al., 2002; California Health Care Interpreters Association, 2002; Collins, Gullette, & Schnepf, 2004; Tang, 1999), poor patient comprehension (Herndon & Joyce, 2004; Ku & Flores, 2005), more medical tests and emergency room visits (Collins, Gullette, & Schnepf, 2004; Elderkin-Thompson et al., 2001; Flores, 2005; Herndon & Joyce, 2004), less compliance (Bowen, 2001b; Elderkin-Thompson et al., 2001; Gagnon, 2002), and lower patient satisfaction (Greenbaum & Flores, 2005; Lee, Batal, Maselli, Kutner, 2002). The inefficient use of resources and potential costs to health care systems, as well as legal implications and liabilities are the most frequently identified long-term consequences of institutions' failure to adequately respond to language barriers in primary health care (Bowen, 2001a; Crammond, 2002; Greenbaum & Flores, 2005; Jacobs, Shepard, Suaya, & Stone, 2004; Tang, 1999). However, there is a substantial difference in the legal implications and liabilities for Canadian health care providers as opposed to, for example, American service providers. In the United States, statues of the Civil Rights Act of 1964 have been interpreted by the courts as protecting patients against discrimination based on language (Herndon & Joyce, 2004; Keers-Sanchez, 2003; Ku & Flores, 2005). As mentioned previously, the provision of interpreter services is legally mandated and enforceable in some states in the United States. In fact, medical negligence due to communication failures can be established in the United States based on tort law (Elderkin-Thompson et al., 2001). No precedent setting legal cases mandating the provision of interpreter services for people with lack of or limited language proficiency exist in Canada to date (Crammond, 2002).

While not all of the immediate adverse effects mentioned above apply to the Canadian context or have been confirmed across Canada, language barriers to health care in the Canadian context have

been associated with rates of service utilization, access, and quality of care (Bowen, 2001b; Crammond, 2002; Gagnon, 2002; Romanow, 2002; Tang, 1999). International literature from the United Kingdom (Gerrish et al., 2004), the United States (California Health Care Interpreters Association, 2002; Greenbaum & Flores, 2005; Jacobs et al., 2004; Karliner et al., 2004; Ku & Flores, 2005), and Switzerland (Bischoff et al., 2003) confirms that access to primary health care and the quality of care are seriously compromised when language barriers are not removed or properly addressed (Bowen, 2001b; Gagnon, 2000). The issue of access is of particular concern in the Canadian context where accessibility and standards of care are ongoing topics of discussion. The findings in this area, however, are inconsistent. Gagnon (2000) reports that immigrants underutilize health services which are guaranteed through the Canada Health Act, while Bowen (2001b) states that language barriers are often linked to the overutilization of health services, particularly emergency health services. Gerrish and colleagues (2004) report that individuals with limited English language skills in the United Kingdom are reluctant to make contact with health care providers, and therefore tend to underutilize services at least initially. Bernstein and colleagues (2002), on the other hand, found that both under- and overutilization of services and treatment were associated with inadequate communication in medical encounters in the United States. Having reviewed a substantial amount of literature, Bowen (2001b) concludes that, in Canada, both lower and higher levels of service utilization have been associated with language barriers. Lower levels of service utilization tend to be related to initial access, wherein limited English language proficiency may discourage and prevent a patient from establishing contact with service providers and obtaining assessments and care (Bowen, 2001b). Language barriers, therefore, play not only a role during the health care encounter but also before initial contact is made with service providers. That is, the tasks involved in accessing health care services alone require a certain level of English (or French) language proficiency that immigrants and refugees may not have. Establishing what and where needed services are available and how these services are to be contracted, for example, requires assistance by an interpreter even before contact is made with health care service providers (Bowen, 2001b). Such initial access issues affect proper diagnosis and timely treatment, potentially resulting in a greater reliance on specialist and diagnostic health care services in the long-run (Gagnon, 2002; Keers-Sanchez, 2003; Romanow, 2002; Tang, 1999).

Part of the greater concern with language and access issues in health care is that ultimately immigrants with limited English language proficiency do not receive the same quality and standards of health care as Canadian-born individuals with proficiency in English (Bowen, 2001b; Crammond, 2002; Tang, 1999). This concern in recognized and echoed throughout the international literature as well (see for example, Flores, 2005; Keers-Sanchez, 2003; Ku & Flores, 2005; and Torres, 2000). The reviewed literature therefore agrees that the provision of interpretation in health care settings matters because in its absence, language barriers have adverse impacts and impede the delivery of quality health care.

Interpreters in health care settings

Responding to language barriers in health care by providing interpretation and interpreter services, however, is not such a straight-forwarded answer to language access issues for immigrants and refugees with limited language proficiency. While there is consensus in the literature on the adverse effects arising from the absence of interpretation, there is less agreement on the pros and cons of providing interpreter services for those with limited language proficiency. This review of the literature reveals that the benefits and costs of interpreter services in primary health care are closely connected to who provides the interpretation and how such interpretation is delivered.

In Canada, interpreter services are often but not always provided for health care patients despite the Canada Health Care Act and several community-based initiatives that aim to improve access to services for immigrants and refugees (Bowen, 2001b; Romanow, 2002; Tang, 1999). Similarly,

Collins and colleagues (2004), Elderkin-Thompson and colleagues (2001), Greenbaum and Flores (2005), Hornberger and colleagues (1997), and more recently Ku and Flores (2005) have documented relatively low levels of interpreter services provision and inconsistencies in the usage of interpreter services in health care in the context of the United States. An overview of the use of interpreters in health care settings in the United States reveals that less than a quarter of hospitals across the country actually employ professional interpreters (Greenbaum & Flores, 2005), the majority of interpreters employed in hospital setting did not receive formal training (Collins et al., 2004; Greenbaum & Flores, 2005), untrained bilingual nurses are most frequently called on to act as interpreters on an ad hoc basis (Elderkin-Thompson et al., 2001), and that there is a general scarcity of on-site trained interpreter services provision in American health care settings (California Health Care Interpreters Association, 2002; Collins et al., 2004; Ku & Flores, 2005). Hornberger and colleagues (2004) and Lee and colleagues (2002) report that some health care providers use commercial telephone-based interpreter services, such as the Language Line, during medical encounters. Findings from a recent survey study involving physicians in California revealed that trained interpreters were used in only 5% of medical encounters, whereas the Language Line was used in 6% of medical encounters with patients with limited English language proficiency (Hornberger et al., 2004). Similarly, health services in Switzerland rarely utilize professional trained interpreters and increasingly rely on bilingual health professionals and staff as interpreters (Bischoff et al., 2003). By contrast, Gagnon (2002) reports that the State of New South Wales in Australia has an extended system of interpreter services, consisting of six Health Care Interpreter Service centres which provide free interpretation in more than 50 languages to public health services users. In some metropolitan areas, these interpreter services are available every day at any time of day or night (Gagnon, 2002).

In the United States, however, the reported failure to provide professional and trained interpreters to patients with limited proficiency in English, despite legal obligations to do so in some states, is often attributed to the financial costs or ‘burden’ associated with such provision (see for example, Collins et al., 2004; Elderkin-Thompson et al., 2001; Karliner et al., 2004). While language interpretation is seen as an integral part of health care, health care providing institutions are expected to offer interpreter services without financial reimbursement for the service (Collins et al., 2004). Rather than pay for additional costs incurred by employing interpreters, hospitals and other health care providers prefer to use bilingual or multilingual staff who are usually not trained as interpreters, such as nurses, when interpretation needs arise (California Health Care Interpreters Association, 2002; Elderkin-Thompson et al., 2001). The use of untrained individuals for interpretation is further enabled through a document published by the Office of Civil Rights that serves as a tool for interpreting the law pertaining to the provision of interpretation for individuals with limited English language proficiency in the United States (Karliner et al., 2004). This document provides patients who are in need of interpreter services with the option of choosing family members or friends as their interpreters (Karliner et al., 2004). Combined with the financial burden experienced by hospitals and other health care providers, it is no surprise then that untrained ad hoc interpreters such as bilingual staff, as well as family members and friends are more often used, rather than professional interpreters who are trained for health care interpretation as documented by the California Health Care Interpreters Association (2002).

While there is some disagreement over the potential benefits of employing ad hoc interpreters, the literature suggests that the adverse effects of employing untrained interpreters greatly outweigh any potential benefits that might be gained (Keers-Sanchez, 2003). The reliance on untrained interpreters on an ad hoc basis introduces many problems and concerns which are extensively covered by the literature reviewed. Based on the reviewed literature, ad hoc interpreters tend to be untrained accompanying friends or family members, particularly children of patients, volunteers, staff, other patients and anyone else who is available on-site and speaks the language of the patients. The California Health Care Interpreters Association (2002) cautions that the ability to speak in one language does not necessarily guarantee an ability to adequately interpret. Similarly, Gilles Bibeau

(1992) argues that sharing an ethnicity is not a guarantee that the person interpreting will listen from a cultural perspective. In Canada errors committed by individuals who have not been trained in health care interpreting include omissions, additions, substitutions, and summaries of the conversation between patient and service provider and results in clinical misunderstandings or misdiagnoses (Tang, 1999). Similar interpreter errors have been identified in the American context. In their study of potential interpreting errors with significant medical consequences in paediatric encounters, Flores and colleagues (2003) identified six specific errors. These intentional and unintentional errors include the omission of questions and instructions on the dose, frequency, and duration of prescribed medication; misinformation about symptoms; and falsely instructing the patient to not answer personal questions (Flores et al., 2003). Bernstein and colleagues (2002) confirm that the use of ad hoc interpreters who lack training in both medical knowledge and interpretation results in omissions, additions, and substitution errors as well as misdiagnosis, errors in treatment, and diagnostic and therapeutic procedures. While some of these errors may occur in any interpretation endeavour, Greenbaum and Flores (2005) report that trained, professional interpreters were considerably less likely to commit interpretation errors that carried clinical consequences than untrained ad hoc interpreters. In fact, Collins and colleagues (2004) cite an American study which found that the usage of ad hoc interpreters in medical settings resulted in a 31% error rate. They also cite another study on interpreter services for Hispanic patients which revealed that untrained nurses who acted as interpreters for these patients created consequential problems in miscommunication in half of the encounters (cited in Collins et al., 2004). Similarly, Flores and colleagues (2003) report that 77% of errors committed by ad hoc interpreters were clinically consequential, compared to 53% of interpreter errors committed by trained hospital interpreters. According to Elderkin-Thompson and colleagues (2001), untrained nurses and other ad hoc interpreters interpret in a manner that could be described as ‘proximate-consecutive’. ‘Proximate-consecutive’ interpreters wait for the individual to finish speaking before interpreting what he or she has said, whereas trained interpreters engage in ‘simultaneous interpreting’ which reduces some of the interpreter errors committed by untrained ad hoc interpreters (Elderkin-Thompson et al., 2001).

In the British context, Gerrish and colleagues (2004) found that primary care nurses who provided interpreter services on an ad hoc basis often acted as gatekeepers. The majority of nurses in Gerrish and colleagues’ (2004) study were not only aware of the adverse effects of untrained interpreters but also encouraged the use of other untrained interpreters such as family members and friends. In other words, by accepting the institutional situation for what it is, the nurses in the study actually exacerbated language access issues, instead of proactively pressing for the provision of professional trained medical interpreters. Indeed, the findings of Gerrish and colleagues’ (2004) study confirmed an overall trend on inadequate and heavy reliance on family members as interpreters in health care settings in the United Kingdom.

The use of friends and family members as interpreters during health care encounters introduces another dimension and additional implications for patients with limited language proficiency and their service providers (Bernstein et al., 2002; Bischoff et al., 2003; Flores, 2005; Greenbaum & Flores, 2005; Herndon & Joyce, 2004; Keers-Sanchez, 2003). Some of the literature explains how the personal relationship between patient and interpreters who are the patient’s friends or family members causes detrimental effects in addition to the potential interpreter errors that are already committed by untrained interpreters. Flores (2005), Greenbaum and Flores (2005), and Herndon and Joyce (2004) state that the accuracy of interpretations is often diminished because many interpreters who are family members or friends tend to consciously or unconsciously screen and filter out what has been said unbeknownst to the practitioner and the patient. Keers-Sanchez (2003) confirms that some relatives who act as interpreters may not interpret some information properly for the purpose of protecting the patient from negative or embarrassing information or news. In some situations, the reverse is also true. In their study of asylum seekers in Switzerland, Bischoff and colleagues (2003) determined that asylum seeking patient were often uncomfortable and reluctant to

disclose information about their psychological suffering in the presence of family members who acted as ad hoc interpreters. The authors found that this was either due to the patient's desire to avoid being stigmatized or alternatively to spare the family member painful information. The use of children as ad hoc interpreters is therefore extremely inappropriate as interpreting may expose them to secondary stress disorder (Bischoff et al., 2003). In general, the use of children as medical interpreters is frowned upon (e.g., Bisaillon, 1989; Mesa, 1997w). Flores (2005) and Torres (2000) caution against the use of children as interpreters because of resulting medical errors, while Bernstein and colleagues (2002) add that family norms of authority may be upset when children act as interpreters. Commenting on the effectiveness of children as interpreters, Bolton (2002) furthermore states that children of immigrants' grasp of their parents' language is often not sufficient to relay its semantic richness during interpretation. Bernstein and colleagues (2002), Herndon and Joyce (2004), and the California Health Care Interpreters Association (2002) ascertain that fundamental ethical aspects such as confidentially and informed consent may be at risk in the presence of untrained interpreters and in particular friends and family members, which may consequently place health care providers at risk for liabilities and medical malpractice.

Models of spoken language interpreter services

Professional and competent interpretation for patients with limited English language skills is reportedly one of the most optimal responses to addressing and overcoming language barriers in health care (Bischoff et al., 2003; Bowen, 2001b; Elderkin-Thompson et al., 2001; Flores, 2005; Greenbaum & Flores, 2005; Herndon & Joyce, 2004; Lee, Batal, Maselli, Kutner, 2002). While it is generally understood that such practice requires formal training and education in interpreting, medical knowledge, and ethical practice (Elderkin-Thompson et al., 2001; Herndon & Joyce, 2004), considerable variation in approaches or models of interpretation services provision exists in Canada as well as internationally (Bowen, 2001b; Ku & Flores, 2005).

Michel Sauvêtre argues that models of interpretation adopted by particular countries are generally influenced by the integration model in use in that country (e.g, multiculturalism) and by whether interpretation is understood as a right of the patient or a way to protect the institution (Sauvêtre, 2000). The establishment of particular models of interpretation services therefore have to be understood in their political and legal contexts. In Montreal, for instance, the Interregional Interpreters' Bank was established in 1993 as a strategy to improve access to health services and adapt them to the needs of immigrants and ethnocultural communities. The bank is a publicly funded centralized regional service. It was established in response to a provincial Health and Social Services Bill, which defines both users' rights in relation to health and social services and the responsibility of institutions to ensure clear communication (Hemlin, 2004).

Though models in use in Canada do not neatly fit into these archetypes, four models of interpretation services can be drawn from the literature reviewed. These are community-based interpretation (Bowen, 2001b; Mikkelson, 1997; Torres, 2000), institutional-based interpretation (Elderkin-Thompson et al., 2001; Kent, 1997; Tang, 1999; Torres, 2000), contracted interpretation (Bowen, 2001b; Torres, 2000), and telephone and remote interpretation (Bowen, 2001b; Herndon & Joyce, 2004; Keers-Sanchez, 2003; Torres, 2000). These practice models are described in more detail in the following sub-sections.

Community-based interpreter services

Community-based interpreter services are offered to residents of the community in which the interpretation takes place (Bowen, 2001b; Mikkelson, 1997). The interpreter, in this model, is literally based in the community but 'follows' the patient around to different services and health care settings (Bowen, 2001b). According to Mikkelson (1997), there are a variety of community-based interpreters who can be amateurs, ad hoc, or formally trained interpreters. Mikkelson (1997) reports

that community-based interpreters often act in the role as advocates or cultural brokers, rather than neutral translators. Bowen (2001b) confirms that their primary responsibility is to the patient, while their actual interpreter service is limited to the functions of the organization that hired them. While there may be differences in the quality of training and service provided depending on a particular organization, community-based interpreters are usually provided through settlement and other immigrant-serving organizations in Canada (Bowen, 2001b). Bowen (2001b) reports that these organizations are marginalized in Canada, because they have not been fully integrated as part of the health care system and consequently receive no health funding for their service provision. The American equivalent of community-based interpretation are 'community interpretation banks' which are community organizations that provide interpreter services in a variety of languages to institutions that need them (Torres, 2000). According to Torres (2000), although such language banks are only available in a few geographical areas across the United States, they can serve as a shared resource for health care institutions.

Institutional-based interpreter services

Institutional-based interpreters are often interpreters who have been hired as employees by health care providing institution (Bowen, 2001b) or health professionals who have been formally educated and trained as interpreters by the institution (Elderkin-Thompson et al., 2001; Kent, 1997; Tang, 1999; Torres, 2000). Torres (2000) refers to the later variation of this model of service provision as 'employee language banks' which provide trained health care professionals for interpreter services when needed. Elderkin-Thompson and colleagues (2001) report that there are many valuable benefits of training health care staff as interpreters, including their expertise as health care professionals and their sensitivity to patients. While calling on hospital employees to interpret may cause tension with other employees and loss of staff time (Tang, 1999), trained nurses may be more apt to assist physicians in eliciting medically-specific information from the patient who has limited English language skills (Elderkin-Thompson et al., 2001). Using health care professionals as trained interpreters may also minimize the patient's perception of invasiveness during the medical encounter because the interpreter is part of the health care providing team (Elderkin-Thompson et al., 2001). Bowen (2001b) adds that using hospital-based interpreters may increase patient satisfaction and compliance with the health care services provided. Additionally, the interpreter's medical knowledge allows him or her to recognize medically significant information (Elderkin-Thompson et al., 2001), thereby minimizing potential interpreter errors such as omissions. According to b (2001), an advantage to hiring hospital or clinic-based interpreters is that they meet the needs of the institution as well as the patient. Studying this model of interpreter service provision in Canada, Kent (1997) found that Vancouver's St. Paul's Hospital trained their hospital staff and volunteers as interpreters. At St. Paul's Hospital bilingual or multilingual employees received a six hour training session on language interpreting (Kent, 1997). Kent (1997) emphasizes that while these employees were part of the larger health care team they were expected to strictly translate, rather than advocate or act as cultural brokers. Interestingly, Kent (1997) explains that as interpreters, staff were advised to inform the health care professional of a cultural issue if it arose but to stay impartial and neutral in the role of an interpreter. Bowen (2001b) explains that this may result in a role conflict for interpreter as they are primarily accountable to the hospital and may be less able to protect or promote the patient's interests. Another major limitation, according to Bowen (2001b), is that interpreters may not be able to provide a continuity of interpreter services for the patient as the focus is on acute care in this model of interpreter services provision.

Contracted or commercial interpreter services

Depending on their financial resources, many hospitals and health care providers contract out commercial interpreter services to meet the needs of their patients (Bowen, 2001b; Kent, 1997; Torres, 2000). In the United States, contract interpreters are professionals who are not direct employees of health care providers but who are hired per diem or on an on-call basis to supplement in-house interpreter services as needed (Torres, 2000). Torres (2000) states that contract-based interpreters, such as freelance interpreters, are particularly used for languages and language groups

that are not represented or available by the service provider's own interpreters. Bowen's (2001b) review of models of interpreter services provision reveals that contracted interpreters are professional interpreters who provide interpreter services independent of a particular health care providing institution or service community or area. The interpreters in this model of service provision are trained, supervised, and coordinated by a central body (Bowen, 2001b). Access Alliance Multicultural Community Health Centre offers such a coordination service in Toronto. The non-profit organisation has developed a fee-for-service health care interpreter program whereby they provide trained, professional interpreters to public health and other institutions to help them meet their language access needs. Bowen (2001b) found that this model of service provision tends to be more efficient because it offers interpretation in a wide range of languages, and generally abides by a professional code of ethics. On the other hand, many organizations lack the resources to provide ongoing training for interpreters who are expected to have knowledge of vocabulary and concepts that are specific to all kinds of sectors (Bowen, 2001b).

Telephone and remote interpreter services

Telephone-based interpreter services are frequently used by health care providing institutions in the United States (Flores, 2005; Herndon & Joyce, 2004; Lee et al., 2002; Torres, 2000). Telephone-based interpreter services provide interpretation in a variety of languages, twenty-four hours a day (Bowen, 2001b; Herndon & Joyce, 2004). In this model, interpreter services are usually provided over a phone line by using a speakerphone during the health care encounter when on-site interpreters are not available (Bowen, 2001b; Herndon & Joyce, 2004; Torres, 2000). The immediacy of telephone language lines is particularly useful for when interpreters are needed for medical emergency situations (Bowen, 2001b; Torres, 2000) and appointments in 'sensitive health care areas' such as sexual and mental health (Bowen, 2001b). On the other hand, speakerphones and other equipment needed for phone-based interpretations may not be always available when needed (Keers-Sanchez, 2003) and interpreters may not have any medical knowledge (Bowen, 2001b). Of course, another disadvantage of this model is that interpreters are not physically present to read the non-verbal communication cues of the interaction between the patient and the health care provider (Herndon & Joyce, 2004; Keers-Sanchez, 2003). And yet, this may be exactly why its use is advantageous in certain medical or health care encounters (Bowen, 2001b). While Torres (2000) cautions that telephone-based interpreter services should only be used as a last resort, Flores (2005) and Lee and colleagues (2002) found that the Language Line, as well as other phone-based interpretation services are quite popular with health care service providers and patients.

A technologically advanced variant of the telephone-based interpretation model is, what Torres (2000) calls, remote simultaneous interpretation. Torres (2000) explains that patients and service providers communicate with the help of an interpreter who provides simultaneous interpretation to the parties. As with international conference interpreting, the interpreter is physically removed from the setting and provides the interpretation over remote wireless headphones (Torres, 2000). As such, the interpreter does not disrupt the direct interaction between the patient and health care provider. However, at this point in time very few health care providers in the United States actually use remote simultaneous interpreter services because of lack of equipment and other resources (Torres, 2000).

Based on the perceived advantages and disadvantages of the various models of interpreter services and interpreter roles, some of the reviewed literature makes recommendations for best practices for interpreter services in health care. First and foremost, Bowen (2001b), Elderkin-Thompson and colleagues (2001), Herndon and Joyce (2004), and Torres (2000) all agree that in addition to language fluency, knowledge of medical terminology and other health care related terms and concepts is a crucial characteristic of 'good' or effective interpretation in health care. Labun (1999) adds that health care interpreters need to be able to interpret culture in addition to language. Herndon and Joyce (2004) argue that good medical interpreters have an ability to interpret in such a way that renders their presence almost unnoticeable. Bolton (2002) suggests that competent

interpreting for patients with limited English language proficiency, such as new immigrants, requires not only understanding language and culture, but also the patient and the influence of migration of the patient's sense of self.

Elderkin-Thompson and colleagues (2001) identified three processes that accompanied successful interpretations in health care. First, physicians used words and sentences that were easily translatable into another language by the interpreter and also understandable by those patients who had some English language skills. Second, both patient and physician communicated in a relatively slow-paced manner, that allowed interpreters sufficient time for interpretation. And lastly, Elderkin-Thompson and colleagues (2001) found that interpretations were most accurate when physicians repeated a patient's symptoms and the interpreter translated them back to the patient to confirm or correct the physician's understanding. Torres (2000) proposes another set of best practices in terms of the coordination and delivery of interpreter services in health care encounters. Torres (2000) suggests that interpreter services be integrated in the health care service provider's overall scheduling system, particularly in situations where language barriers can be anticipated ahead of time. The author explains that computerized systems in most health care settings can be used to assist in facilitating the coordination of interpreter services provision and streamlining care for patients with limited English language proficiency (Torres, 2000). According to Torres (2000), continuity of patient care can be further supported by arranging the same interpreter for a patient's follow-up visit. Depending on the particular patient and health care situation, arranging for an interpreter of the same gender or ethno-cultural background as the patient may be additionally beneficial (Torres, 2000).

Abiding by a professional code of ethics, providing uniform training for health care interpreters, developing structured means for evaluating interpreter competency, and developing standards of practice further ensure that interpreter services provide accurate, effective, and high quality interpretation for the client. (Bowen, 2001b; Mikkelson, 1997; Torres, 2000). In short, the reviewed literature suggests that it is imperative to professionalize health care interpreter services in order to address some of the current short-comings identified above.

Roles

The variety of interpreter services models also points to a range of interpreter roles. As Bowen (2001b) states, the "'model' of service provision cannot be isolated easily from the definition of the interpreter role" (p.46) which is shaped according to the objective of a given program. The Interregional Interpreters' Bank in Montreal uses the following definition:

> "Cultural interpreters are professionals who, with utmost confidentiality, convey all information contained in both verbal and non-verbal communication between people of different languages and cultures. They help clients as well as professionals in different fields to understand the values, concepts, and cultural practices of the other, while remaining neutral, using language adapted to those present, and respecting strict professional ethics" (Bourque, Hemlin and Clarke, 2004).

A review of the literature indicates that this understanding of interpreters' roles is not universal. For instance, some will disagree with the interpreter's role in revealing meanings from non-verbal communication while others will argue that the interpreter should stand with the patient rather than be neutral. Indeed the variety of roles assigned to the interpreters covers a spectrum that goes from "voice box" to advocate or co-therapist (e.g., Goguikian Ratcliff & Changkakoti, 2001; Métraux & Alvir, 1995). The terminology used to refer to these roles differs from country to country.

In the U.S., The California Health Care Interpreters Association (2001) describes four possible roles for interpreters in the health care system. According to the Association, a 'message converter' strictly translates statements from one language into the other. A 'message clarifier' moves from literal translation to actively assists patients and service providers in clarifying potential confusion (California Health Care Interpreters Association, 2001). Although the type of interpreting described as 'message converter' is frustrating for patients, health care providers, and interpreters (Bowen, 2001b), some of the literature continues to insist that it represents the most ideal role of an interpreter (see for example, Elderkin-Thompson et al., 2001; and Herndon & Joyce, 2004). The Association refers to an interpreter who supports the health and well-being of patients and acts on behalf of and in the best interest of the patient as a "patient advocate". Acting as a 'patient advocate' requires making ethical decisions on part of the interpreter to determine when and what to advocate on behalf of the patient (California Health Care Interpreters Association, 2001). Finally, a 'cultural clarifier' does not necessarily entail the responsibility to advocate. Interpreters acting as 'cultural clarifiers' differ from 'message clarifiers' in that the 'cultural clarifier' goes beyond spoken words by clarifying culturally-specific concepts which may be otherwise misunderstood (California Health Care Interpreters Association, 2001).

Similar to the idea of a 'cultural clarifier', Labun (1999) describes the importance of culture through the concept of shared brokering. As a 'cultural broker', the health care interpreter navigates between two or more culturally defined worldviews to advocate for the patient during interpretation (Labun, 1999). In her study of health care to Vietnamese patients in the United States and Canada, Labun (1999) found that nurses and interpreters worked closely together to provide patients with culturally competent health care. As a team, nurses and interpreters engaged in a shared brokering partnership for the purpose of addressing and meeting the complex needs of Vietnamese refugees (Labun, 1999). This requires that interpreters who are 'cultural brokers' have not only language skills but also knowledge about the cultural ways of the population served (Labun, 1999).

The Swiss literature generally identifies three roles for interpreters: translator, "cultural mediator" and co-therapist (Métraux et Alvir, 1995). The first role is the closest to literal translation and is sometimes referred to as a "black box" (e.g., Jalbert, 1998). Interestingly, a Swiss study indicates a clear tendency among doctors to prefer to work with interpreters who limit themselves to word-for-word translation whereas interpreters want to be full participants in the medical consultation (Singy, 2001; Singy & Weber, 2001).

A second role that an interpreter can play is that of cultural mediator ("médiateur culturel" as it is called in French) who interprets verbal as well as non-verbal messages and takes into consideration socio-cultural customs, social norms, symbolic meanings and cultural connotations, which are implied in words used (Métraux et Alvir, 1995). Interpret, the Swiss Association for Community Interpretation and Cultural Mediation, indicates that "cultural mediators" inform immigrants and service providers of cultural differences, rules regulating political and social systems and different ways of behaving (Interpret, n/a). They refer to this work as "building bridges" between immigrants and institutions or service providers. This role is not limited to the health care sector but rather is also used in the court or education systems. Métraux and Alvir (1995) go further to argue that cultural mediators have a role to play in redressing the power asymmetries between the service provider and user (which weigh in favour of the provider). This may involve raising the user's awareness of their rights and sometimes even taking action outside of the consultation itself. This happens when the interpreter's loyalty towards the patient is greater than for the provider and he/she positions him/herself as an advocate for the patient (Jalbert, 1998). Goguikian Ratcliff and Chankakoti (2001) argue that this advocacy role is actually more frequent in anglo-saxon contexts.

Finally, a third role that is mentioned in the Swiss literature is that of co-therapist (Goguikian Ratcliff & Chankakoti, 2001; Métraux & Alvir, 1995). In this role, the interpreter has more autonomy and can

express his/her own opinion. Most health care professionals do not feel comfortable with interpreters playing this role, partly because they lose their sense of control over the communication process (Métraux & Alvir, 1995). If the interpreter adopts the bio-medical discourse at the expense of the ethnotheories of the patient, his role may become the opposite of an advocate in that he/she begins to act as an agent of the system (Leanza, 2003).

Challenges

Though the presence of a trained interpreter can help avoid medical errors and other adverse outcomes, some of the literature speaks to the challenges that the presence of an interpreter may introduce in a health care encounter. Discussing specifically the therapeutic relationship between clinician and patient, Miller and colleagues (2005) comment that the interpreter by virtue of his or her presence alters the traditionally dyadic relationship of psychotherapy. That is, the addition of the third person, the interpreter, inevitably influences aspects of the therapy. Elderkin-Thompson and colleagues (2001), for example, argue that the use of an interpreter, and thereby the introduction of a third person, renders the communication between patient and physician impersonal. The authors suggest that the development of trust which is crucial in a patient-physician relationship may be hindered because of the interpreter (Elderkin-Thompson et al., 2001). Bolton (2002) discusses a similar kind of distancing that occurs when an interpreter is used. The author explains that communicating through an interpreter takes away from the immediacy of direct communication (Bolton, 2002). This loss of immediacy in communication creates a so-called buffer zone where emotions can be kept in check (Bolton, 2002). According to Bolton (2002), such a buffer zone is counterproductive to the therapeutic relationship it creates a sense of insulation for both the patient and the psychiatrist, because their interaction is more buffered or inhibited and polite with the interpreter present. The findings of a study by Karliner and colleagues (2004), on the other hand, revealed that nearly two-thirds of participating practitioners were able to connect personally with their patients despite the presence of an interpreter. Yet, as mentioned above, the intervention of a third party in a medical encounter can provoke discomfort for the provider, a sense of losing control and being observed (Bischoff, Loutan & Stalder, 2001; Leanza, 2003; Singy, 2001).

A few authors argue that the quality of the interpretation and the possible degree of interpreter influence are also closely related to factors such as age, gender, class, and education (Bolton, 2002; Elderkin-Thompson et al., 2001; Tang, 1999). Without engaging in a critical analysis of the consequences of these factors, Tang (1999) acknowledges that differences in age, gender, and social class have a potential to affect and complicate the interpretation taking place in a health care encounter. Illustrating the effects of class bias, Elderkin-Thompson and colleagues (2001), for example, explain that an interpreter who sees himself or herself as socially superior to the patient may misunderstand and misinterpret what the patient is saying. The authors explain that an interpreter's perceptions, beliefs, and assumptions frame interpretations, such that the interpreter's views about the patient influences how the patient is understood and how accurately the interpreter is able to convey the patient's narratives to the service provider (Elderkin-Thompson et al., 2001).

Professionalisation

The Critical Link 2 international conference, which took place in Vancouver in 1998, was reflective of a growing desire to professionalize community interpretation (including but not limited to interpretation in health care settings). This movement is both a way of ensuring the quality of interpretation as well as gain recognition for community interpretation as a profession. In a paper presented at the conference, Sauvêtre, for example, reported on a survey of forty European organizations that provided evidence of a strong desire for professionalization, particularly in the areas of recruiting and training (Sauvêtre, 2000).

Standards, training and accreditation
One way to promote professionalism is to develop standards to guide training and certification. In Switzerland, *Interpret*, has developed training standards for community interpreters working in health and social services (Interpret, 2002). In Canada and the United States, however, certification/accreditation and standardization of interpretation in health care have not been established at a national level (Bowen, 2001b; Keers-Sanchez, 2003; Torres, 2000).

Bowen (2001b) ascertains that in general, the accreditation and training of sign language interpreters in Canada is more advanced than for interpreters in health care. Similarly, in Ontario, court interpreters abide by practice standards that have been set by the courts and have been enforced through legislation since 1989, and are members of the Association of Translators and Interpreters of Ontario, unlike health care interpreters (Crammond, 2002).

According to the literature, most health care interpreters in Canada have also not received formal education or training in interpreting (Bowen, 2001b; Crammond, 2002). There are, however, some interpreter training programs including certificate and diploma programs provided to health care interpreters outside of formal academic settings (Bowen, 2001b). Interpreter training tends to be quite varied especially among and between provinces and regions (Bowen, 2001b). Some provinces are starting to develop standards for interpretation programs (Bowen, 2001b).

The situation is similar in the U.S., the American literature reports that unlike interpretation services for the hearing-impaired, there are no national standards and certification programs for interpreters in the United States (Herndon & Joyce, 2004; Keers-Sanchez, 2003; Torres, 2000). The Massachusetts Medical Interpreter Association has set practice standards for competent interpretation (Keers-Sanchez, 2003; Torres, 2000). In fact, Massachusetts and Washington are the only states that have not only developed but also implemented standards for medical interpretations on a state-wide level (Keers-Sanchez, 2003). Similarly, the California Health Care Interpreters Association (2002) has proposed a set of practice standards including certification requirements for health care interpreters in the state of California where legislation requires the provision of language interpreters in hospitals. According to the California Health Care Interpreters Association (2002), such standards are necessary to ensure some consistency in interpretation and interpreter services provision across all health care providing sites. In addition, the Office of Minority Health issued the National Standards on Culturally and Linguistically Appropriate Services in Health Care in 2000, which included four standards on how to address linguistic barriers to health care (Torres, 2000).

Despite the lack of consistency in the provision and reception of interpreter training (Bowen, 2001b; Flores et al., 2003; Torres, 2000), the reviewed literature highlights the importance of training for interpreters as well as training for the use of interpreters in the health care field. As discussed earlier, without adequate training, health care interpreters can cause adverse effects which ultimately compromise the health and well-being of the patient (Bowen, 2001b; California Health Care Interpreters Association, 2002; Flores et al., 2003; Gerrish et al., 2004; Karliner et al., 2004; Miller et al., 2005; Tang, 1999; Torres, 2000). In the United States, several authors found that hospital-based interpreters received inadequate interpreting training from the hospitals, while hospital practitioners themselves lacked training in the use of interpreters (Flores et al., 2003; Karliner et al., 2004; Torres, 2000). Flores and colleagues (2003), for example, report that only 14% of all hospitals in the United States actually provide their interpreters with training. Even in the cases where training is provided, Flores and colleagues (2003) found that it was only mandatory at half of the hospitals and that it often consisted of short orientation sessions or shadowing other interpreters.

Proper training, however, should cover various themes, including: the process of migration and its psychosocial impact, the functions of the interpreter, translation techniques in the psycho-social domain; the ethics of interpretation; and the role of the interpreter in prevention and health promotion (Métraux & Alvir, 1995).

Issues of training and professionalization of health care interpreters go hand in hand (Bowen, 2001; Mikkelson, 1997). Rochefort (as cited in Bowen, 2001b), for example, explains that the lack of professional standards results in low demand for trained, professional interpreters, which in turn explains the low student enrolment rate in interpreter training programs since employment opportunities cannot be guaranteed. In addition, as a result of the small number of students, many interpreter training courses cannot be offered on a regular basis (Bowen, 2001b).

Professional bodies
Another key condition for establishing formally recognized professions, according to Tseng (as cited in Mikkelson, 1997), is membership in a professional body such as an association. In Tseng's view, it is this lack of professional associations for interpreters and health care interpreters specifically that that contributes to the lack of training and practice standards (cited in Mikkelson, 1997).

Critical issues

There is little in the interpretation literature that is written from a critical theoretical framework, that takes into account the dominant culture and unequal power relationships. The Critical Link 3 conference did contribute to raising awareness that interpreters are 'social actors" rather than mere voice boxes and that as such, they are sometimes witness to injustices and have opportunities to make their own voices heard and their influence felt (Brunette & Bastin, 2003). Marco A. Fiola (2003) provides an example of this in a paper which he argues that community interpreters may have a role to play in ensuring that Aboriginal people have the resources to revitalize their language.

References are often made to the need to have knowledge about the cultural ways of the population served (e.g., Labun, 1999) but the dominant culture prevalent in the health care system is less often acknowledged. The danger of attributing meaning to the words or behaviours of a patient based on their culture is that this will lead to stereotyping. Yvan Leanza (2004) acknowledges this danger by specifically employing the term "cultural difference" instead of "cultural differences" so as to avoid the assumption that culture is definitive and static. In his doctoral thesis, he also points to the risk that the interpreter may be more inclined to favour the dominant discourse, which may actually exclude the patient (Leanza, 2003).

A related issue is that while there are some accredited training programs available specifically for medical interpreters (Herndon & Joyce, 2004), the majority of medical schools which train health care practitioners do not include education or training about linguistic and cultural issues that may arise when working with patients or about working with interpreters (Flores et al., 2003; Leanza, 2003). Flores and colleagues (2003) found that, as a result, clinicians made several errors when working with interpreters, particularly when the interpreter left the room or took a phone call. In order to be able to see the benefits of collaborating with interpreters as cultural mediators or co-therapists, Métraux & Alvir (1995) argue that the providers need be trained. Bischoff and his colleagues (2001) go as far as to argue that all the training and professionalization of interpreters only makes sense if it is accompanied by awareness-raising and training for the providers.

Conclusion

Health care interpretation is a complex profession and the dilemmas it brings to the fore are largely of an ethical nature and of great significance to the transformation of the health care system into one that is more accessible and equitable. While the question of training, certification, accreditation, and associations for interpretation in health care appears quite relevant given the inconsistencies of interpreter services provision in health care, there is a scarcity of discussions on this topic in the

reviewed literature. Although there may be many similarities with regards to health care and interpreter services in the United States, the United Kingdom, Switzerland and elsewhere in the international arena, the gaps in the Canadian literature illustrate the need and demand for more Canadian-specific materials. While the international literature helps in comparing the state of interpretation services provision in health care encounters, the combination of Canada's immigration policies, demographic make-up of the population, and the Canada Health Act create a unique context for studies about the need for competent interpreter services in health care. In a country with a large number of immigrants and refugees and residents who speak neither of the official languages, failure to enforce the provision of trained professional interpreter services in health care becomes a failure of removing language barriers and providing access to services. The limited number of Canadian-specific sources suggests that using untrained ad hoc interpreters in primary health care carries detrimental consequences for the health and well-being of those with limited proficiency in English or French. Furthermore, as the review of the literature indicates, there exists substantial knowledge gaps in better understanding the implications of the use of untrained interpreters in health care that is beyond acknowledging immediate interpreter and medical errors.

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