Health Care Interpreter Services

Strengthening Access to Primary Health Care

Toronto Regional Report:

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

SAPHC Toronto Regional Report:

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2006

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I. Introduction

In 2003, the Healthcare Interpretation Network (HIN)[1] and Critical Link Canada initiated a project to strengthen access to primary health care by people with limited English or French proficiency (LEP/LFP). Funded by Health Canada under the Primary Health Care Transition Fund, project goals included:

- the investigation and documentation of the current state of primary health care service delivery to patient populations with LEP/LFP; and
- an examination of health care providers' familiarity with services provided by trained interpreters and their opinions about interpreters' roles in primary health care.

Research to document the state of service delivery to this group included an examination of how health care providers address their communication with LEP/LFP patients in Montreal, Vancouver and Toronto.

HIN initiated this project with an awareness of the impacts of language barriers on patients' access to health care, as well as the quality of care they receive and their health outcomes. Impacts reported in the literature include: increased admissions and diagnostic testing; delays in seeking care; misdiagnosis; inappropriate treatment; inappropriate and ineffective referral; reduced comprehension and compliance by patients; lack of confidentiality; and failure to obtain informed consent.[2] The provision of quality interpreting in the delivery of health care is intended to reduce language barriers, improve communication and avoid these negative impacts.

This report, focussing on service delivery to LEP/LFP patients in Toronto, includes a review of the Ontario context and current interpreting service delivery, and an analysis of information collected from health care providers, settlement workers and interpreters in the Greater Toronto Area. In this report, the term "health care" is used to refer to primary health care and includes hospital emergency department services.[3]

The report is organized as follows:

Part II. The Ontario Context

- Review of demographic information about immigration and language in Canada and Toronto;
- Overview of interpreter service and policy development in Ontario and Toronto;
- Summary of the development and current status of training and standards; and
- Overview of issues and challenges.

Part III. Research Findings

- Service delivery, models and interpreter's roles in Toronto;
- Training and standards; and
- Government and organizational policy.

Part IV. Concluding Remarks

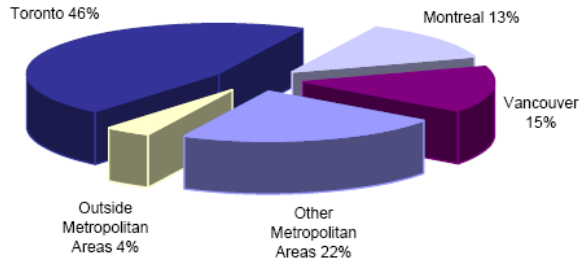
II. The Ontario Context

Ontario and Toronto Demographics

Shifts in Canada's immigration policy over the past thirty years have changed the number and source countries of Canada's immigrants. Between 1991 and 2000, 2.2 million immigrants came to Canada - the highest number in any decade this century.[4]

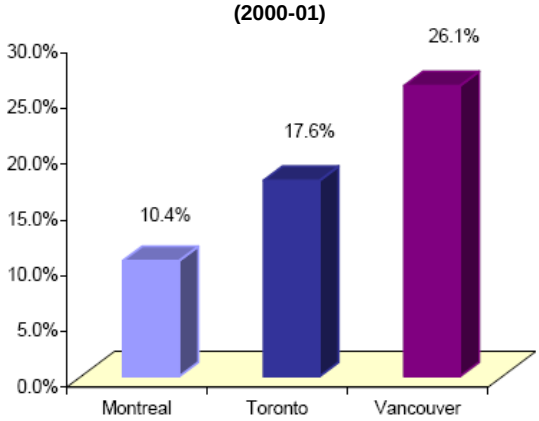
Nearly half of all newcomers to Canada settle in Toronto. A Statistics Canada longitudinal study of immigrants over a one year period found that 75,400 (46%) of the 164,200 immigrants settled in Toronto, with approximately 15% going to Vancouver and 13% to Montreal (see pie chart below).[5] Currently, about three quarters (74%) of immigrants settle in the three major metropolitan areas, a shift from the 1970s when 58% of immigrants came to these three cities. Between 1996 and 2001, 415,505 immigrants settled in Toronto. This influx of newcomers has meant a reputation for Toronto as one of the most multicultural cities in the world.

Immigrant Settlement Locations (2000-01)



- About one sixth (18%) of Toronto's new immigrants in 2000-01 had no knowledge of English or French, similar to the proportion for all immigrants to Canada that year (Vancouver, 26% and Montreal, 10%; see graph to the right).
- Of the total Toronto Census Metropolitan Area population in 2001, 181,460 people (3.9%) in Toronto had no knowledge of English or French (Vancouver, 4.7% and Montreal, 1.5%).[6]
- The longitudinal study found that older people are least likely to know an official language: 60% of those 65 or older and 40% of those ages 45 to 64, compared with 18% for all ages. About 23% of women had little knowledge of English or French, compared with 13% of men.
- This study also reported on the experience of immigrants in seeking health care. Of the 122,500 immigrants who tried to get health services, 23% reported at least one problem. Approximately 15% experienced language barriers in accessing health care.

Proportion of Immigrants with No Knowledge of French or English for Major Metropolitan Areas (2000-01)



Note: The total number of immigrants to Canada between Oct 2000 and Sep 2001 was 164,200
Source: Statistics Canada Longitudinal Study (2003)

Some other statistics to note:

- More than two-thirds (68%) immigrants were from Asia or the Middle East, continuing a 20-year trend away from European-born immigrants according to the Longitudinal Study.

In summary, based on the above statistics, nearly one in five (about 20%) of the 75,000 new immigrants and refugees settling in Toronto every year have no knowledge of either official language. If recent trends continue, this means that every year about 13,000-15,000 additional newcomers to

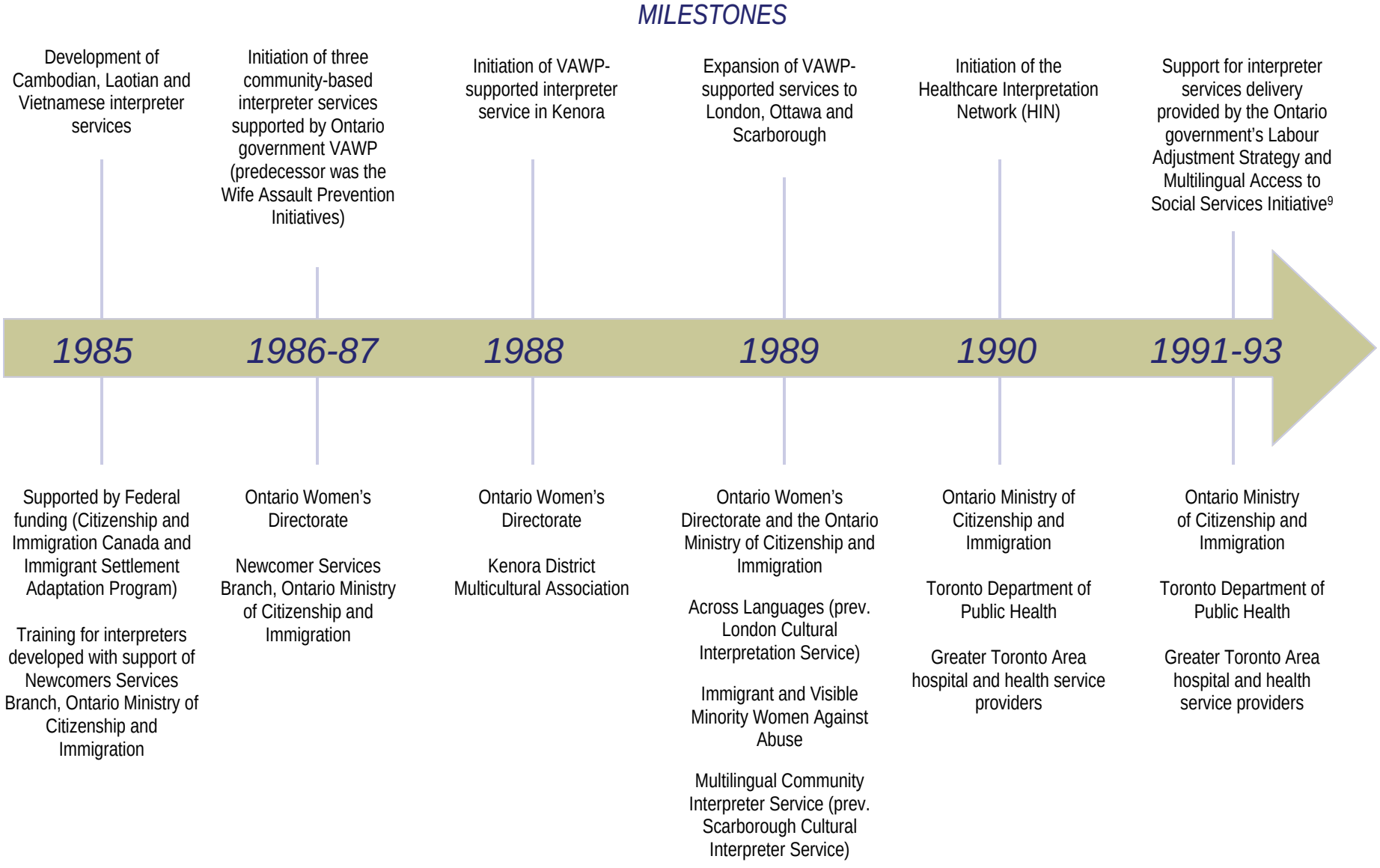
Toronto will have to overcome the language barrier in order to access health care due to their limited English or French proficiency. Women and older people are disproportionately represented in this group.

The health care system is left struggling to respond within available resources to provide access and quality service to Canada's immigrants. This challenge will likely continue as Toronto's multicultural image attracts immigrants to make their home there.

Overview of Ontario Interpreter Service Development

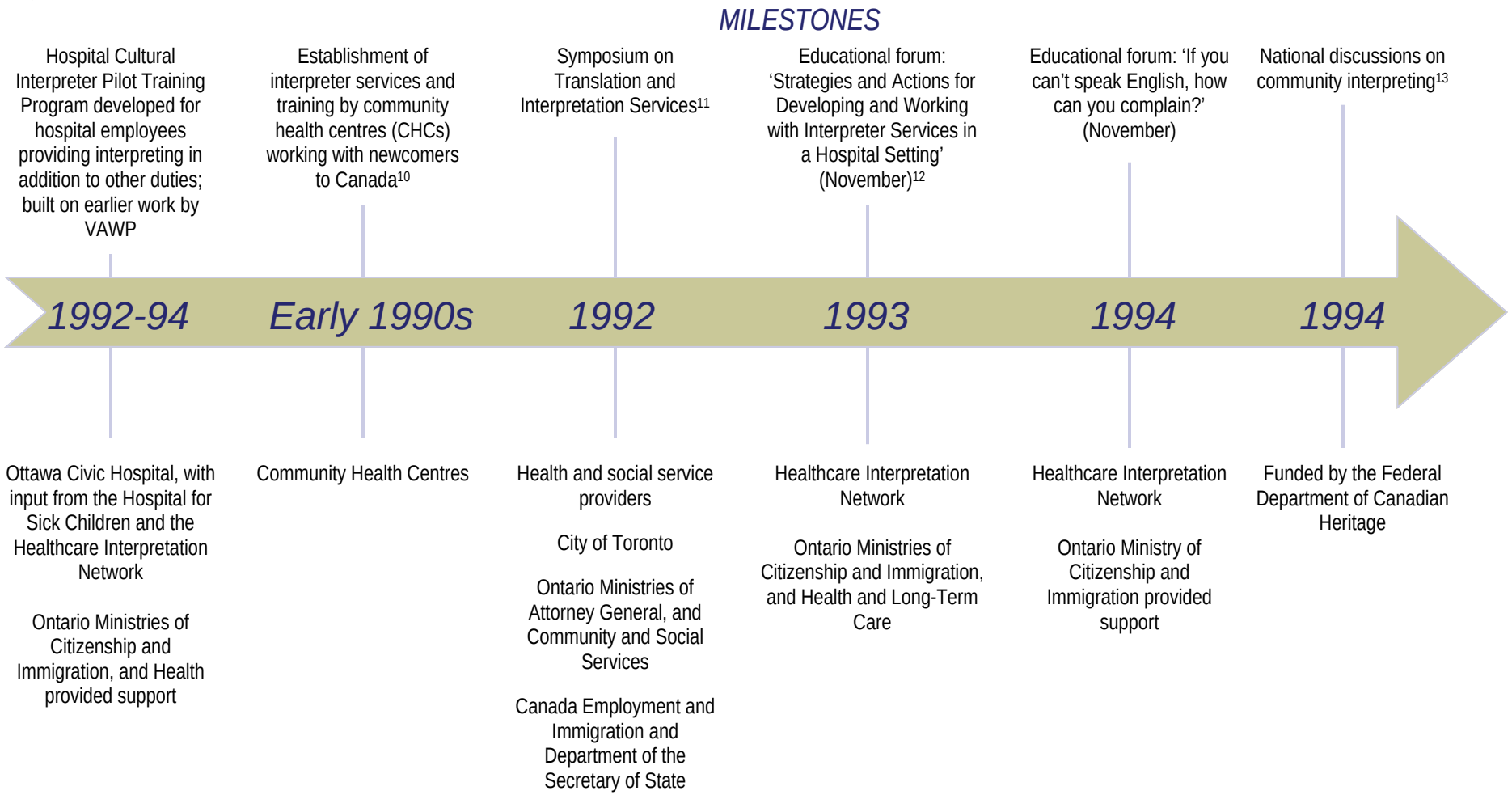
Interpreting as a formal government-funded service to enable access to Ontario health and social services evolved primarily within the context of the Ontario government's Violence Against Women Prevention (VAWP) initiatives[7] and the health care sector. Key players in this initiative included community-based services supported by the VAWP program, hospitals, community health centres and the Ministry of Citizenship and Immigration (MCI).[8] The diagrams on the following pages outline major milestones in this history.

Key Milestones in the Development of Formal Health Care Interpreter Services in Ontario



[9] Funding for interpreter services terminated with the change in government in 1992.

Key Milestones in the Development of Formal Health Care Interpreter Services in Ontario Cont'd



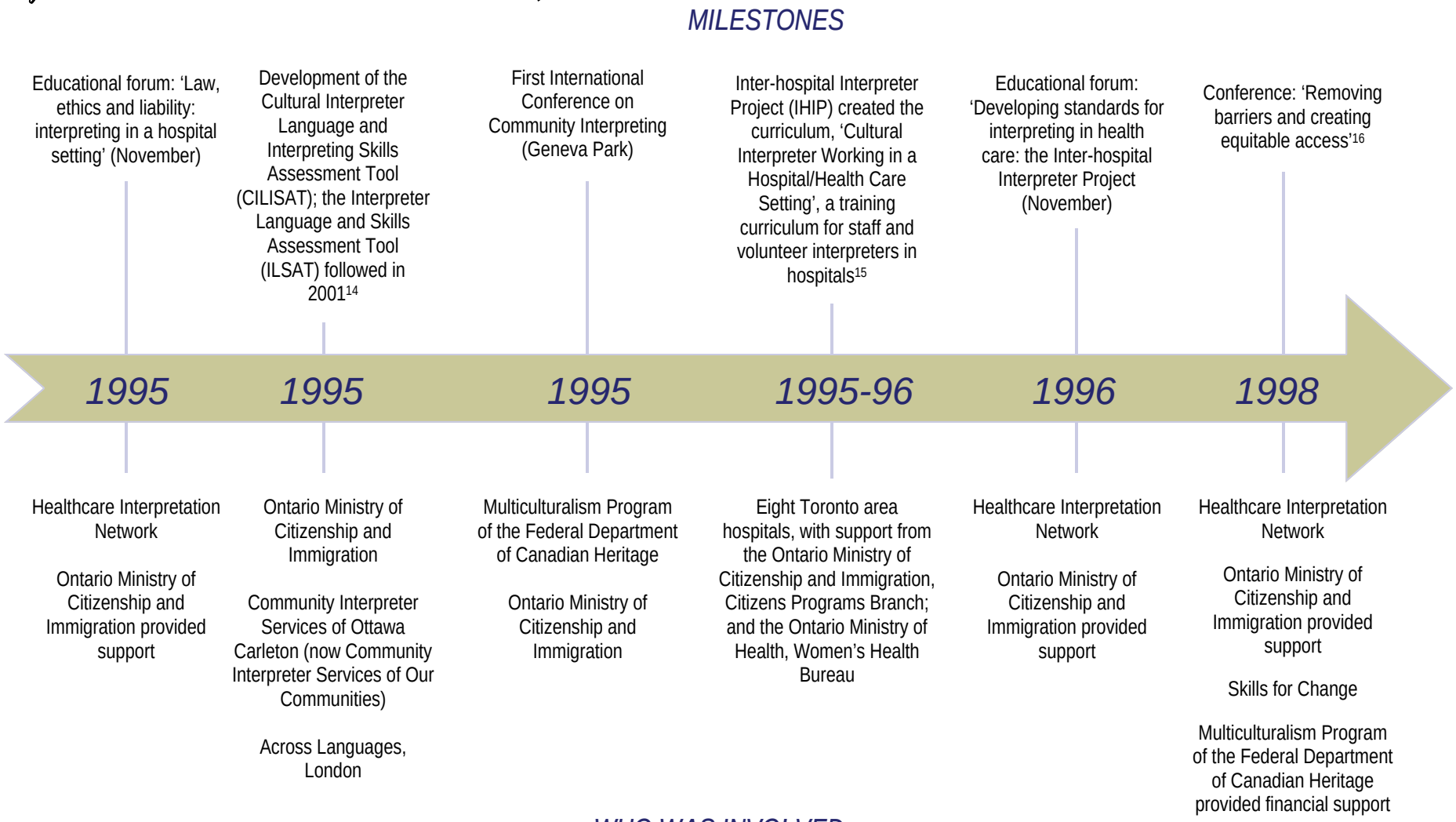
[10] Community health centres (CHCs) established interpreter services within their core services, some of which are funded by the Ontario Ministry of Health and Long-Term Care. Centre médico social communautaire, Access Alliance and South Riverdale are examples.

[11] This symposium focused on accessibility and equity and was an early forum for discussion of the role of the cultural/community interpreters and the question of accreditation for interpreters.

[12] Educational forums were documented un reports by the Healthcare Interpretation Network and its precursors.

[13] Steyn (1994) reported on discussions held in 5 cities resulting in recommendations about community interpreting that supported national standards, professionalization, on-line resources and college/university level training.

Key Milestones in the Development of Formal Health Care Interpreter Services in Ontario Cont'd

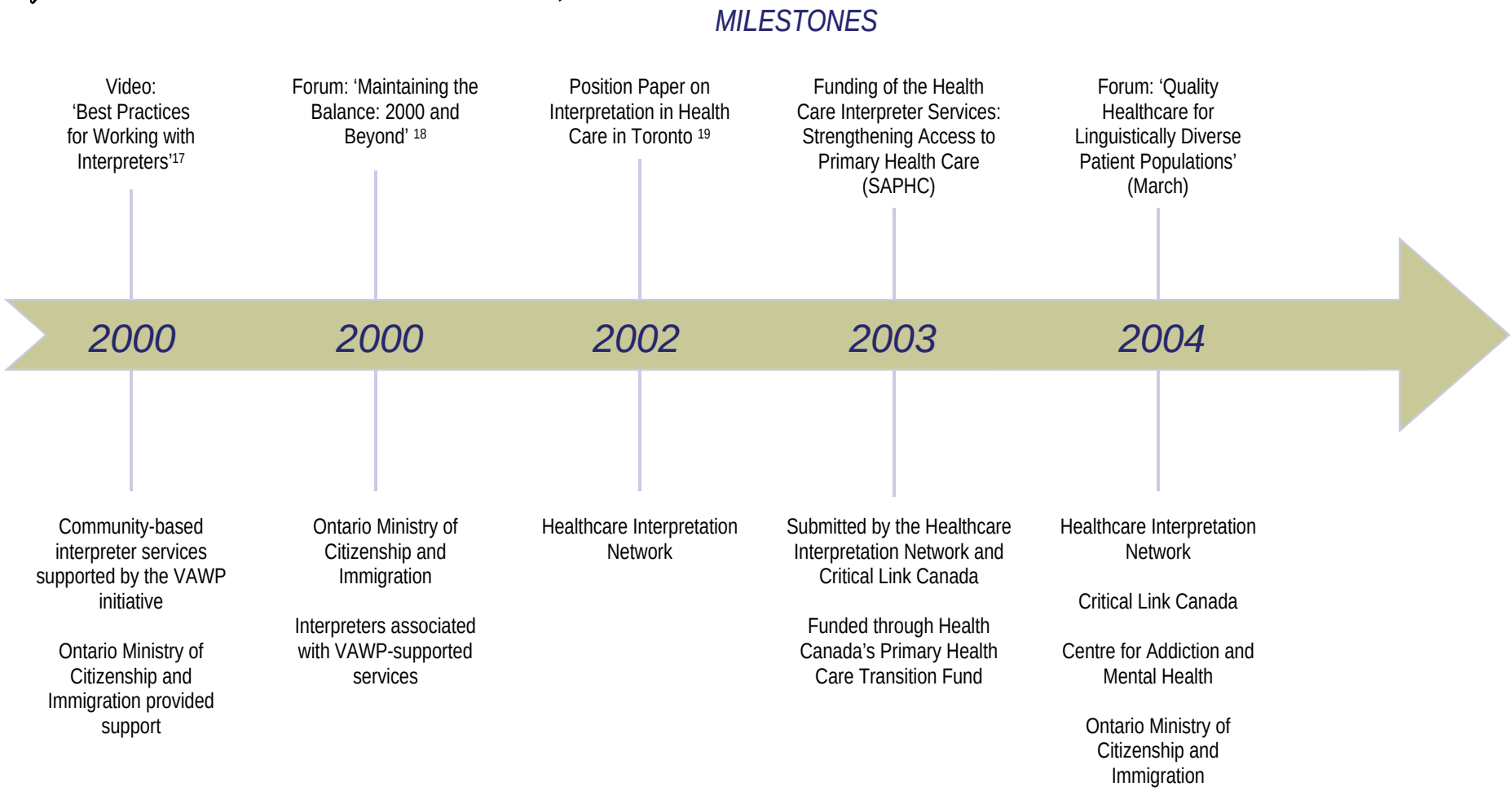


[14] The CILISAT and ILSAT were developed to assess the language competencies and interpreting potential of individuals seeking to be trained as interpreters with the VAWP. These tools now include testing for over 50 languages.

[15] Seven Toronto area hospitals produced and tested resources, training curriculum and service protocols "designed to improve the effectiveness of interpreter services in a health care setting" (HCIN, Final report, 1997).

[16] The HCIN Conference Proceedings Report (1998) includes an overview of the training curriculum and a discussion of interpreting in organizational contexts, including risk management.

Key Milestones in the Development of Formal Health Care Interpreter Services in Ontario Cont'd



[17] This video is oriented toward service providers working with victims of domestic violence (D. Abraham, personal communication, December 8, 2005).

[18] This Toronto conference was attended by more than 100 Ontario interpreters and service administrators who discussed their views on community interpreting and attended professional development workshops.

[19] Crammond's 2002 paper documented HIN's position regarding health care interpreting in Toronto.

Policy and Funding for Interpreter Services in Ontario

Provincial Policy

By the mid 1980s, service providers and the provincial government began to recognize the need for interpreter services to enable women experiencing violence to use the services and supports available. The Ministry of Citizenship and Immigration (MCI), with funding support from the Violence Against Women Prevention Initiative (VAWP) and Ontario Women's Directorate, provided early leadership for the development of spoken language interpreting in a variety of community-based settings. Over time, Ministry program staff have been responsible for setting standards and initiating competency-based training programs for the interpreters associated with their funded services, as shown in the Key Milestones above.

In health care, MCI worked with representatives from the sector on the creation of the Hospital Cultural Interpreter Network. By 1994, MCI was funding cultural interpreter centres across Ontario, including four in Toronto, focusing on violence against women and children.[20]

During the early 1990s, the Ontario Ministry of Health and Long-Term Care (MOHLTC) also supported or sponsored collaboration among service providers (along with MCI) through the funding of conferences and training development. The MOHLTC has no policy mandating interpreter services. The Ministry funds some interpreting in community health centres, and hospitals sometimes include limited interpreter service costs in their budgets.[21]

In 2003, the Ontario government announced plans for the transformation of Ontario's health care system. Following the lead of other provinces in the regionalization of health care planning, decision-making and funding (e.g., British Columbia and Quebec), the MOHLTC established Local Integrated Health Networks (LHINs) in 2005. This vision for health care transformation is rooted in the principles of equitable access to service based on patient need, preservation of patient choice and "people centred, community-focused care."[22] It is too early to tell whether the implementation of this vision will include interpreter services within health care in Ontario, but these services have not been highlighted in the planning and implementation of LHINs, to date.

Overall, the province of Ontario currently has no cross-ministry legislation or policy about language interpreting within health and social services, except for the provision of services in French. The *French Language Services Act, 1990* requires government departments to provide services in French in designated areas, but does not make this requirement of government-funded service organizations. Organizations may become "designated" providers of French language services. In Toronto, no hospitals have this designation. The Centre médico social communautaire is the only designated community health centre in Toronto.[23]

Service Delivery Policy and Role Development

Unlike other areas (e.g., British Columbia, Montreal), Ontario has no centralized interpreter service operated by regional or local authorities. In the absence of overall provincial policy, funding for health care interpreting varies by sector and by individual health care organization. Although policies, training programs and competencies associated with VAWP services have provided some guidance to health care interpreter service development, health care organizations have been left to develop their own internal policies about how, when and to whom interpreter service will be provided; appropriate interpreter roles; standards for interpreting; and competencies of interpreters.

A key area of debate has been the interpreter role. "Cultural interpreter" as a descriptor for the role came into use in the late 1980s. As the name suggests, it implies responsibility for providing cultural information and explanations along with language interpreting. VAWP's early use of the term "cultural interpreter" was incorporated into the hospitals' initial conceptualization of the role, as seen in the

"Hospital Cultural Interpreter Services Network" formed in 1990 and the title of the inter-hospital project's 1996 training curriculum. By the late 1990s, concern was being raised about the feasibility and appropriateness of this aspect of the role and in 2002 the word "cultural" was eliminated in the network's name change to "Healthcare Interpreters Network."

This debate about the scope of interpreting and interpreters' roles is not limited to the Canadian context. A National Council on Interpretation in Health Care working paper reports on a series of discussions about interpreters' roles in the United States. The author traces the evolution of the role and outlines the range of views about interpreters' roles: the "conduit" role, facilitating cross-cultural as well as cross-linguistic communication, cultural brokering and advocacy.[24] He concludes with a discussion of the creative tension among the different views and an outline of where agreement exists—the importance of accuracy and completeness, and the need for transparency when the interpreter steps out of the conduit role.

The current statement of interpreter Role and Responsibilities for VAWP and DVJS Initiatives specifies a conduit role, expressed as follows: "to deliver, as faithfully as possible, messages transmitted between individuals who do not share a common language."[25] This definition is intended to exclude cultural explanations.[26] This definition and competencies for interpreters associated with VAWP and DVJS Initiatives also apply to the hospital-based Domestic Violence Projects.

In HIN's 2002 Position Paper on Interpretation in Health Care in Toronto, the network recognizes the need for cultural interpreting, but views language interpreting as the "first step in overcoming cultural barriers."[27] HIN recommends distinguishing cultural brokerage and advocacy roles from the health care interpreter role. The network's view of the role is that it should address language barriers between patients and health care providers and ensure patients have access to health care information.

A note about the term "community interpreting": this paper uses the terms "interpreter" and "interpreting" to refer to interpreting in the community, exclusive of court, business and conference interpreting. "Community interpreting" applies to interpreting that generally takes place in the context of health, legal, education and social service delivery and other community-based activities.

Toronto Area Service Development and Networking

Early Service Delivery and Current Services

In Toronto, several organizations initiated interpreter services with VAWP support, including the following:

- The Multilingual Community Interpreter Services (MCIS) started as the Scarborough Cultural Interpreter Service in 1987. MCIS now provides interpreter services for agencies funded through the Ministry of Citizenship and Immigration (MCI), Violence Against Women Prevention Initiative (VAWP) and Domestic Violence Court Program for agencies in Scarborough, York and Durham.
- The Barbra Schlifer Commemorative Clinic has been funded by MCI and VAWP for interpreter services since 1989. The Schlifer Clinic currently offers these services in addition to counselling, legal and information and referral services for Greater Toronto Area women who have been abused.

Toronto hospitals, community health centres and other health care organizations have developed internal interpreter services to support their own service provision, as required. Within hospitals, this was often accomplished by bringing clinical and non-clinical hospital employees who happened to speak the needed language into patient-clinician interactions. Some hospitals created "language banks" of employees who could be called from their regular duties to perform interpreting, while others worked with rosters of volunteers.

The internal programs of some community-based organizations later grew to offer fee-for-service health care interpreting, including the following:

- Access Alliance Multicultural Community Health Centre (AAMCHC) was initiated in the early 1990s. AAMCHC developed an interpreter service to support the provision of primary health care to the CHC's clients. This service expanded to a 24 hour fee-for-service operation and added interpreter training for volunteers, other language access training and orientation to service providers working with interpreters, as part of AAMCHC advocacy and community capacity building strategy.
- Riverdale Interpreters was established in 2001 through the joint efforts of South Riverdale CHC, MCI and Riverdale Community Development Corporation. This service is part of the not-for-profit corporation, the Elspeth Heyworth Centre for Women.[28] Riverdale Interpreters focuses on health care interpreting and offers 24 hour, 7-day-a-week service across the GTA.

In addition, numerous settlement service agencies offer interpreter services[29] and for-profit agencies have developed interpreting and translation services in the Toronto area.

Service Delivery Models and Interpreter Roles

Greater Toronto Area interpreter services are a patchwork of models funded through global and line-by-line budgets and by fee-for-service arrangements. Services are operated by not-for-profit and for-profit organizations. In health care and violence against women prevention, models of service include:

- In large organizations (e.g., hospitals), clinical and non-clinical staff employed in other capacities, as well as volunteers, are called upon to interpret (sometimes referred to as "language banks"). They may or may not be trained on their role as an interpreter.
- Staff interpreters and/or interpreting units operate in a few large hospitals and CHCs.
- Fee-for-service interpreter service agencies operated by for-profit and not-for-profit organizations dispatch interpreters for telephone and face-to-face interpreting. Some interpreters are trained through their own agency's program or programs from other agencies, occasionally with a focus on specific fields.

Healthcare Interpretation Network (HIN)

Recognizing the need for information sharing and advocacy for needed services, health care providers in the Greater Toronto Area initiated HIN in 1990. This non-profit organization now includes representatives from hospitals, rehabilitation and chronic care facilities, community health centres and other community-based organizations from across the province.

With the formation of HIN, hospitals and other providers began to share information, experiences and resources. HIN has furthered coordination and service development by involving a broad range of providers so that information about "who is doing what" and "what works well" can be shared. The network organized five conferences in the 1990s and spearheaded the development of the hospital interpreter training curriculum described in the next section.

HIN's current statement of purpose emphasizes the interpreting needs of those who have limited proficiency in either of Canada's official languages in order to improve their access to health care. As one of the sponsors for the Strengthening Access to Primary Health Care (SAPHC) project, this network continues to promote access to interpreter services in the full range of health care services and settings.

Interpreter Training in Ontario

As with the development of interpreting services, the Ontario Ministry of Citizenship and Immigration (MCI) has provided leadership in training and standards for interpreting since the late 1980s. Created to support service provision to women experiencing domestic

violence, MCI's training program became a basis for curriculum development in health care interpreting.

In 1994, eight Toronto Area Hospitals collaborated on the Interhospital Interpreter Project (IHIP), building on the MCI curriculum and an earlier training program developed by Ottawa Civic Hospital. This partnership produced and tested a training curriculum and service protocol, resulting in the manual, "Cultural Interpreters Working in a Hospital/Health Care Setting." The training curriculum included core competencies, role and responsibilities, a code of ethics and considerations for interpreter service delivery.[30] The IHIP curriculum provided a basis for training programs now used by several hospitals and community programs, including the University Health Network and Access Alliance.

Current training programs in hospitals and community agencies range from a few hours to more than 100 hours. For example, AAMCHC training is 70 hours, with an additional 45 hours of specialized medical terminology, while VAWP-supported training programs recognized by MCI are 100 hours, with core and specialized training on working homeless individuals, refugees, victims of domestic violence, etc.[31] All include skill development, core competencies, ethics and different approaches to interpreting.

Academic post-secondary courses have previously had little success in Ontario due to limited interest (possibly related to limited employment opportunities). However, Niagara College (near Toronto) has an established program that is self-sufficient.

In 2004-05, MCI funded the development of an 180-hour competency-based curriculum for the training of community interpreters. This curriculum development is being coordinated by Information Niagara with input from an advisory committee that includes the Ontario Ministries of Citizenship and Immigration, Attorney General, and Training, Colleges and Universities; four community colleges; College Network for Education and training – CON*NECT; and organizations using interpreter services. It is anticipated that the program will be offered at community colleges across Ontario beginning in the fall of 2006. Graduates will receive a Certificate of Language Interpretation.[32]

Standards Development

MCI was also instrumental in the creation of language testing for interpreters in Ontario, starting with the Cultural Interpreter Language and Interpreting Skills Assessment Tool (CILISAT). A separate tool focusing on language only followed: the Interpreter Language Skills Assessment Tool (ILSAT). Based on a set of core competencies,[33] these tools include a dual-language audio and text test to assess language fluency and interpreting in more than 50 languages.[34] They are used to measure potential for interpreting, that is, the level of prerequisite skill competency for learning interpreting, rather than competency in interpreting itself.

Many interpreter services use these tools as one measure of competency in hiring and evaluating interpreters, often for entry level screening (e.g., Access Alliance, MCIS). Community-based interpreter services and hospitals also use other methods of testing for proficiency.[35] Standards for community interpreters have not been developed. However, the Association of Translators and Interpreters of Ontario (ATIO) has taken on responsibility for certifying court and conference interpreters.[36] Apart from the ILSAT and CILISAT, there are no standards or systems of accreditation for health care interpreters in Ontario.

To address this gap in health care interpreting, community organizations and hospitals providing training establish their own set of core competencies. These competencies are generally based on the MCI Manual, the HIN manual *A Handbook for Trainers: Language Interpreting in the Healthcare Sector* or work by Daniel Gile that proposes three components of knowledge for quality interpreting: knowledge of both languages, the subject matter and translation practices.[37]

Issues and Challenges in Greater Toronto Area Interpreter Services

Current debate among health care providers in Toronto focuses on several service delivery and organizational/management issues, such as:

- How to use interpreter services to maximize access to health services while managing limited resources (e.g., cost efficient delivery of services, timeliness, accuracy)
- Appropriate interpreter role or roles (e.g., cultural interpreting, a broader or a more limited role)
- The management of risk and liability to organizations
- Standards, core competencies required to learn and then practice interpreting, training and professionalization.

Interpreting in Toronto has evolved over the past 20 years. Increasing numbers of immigrants and languages of lesser diffusion challenge health care providers to deliver quality services using a patchwork of interpreter service models and funding.

III. Research Findings

The Health Care Interpreter Services: Strengthening Access to Primary Health Care project set out to investigate the current state of interpreting services in Vancouver, Toronto and Montreal, conduct a literature review of resources related to interpreting, and to involve stakeholders in pilot testing various projects and tools. The research was undertaken to examine the familiarity of health service providers with interpreter services, their views about interpreter roles and other aspects of communication with patients with LEP/LFP. Four main areas were to be addressed: Policy, Service Delivery, Training and Standards.

The intent of the Toronto Project Management Committee was to involve the primary stakeholders in this research, especially those most directly affected by language barriers—patients with LEP/LFP and those who deliver health care services. Other stakeholders include settlement workers who work with people with LEP/LFP, interpreters and interpreter service agencies. The Committee recognized the value of directly involving patients with LEP/LFP in the research, but given the procedures necessary to seek consent of patients and the resources required to include interpreters in the research process, this population was not included in the informant group. Settlement workers were included in the information collection as a way to give voice to people with LEP/LFP.

Part III begins with a summary of the methodology, then presents the findings under three headings:

- Service Delivery, Models and Roles
- Training and Standards for Interpreting
- Government and Institutional Policy and Funding.

Informants' recommendations and a synopsis of the findings follow each section. These framed synopses include reference to the informant groups [in brackets].

Methodology

Consultations were administered by the Glendon College Working Group on Healthcare Interpreting during 2004.[38] The informants and research approach are followed by a summary of the limitations of the research results.

The Informants and Method

Using a qualitative emergent approach, approximately 60 people were interviewed individually or in groups. The Toronto Project Management Committee and the Toronto Project Advisory Committee identified potential informants on the basis of their professional locations within the primary health care sector, settlement services agencies and interpreter services agencies. The informants were:

- Health care interpreters
- Interpreter service provider agency
- Settlement workers
- Nurses
- Social workers
- Physicians
- Community health centres
- Hospital emergency services
- Interpreting/translation professional association.

Further detail about the informants is provided in Appendix A.

Limitations

The qualitative emergent approach was chosen to gather information from a wide range of informants who have varying levels of knowledge and experience with interpreting. Advantages of this approach include the reduction of researcher bias and the freedom informants have to raise issues from their perspectives and focus on their concerns. However, in using this method, the research could not aim to collect comprehensive information, especially in relation to policy, because particular issues may not be of concern or raised by informants in the interview context.

The Management Committee, based on the advice of the Toronto Project Advisory Committee, used a snowball selection process in the identification of informants, with the objective of achieving maximum representation, rather than using random selection or issuing an open invitation. This sampling method must be taken into consideration in analysing and reading the findings of the research as it may have led to what could be perceived as a lack of information about particular issues or aspects of interpreting (e.g., providers' awareness of specific types of services), since only those participating were in a position to provide information in the investigation. For example, settlement workers noted that they were called upon to interpret, but clinicians rarely mentioned that settlement workers provided interpreter services, possibly because the clinicians involved as informants had not come across settlement workers as interpreters.

Finally, this report on the research is based on an abridged version of the information collected, rather than full transcripts of each of the focus groups and individual interviews. The process of summarizing transcripts by themes may be affected by the views of the researchers in preparing this information.

The non-random selection of informants, the use of the emergent approach and the analysis using abridged information may have limited the comprehensiveness and objectivity of the investigation. These are important limitations that must be considered when drawing conclusions from the findings. However, the findings provide an indication of the status of interpreting in Toronto, including the awareness and views of a broad range of informants involved in service delivery to LEP/LFP patients.

Service Delivery, Models and Roles: Informants' Views

Informants were generally concerned about the quality and access to health care for patients with LEP/LFP. However, they held varying opinions about the impact of language barriers. Following a discussion of LEP/LFP impacts on service quality, this section reports on informants' views about delivery models, the limitations of current service delivery and interpreter roles.

Patients with Limited English or French Proficiency and Impacts on Health Care

Informants described LEP/LFP patients as diverse: some are newcomers to Canada; others have been here for some time. Some bring their own family or friends as interpreters, others appreciate interpreters provided by the health care setting, and some are reluctant to use interpreters of any kind for fear of exposing themselves to government authorities or to judgement by others from their culture.

Although some health care providers minimized the impact of LEP/LFP on health care quality, most informants strongly agreed that language can be an obstacle to health care access and quality. They argued that limited communication impacts primary health care particularly in the following areas:

- Understanding patients' symptoms
- Communication about diagnosis, treatment and informed consent
- Ensuring effective after-care and making successful referrals to other providers.

Informants cited examples of patients being given medication and repeated diagnostic tests due to lack of communication, rather than appropriate investigation of their symptoms. Several physicians stressed the negative impacts of the lack of communication or miscommunication on the compliance of patients with treatment, numbers of return visits (especially to emergency) and continuity among clinicians.

Impacts of Limited English/French (LEP/LFP) Proficiency on Health Care Quality

Informants cited barriers and reasons for LEP/LFP patients' reluctance to using interpreters or multilingual clinicians:

- Fear of exposing themselves to judgement by others from their culture or to Canadian government authorities (e.g., concern re: their Canadian status, past experiences in oppressive regimes) [settlement workers, social workers (SWs), physicians]
- Reluctant to acknowledge their limited English/French proficiency [SWs]
- Preferring monolingual clinicians with whom they already have good working relationships [settlement workers, physicians]
- Views by clinicians that LEP/LFP patients should take more responsibility for communication (e.g., learn English, bring their own interpreter, find a multilingual clinician) [physicians, nurses]

Informants in general reported that patients deal with limited English/French proficiency by:

- Bringing their own interpreters—family members, neighbours, friends
- Asking settlement workers to interpret
- Developing informal networks at clinics/centres where they meet and help each other
- When these three strategies fail, informants resorted to not communicating symptoms, history or circumstances that affect their health.

Orientation to Canadian health care could help newcomers use health care more effectively [physicians, settlement workers]. Orientation should include:

- What can be expected from the health care system
- How and when medication is used in Canada, which may differ from other countries
- Reliance on research evidence in determining what treatments will be used.

Informants disagreed about whether LEP/LFP affects the quality of health care patients receive:

- Many believe quality is impacted [CHC staff, SWs, settlement workers, interpreters, some physicians]. They pointed out that:
  - language can be the biggest obstacle to both access to health care and quality of service
  - lack of understanding has negative impacts on particular aspects of health care [physicians, nurses, SWs]:
    - for the patient: communicating diagnoses, history and circumstances affecting illness; asking questions and being fully informed
    - for the clinician: understanding patients' symptoms, determining diagnoses and communicating treatment options, instructions and use of medications
    - validity of consents for treatment; determining competency
    - compliance with aftercare instructions
    - use of emergency over other health care options, especially higher rates of return to emergency
    - continuity, information and referral to other clinicians/specialists; navigating the health care system
    - mental health, psychiatry and counselling services, because they use language as a primary tool.

A few informants did not agree that quality is affected (some physicians, nurses, CHCs). Their perception is that:

- relationships and trust are possible without congruent language or interpreting [nurses, physicians]
- family and friends are able to act as effective interpreters [variety of clinicians]
- non-verbal communication can be very effective [nurses, physicians].

Models of Service Delivery

Most informants believe that potential negative effects of LEP/LFP on the quality of health care can be ameliorated through the use of interpreting or language-congruent clinicians (i.e., where both patient and clinician speak the same language). Informants described how patients and health care providers use a broad range of communication means and models of interpreting to communicate: trained interpreters; multilingual clinicians and non-clinicians within the same organization; telephone interpreters; settlement workers; and families and friends.

Trained Interpreters

In general, informants identified primary factors determining the effectiveness of interpreting: the objectivity and impartiality of the interpreters and the amount and quality of the training. Most of those who had worked with trained interpreters had positive experiences, and almost all agreed on the positive impact on health care quality. In fact, many informants from all professions and settings argued that trained interpreters are essential in provision of high quality health care to LEP/LFP patients. A few clinician informants, however, were not convinced that trained interpreting is needed in order to provide high quality health care; instead they used family and friends as interpreters or non-verbal communication. Some physicians and nurses emphasized that patient-clinician relationships are built on trust, which can develop regardless of language barriers or the communication strategies used.

Internal "Language Banks" and Other Use of Staff Volunteers

Informants described working with physicians and other clinicians who have been hired in part because of their language skills (e.g., in CHCs). In addition to offering direct service themselves, multilingual clinicians assist their monolingual colleagues in history taking, explanation of procedures and taking informed consents. With non-clinical staff, private practice physicians in particular reported hiring secretaries whose language skills were required for the position.

Hospital-based informants referred to working with staff who may have been trained through a hospital-oriented curriculum (such as the one developed in the mid-1990s)[39]. Some hospitals do not provide training for these staff or volunteer interpreters; those who do provide varying amounts of training.

One advantage of developing databases of staff who speak other languages (also known as language banks) is the speedy availability of these internal staff as interpreters. However, some clinical informants were concerned about accuracy in these situations, especially when staff are not trained to interpret. In addition, staff are taken away from their other responsibilities (including their own patients). They may feel taken advantage of if interpreting (that is in addition to their regular jobs) is not acknowledged, especially likely where unpaid or even paid overtime is involved. A few hospitals have moved away from language banks and now have trained interpreter staff.

Telephone Interpreting

Of all the informants, those in emergency departments and hospitals reported working with telephone interpreters most frequently. CHC staff and public health nurses (PHNs) described occasional use. Phone interpreting is usually utilized when interpreting is needed right away and other services are not readily available (i.e., immediately or for languages of lesser diffusion). Most informants who used the service believed the quality ranged from Very Good to Adequate, especially considering the limitations of communication that is not face-to-face. They noted that the absence of non-verbal cues makes it difficult to ensure accuracy and that speakerphone equipment may enhance telephone interpreting.

Families and Friends

Some physicians and social workers frequently worked with family and friends as interpreters. Most other informants involve them occasionally, especially when trained impartial interpreters are not available. Informants thought that families and friends are particularly helpful for concrete

information and their presence may help patients feel comfortable. Many recognized the potential limitations of family and friends as interpreters: risk of less-than-perfect accuracy; lack of objectivity (i.e. they may have their own agenda); confidentiality; family dynamics; potential bias about competency and consents; and lack of knowledge of medical terminology.

Some informants suggested ways of enhancing interpreting under these circumstances, for example:

- monitoring for accuracy by watching for non-verbal cues, noting the length of utterances
- acknowledging and appreciating interpreter roles taken on by family members or friends
- asking the patient about their understanding.

Informants reported calling in other staff or working with professional interpreters for key or especially sensitive encounters. To ensure adequate communication when referring patients to specialists, some clinicians indicated they provide more extensive detail than with a patient proficient in English who can answer questions readily.

Settlement Workers

Health care provider informants rarely referred to settlement workers as interpreters, although workers themselves reported volunteering or being asked to interpret.

Making Choices about Interpreting with Individual Patients

Informants mentioned several factors affecting decisions about which model of interpreting they would use with an individual patient:

- Patient choice
- Circumstances (e.g., emergency vs. planned service)
- What was to be communicated as part of the encounter (i.e., simple concepts vs. health care information, diagnoses, instructions or consents)
- The management of risks in relation to the critical nature of communications.

Clinicians also reported that their choices may be limited by funding, availability of trained interpreters, and the presence of family or friends, in addition to the circumstances.

Limitations of Current Service Delivery

Trained interpreters are in demand and used extensively in some Toronto health care settings. However, informants pointed to a number of short-comings in the availability and delivery of services.

Many informants who value professional interpreting argue that there is little evidence that government or organization senior management recognize the importance of professional interpreting to health care quality. Some hospital and CHC settings were noted as exceptions.

At the service delivery level, physicians, nurses and social workers noted differences even within sectors. Varying practices among hospitals were cited: in-house interpreters; working with fee-for-service trained interpreters; and not using trained interpreters for financial reasons, even where internal policy and budget provisions have been made. Within CHCs' policies, funding and practices vary as well.

Compounding the delivery of interpreting is the variation in availability for different languages—interpreters of languages of lesser diffusion are generally harder to find and waiting times are longer.

For the interpreters themselves, the patchwork of funding and delivery models contraindicates a career in interpreting. Social workers and physicians, as well as interpreters, pointed out that interpreters are contracted on a part-time basis and are not systematically encouraged to develop their skills and expertise. There is little incentive for their commitment to interpreting as a developing profession, although there is evidence of cooperative efforts toward professionalization (Abraham and Weston, 2004).

Service Delivery Models and Clinicians' Coping Strategies

Informants reported five types of interpreting:

1. Internal organization resources:
   - ⇨ Multilingual clinicians, trained and untrained in interpreting; some use of language banks [used by CHCs, physicians, nurses, SWs]
   - ⇨ Other multilingual staff (e.g., non-clinicians or secretaries sometimes hired for multilingual capability), trained and untrained, some use of language banks [used by physicians; reported by settlement workers]
   - ⇨ Single-purpose interpreter staff within hospitals [used by physicians, nurses]
   - ⇨ Experiences were mixed: praise for knowledge of medical terms, but limitations in training [physicians, nurses, SWs]
2. Fee-for-service trained community/professional interpreters—face-to-face [used by all types of informants]:
   - ⇨ Experiences were generally positive
3. Fee-for-service trained community/professional interpreters—telephone
   - ⇨ Use varies among informants: used frequently by a few emergency physicians/staff, occasionally by CHC staff and PHNs, and as a last resort by other physicians
   - ⇨ *Advantages*: quality was generally adequate to very good [physicians], and its use is advantageous for languages of lesser diffusion and after hours and emergency services [physicians, SWs, CHC staff]
   - ⇨ *Disadvantages*: cost, stilted conversation flow, lack of non-verbal cues, uneven or poor quality, difficulty in determining accuracy and knowledge of medical terminology [physicians, SWs, CHC staff].
4. Family and Friends
   - ⇨ Use varies among informant groups: frequent use by physicians and nurses (especially emergency and hospital); occasional use by other physicians and SWs; some physicians and SWs seldom or never
   - ⇨ *Advantages*: the patient may feel more trusting and comfortable [NPs, PHNs, some physicians] and it may be a fast solution, especially helpful for basic information and emergencies [some physicians]
   - ⇨ *Disadvantages*: confidentiality and accuracy may be issues; lack of knowledge of medical terms may result in misunderstanding; and interpreting may be affected by family dynamics or biases regarding competency or consent; asking a child to interpret may be inappropriate [CHCs, SWs, physicians].
   - ⇨ Considerations in using family and friends included:
     - ⇨ ensuring this is the patients' choice (which may be difficult to ascertain) and considering family relationships, gender, child's age [variety of clinicians]
     - ⇨ complexity of interpreting needed and whether informed consent is needed [variety of clinicians]
     - ⇨ saving professional interpreting budget for high needs
     - ⇨ specific suggestions about how to best use family and friends, including careful observation, monitoring and asking the patient, eye contact with the patient, calling in another staff when discussing sensitive information and acknowledging and thanking the interpreting family member or friend [physician, CHC].
5. Settlement workers
   - ⇨ few informants mentioned the use of settlement workers as interpreters [settlement workers, one physician].

A few informants never or seldom use interpreters, but use non-verbal communication instead [physicians, nurses]

Clinicians reported using various other strategies to address communication and cultural barriers:

- ⇨ Attention and sensitivity to communication problems and cultural differences
- ⇨ Learning about traditional healing practices
- ⇨ Seeking orientation about how to work with interpreters.

Limitations of Current Delivery

- ⇨ Variations in funding, policies and practices, even within sectors [all informants]
- ⇨ Risks to health care quality/outcomes are not widely recognized [physicians, SWs]
- ⇨ Patchwork of models mitigates against interpreting as a career

Roles of Interpreters

Informants generally agreed that, in their opinion, interpreters' primary role should be as a "conduit" between the patient and the clinician: their first task is to provide accurate and impartial interpreting.

As described in Part II, agreement about whether interpreting with cultural explanations has a place in the interpreter role is lacking in the field. Many informants see the role of interpreters in health care as including cultural interpreting in some form. However, some believe clinicians should be the ones to initiate seeking cultural explanations, while others put the onus on the interpreter to raise cultural issues. In some interviews and focus groups, informants did not discuss this issue.

Informants included a broad range of cultural information when describing what cultural interpreting is, such as: basic facts about holidays and associated practices that could conflict with scheduling; healing practices; cultural attitudes and practices related to family roles, sexuality and health; and behaviour that could be misconstrued in the Canadian social context. Physicians and social workers were especially concerned about cultural attitudes and practices in the context of providing mental health services. Some proposed that cultural explanations are essential in determining whether patients' behaviour is consistent with cultural norms or symptomatic of a thought disorder.

Of all the informants, interpreter service agencies, one CHC and some nurses were the most cautious about interpreters offering cultural input. Interpreting agencies were likely to have policies avoiding cultural explanation and would put the onus on clinicians to request cultural input. These agencies, along with CHCs and some physicians, emphasized the responsibility of clinicians for cultural understanding.

Some informants believe that interpreters should only offer cultural information in instances where miscommunication would result without it. There were different views about how that input should be provided: examples included stopping the session and asking questions about potential cultural impacts or any misunderstandings; and calling the clinician out of the room. For their part, interpreters argued for increased opportunities to brief and debrief clinicians in order to clarify and develop mutually agreeable expectations of interpreters' role(s).

Some informants emphasized the need for guidelines at the organization level that clarify when and how interpreters include cultural information, especially if broader standards are not available. Guidelines about interpreters' roles have been established in some organizations (e.g., CHCs). As in all interpreting, informants agreed that interpreters need to make clear whose words they are speaking.

Some informants from all professions and settings, especially physicians and social workers, would like to see interpreters as part of health care teams. They argue that interpreters as team members could take on the following:

- Take initiative in offering cultural input
- Ask patient about cultural practices and impacts
- Raise concerns where patient is not understanding or has difficulty describing symptoms, especially related to cultural mores
- Suggest to clinician what to ask
- Explain to the patient about other health care services.

Roles of Interpreters

Informants agreed that the primary role of interpreters should be as a conduit between the patient/client and service provider. Informants also reported that:

- Neutrality, impartiality and objectivity are essential (e.g., not changing or adding to what the patient says; avoiding the establishment of a separate relationship with client/patient). Specifically this includes:
  - Introducing themselves and being clear about their role [nurse, physician]
  - Making clear which are the patient's words and which are interpreter's [nurse, CHC]
  - Pointing out when the patient or clinician is not understanding [CHC, physician]
  - Refraining from influencing the patient [SW]
  - Recognizing that patients may place inappropriate expectations on interpreters [physician].

Whether interpreters should provide cultural information was an important topic of discussion to many informants. There was no overall agreement; informants' views included the following:

- Interpreters should not provide any cultural input or only in very limited circumstances [interpreting service managers, a few CHC staff]
- The role might include cultural input only in very limited circumstances, for example, when asked [CHC staff, interpreting service managers]
- The role may include offering cultural information [CHC, emergency staff]
- Interpreters should offer cultural information and they must be mindful of cultural differences and convey emotional nuances [CHC staff, emergency staff, physicians, SWs, nurses]
- The inclusion of cultural information is essential especially in mental health services interpreting where the difference between culturally specific behaviour/norms and behaviour that may be interpreted as a thought disorder, etc. [SWs, physicians in mental health practice]
- Interpreters should be advocates for clients [SWs]
- Interpreters should be members of health care teams to complement clinician cultural knowledge and maintain an ongoing relationship and communication with clinicians. This requires professionalism from the interpreter [nurses, physicians].

Many informants perceive that interpreting service agencies limit the interpreter role to the conduit model and do not include cultural explanation [SWs, CHC staff]. An interpreter agency confirmed this policy.

Client's fear of being exposed and feeling shame about actions contrary to cultural norms was identified as a barrier to interpreters carrying out their roles; some informants believe this barrier often dissolves during crises [SWs].

Where cultural interpreting is practiced, informants suggested guidelines:

- The interpreter needs to take initiative:
  - raise concerns regarding patient understanding and difficulty in describing symptoms [nurses, physicians]
  - ask the patient about possible culture influences/impacts [SWs]
  - help the patient understand other services [nurses, physicians]
  - make suggestions to clinicians regarding what to ask) [nurses, physicians]
- The ultimate responsibility rests with clinicians; it is the clinician's responsibility to understand cultural impacts on the patients' health needs and to ask for cultural input [CHC staff, physicians, interpreter service].

Recommendations from Informants: Service Delivery and Roles

Informants proposed changes to the service delivery system and interpreters' roles in several areas, as listed below. Most of these recommendations have policy implications for government as well as health care service providers. Note that not all informants would agree with all of these recommendations. The specific recommendations of informants were:

- *Clarification of interpreter role(s):*

  Since the appropriateness of cultural interpreting has been questioned in some contexts, some interpreting programs and agencies no longer provide this service. When the provision of cultural explanations is appropriate, the question of suitable settings needs to be resolved.

- *Standardization of policies to improve interpreter service throughout health care:*

  A standard approach would require the development of broad government policy applying to all health care settings. In this context, informants recommended the following at the service delivery level:
  - Promote respect for interpreters; recognize and encourage professionalism of interpreters and interpreting as a career
  - Ensure patient access to interpreters, recognizing:
    - LEP/LFP impacts on access, service quality and outcomes in the health care system
    - the management of risk in the health care system
    - the long-term costs of health care.

- *Implementation of service delivery models and mechanisms to improve access to interpreter services:*

  A variety of mechanisms were suggested including internal interpreter staff, shared interpreter staff and improved funding for purchased interpreter services:
  - centralized interpreter services directly funded by government
  - sharing of all interpreters among organizations
  - in-house staff interpreters for common languages (i.e., in large organizations such as hospitals) and, for languages of lesser diffusion, sharing among organizations or using fee-for-service interpreting
  - ensuring clinicians have access to information (e.g., lists of interpreter resources, including settlement workers who can interpret without cost)
  - ensuring patients' language is recorded accurately (i.e., as an organizational policy and practice)
  - building organizational culture for competency (e.g., multilingual front-desk/secretarial staff)
  - physicians hiring their own interpreters (e.g., part-time).

- *Training for clinicians and health care managers about the need for and use of interpreters (more detail in the section on Training and Standards).*

Training and Standards for Interpreters: Informants' Views

Existing training was discussed very little in the focus groups and interviews. As outlined above in the Ontario Context (see p. 9), most training is currently provided by not-for-profit and for-profit interpreter service agencies. Community college level training should be expanded across the province in Fall 2006.

Training Needs and Content

Informants expressed their views about what training should include. Although training for interpreting encompasses a broad spectrum of topics and themes, clinicians were concerned with what was immediately apparent in their work with interpreters. First, accuracy was a high priority—some informants described accuracy as avoiding distortions, additions or

omissions. Impartiality was also very important, that is, interpreters should not offer their own opinions and perspective on patients' messages. Informants from CHCs, emergency departments, physicians and social workers made other suggestions for training content and methods (see the Recommendations from Informants below.

Informants' suggestions point to the need for clarification about trained interpreters' role(s) in order to determine training content and competencies. Some informants' comments suggest that training for specializations may be useful and can be tailored to the needs of the setting. For example, medical terminology is now sometimes offered separately; for interpreters in counselling settings, it might not be needed. Training in cultural interpreting and advocacy might be separate modules since they are not roles that all agree are appropriate for interpreting.

Standards and Professionalization

Community interpreters are generally viewed as less established than court, conference and American Sign Language interpreters, according to informants, and this perception is accurate. However, the upcoming implementation of community college level training provides some initial evidence that interpreting may become increasingly recognized as a viable career path, if not a profession.

The ILSAT and CILISAT are in general use; as noted, these measure the level of language skills required for learning interpreting, not competency in interpreting. Without standards for interpreting competency and ongoing professional development expectations, it is difficult for community interpreters to gain respect and be treated and recognized as professional. Although there are no clear expectations among informants in terms of the types of competency required of community interpreters, professional behaviour was expected by most. Interpreters and some physicians and social workers who use interpreters regularly noted that interpreters' roles and efforts are not always recognized and appreciated as professional. They argued that the lack of appreciation for the role does little to encourage the development of a professional approach, but doesn't necessarily preclude it either.

Interpreters and interpreter service agencies pointed out that community-based interpreting as a career is very limited at this time. One reason is the structure of the field: there are very few staff positions in community interpreting and most of the work is contract-based and part-time. This fee-for-service workload can be uneven and unpredictable. For languages of lesser diffusion, this limitation is even more severe—the demand is less consistent than for more commonly spoken languages.

Interpreters and some other informants would like to see regular professional development opportunities made available. Some interpreting service agencies do provide periodic training and development, as well as regular group debriefing and meetings to raise and address issues. Some agencies also reported setting guidelines for interpreters and evaluating performance through clinician's feedback.
In this unregulated environment, interpreters pointed out a number of examples of the lack of standards for the interpreting "industry": different practices in the payment of travel expenses and travel time; inconsistencies in conveying complete and accurate information about work assignments; and lack of communication and support in some work settings.

A few interpreters suggest that another approach to regulating the field would be the licensing of interpreter service agencies. This approach could be used to implement both industry and professional standards. For example, informants argued that agencies' roles should include adhering to industry standards in hiring or contracting interpreters; development of internal guidelines for interpreting; and support in resolving problems when these occur.

From the Other Side: Training for Clinicians

Interpreters suggested that their agencies advocate for training of clinicians. They

proposed that this training include modules on the interpreters' roles and on how to effectively work with interpreters. They also argued for increased opportunities to brief and debrief with clinicians: some wanted discussion about their interpreting role, especially where they had observed that clinicians had unrealistic or inappropriate expectations about their roles. Others wanted debriefing time related to emotional interpreting sessions, for example, informing a patient about a life-threatening illness.

In support of their belief that clinicians need training, interpreters and a few clinicians described instances of clinicians' inappropriate expectations of interpreters (e.g., requests to act as an "assistant clinician" and provide health information rather than interpret clinicians' words; requests to help patients dress/undress). Interpreters were concerned about clinicians not articulating complete thoughts and not speaking clearly, which compounds the difficulty of their task. Lack of sensitivity to political and religious differences and to potential discomfort for patients was an issue for interpreters and a few clinicians.

From a broader perspective, the need for interpreter services may not be recognized in part because family and friends are frequently used without an appreciation for the risks associated with this practice. Clinician informants who value professional interpreting mentioned risks to both clinicians and organizations they believe are not generally recognized and addressed. This lack of understanding of risks suggests the need for enhanced training for clinicians about the importance of effective communication and the role of interpreters in addressing language barriers.

Training and Standards

Informants believe that clarifying interpreter roles is fundamental to determining training content and standards of professional practice.

- Generally, these informants agree that role clarity and training will affect how community interpreters are perceived [nurses, physicians]. They also raised specific functions that have implications for training:
  - whether and how to include cultural interpreting
  - advocacy and participating in a health care team

Informants generally agree that clear expectations or standards for interpreters are necessary to a professional approach to interpreting. Expectations should include:

- Accuracy and impartiality [all informants]
- Competency in the conduit mode [interpreter service]
- Ability to work in emotionally intense situations and be aware of family dynamics [interpreter service]
- Good education and knowledge of English [interpreter service]
- Competency, which may be determined through testing such as ILSAT or CILISAT [interpreter service].

Interpreters and interpreter agencies raised Issues about interpreting as a career and industry working conditions:

- The amount of work is often uneven and not enough to enable community interpreting full-time
- Agency scheduling systems need to be fair and consider on-call-related stress for interpreters
- Good communication between interpreter and agency is necessary (e.g., regular meetings and feedback).

Interpreters and interpreter service agencies also identified interpreter agency tasks, including:

- Setting clear industrial and professional standards
- Evaluating the service, for example, get clinicians' input
- Developing, implementing and informing all parties about complaints' procedures
- Providing professional development and support (e.g., interaction with the agency and other interpreters).

Informants raised advantages and barriers to the profession-alization of interpreters:

- Professionalization would promote respect for the interpreter role, ensure clear standards and expectations and require ongoing professional development
- Barriers include the costs of assessing competency, training and ongoing development; the current negative view of community interpreting by other translation professionals and hesitation by the Association of Translators and Interpreters of Ontario to take on community interpreters.

Informants identified considerations for the training of interpreters, including:

- Training content [CHCs, emergency staff, physicians, SWs, interpreters]:
  - office set-up, confidentiality, dynamics of encounters, familiarity with medical practice and terminology for health care interpreting (including data banks of terms), conduit role, cultural interpreting and other roles, including patient advocacy
  - use of case studies of typical situations in training.

A number of informants identified their own need for training in how to work with interpreters [SWs, physicians, interpreters, interpreter serv-ices] specifically regarding:

- impacts of language barriers and the need for interpreting
- how to work with interpreters and how to set up the office
- issues such as child and woman abuse.

Interpreters and agencies suggested licensing agencies to promote professional and industrial standards.

Some informants proposed developing standards and examinations, the route taken by court and conference interpreters [CHC staff, professional assoc. member].

Recommendations from Informants: Training and Standards

Informants recommended improvements in training for health care interpreters as follows:

- *Training content for all interpreters and for specific areas of specialization may include, but not be limited to:*
  - Confidentiality
  - Dynamics in interpreting encounters, working in intense emotional situations and awareness of family dynamics
  - Medical terminology (including the establishment of a personal databank of medical terms)
  - Familiarity with clinician's roles, medical practices and settings
  - Various interpreting roles, including the conduit role, cultural interpreting and patient advocacy
  - Arrangement/set-up of the office or setting.

- *Experiential training methods, especially case studies involving typical interpreting situations and visits to health care interpreting settings.*

Although they expressed the desire to move toward more professionalism in the field, interpreters and other clinicians did not have specific recommendations as to how to accomplish that goal. Their own concerns and those of other informants would need to be addressed—concerns about:

- Lack of respect for their role
- Lack of standards and clarity about competency
- Limited professional development and employment opportunities
- Low pay, poor working conditions and unpredictable work availability.

A few informants suggested the licensing of interpreter service agencies as one way to develop and implement industry standards and promote professionalization. However, it would also have to be paired with a requirement for clinicians to use these agencies if they wish to be compensated financially for these interpreting services.

Specific recommendations for training for clinicians included the following content: impacts of cultural diversity and language incongruence between patients and clinicians on health care and the quality of service; the need for professional interpreters; how to locate and work with interpreters; and how to deal with sensitive encounters such as those involving sexuality or child/woman abuse. Clinicians themselves suggested that training mechanisms include videos (e.g., role playing working with interpreters), one-hour workshops and staff retreats.

Government and Organizational Policy: Informants' Views

Informants discussed existing government or organization policy much less than they talked about funding, perhaps because of the absence of provincial policy (as described in the Ontario context, pp. 6-7). In reality, funding provides visible evidence of policy.

Policy at the Provincial Level

Most informants encouraged the development of a more standardized approach to interpreting across the health care system. Ontario's Local Integrated Health Networks had not yet been established at the time of the focus groups and interviews, so their role was not mentioned in these discussions.
Some physicians and social workers were aware of differences between and within the CHC and hospital sectors in the funding and support for interpreter use. Informants expressed a number of suggestions about standardizing interpreting and its funding across the province. These are reported in Informants' Recommendations below.

Policy at the Organization Level

A few health care organizations have created policies outlining expectations about interpreting

and the circumstances under which it may or should be used, according to informants.

Hospital-based clinicians noted that organizational policies and practices sometimes encourage or discourage the use of interpreters. For example, emergency staff and physicians described internal services in hospitals (where they exist) as adhering to business hours when the greatest need in hospitals was between 4:00 p.m. and 2:00 a.m., especially for emergencies. Informants reported that they regularly hear hospital staff being paged to interpret, even when staff or fee-for-service interpreters are available. On the other hand, interpreting units have been placed in organizations' risk management structures, a recognition of the importance of interpreting to health care quality and access for patients with LEP/LFP.

Physicians pointed out that the compensation structure for private practice in medicine does not encourage quality service to LEP/LFP patients. The experience of physicians and nurses indicates that clinicians need to spend extra time with these patients, whether or not family, friends or a trained interpreter is present. Moreover, interpreter costs must be borne by the physician or patient unless free service is provided (e.g., by settlement workers, volunteers or other hospital staff). Neither the extra time nor interpreter costs are recognized by the physician fee structure in Ontario. This limited and inflexible funding was seen as a disincentive for physicians to serve LEP/LFP patients. In summary, informants argued that hospitals as well as physicians are not encouraged to structure their services in a way that promotes access and quality health care to LEP/LFP patients.

Policy and Funding for Trained Interpreters

Informants did not highlight public policy or its absence in their discussions. However, they raised perceived variations in organizations' approaches to budgeting for interpreting, which are an indication of the lack of clear public policy [emergency staff, physicians, CHCs, nurses, SWs], for example:

- Separate budget line or sub-line
- Integrated into the budget or allowed as an expenditure
- No budget line.

Some informants [physicians in various settings] pointed out that the compensation structure for physicians in private practice discourages serving LEP/LFP patients and using trained interpreters:

- The payment system for encounters does not recognize LEP/LFP patients' needs and time required; as a result, there is a financial penalty for serving LEP/LFP patients
- There is no provision for hiring interpreters in the private practice compensation system.
- Patients would not want to pay for interpreters if physicians tried to charge them.

At the organization level, use of interpreting may be discouraged due to costs. Staff are sometimes encouraged to find alternatives to trained interpreters even though experience has shown positive results from using trained interpreters [emergency staff, physicians, CHCs, nurses, SWs].

Some informants believe that physicians would not want to manage paperwork required to claim for payments, even if there were a way to be compensated for hiring interpreters. A few noted that salaries for clinicians avoid these time and payment issues. Some informants suggested a centralized government system for paying and dispatching interpreters.

Informants identified that research and policy development are needed to examine the following [physicians, SWs, CHCs]:

- Impacts on outcomes (e.g., aftercare, misdiagnoses)
- Impacts on long-term costs (e.g., patients returning to emergency, unnecessarily repeated diagnostic testing)
- Accessibility to health care services
- Risk management (especially informed consent, non-compliance with treatment, aftercare, referrals to specialists).

Recommendations from Informants: Policy

Informants made a number of suggestions and recommendations that would have policy and funding implications for the provincial government and health care provider organizations:

- *Standardize interpreter services across health care system*

  A standard approach would require the development of broad Ontario government policy applying to all health care settings, policy that addresses:
  - communication for LEP/LFP patients as a matter of equity of access
  - long-term benefits and cost savings
  - reduced risk to physicians and organizations.

- *Similarly, develop research to investigate impacts on outcomes and long-term health care costs, accessibility for LEP/LFP patients and risk management.*

- *Establish funding for organizations and physicians providing primary, secondary and tertiary health care, with attention to the following:*

  For provider organizations:
  - set up interpreting budgets hospital/organization-wide, not department specific, to avoid competition with other salaries and expenditures
  - expand comprehensive service models that consider/accommodate LEP/LFP patients using salaried positions
  - address/improve salary levels for salaried physicians

  For physicians in private practice, informants suggested the following different approaches:
  - establish a separate fee codes for LEP/LFP patients to address additional time required for service, as well as interpreter costs
  - initiate direct payment of interpreters by government
  - create a centralized (regionalized) service that dispatches and pays interpreters
  - consider the model of physicians hiring their own interpreters part-time.

- *Organizational policies, practices and structures should:*
  - guide the development and use of interpreting to promote access to health care
  - support communication with LEP/LFP patients (e.g., getting accurate language information about patients at intake)
  - promote culturally sensitive and competent care within the organization's culture
  - ensure training of clinicians in the need for and use of interpreting
  - consider a range of cost-efficient service models (e.g., in-house interpreters for common languages and interpreters shared with other organizations for languages of lesser diffusion; centralized system for downtown hospital emergency units).

IV. Concluding Remarks

These findings raise important issues about access to accurate and impartial interpreting needed to promote access and quality in health care for people with limited English/French proficiency. Information collected through the research helps to clarify the status of interpreting in Toronto—its strengths and areas that need development. These concluding remarks summarize and discuss the current state of interpreting and communication with LEP/LFP patients and offer recommendations for consideration by governments, health care service organizations, clinicians and the field of community interpreting.

Current State of Interpreting and Communication with LEP/LFP Patients

LEP/LFP and Its Impacts

Toronto is home to more than 180,000 people with LEP/LFP who speak a wide range of other languages. Substantial numbers and proportions of immigrants continue to arrive in Toronto with limited or no proficiency in Canada's official languages. These numbers and the diversity of newcomers continue to challenge the health care system to respond to the health needs of newcomers.

Informants in this research lacked agreement about the impact of language barriers on health care access, quality and outcomes. Many held the belief that LEP/LFP affects health care which in turn impacts on outcomes. However, some thought LEP/LFP could be addressed through non-verbal communication and/or the assistance of family and friends. The possibility of risks arising from language barriers that have been identified through studies of language barriers in health care was not evident in their comments. These risks include misdiagnosis, delays or inappropriate treatment, misunderstandings about diagnoses and treatments, higher long-term health care costs and poor health outcomes. Lack of knowledge about research documenting these impacts and risks suggests the need for broader education of health care providers, managers and administrators.

Ontario Provincial Policy and Funding

Ontario's absence of provincial government policy not only limits the capability of health care services and the interpreting field to respond to the needs of people with limited English or French proficiency. It also ignores the risks associated with language barriers mentioned in the previous paragraph. In contrast with the health care field, for violence against women prevention services, the provincial government has set expectations about the role and competencies of interpreters and committed funding for interpreting.

Without provincial policy to ensure access to health care interpreting and to define patient eligibility for interpreting, health service organizations must develop their own responses within budgets that are intended to address many other demands. A patchwork of funding and service delivery of interpreting has grown up in Toronto, evident in the experiences of informants in this research. Examples include variations in policies and practices among hospitals and community health centres. Clearly, action is required to standardize access to interpreting across health care throughout Ontario.

Current Service Delivery in Toronto

Health care service to patients with LEP/LFP is provided through a mix of multilingual clinicians, other multilingual staff who "volunteer" as interpreters, a few staff interpreters and a large contingent of free-lance interpreters who are dispatched through for-profit and not-for-profit fee-for-service agencies. As noted, families and friends often step in to interpret for patients. This lack of consistency across health care services results in uneven access and quality of health care.

In Toronto and other parts of the province, the efforts of individuals, organizations and collaborations have created training programs,

enhanced service delivery and set the stage for further development to increase and standardize access to health care interpreting across Toronto.

Interpreter Roles

The lack of agreement about appropriate roles of interpreters was notable. There was agreement that the fundamental role is to assist health care providers and patients to better communicate. However, there did not appear to be a common understanding of a primary goal of interpreting—to ensure messages are conveyed so that they have effects that are equivalent to those given to language-congruent patients and clinicians.

Beyond basic agreement about the provision of accurate, impartial language interpreting, clinicians tended to want cultural input from interpreters. Interpreter agencies hold to a more limited role for interpreters, one that is consistent with the only provincial government-funded interpreter service through VAWP and DVJS programs. The latter approach may be related to a desire to maintain impartiality, avoid controversial issues related to cultural differences and minimize risk and liability. This lack of congruence about roles demands further examination and discussion.

Training, Standards and Professionalization

In Ontario, interpreting has had limited viability as a career choice. The work is not generally well-respected or recognized as professional, although some clinicians praised the work of trained interpreters and expressed the desire for greater professionalization of the field. Until recently, there has not been wide-spread acceptance of the need for standards and expectations about core competencies. Provincial government funding of the community college certificate program is a sign of this increased recognition for interpreting work as a potential profession and viable career path. On the other hand, there are a limited number of permanent positions and most interpreting now appears to be conducted on a part-time contract basis.

In the research, informants pointed out the need for professional and industry standards required to enhance interpreting in Ontario. Licensing of interpreter agencies was suggested as one way to implement these standards and ensure interpreters are provided with professional development, support, regular evaluation and complaints resolution procedures.
Some interpreters and service agencies are already working toward increased professionalization as well as improved training and ongoing professional development opportunities.

Recommendations

Directions for future development are outlined below. These are derived from the observations, opinions and recommendations of informants, as well as an analysis and synthesis of information presented in Part II, The Ontario Context:

- Service delivery models
- Health care system and providers
- Provincial policy and funding
- Interpreter field.

Service Delivery Models for Examination

A number of models and approaches for interpreter service delivery require further examination, evaluation of their implementation in other jurisdictions and assessment of their viability and cost-efficiency in the Ontario context. These include the following approaches:

- Centralized interpreter services directly funded by government
- Increased centralization of interpreter services at the community level, for example, sharing of interpreters among organizations and private practices (e.g., all interpreters or only interpreters for languages of lesser diffusion)
- Physicians hiring their own interpreters (e.g., part-time).

Health Care System and Providers

Education of health care administrators and providers about the impacts of language barriers is essential. In addition to the benefit of having informed providers and organizations, educating those in the health care system might also increase the demand for provincial policy and funding. Health care administrators and providers need to know about the risks of poor communication to their patients and to themselves as practitioners and organizations.

Education about the many benefits of improved access to interpreting should include:

- Improved health care access, service quality and health outcomes for patients with LEP/LFP
- Reduced long-term costs of health care
- Reduced risks to patients, practitioners and organizations.

Clinicians should have information about the need for professional interpreting; the limitations and risks of using families, friends and other untrained interpreters; how to access interpreting services and work with interpreters; and how to deal with issues such as sexuality, child and woman abuse that particularly require trained interpreting. To minimize miscommunication and risk, clinicians need to know what they can do when interpreting is not available. Providers can also benefit from a more in-depth understanding of the impacts of culture on health care and health outcomes.

Health care providers and administrators need information about the range of health care interpreting roles and their benefits and limitations. They need to engage with interpreters and others in discussion about these potential roles, especially related to cultural interpreting and patient advocacy. Clarity about health care providers' expectations is necessary so that interpreting can achieve the benefits listed above. Lack of clarity can lead to unrealistic expectations, frustration and ineffective interpreting.

For organizations, strategies that go beyond addressing specific language barriers are needed to promote health care service quality for patients with LEP/LFP. Building a culture throughout organizations that engenders competency in serving diverse patients will include policies and practices to enhance understanding and acting on patients' needs (e.g., ensuring patients' languages are recorded accurately front-desk/secretarial staff speak needed languages).

Provincial Policy and Funding

The need to develop a provincial policy cannot be overstated. A overall policy is required in order to address the communication needs of people with LEP/LFP in the health and social service sectors. The health care system is not only vulnerable to less than optimal outcomes associated with poor communication but also to liability for misdiagnosis and inappropriate treatment. A broad provincial framework needs to consider the probability of higher long-term costs of delivering health care unless language barriers faced by substantial numbers of Ontario residents are addressed. The provincial approach to the VAWP and Domestic Violence Justice Strategy initiatives is one strategy that could be examined for its strengths, limitations and relevance to health care.

Funding to implement policy is required, such that interpreting is available in all types of primary, secondary and tertiary health services, including hospitals, private practice, family health teams, community health centres, public health units and specialist services, etc.

Interpreters and the Community Interpreting Field

Central for interpreters is the issue of role—what are appropriate roles for interpreters. Continued discussion within the field is necessary in order to guide the establishment of standards, core competencies and training, as well as mutually agreed-upon roles and specializations. The interpreter field would do well to examine the needs of clinicians for cultural input and how that can be responsibly provided. Roles may vary by

setting and according to the needs of the setting and organizational context.

As a fledgling profession, interpreting will also benefit from research and documentation of the benefits of interpreting to patients and other service recipients, and to providers of health and social services. Both professional and industry standards are needed to improve the effectiveness of health care interpreting and its attractiveness as a career path. Service delivery models need to be examined in relation to their impact on the viability of interpreting as a career and the quality of the interpreting provided, as well as their ability to enhance health care access, quality and outcomes.

Depending on areas of specialization, interpreter training programs should include, at minimum:

- Confidentiality: an understanding of its importance and meaning to patients from different cultures and backgrounds
- Dynamics in interpreting encounters, working in intense emotional situations and awareness of family dynamics
- Arrangement/set-up of the office or setting
- Medical terminology and familiarity with clinician's roles and medical practices
- Various interpreting roles, including the conduit role, cultural interpreting and patient advocacy.

As in other professions involving the provision of human services, training in interpreting needs to include a variety of skill-based and experiential training methods, including case studies involving typical interpreting situations, visits to health care interpreting settings and practice in supervised settings.

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Appendix A: Informants

Context	Quantity	Informants
Health Care Interpreters	12	Interpreters
Interpreter Service Provider Agency	2	Interpreter Service Managers
Settlement Agencies	10	Settlement Workers
Nurses	7	Public Health Nurses, Nurse Practitioners in a CHC and in Family Practice Clinics, and Nurses in CHCs
Social Workers	8	Hospital-based, Toronto District School Board, CHCs
Physicians	11	Hospital, Emergency Department, Family Practice, CHC, Private Practice, Clinics, Obstetrics
Community Health Centres	6	Executive Director, Manager, Clinical Manager, Health Promoter, Community Worker, Legal Worker
Hospital Emergency Department	3	Director, Nurse, Admissions Clerk
Professional Association	1	Member
TOTAL	**60**	

Appendix B: Endnotes

[1] As the Healthcare Interpretation Network (HIN) has evolved, the name has changed several times, including the Hospital Cultural Interpreter Services Network (HCISN); the Hospital Cultural Interpreters Network (HCIN), and the Health Care Information, Interpretation and Education Network (HCIIEN).

[2] See Bowen (2001), Chapter 6 for a discussion of impacts of language barriers on health care access, quality and outcomes.

[3] The Toronto Project Management Committee chose to include emergency services because these are often newcomers' first point of health care contact when they have not yet formed a relationship with a primary health care provider.

[4] See Statistics Canada Web Site for 2001 census data; details are in the Reference List. Comparisons across the century are found in the Statistics Canada (2005a) table: "Population and growth components (1851-2001 Censuses)."

[5] The Longitudinal Study reported in 2003 examined all immigrants to Canada between October 1, 2000 and September 30, 2001.

[6] Statistics Canada (2005b) table "Population by knowledge of official language, by census metropolitan areas (2001 Census)."

[7] The Violence Against Women Prevention Initiatives superseded the Wife Assault Prevention Initiatives in 1996.

[8] Ministry of Citizenship and Immigration (MCI) names since the early 1990s have included "Ministry of Citizenship" and "Ministry of Citizenship, Culture and Recreation."

[20] Steyn, p. 7

[21] Crammond, p. 9.

[22] Ministry of Health and Long-Term Care (2004). LHIN Bulletin, No. 1, October 6, 2004.

[23] Crammond, p. 7.

[24] See Avery (2001).

[25] Abraham and Weston (2002).

[26] Personal communication, D. Abraham, December 8, 2005.

[27] Crammond, p. 11.

[28] Personal Communication, Sunder Singh, December 23, 2005.

[29] Settlement organizations funded by government and culturally-specific services not funded by government are listed at: http://www.settlement.org/sys/regions_detail.asp?doc_id=1003043#MJR

[30] HCIN (1997).

[31] D. Abraham, personal communication, December 8, 2005; see also Web Sites for Access Alliance Multicultural Community Health Centre and Multilingual Community Interpreter Services (details provided in References).

[32] See Ministry of Citizenship and Immigration News Release and Backgrounder, September 26, 2005 for further information.

[33] Crammond, p. 15.

[34] Across Languages Web Site. (Details provided in References).

[35] Crammond, p. 14-15.

[36] The ATIO internet site outlines requirements for certification for conference interpreters and court interpreters; these include an examination or evaluation of the candidate's professional dossier. Please see http://www.atio.on.ca/info/criteria.asp and http://www.atio.on.ca/info/what_is_conf.asp.

[37] As referenced by Crammond, pp. 13-15.

[38] Glendon College Working Group in Health Care Interpreting, 2004.

[39] Seven Toronto area hospitals produced and tested resources, training curriculum and service protocols "designed to improve the effectiveness of interpreter services in a health care setting" (HCIN, Final report, 1997).