Health Care Interpreter Services

Strengthening Access to Primary Health Care

Vancouver Regional Report:

An overview of the history, development and current state of interpreter services in British Columbia

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2006

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This project was supported by a financial contribution from the Primary Health Care Transition Fund, Health Canada. The views expressed herein do not necessarily reflect the views of Health Canada.

Acknowledgments

The author of this report would like to gratefully acknowledge the contributions of the following members of the Vancouver Local Action Committee for their time in reviewing the research data and for their contributions to the content of this report: Silvana Carr, Elizabeth Stanger, Kiran Malli.

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NOTE: Information taken from the Achieving Equal Access to Health Care project by permission from the Affiliation of Multicultural Service Agencies and Societies of BC (AMSSA).

NOTE: All statistical data has been obtained from the 2001 Canada Census and from the BC Stats reports.

Table of Contents

I. Demographics

Over the last two decades, British Columbia has seen a considerable segment of the immigrant population to Canada settle within its borders. While numbers may have decreased from the highs experienced in the 1980's, they still remain healthy: in 2003 a total of 16% of all immigrants chose BC as their province of settlement. Statistics show that the majority of immigrants to BC elect to make their initial residence in the larger urban centers of the BC Lower Mainland. In 2001, a total of 88.6% of all immigrants to BC settled in the Vancouver Census Metropolitan Areas (CMA) versus 2.5% in the Victoria CMA or 2.7% in the Abbotsford CMA.

Most striking is that within the five year period from 1996 to 2001 the immigrant population in BC grew at a faster rate than that of its Canadian-born counterpart in the province. The immigrant population grew by 11.8% while the overall BC population growth was only 4.9%. Approximately one in every 10 immigrants to BC in 2001 could not speak, write or understand English. During the ten year period of 1992 - 2001, half of the immigrants to BC could not speak, read or write English. Census data shows that immigrants whose mother tongue is not English are more likely to settle in a larger urban centre.

This scenario presents opportunities as well as challenges for both newcomers and community-based, government funded services, such as health care. Another factor that influences service provision is the broadening of the ethnic make-up. BC has experienced a shift in source-countries: prior to 1980, the immigrant population was more likely to have come from Europe, while the last two decades has experienced an increase in Asian immigrants – in 2001, 77.3% of the Asian immigrants had come to Canada after 1980. This diversification of the immigrant population, and at such a rapid rate of growth, impels community services to respond. In BC, health care services have responded, initially in an improvised and spontaneous approach, but in recent years with more forethought and planning. The continued influx of immigrants to BC necessitates that health care services respond in ways that are relevant, meaningful and accessible.

II. An Overview of Language Service Delivery in BC: A Recent History

In British Columbia, the Lower Mainland region has seen the greatest development in the provision of language services in the last 10 – 15 years. While the non-profit immigrant service sector tried repeatedly to bring the issue of access to the forefront of the health care agenda, it was not until 1994 that interpreter services really began to have a presence in health care. In 1994, with funding from the BC Health Research Foundation, the BC Children's Hospital, Mount Saint Joseph Hospital, the Vancouver Health Department, Vancouver Community College and MOSAIC (Multilingual Orientation Services Assisting Immigrant Communities), formed the **Health Care Interpreter Partnership Project (HCIPP)**, a seminal community-based, action research project that defined the path for many health care agencies in the BC Lower Mainland. The HCIPP produced the first set of Health Care Interpreter Standards to guide the professional conduct of health care interpreters and the provision of language services. These standards became the foundation upon which many services at a variety of Lower Mainland facilities were constructed.

Incorporating the realities of language services of the time, the project outlined a three-tiered approach to language services: the use of community volunteers; bilingual staff members of health care agencies; and professional interpreters. The objectives of the project were to:

- Develop standards for quality and delivery of interpreter services and criteria for evaluation

- Develop and deliver training programs for all three tiers of language services and to evaluate these against set standards
- Implement a centralized bank and a delivery service for professional and volunteer language sources
- Evaluate the model's efficiency
- Develop guidelines of the model for use in other communities (*Carr, 1995)*

The project met with varying levels of success depending upon which project objective the evaluation lens is focused. Most certainly, the standards for service delivery and performance - Standards for Health Care Interpreting – were the most successful product to emerge. These service and performance standards, a comprehensive list of 12 standards, were well researched, drawing on national and international resources, and yet incorporated the regional and contextual realities of the project geography – the BC Lower Mainland.

Another successful outcome was the development of curriculum for both professional and volunteer interpreters. The current Health Care Interpreting Certificate (HCIC) program, available through the Vancouver Community College (VCC), is based on this earlier, piloted version of the training curriculum. It is the only post-secondary, institutional training available for interpreters working in health care in the province. The HCIC program also links, as does the VCC Court Interpreter Certificate program, directly to professional accreditation for interpreters who successfully complete either program.

It is now a common conviction of those working within the health care interpreting field in the Lower Mainland that community-based volunteers are not a suitable resource for professional language services for a multitude of reasons having to do with professionalization of the field and adherence to accepted standards. However the utilization of volunteers also brings with it other difficulties. Certainly, the HCIP project demonstrated the difficulty of including community-based volunteers in a centralized model (*Overcoming Language Barriers Quality Health Care – Final Report*, 1996) due mainly to the fact that volunteers tend to align themselves with organizations with which they have either personal or philosophical connections. To request volunteers to travel long distances to perform a volunteer task for an organization that they may not even have heard of proved to be a difficult and not particularly efficient undertaking. However, the curriculum developed was also intended for bilingual health care staff – in whatever capacity they work within the health care system – that 'volunteer' their time as interpreters within the course of their work day. These are not individuals that are delivering services in the first language of the patient – known as language-congruent encounters – but those who are called upon to assist as interpreters in an interpreter-assisted situation.

While studies have shown that it is not always an efficient use of staff time to pull bilingual health care staff members away from regular duties (Brunners, 1991), it is also a reality that health care will continue to do so, and it is naïve to assume that such a practice will completely cease until we've reached an ideal state. The curriculum developed during the HCIP project is flexible in that a training session as short as 2 hours to something as long as 2 days can be delivered to bilingual staff volunteers. The training provides participants with a basic exploration and introduction to interpreting skills, a more profound appreciation of interpreting, and helps to define the limitations of the volunteer role. Training for volunteers has always been successful in building awareness around the complexity of the interpreting task and the potential ramifications of a misinterpreted word or concept. This awareness is important, because bilingual staff volunteers must clearly understand the role they undertake when they agree to interpret.

Even though the vision of a centralized bank and service delivery for professional and

volunteer language sources was not realized, the project was instrumental in raising the profile of interpreter services within the health care community and became the foundation upon which future interpreter services were constructed.

Successive projects that spoke to the matter of access to health care were the *Multicultural Change in Health Services Delivery Project* and the *Translated Health Education Materials Demonstration Project*. Both projects explored the fundamental ideals of collaboration and partnership as foundations for advancement and change and worthwhile outcomes resulted from both projects.

The *Multicultural Change in Health Services Delivery* (MCCHSD) *Project* was instrumental in bringing the broader picture of culturally competent health care to the agenda. The project developed the *Exploring Multiculturalism and Diversity in Health Care Handbook for Trainers* and *Multicultural Change in Health Services Delivery Project Resource Manual* in 1997. Both an Interpretation and a Translation Committee emerged from the MCCHSD project that continued on for sometime after the project concluded in 1997. While the Interpretation Committee eventually split up into various less formal committees, the Translation Committee continued to be funded by the Ministry of Health and supported the initiation of the *Translated Health Education Materials Demonstration Project.*

The *Translated Health Education Materials Demonstration Project* was a cooperative venture to emerge from the *Multicultural Change in Health Services Delivery Project* as more and more service providers were looking for practical, hands-on resources and as it became more apparent that numerous concerns around translated materials were arising. The goal of the project was to synthesize translated health care resources and to link them to a centralized database, as well as to develop standards around translation of health care documents. The common practice for many years had been for each health care institution to independently have its own resources translated, often at great expense or time. The lack of coordination around these services resulted in numerous problems:

- Lack of awareness around the importance of using professional translators
- Resource rich institutions were able to have documents translated while relatively poorer institutions would have to use volunteers – often compromising the quality of the translation
- The *Multicultural Change in Health Services Delivery Project* became aware of numerous critical errors in translated documents in general circulation
- Institutions would frequently have similar, if not the same, type of information translated, without being aware of this, resulting in a wasteful use of financial resources
- There was little coordination between translators or translation services and the agencies seeking translations to ensure that a document translation was the most effective method to get their message across, or that the document itself was worthy of a translation. In some cases, where minority populations lack the necessary reading or health-related literacy skills, translations are simply a waste of valuable health care dollars.

Given these facts, the *Translated Health Education Materials Demonstration Project* sought to bring together service providers and translators (freelancer and service brokers) to implement a protocol around translations and to develop a platform for the sharing of information. The project was hosted by Providence Health Care but is no longer operational as of April 2005.

III. Models of Language Service Delivery in BC

Subsequent to the HCIP project, a number of different initiatives occurred. This is not to say that concurrent initiatives were not already underway. Certainly, the three partnering health care agencies involved in the HCIP project were leaders in their approach to language services, and had, independently, already implemented various programs to improve access for non- and limited-English speakers within their institutions. In addition, community-based immigrant service agencies, such as MOSAIC, an HCIP project partner, as well as other agencies (Surrey-Delta Immigrant Service Agency, Immigrant Service Agency), were critically important in championing the need for trained interpreters in health care. The HCIP project helped bring together the various efforts at work and to define a common language and a collective ideal behind the actions that were happening, and were about to take place.

Below is a catalogue of current practices in language services and their origins. The headings below refer to the current designation or group to which various HCIP facilities now belong.

Providence Health Care Group – The Vancouver Coastal Health Authority

Currently a member of the Providence Health Care group of the Vancouver Coastal Health Authority, Mount St. Joseph's Hospital (MSJ) was an important partner in the HCIP project because of the high non-English speaking patient base, and because of the supportive environment of the institution around addressing issues of access.

Once the HCIP project concluded, MSJ, an HCIP project test site, continued to maintain their interpreter service. Building on a strong volunteer based response, the hospital began to recruit its own professional interpreters, using interpreter services provided by community agencies (MOSAIC and Surrey Delta Immigrant Services are two examples) only when the need could not be met within their own pool of interpreters. The volume of need for one language group was so high at MSJ that relatively early on they were able to "block-book" interpreters, being one of the first agencies to do so. The practice of block-booking refers to booking interpreters in high demand languages to be on site for a defined length of time or shift. Their availability is then communicated to health care providers who are able to then schedule the interpreter to fit their own agendas. If interpreters were to find themselves with lag time on their hands, they were asked to do patient visits or generally make themselves available to the health care staff. The practice of block booking varies from agency to agency.

Since 1996, and the conclusion of the HCIP project, MSJ has undergone some organizational shifts, as have all of the health care agencies in BC, and went from providing services internally in one institution, to currently providing interpreters to four different sites within Providence Health Care.

The Provincial Language Service – Provincial Health Services Authority

The Provincial Language Service (PLS) is a program of the Provincial Health Services Authority (PHSA) and evolved from the initial interpreter services run out of BC's Children's Hospital in 1994. From 1996 to 2003 interpreting services were managed by the Office for Cross-Cultural Care and Diversity at Children's & Women's Health Centre of British Columbia (C&W). As with the majority of health care institutions, Children's Hospital had been meeting its language needs through bilingual staff members and hospital volunteers. Not seeing this as a realistic resolution to the increasing need for interpreter services, the Office for Cross-Cultural Care and Diversity began utilizing the services of professional interpreters through interpreter brokers and then later to running its

own language service and recruiting its own freelance interpreters. During that time, well developed organizational policies and procedures were in place at C&W to manage the service, and more significantly, staff of the program developed ***FITS – The Friendly Interpretation Tracking System*** © 2000-2005 to enhance the dispatching of interpreters and to gather utilization statistics key to improving quality assurance and management of resources. FITS is also used by other hospital-based interpreter services.

With the restructuring of BC Health Care in 2001-2002 C&W became part of the Provincial Health Services Authority, which has a mandate for ensuring that BC residents have access to a coordinated network of high-quality specialized health care services. To help meet its mandate of ensuring access to health services throughout BC, the PHSA supported the development of the PLS, a centrally managed and centrally coordinated language service for the health system. The PLS is unique in that it operates province-wide, works with community partners to deliver services outside the Lower Mainland, and relies on technology which provides access to interpreters schedules and utilization reports over the web. A new authority-wide policy to reflect the expanded scope of the service is in development.

Vancouver Coastal Health Authority

Vancouver Hospital and Health Sciences Centre

In 1996, the Vancouver Hospital and Health Sciences Centre (comprising Vancouver Hospital, the UBC Hospital, GF Strong Rehabilitation Centre and the George Pearson Centre) also implemented a language service centralized at the Vancouver Hospital location intended to meet the needs of all four locations. In the pilot stages, the project intended to involve only the Vancouver and UBC Hospital sites. The project was successful in building awareness around the issues and resulted in the implementation of a centralized dispatch, a one-call, one-number system, and policies, procedures and protocols around the service. Currently, the service is provided to the Vancouver Coastal Health acute care facilities.

In 2001, the Vancouver Coastal Health Authority, in partnership with The David Lam Centre for International Communication and Continuing Studies at Simon Fraser University, responded to the perceived need of health care professionals for "further assistance and additional services to assist them in providing culturally suitable patient centered care to non- and limited-English speaking patients and their families," (Hilton, Report of the Evaluation of the Advanced Health Care Interpreter Program, 2003, pp13). The *Advanced Health Care Interpreter Program* augmented the interpreter role by 'advancing' the role of the interpreter to that of cultural facilitator/interpreter. The program trained 8 interpreters in a 15 month program to provide services to health care personnel that would respond to the need for more culturally specific information. The evaluation report, a comprehensive publication, concluded that the "findings … reflect the challenges in implementing the Program … The Program improved the skills of the interpreters and made them more able to consider and the [sic] act on the issues and challenges that face interpreters when dealing with complex interpretation sessions," (Hilton, Report of the Evaluation of the Advanced Health Care Interpreter Program, 2003, pp71). The program has not trained any additional interpreters to date.

The Richmond Hospital

The Interpreter Services Assessment Project began with the Richmond Hospital Diversity Committee recognizing the current system was not effectively meeting the increased demand for language assistance at the hospital. Committee members also recognized the value of professional health care interpreters and required a process of implementing a service that would eventually include professional interpreters. In November

2000 Richmond Health Services (including Richmond Hospital) launched a region-wide interpreter service for all its health service area – community health, mental health, continuing care, residential and acute care.

Within the Vancouver Coastal Health Authority, both Vancouver Hospital and Richmond Health Services (acute, community, mental health and long-term care services) continue to provide centralized interpreter services to a defined agency base within certain geographical boundaries. Currently, the sectors not being serviced by a centralized system within Vancouver Coastal are Vancouver Community Health, and the Vancouver North Shore/Coast Garibaldi region.

Fraser Health Authority

Surrey Memorial Hospital and the Fraser Valley Cancer Centre

In 1996 Surrey Memorial Hospital (SMH) and the Fraser Valley Cancer Centre (FVCC), part of the BC Cancer Agency, began to review their needs for language services. As the central acute care facility for the community of Surrey, SMH needed to address the increasing number of non- and limited-English speaking members of their patient population. The two agencies combined resources to form one of the first models of a centralized service in BC. Located adjacent to each other, the two facilities were able to share one language service coordinator that ensured services for both sites. The pilot project initially tested the feasibility of using the three-tiered approach as designed in the HCIP project. It soon became apparent that the effort required to maintain an effective and efficient community volunteer list did not justify continuing the practice, and the facilities soon concentrated their efforts on training internal bilingual staff members who volunteered their services and on securing a roster of professionally trained interpreters.

The Fraser Valley Health Region

In 1999, the Fraser Valley Health Region (FVHR), comprising the communities from Abbotsford to Hope, implemented the first regional model of interpreter services in BC. The service implemented a two-tiered service involving the utilization of bilingual staff and professional interpreters obtained primarily through a service broker – The Interpretation and Translation Services of the Abbotsford Community Resources. Any staff or patient of the FVHR could request an interpreter by calling one centralized number. A communication plan was implemented that involved table cards and telephone stickers to encourage people to use the service. Service coordinators conducted educational sessions and FVHR staff were appreciative of the service. As long as education was done around the service, the volume of usage increased. Any lag in information sessions resulted in a stabilizing effect on the volume of requests. This is a very critical point and indicates that when people are not facilitated in their understanding nor supported in their usage of a new system, they will revert to old habits.

Both the FVHR and SMH merged into the Fraser Health Authority (FHA) once the most recent reconfiguration of health services was implemented by the BC provincial government. While the BC Cancer Agency became a PHSA service delivery area, the interpreter services to the FVCC continue to be provided by Fraser Health Authority because of the successful and historical collaborative relationship between the two agencies. Interpreter services in the FHA are centralized at SMH and currently policies and practices are being redesigned to meet the current realities of the health authority.

Summary of Models of Language Service Delivery in BC

This brief sketch of services in the Lower Mainland demonstrates the range of potential models for interpreter services from institution-

based services that respond to local demands to centralized services that cover a broader field – in the case of BC, centralized service is usually defined as centralized within a particular health authority with the exception of the Provincial Language Service which is working to provide services province-wide.

As a final footnote, it is important to mention the substantial contributions that community agencies have made to the development of community interpreting as a whole, and more specifically to the field of health care interpreting in the BC Lower Mainland. Were it not for the talent, experiences and expertise that these agencies brought to the health care stage, the subsequent developments in the field of health care interpreting would have had a less fertile ground in which to grow. One of the principal agencies, MOSAIC, has been providing interpreter services, in one form or another, since the early 1970's. Other agencies that were valuable contributors were the Immigrant Services Society, Surrey Delta Immigrant Services Society, and Abbotsford Community Services. This is not an exhaustive list of collaborators as considerable contributions were made by the many BC non-profit agencies advocating access rights for their clients.

Sign Language Interpreting

BC also has a province-wide, centralized interpreter service for the deaf and hard of hearing and the deaf/blind communities. The service is operated by the Western Institute for the Deaf and Hard of Hearing on the Mainland and by the Island Deaf and Hard of Hearing Centre Association across Vancouver Island and is managed by the PHSA on behalf of the Ministry of Health.

A toll-free number on the Island and on the mainland connects callers directly to a dispatch or to an emergency after-hours answering service. Sign Language Interpreters are screened as medical interpreters and are available as far north as Prince George and surrounding area. Currently the service fields approximately 250 calls monthly.

This service is a direct result of a 1997 Supreme Court of Canada decision (The Eldridge Decision) requiring the province of British Columbia to support a government funded sign language interpreter services for deaf, hard of hearing, and deaf-blind medical patients. Patients or health care professionals can call from anywhere in the province and receive a sign language interpreter on-site for any pre-planned appointments. The service is free to patients. The service also offers emergency on-site response, province wide, available 24 hours per day, 7 days per week.

IV. Interpreter Training

In BC, the most comprehensive post-secondary interpreter training is offered through the Vancouver Community College (VCC) Interpreting Program for individuals choosing to work in the community and court context. The program offers certificate programs in Community Interpreting, Court Interpreting and Health Care Interpreting. Courses vary in length, and the Community Interpreting Certificate Program is a prerequisite for both the Court Interpreting and Health Care Interpreting courses. Completion in the Court Interpreting course provides proof of accreditation to work as an interpreter in the BC courts system.

Simon Fraser University also offers Interpretation and Translation Programs through the Continuing Studies office. The programs are available to interpreters and translators working in Chinese and Japanese languages and have a more international focus, although a four-month, full time certificate program is available for community interpreting.

Training is also available on a community-based level with contract trainers offering specialized training in medical interpreting and mental health interpreting. VCC also offers community based training that they custom

develop for agencies as well as distance and on-line training options for the community and court interpreting programs.

The major issues in interpreter training in BC are:

- Tuition costs
- Low remuneration rates for interpreters discourages interpreters from taking on the expense of training
- Accessibility for communities outside of the Greater Vancouver Regional District such as Victoria and the BC Fraser Valley
- Providing training for languages of lesser diffusion
- The incorporation of mental health interpreter training within the institutional framework (currently interpreting in mental health is only offered intermittently by the Health Authorities through a 24-hour training program developed by community-based consultants.)

No thorough research has been conducted into the state of health care interpreter training in BC since the *Health Care Interpreter Partnership Project* (1994–1996). The HCIP project resulted in a training program for medical interpreters that has since undergone some modification. However, the ten-year period since the culmination of the HCIP project has seen numerous changes in interpreter services, the needs of the interpreter practitioner and the needs of the health care community. It is anticipated that a comprehensive research project would result in a set of recommendations on models of training.

V. Policy

In the BC Lower Mainland, health care institutions that have current policies concerning language services are few. During the developmental stages of the mid to late 1990's many of the health care agencies that undertook the implementation of language services in their institutions did so with policy being a primary step. Certainly, at the time, policy mandated the practice and procedure for agency staff and moved the language services agenda further along the developmental cycle. The relatively recent reconfiguration of the health care regions into health authorities in 2001-2002, and its subsequent amalgamations of facilities and geographies, has created a dissonance between previously developed policies and current operations and services, leaving organizations having to review or rewrite policies as they apply to language services. The current policy picture is:

- The Fraser Health Authority is amending its policy which had originally been drafted when the service area was Fraser Valley Health Region
- The Provincial Health Services Authority – one of the larger providers of language services for health care – continues to rely on an outdated policy which was developed for the service when it was run out of Children's & Women's Health Centre of BC. The policy is in the process of being revised to reflect the expanded scope of the services.
- Within the Vancouver Coastal Health Authority there are two language service policies, one in place at Vancouver Hospital and Health Sciences Centre and one at Richmond Hospital. There is a need for an authority-wide policy to encompass all the service delivery areas.

Perhaps the current state of policy development in BC is at the root of the confusion that exists around the role of the interpreter as demonstrated in the research data (see summaries of data below). Without clear policy and guidelines around service protocols, health care providers are left to make assumptions about the need, role and reason for language services, and often obtain and use services in a manner that is inconsistent within and across health care service areas. Policy creates a framework within which all parties are given a clear rationale and protocol for service usage.

VI. Standards

As with any professional group, interpreting follows set standards of performance and ethical guidelines. Prior to 1994 and the implementation of the *Health Care Interpreter Partnership Project* (HCIPP) there was no common language around interpreter standards in health care in BC. As already discussed, one of the successful outcomes to emerge from the project was the definition of a set of 12 performance standards and ethical guidelines for interpreters and interpreter service delivery. While there still exists no centralized body that oversees and enforces adherence to the standards, some providers of interpreter services have set up their own quality assurance measures to guarantee that standards are met and followed. Some of the most advanced services have implemented protocols to safeguard quality assurance practices.

Standards and ethical guidelines may be expressed in different terms among the different agencies and communities involved in language services, but there are common underlying principles that guide them. Chief among these principles are the four cornerstone values: confidentiality, impartiality, accuracy and proficiency. These 4 guiding principles frame the work of interpreters and if disregarded, either through a lack of awareness or a lack of training, create a danger of miscommunication, mistrust and in the case of health care, misdiagnosis.

The primary means to ensure that interpreters new to the field receive careful orientation to and an awareness of ethical guidelines and professional standards is to provide training. In addition to teaching foundational skills, an imperative for all interpreters, training also provides a profound understanding of the values underlying the profession.

There is a danger, however, in accepting standards as static elements. A periodic review of standards is essential as is the implementation of a quality assurance system to ensure that standards are met, followed, and understood by all parities involved. In BC, no comprehensive review of interpreting standards has been undertaken since 1994-1996. Given this, it may be the case that there are broad differences of opinion around interpreter standards and the manifestation of those standards in daily interpreting practice. Certainly, in primary care, the application of standards has not been approached in any systemic way: an indicator of this lack of awareness is the continued usage of family members and friends as interpreters.

VII. Research Findings

The research of the *Strengthening Access to Primary Health Care (SAPHC) Project* was principally conducted by means of focus groups and key informant interviews. The project was charged with researching four main topic areas: Policy; Service Delivery; Training; and Standards. The data shows very little collected comment or opinion on the first topic area – Policy. What the data does demonstrate is a need among project informants to discuss the role of the interpreter. In fact, the discussion on the role of the interpreter permeated almost all of the specific topic area and dominated the focus group discussions. Decidedly, this tendency among the groups to discuss the role of the interpreter speaks to a community that is at odds with, or at a minimum, uncertain about, the tasks and role of the interpreter. It also demonstrates the need for more discussion, education and training in this area and may be an indicator of health care professionals' need and desire for more cultural information which might be better addressed through means other than an interpreter (for example, by providing cultural competency training for staff).

The following sections are summaries of the data originally collected during the SAPHC research stage and recapitulated, in part, by members of the Vancouver SAPHC Local Action Committee (LAC). Organized by topic areas, the summaries bring together focus group and key information interview findings

and are augmented by comments by the LAC members. In lieu of the Policy topic area, and because the role of the interpreter figured so prominently in the discussions, the LAC elected to review the data and extract those comments directly dealing with this topic area.

Limitations of the Data

It is important to recognize that materials presented are summaries of interviews and focus groups and present the perceptions and opinions of two key groups of stakeholders in interpreter services: healthcare providers and health program managers on one hand, and interpreters and managers of interpreter services on the other. As perceptual data, this material is both subjective and partial rather than objective and holistic, often indicating preferences rather than stating actualities. Further, some of the presented material is inaccurate or incorrect indicating a need for more training and communication about interpreting in health care for interpreters, health care professionals and interpreter services providers. A summary of the data collected during the focus groups and key informant interviews are presented immediately following each section.

Models of Service Delivery: The Role of the Interpreter

Who provides language services besides face-to-face, freelance professional interpreters?

Health care providers use a variety of means to fulfill the interpreter function. These include family and friends, bilingual staff, language designated clinical staff, telephone interpretation services and so-called 'in-house' staff interpreters. Care providers recognize many of the strengths as well as limitations of each of these. Professional, face-to-face interpreters are welcomed and valued. Nonetheless, for a number of reasons, providers continue to use these other means of interpretation even when professional, face-to-face interpreters are accessible to them.

It is clear that more attention needs to be given to delineating the strengths and limitations to all methods of interpreting, and identifying the most appropriate and effective use of each method in health care settings. As discussed in the previous policy section, the implementation and communication of clear policies and policy guidelines would eliminate some of the inconsistencies and confusion around the role of the interpreter.

The Desired Attributes and Roles of the Interpreter

Health care providers value interpreters who can assist them to achieve their role and function in the patient-provider encounter. They value professionalism and technical competency in facilitating communication. Most providers want to take responsibility for the cross-cultural dimension of patient care; and their preference is for interpreters to educate them about the impact of clients' culture on their care. Health care providers like to work consistently with the same interpreters to build their professional relationship with them.

The cultural broker role was also identified as valuable to assist clients and patients to navigate the health care system. Strategies to foster professional team building between providers and health care interpreters would strengthen the profile of the interpreter in health care and would further educate health care providers on the role boundaries of the professional interpreter as language assistant.

Strategies might include more:

- professional development opportunities for interpreters;
- education for health care providers;
- effort to match interpreters to professionals as well as to patients;
- use of 'in house' (block booked) interpreters where possible.

Limitations to Interpreter Services

Informants identified four limitations to current interpreter services. Two of these relate to limited and piecemeal funding for interpreter services across regions and across the continuum of care. The other two were operational limitations: lack of interpreters in languages of lesser diffusion and lack of timeliness for accessing interpreters in certain situations.

Without consistent funding across the continuum of care, momentum and support for interpreter services is lost. It is important that a strategy for lobbying for dedicated regional interpreter services' funding be developed to ensure this consistency.

Interpreter services operate on a supply and demand service model: expose the demand and the supply responds. Increased demand for the service will result in efforts to provide comprehensive resources across language groups in a timely manner. The more potential work there is for interpreters, the more likely it is that they will invest in training and make themselves available for work. Currently the high demand for interpreters is often masked by the fact that health care providers may still often rely on family and friends to interpret. Inconsistencies across service areas dilute the potential work opportunities for interpreters and delay the development of a system that is truly responsive to the existing demands.

The demand for interpreters is intrinsically tied to immigration and migration cycles which cannot always be anticipated or controlled. The need for languages of lesser diffusion frequently arises when new immigrant or, more likely, refugee populations immigrate to BC. With few resources to respond, services are often left unable to cover the need. This highlights the importance of planning and collaboration among community service agencies to better understand immigration and refugee settlement trends and better anticipate and manage the resulting language service needs. Currently in the Vancouver Area there is a working group, comprised of representatives from the health care language service providers, training institutions, and community agencies that is examining the issue of languages of lesser diffusion and how to address these.

Interpreter Service Operational Features

Finally, informants who were providers of interpreter services identified features they perceive as essential to reducing costs and maintaining or enhancing quality along a number of dimensions. Chief among these was the increased use of technology to centralize dispatch, invoicing and reporting mechanisms in order to generate efficiencies for users of the service; to allow for expansion that creates economies of scale; and to reduce labour costs per unit. While the benefits of centralization were acknowledged and recognized, many informants also expressed the perception of value for on-site management for quality and risk management; for development of relations with providers, for education of providers, and for management of provider expectations.

Overall, there is a desire to achieve high level commitment in the form of dedicated regional budgets for interpreter services. British Columbia would benefit from a thorough review to identify best practices to achieving cost reductions and to maintaining/improving quality. Currently, due mainly to the way in which health care was previously structured, many of the larger health care centers in the BC Lower Mainland offer many of the same intake and dispatch services at each of their facilities, resulting in less time to conduct important supporting activities such as lobbying for policy development, lobbying for dedicated regional interpreter services funding across the continuum of care, education and communication for staff, and development of professional development opportunities for interpreters.

Models of Interpreter Services

Informants identified family members, bilingual clinicians, telephone interpreters and in-house interpreters as sources for language assistance aside from professional, face-to-face interpreters.

Reasons for using family members to interpret included:

- It is considered difficult to bring in an interpreter in a reasonable amount of time
- It is considered too costly to use Language Line or a local interpreter
- It is most appropriate to use family members because they are culturally competent
- The family is concerned about privacy
- Families are more comfortable handling the interpretation themselves

Bilingual staff members are enlisted to act as interpreters. This was regarded as both positive and negative.

- Positive points:
  - Staff have the necessary understanding of medical terms and technical background to provide additional explanation and clarification to the patient
  - Staff understand the kind of information the practitioner needs and does not need
- Concerns:
  - Not all bilingual staff can interpret well
  - Staff have a great deal of difficulty distinguishing between their role as interpreter and role as staff; they may add their own professional opinion to the conversation between the other clinician and the patient
  - Staff may have their own agenda, different from that of the provider

Some health care settings have developed *language designated* positions for clinicians, primarily for nursing positions. A limited number of these positions are available because there is requirement to justify the hiring practices as they may be challenged by the union. It is more likely to find 'bilingual clinicians' among private practitioners, such as doctors.

Telephone Interpreting is also used. Some of the practitioners seemed content with the service, but the administrator mentioned that she discouraged its use due to cost. Some stated that the quality of the interpretation varied from call to call; and lacked the non-verbal dimension of communication.

Some identified in-house interpreters as permanent staff as a cost effective measure if the interpreter could speak a combination of languages that were in great demand. This situation also provides opportunities for the interpreters to build professional relationships with providers and patients.

Informants identified a number of desirable attributes for face-to-face interpreters:

- Knowledge of medical terminology and concepts
- Able to communicate their professional role to clinicians
- Able to maintain confidentiality
- Able to perform the communication task

Informants identified a number of different role expectations for face-to-face interpreters:

- Conduit of linguistic meaning of communication
- Conduit of cultural meanings of communication
- Cultural consultant to clinician
- Cultural consultant to the patient
- Cultural broker

Informants identified a number of limitations to current interpreter services:

- Lack of timeliness of response to requests for interpreters
- Lack of availability across the continuum of care
- Lack of dedicated budgeting for interpreters
- Changing language needs of clients, particularly refugees

Finally, informants who were providers of interpreter services identified features of their services that contributed to a successful service:

- Centralized service – calling one number to book an interpreter, with centralized invoicing and other administrative functions, streamlines operations
- On-site management – to use interpreters' paid time fully, develop relations with providers, educate and manage their expectations, and manage quality
- High level commitment – authority level commitment to budget for interpreter services
- Economies of scale –to reduce per unit cost
- Use of technology – to increase efficiencies and reduce labour costs per unit

Interpreter Training

Training

Informants overwhelmingly endorsed the training of interpreters. Many informants were unfamiliar with current training opportunities for interpreters and the complexities of implementing and administrating comprehensive training programs. The picture that emerged from the focus groups was one of a vague sense of the types of components that should be included without any awareness of the current training context. The data does not examine existing training programs, nor does it attempt to identify components of that training.

What is required in Vancouver and surrounding communities is research into existing programs and the best training methodology so that a model training program for health care interpreters can be developed – one in which mental health interpreting is included. Interpreter training would also benefit from on-going professional development opportunities made available for practicing interpreters.

Role of the interpreter

As discussed above, informants demonstrated conflicting perceptions of the role of the interpreter. Health care providers generally espoused a version of the interpreter as cultural consultant, and many put the onus of responsibility for clarification of cultural issues on the interpreter. Interpreters, while recognizing that communication and culture are intrinsically bound, were more cautious about their role. They are aware that they are not cultural anthropologists, all-knowledgeable about Canadian and their other culture. They are also aware that patients are individuals, and gave examples to demonstrate that not all individuals of a certain culture behave and think alike. As one informant, referring to culture, put it: "After all, how can the interpreter be certain that she understands either party completely? It could be the case that her working languages are spoken widely, and that speakers of those languages vary widely in their attitudes and beliefs." An interpreter's knowledge of the home culture will also be affected by the number of years away from the home country, and the degree of assimilation into Canadian culture.

Consequently, most professional interpreters are uncomfortable taking on the responsibility of explaining a patient's culture to a health care provider. They feel that should be the job of a trained cultural broker.

Generally, interpreters agreed that if a cultural misunderstanding arose, they would inform the health care provider, but would prefer that the provider pursue clarification. Interpreting in mental health is a different case, requiring more active participation from the interpreter.

As stated previously, this inclination to turn to the interpreter as cross-cultural mediator and authority can be acknowledged as a symptom of a health care system that is not competent to respond to an ethnically, culturally and linguistically shifting community. The issue of the role of the interpreter at the intersection of culture and language needs further examination and consideration as it is of key importance for not only interpreter training but in all aspects of language services as well as for the health care provider. This examination must take into account not only the expectations of health care providers, but also the discomfort of interpreters in meeting stated expectations.

Challenges in Interpreter Training

The main challenges identified were:

- the lack of funding for training programs
- the issue of low remuneration which does not encourage interpreters to seek training
- the non-recognition of interpreting as a profession on the part of clinicians
- the lack of a nationally recognized certification.

Considerations for Interpreter Training

- Pursue the education of clinicians on interpreter issues, beginning with medical schools. (Involve interpreters in this initiative).
- Expose a large number of health care providers to the issues of interpreting through contacts with peers who understand the realities of professional practice in a multicultural milieu.
- Develop a national certification procedure in conjunction with a professional association of interpreters.
- Encourage bilingual individuals to pursue training by making a substantial differentiation in the rate of pay between trained and untrained interpreters.
- Health care institutions need to assist training institutions in lobbying for base funding for interpreter training programs in order to make training more affordable.
- Explore strategies to financially assist bilingual individuals to pursue interpreter training programs (for example, by establishing an endowment to provide bursaries to interpreters)
- Put increased emphasis on developing training for interpreters in languages of lesser diffusion.
- Explore and develop strategies for training interpreters in smaller communities.

Standards and Training

The section on training includes a summary of a focus group with representatives from a community college that has been offering health care interpreter training for a number of years, a university that has delivered only one pilot offering geared to a specific contract, and solo trainers with experience in community-based training and in interpreting in mental health. Issues on training also appear in the other sections of the report, and were discussed by informants with no expertise in interpreter training.

Standards for Interpreting

Informants stated that valid standards for interpreting are already in place in BC. However, they identified challenges:

- Finding interpreters who are able to perform at the level dictated by such standards
- Monitoring and evaluating working interpreters against the standards
- Lack of national recognition of standards

Training

Informants recognized the importance of training and that training over the past few years has already made a difference in the quality of interpreting. They identified several necessary components for the training of health care interpreters:

- Knowledge of medical terminology and issues
- Ethics
- Role of the interpreter*
- Interpreting practice
- Understanding of procedures
- Mental health issues
- Practicum

Working interpreters expressed frustration with interpreting agencies or institutions that expect professional interpretation, yet do not provide professional development opportunities.

The need to train health care interpreters was emphasized on three levels:

- (1) Familiarization with cross-cultural issues
- (2) Recognition of interpreting as a profession
- (3) Acquisition of techniques of working effectively with interpreters

***Role of the Interpreter**

There was much discussion and no consensus about the expectations of the role of the interpreter.

Challenges in Interpreter Training

Informants identified the following challenges in the training of interpreters:

- lack of funding for training programs
- Cost to students: full tuition cannot be borne by students due to low remuneration and low professional opportunities (interpreters work as free-lancers, as needed)
- Training for languages of lesser diffusion, where the opportunities to work are even more restricted
- Bringing clinicians on board
- Lack of certification and recognition of the profession
- Lack of nationally recognized certification

Standards for Medical Interpreting

As previously stated, Standards for Health Care Interpreting Services were established in British Columbia in 1994, and are recognized by a small number of health care institutions. Informants recognize that these standards are "both rigorous enough to satisfy professional ethics and broad enough to be implemented in many institutions." Informants identified several challenges to the implementation and recognition of these standards.

- Every effort should be made to develop nationally recognized standards, and to adequately fund training programs that prepare interpreters to meet those standards.
- An assessment tool for interpreters working in health care should be developed and implemented to periodically assess interpreter skills and adherence to standards.

Without a doubt the research around standards for interpreters and for providers of interpreter services was incomplete. A full and comprehensive picture of the state of interpreting in the Lower Mainland was not presented, but rather what was offered through the research findings were snippets of opinions relating to individuals' experiences in addressing language needs. Although opinions are important in gathering data for action oriented research, they should be balanced with a picture of what actually exist in the Lower Mainland; these were not. Therefore, the research presented us with opinions but with no context of the current reality.

The data does offer a window into the challenges faced daily by health care providers and interpreter practitioners. They present a glimpse into the perspectives of the many stakeholders and parties involved. For those working in health care interpreting services, as trainers, practitioners and providers, the data demonstrated the amount of information and misinformation that exists about this field, and represented the challenges that may be faced when trying to implement policies and practices around language services.

Expectations of Informants

Informants identified a number of expectations regarding professional interpreters. Overall informants agreed on some of the existing Health Care Interpreting Standards, namely accuracy, proficiency, objectivity and confidentiality. Health care providers, educators, interpreters and interpreter service providers all agreed that these are integral to the profession of medical interpreting.

Health care providers are very concerned with proficiency in medical terminology. Informants reasoned that true accuracy cannot be achieved unless there is proficiency in technical language and in the understanding of clinical procedures and intended outcomes.

There was clearly broad disagreement around standards that relate to cultural facilitation and clear role boundaries. While there was general agreement that communication is vital in the effective delivery of health care, where the opinions diverged was around the additional role of interpreter as cultural mediator. As discussed previously, the principal questions that arise from this debate are: If the job of the interpreter is to provide language assistance to ensure communication and if language and culture cannot be separated, then is the interpreter also a cultural facilitator or cultural broker?; How are the roles delineated, and, if the roles are not delineated, at what cost to the standards of accuracy, impartiality and confidentiality?

It was clear that health care providers felt that the role of an interpreter is to address both language and cultural issues. The generally accepted Health Care Interpreting Standards developed through the 1994-1996 HCIP project include standards around cultural sensitivity as a nod to the reality that culture and language are inseparable. However, the standard expects that the interpreter maintain the role of language facilitator rather than that

of cultural facilitator – the standard is limited to culture as it directly relates to language.

Furthermore, there is no agreement about the role of culture within the Health Care Interpreting Standards even among interpreter service providers. Lower Mainland based health care institutions with interpreter service programs have different expectations of how their interpreters should handle situations that address culture – even though a standard exists. Because there is so little agreement related to this role, interpreters are often confused about how to deal with the situation at hand.

Clearly, more consideration needs to be given to identifying the scope and boundaries of a cultural broker within health care as compared to an interpreter within health care

As discussed previously, health care informants felt that the role of the interpreter should be expanded to allow the interpreter to act more as a team member. This approach would involve interpreters being assigned to the same patient throughout their medical process or interpreters would be repeatedly used in the same clinic. Informants stated that this would facilitate the interpreters understanding of the purpose of the session. In addition, clinicians also stated that allowing time for briefing the interpreter before the session and debriefing after the session assisted in the session going more smoothly or in gaining some understanding into the issues at hand.

Interpreters receive education related to medical interpreting standards through training programs. But often, these standards are not completely entrenched or second nature for interpreters until they gain hands-on experience and can implement them in their daily practice. It is only through experience that interpreters become fluent and proficient in applying the standards.

In contrast to languages where there are high volumes of requests, languages of lesser diffusion do not have dedicated training programs in which an interpreter would get a solid understanding of medical interpreting standards, nor do they have ample opportunity in which to practice their skills. This may result in potentially lower standard of service for health care practitioners and for their clients from smaller language communities.

While there was general consensus around the need for confidentiality, as previously stated, the way in which confidentiality was understood varied. For some informants, they understood that the use of family members better guaranteed confidentiality versus using third-party interpreters – this specifically related to small language communities. Interestingly, these health care providers did not question the potential biases of using family members as interpreters.

What becomes apparent through the data is that health care providers do not recognize interpreting as a profession. This lack of awareness leads health care providers to subjective and inconsistent application of standards as they understand them. Ensuring that health care providers become more fully responsive to the need for uniform standards for health care interpreting facilitates the process of effectively using an interpreter in small language communities, and helps members of these communities better understand the role of the interpreter and the professional relationship an interpreter has with the institution for which they interpret.

Educating health care providers on the role of the interpreter and on the Health Care Interpreting Standards requires more emphasis. Because the profession of interpreting is relatively new to the field of health care, greater consistency in the understanding of the role of the interpreter is required across the continuum of care.

VIII. Concluding Remarks

While the research data provides some valuable information, it does not provide a comprehensive or accurate view of the current state of interpreter services in the Vancouver Lower Mainland. The discussions in the majority of the focus groups focused on the role of the interpreter rather than on the one of the four designated topic areas as set by the project goals. However, the preference for this topic of discussion is a significant indicator of the state of language services in BC – it illuminates the need for clarification around the role of the health care interpreter. It also illustrates the need for consensus building among health care professionals, interpreters, and interpreting service providers. The question for interpreter service providers, interpreter practitioners and training institutions is how to come to agreement or consensus around this issue. One argument put forward in this report is that the confusion around the role of the interpreter is shaped by a system that is lacking in ability to respond to a culturally transforming society. Given this void, or inability to respond, health care providers turn to the one resource they do have – the interpreter. Seen as an answer for all things cultural, interpreters can sometimes feel isolated because they are expected to respond. For those who broker interpreter services, and for those who train interpreters, it can be easy to ask interpreters to stick to their role, but until there are clear policies in place to support those assertions, it will be difficult for health care providers and interpreters to fully appreciate the other's position. Because the discussion of the role of the interpreter so dominated the focus groups it is important that the root cause for this be explored.

The need for the interpreter as cultural broker must be examined within the broader scope of the provision of culturally appropriate, accessible and available care. If health care operated as a culturally competent system – and thereby had the capacity to understand its constituency – would the interpreter still be required to act as a cultural broker? Certainly cultural differences between provider and patient will always press the interpreter for further explanation during an interpreting session – it is impossible to separate language from culture – but when such demands were presented within a context of culturally competent care, they would not only decrease in number but would also place less burden on the interpreter as the one to resolve all cultural misunderstandings. It is within this context that the interpreter is able to realize their true role as language facilitator.

However, it is not only an argument of the interpreter being better able to fulfill their proper role within a culturally competent system. The broader issues are those of risk management and professional responsibility of care. Is it the responsibility of the interpreter to ensure that the health care provider has understood the patient's culture? Is it the responsibility of the interpreter to ensure that risk has been considered when a provider does not understand points of cultural distinction? Culturally competent care speaks to a system's ability to integrate the realities of an increasingly diverse population meaningfully in health care and to provide services that are responsive to that population. Culturally competent care is a vision that includes responsiveness at all levels of an organization: policy; management; finance; work force; and consumers. And culturally competent care accepts the responsibility to understand and speak to a health care patient completely – inclusive of culture.

While the data may not have demonstrated explicitly the need for better, more consistent policies and/or the need for further development of training and training opportunities for interpreters and health care providers, on closer examination, this divergence into the discussion of the role of the interpreter does in fact support these recommendations. The confusion on the role of the interpreter arises because there are no clear policies and procedures in place. Health care personnel do not know what to expect and, in the absence of clear set guidelines, respond by saying what they need and how

they would like the interpreter to fulfill that need. Policy, if developed correctly, and when accompanied by a comprehensive dissemination and communication plan, can eliminate the confusion that health care providers are currently experiencing. In addition to clearly framing the role of the interpreter, broader policies that manage a system's response to a transforming client base also work to support policies around language services by providing method and structures for the broader goal of culturally competent care.

As for the area of service delivery, the data demonstrates that in many cases health care providers are hesitant to use professional, third-party interpreters. But until volume requests reach certain levels, and until interpreters can be confident that they can make a living as interpreters, interpreter pools will not swell to proportions that enable immediate response. This is a fact of supply and demand. Once the real need for language services is realized, then the ability to better respond will follow.

IX. Recommendations

The need to clarify the role of the interpreter cannot be understated. As was seen in the collected focus group data it was the number one point of confusion and discussion. Even while acknowledging that the collected data did not draw from either a broad enough nor informed enough groups of informants, the debate cannot be dismissed and must be addressed. There are several contributing factors in this debate: one is that there is a lack of education for health care providers around the role of the interpreter; and, still more broadly, there is a lack of sophistication in the system to respond to a changing constituency thereby creating a void, role confusion and the need for a quick fix (i.e.: the 'interpreter as all-binding agent').

It is recommended that the first step is to look at the development of a policy framework that begins to address not only language services, and by extension the role of the interpreter, but more principally the issue of culturally competent care. Drawing upon the work done by the Winnipeg Regional Health Authority (WRHA) (Sarah Bowen & Dave Rubel) as a template for review and planning, a policy framework would begin to address the role of the interpreter as well as the larger picture of a systemic response. Cultural responsiveness extends beyond language to include a much larger set of professional attitudes, knowledge, behaviours and practices, and organizational policies, standards and performance management mechanisms to ensure responsiveness to the diversity of the patients who walk through our health services' doors. The policy development at this point should focus on risk management and professional responsibility of care. The WRHA has developed a matrix that looks at the layering of the *Canadian Council on Health Services Accreditation* against the backdrop of current practices - this matrix provides an opportunity to expose the inherent risks in a system that is currently not culturally responsive.

Further to the development of a policy framework, the project should also develop a clear dissemination plan that plainly identifies how the education of health care staff will occur (materials, process, and content). This plan should identify a timeline and process to be undertaken. The education plan should include both instruction on working with language services in addition to other practical tools such as clinical assessment tools. The dissemination should also highlight the policy framework and gather input from various sources on their own particular difficulties and needs.

To have any real effective change, the policy framework should be an inclusive project and should be done in partnership with the Ministry of Health and representation from the 5 regional health authorities and the provincial health authority. An initial package of information needs to be developed to bring partners into the project – this package should draw upon the wealth of informational materials already developed.

While the development of policy is itself a difficult task, the paradigm shift that needs to happen to create change in a system as large as that of health care is an even more difficult one. However, a critical mass is on the verge of forming and the argument for change can be made. Of course the message must be strategically aligned with current areas of priority – areas such as risk management and professional responsibility of care.

References

Berman, Sandy and McLaren, Norma-Jean, (1996) Exploring Multiculturalism and Diversity in Health Care – A Handbook for Trainers. Vancouver, Canada.

Brawley, Bev and Sasso, Angela, (1996). The Health Care Interpreter Partnership Project – Training Curriculum for Volunteer and Staff Interpreters. Vancouver, Canada

Brawley, Bev and Sasso, Angela, (1996). Overcoming Language Barriers to Quality Health Care: Final Report of the Health Care Interpreter Partnership Project. Vancouver, Canada

Bruner, D. (1990) Summary: Feasibility Study for a Centralized Interpreter Service in Alberta. Diana A Bruner and Associates, Consultants, Edmonton, Alberta.

Hilton, Ann et al., (2003). Report of the Evaluation of the Advanced Interpreter Program in Health Care. Vancouver Coastal Health Authority. Vancouver, Canada.

Language Interpretation Task Group, (1999). Fraser Valley Health Region: Language Services Proposal.

Malli, Kiran, 1998. Final Report: Interpreter Services Assessment Project. The Richmond Hospital.

Sasso, Angela and Malli, Kiran, Final Report - Surrey Memorial Hospital and Fraser Valley Cancer Centre – Language Service. (1996-1997). Vancouver, Canada

Sasso, Angela, (2000). Interpreter Services in Health Care: A Call for Provincial Standards and Service. Vancouver, Canada. AMSSA

Sasso, Angela, (2004). Achieving Equal Access in Health Care. Vancouver, Canada. AMSSA (www.amssa.org)