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Thank you to the eighty six research participants, from the Italian, Vietnamese, Iraqi and South Sudanese communities, whose generosity, candour and insight gave these findings their richness and depth. The anecdotes, experiences and ideas that the research participants shared with the project team were often moving, sometimes funny, sometimes shocking, but always a compelling reminder of the need for change.

Thank you to my co-researchers Shroug Mohamed, Hien Tran, Violetta Prestia and Iskandar Chabran, without whose dedication, enthusiasm and enormous skill this research project would not have been possible.

Thank you to Annabel Barbara, Nancie-Lee Robinson, Spase Velanovski and Amy Kirwan from the Centre for Culture Ethnicity & Health whose commitment to hearing the voices of consumers, guidance and support carried this project from inception to completion.

Thank you to Dr Marilys Guillemin from the Centre for the Study of Health and Society from the University of Melbourne for valuable advice and support around research methodology.

Thank you to the individuals within the Iraqi, South Sudanese, Vietnamese and Italian communities, as well as the community organisations who gave us valuable advice, assistance with recruiting participants or generously provided venues for our focus groups. These included the Victorian Arabic Social Services, Australian Vietnamese Women’s Welfare Association, Moreland City Council, Working Women’s Health and AMES Education.

Thank you to the project reference group for their energy and ideas and for providing a valuable context to the findings. The reference group included:

Karella de Jongh (Royal Women’s Hospital)
Paul Leonard (Victorian Office of Multicultural Affairs)
James Butterfield (Victorian Office of Multicultural Affairs)
Jaya Manchikanti (Ethnic Communities’ Council of Victoria)
Andrea Smith (Diversity Unit, Department of Human Services)
Dr Marilys Guillemin (Centre for the Study of Health and Society)
Sarina Phan (Australian Institute of Interpreters and Translators, Vic)
Lyn Bongiovanni (Australian Institute of Interpreters and Translators, Vic)
Maria Magio De Leo (Australian Association of Hospital Interpreters & Translators, Vic)
Dave Taylor (Springvale Monash Legal Service)

Thank you to the Victorian Office of Multicultural Affairs and the Scanlon Foundation for funding this project and therefore providing a means through which consumer voices can be heard.

Cara Brough
Principal Researcher
Executive Summary

The objectives of this research were to analyse how Culturally and Linguistically Diverse (CALD) consumers access and use language services – specifically interpreters - and to determine consumer views on the effectiveness of language service provision in health settings. CEH interviewed a total of 86 people from the Italian, Vietnamese, Iraqi and South Sudanese communities across metropolitan Melbourne. All participants had used language services in the twelve months prior to the interviews. Four bilingual co-researchers were employed to work with the CEH principal researcher to undertake this research.

Key findings

1. **Participants believed that high quality language services enabled full communication between the health professional and the consumer and were essential to effective healthcare.**

   For participants, full communication involved listening, asking questions, discussing issues, advocating for themselves and their families, as well as communicating the very specific language used in a health setting. Participants believed this communication was fundamental to obtaining positive health outcomes for themselves and their families. Participants repeatedly said that when communication in a health setting was ineffective or non-existent, either because interpreting services were not provided or because interpreting services were of an inadequate standard, contact with the health system became confusing, ineffective and, sometimes, dangerous and traumatic.

2. **Most participants preferred to use a professional interpreter but often chose to use family to interpret or to manage with no language assistance at all.**

   Participants mostly preferred to use a professional interpreter over a family member, even when they were more comfortable with a family member, to ensure that communication was effective. This was particularly true in situations where the participant believed the health matter to be serious, an emergency, private or embarrassing. However, while many participants preferred to use a professional interpreter they often chose to use a family member to interpret. Participants usually, but not always, chose to use family to interpret because they:
   - were not provided with interpreting services
   - had to wait too long for interpreting services
   - felt uncomfortable asking for an interpreter
   - feared language services would be unreliable, delayed or inadequate.

   While most participants highly valued the support of their families, they often described communication facilitated by family as limited or compromised. For other participants, the option to use family to interpret was not available. This was particularly the case for participants from newly arrived communities who often had no English speaking family members and sometimes no families at all.

3. **Participants believed that the current level of service provision was inadequate to meet their needs. As a result, participants were often forced to use inadequate communication means such as family members or ‘getting by’ without assistance.**

   Participants said that when they attempted to access health services they experienced prohibitively long waits for interpreting services. When attending pre-booked appointments, participants often found language service provision inconsistent or unreliable and health and language services often poorly coordinated. When accessing some services, particularly emergency departments, specialist or in-patient services, participants were often denied language services altogether.
4. Participants believed that the current standard of language service provision was inadequate to meet their needs. As a result participants believed that the effectiveness and quality of healthcare that participants and their families received was often compromised.

Participants repeatedly stressed that to be effective, interpreting services needed to act as a conduit for all that a health professional and participant said to one another. Participants said the accuracy of the interpreting, and hence the effectiveness of communication, varied markedly from interpreter to interpreter. Participants highly commended interpreters who meticulously interpreted everything the health professional and participant said to one another.

Participants spoke highly of interpreters who were trained in medical interpreting, and expressed concern about other interpreters not able to communicate the language associated with a medical setting. Participants said that it was around medical terminology that the most inaccurate interpreting occurred.

5. Participants repeatedly said that they needed more information.

Participants said that they needed more information about when and where interpreters were available, how to access them and what actions to take when interpreter services were denied or inadequate. Participants also said that they needed clear information about where and how to make complaints or give feedback about the provision of language services in a health setting.

6. The findings suggest a possible under utilisation of available language services in some health settings, and a lack of availability of language services in other health settings.

Participants said they were often denied access to language services, particularly when accessing emergency departments, specialist or in-patient services. However, emergency departments, specialist or in-patient services do have access, within certain resource constraints, to interpreting services. This suggests a possible under utilisation of language services in these settings. The excessive waiting times, overstretched services and the varying quality of language services, described repeatedly by consumers, also suggest a lack of availability of interpreters in general as well as a lack of appropriately skilled interpreters in particular.

7. The findings suggest some possible gaps between Victorian Government language service policy and practice in health settings.

Participants said that health services often actively encouraged them to use family members as interpreters, a practice discouraged in Victorian government policy regarding language services. The apparent commonplace practice, by health services, of using family to interpret or using no interpreting assistance, even when language services are available, also raises questions about how health professionals are ensuring that duty of care requirements and legal obligations around informed consent are being met.
Participants believed that high quality language services enabled full communication between the health professional and the consumer and were essential to effective healthcare.

Recommendations

On the basis of these research findings, CEH makes the following recommendations:

1. That the Department of Human Services (DHS), in conjunction with the relevant Government agencies, ensures that there is an increase in the utilisation and availability of appropriately qualified interpreters in health settings.

2. That DHS investigates the reasons why interpreters may be under-utilised by health professionals, particularly in emergency, specialist, in-patient and GP services.

3. That DHS undertakes consultation to determine the best way to establish a ‘language services in health’ consumer advocacy body (or capacity in an already existing service) that:
   a) Assists CALD consumers to make complaints through the relevant channels
   b) Can arrange language services for consumers who want to make complaints
   c) Provides culturally relevant and accessible information on how to make complaints
   d) Provides consumers with advocacy support in order to make complaints
   e) Provides a central point where consumers can make complaints about services who refuse to provide interpreters
   f) Monitors themes and trends in consumer complaints
   g) Provides policy advice
   h) Conducts a regular, state-wide review that seeks consumer perspectives on language service provision in the health system.

4. That DHS in conjunction with Victorian Office of Multicultural Affairs (VOMA), investigate strategies to increase the number of interpreters (particularly female) that speak newly arrived community languages, including Dinka, Bari, Nuer and Cholok (South Sudanese), Kildanean (Iraqi), Sudanese Arabic and Iraqi Arabic.

5. That DHS develop and implement a system for ongoing monitoring and reporting on interpreter utilisation that specifically identifies usage in emergency departments and specialist, GP and in-patient services.

6. That both health services and language service providers ensure internal complaints mechanisms are more accessible and are promoted to consumers in a culturally appropriate manner.

7. That DHS and health service providers ensure that health service organisations comply with Victorian Government policy regarding language services, particularly in relation to using family as interpreters.
8. That health service providers, health professional peak bodies and key stakeholders in the private sector improve the delivery of their language services to ensure the needs of CALD consumers are met. This may include:
   a) Providing interpreters who are of the consumer's preferred gender and speak a language/dialect of the consumer's choice
   b) Decreasing waiting times for access to interpreters
   c) Ensuring timely, uninterrupted consultations
   d) Improving coordination between health service and language service appointments
   e) Improving organisational systems that indicate consumer language needs and ensuring language service provision at all critical service points.

9. That health service providers and health professional peak bodies improve ongoing training to all staff in relation to using interpreters in a health setting. Training should place particular emphasis on improving the quality of communication between practitioners and consumers, duty of care requirements, and respect for consumers’ rights in relation to language services.

10. That the Victorian Government and language service providers ensure that interpreters working in health settings meet minimum standards, including accreditation at NAATI Level 3 and are experienced in, or trained to develop specialist skills for, interpreting in health settings.

11. That language service providers seek and take into account consumer perspectives and complaints when monitoring service quality.

12. That interpreter training providers and language service providers ensure that interpreter education and training places particular emphasis on improving accuracy and working sensitively with consumers in a health setting.

13. That DHS implement community education strategies to improve/increase consumer knowledge in relation to language services including:
   a) How to request an interpreter in a health setting
   b) Where, and in what settings, interpreters are available
   c) How to make the most out of using an interpreter in a health setting
   d) Consumer rights and entitlements in relation to interpreting services in a health setting
   e) How to give feedback or make a complaint about interpreting services
   f) Information on the professional code of conduct for interpreters.
Introduction

This report not only gives voice to the experiences of CALD consumers, but also provides valuable insights into those areas of language service provision that will require further work in the years to come.
Introduction

The research project Language Services in Victoria’s Health System: Perspectives of Culturally and Linguistically Diverse Consumers was conducted by the Centre for Culture Ethnicity & Health (CEH) and was funded by the Victorian Office of Multicultural Affairs (VOMA) and the Scanlon Foundation.

VOMA provided funding for this project as part of the Language Services Strategy, which aims to improve the delivery of language services to ensure that individuals from non-English speaking backgrounds have fair and equitable access to all Victorian Government services. The health sector has been one of Strategy’s primary areas of focus. Initiatives have concentrated on interpreter awareness training programs in community health centres and hospitals around Victoria, an online translations project that consolidates translated health information, improving structural arrangements for the purchase of language services and increasing the number of interpreters and translators.

Thus far, the majority of discussion, review and evaluation in the field of language service provision in health settings have been conducted from a service provider (health and language services) perspective. Similarly, current Government policies regarding language services are oriented toward the needs of service providers and have a strong emphasis on risk management and minimum requirements for agencies to avoid litigation. Little research has been undertaken that explores consumer experiences and perspectives of using language services in a health setting or how utilisation of language services impact on effective healthcare. CEH initiated this project in order to investigate this gap.

Existing knowledge about the needs, preferences and experiences of CALD consumers has been mainly anecdotal. This project was established to find out more about consumer perspectives in this area so that policy development and service development initiatives could be informed by, and responsive to, consumer perspectives, needs and priorities. The report’s intended audience includes health professionals and agencies, language service providers and professionals, state Government, ethnic communities and ethnic community organisations.

Between July and December 2005, CEH’s project team interviewed over 80 people from Italian, Vietnamese, Iraqi and South Sudanese communities across the metropolitan area about their experiences and perspectives on using language services in Victoria’s health system. This report presents the findings of focus group discussions.

The objectives of the research project were to analyse:
- How CALD communities access and use language services in facilitating access to health services
- How CALD communities perceive the effectiveness of language service provision within the health system
- What factors assist CALD communities to access language services
- Whether there are differences between newly arrived and established community experiences of using language services in a health setting.

The project also aimed to develop recommendations for improving CALD communities’ access to, and use of, language services. The project was initiated as a seed project that would inform further research.

This report emphasises the high value that consumers place on language service provision in a health setting as well as the aspects of language service provision in a health setting that need improvement. This report not only gives voice to the experiences of CALD consumers, but also provides valuable insights into those areas of language service provision that will require further work in the years to come.
Method

Four bilingual co-researchers were employed to recruit participants for the focus group interviews and to facilitate the focus group interviews in community languages.
Method

Selection of Communities

One of the objectives of the research project was to determine the difference, if any, between newly arrived and established communities’ experiences of using language services in a health setting. Therefore, two communities considered recently arrived, the South Sudanese and Iraqi communities, and two communities considered relatively established, the Italian and Vietnamese communities, were chosen as communities from which to recruit participants. These four communities were also selected because they differed from each other, and were diverse within the communities themselves, in migration history, culture, religion and/or other demographic factors. However, once research interviews began, it soon became apparent that determining significant differences between communities would be difficult. For the most part, this was because the responses given by participants were remarkably similar across the four communities. The range of opinions and experiences related in a focus group were usually repeated in other focus groups regardless of the cultural and linguistic diversity of the participants. Another reason for the difficulty in finding significant differences between communities was that the small sample size for each community (between 19 and 24) meant that it was not possible to generalise themes about an individual community’s experience or to make comparisons between newly arrived and established communities. Occasionally we have included in the findings a theme we have identified in a particular community’s response. We have only done this when a theme appeared to be consistent within that specific community.

It was not only the small sample size that made us reluctant to draw many conclusions about the differences between newly arrived and established communities’ experiences. When we compared the dates that the Vietnamese participants arrived in Australia with dates that the Iraqi participants arrived in Australia, the distinction between these participants, as established and newly arrived respectively, had to be questioned. Approximately half the Vietnamese participants had arrived in Australia in the early to mid 1990’s and approximately half the Iraqi participants had arrived in Australia in the mid to late 1990’s. However, the established/newly arrived distinction appeared to have some use in this situation as more recently arrived Vietnamese participants arrived into a community that was much more established than the Iraqi community in Australia. This difference was evidenced in that Vietnamese participants appeared to have slightly more English speaking people in their family networks than did Iraqi participants. This point, and other differences between newly arrived and established communities, are elaborated on page 32.

Quotes

Many quotes from the research participants are included in the body of the report. Quotes have been included only when they are typical of a number of experiences or opinions related in the interviews. Therefore we have chosen not to distinguish the quotes contained within the findings with an accompanying descriptor that designates gender, region or ethnic community of the individual making the quote.

Recruiting participants and conducting interviews

In the early stages of the project four bilingual co-researchers were employed to recruit participants for the focus group interviews, provide advice on developing culturally relevant interview questions, proof-read translated project materials, and to facilitate the focus group interviews in community languages.
The definition of ‘language services’ was limited to interpreting services, rather than interpreting and translating services.

Participants were recruited through a number of formal and informal networks within each community. Participants were not recruited through health services. This was so that the responses would not be weighted towards any particular health setting. As the research project aimed to focus on participants’ experiences of using language services in a health setting, only people who had used language services in a health setting in the twelve months prior to the interview were asked to participate. For the purposes of the project, the definition of ‘language services’ was limited to interpreting services, rather than interpreting and translating services. This limited definition was made because the project was too small to meaningfully examine both aspects of language services.

Participant interviews were conducted in a focus group format. Four focus groups were conducted in each community. Each focus group involved up to six participants and ran for three hours. Participants were asked a range of questions about:

- When and why they used, or did not use, language services in a health setting
- What they liked and disliked about using language services in a health setting
- How they perceived the role of the interpreter
- What their opinions and experiences were of using family as interpreters in a health setting
- Their views on how language service provision within a health setting could be improved for the participant, their families and communities.

Each participant was also briefly interviewed individually in order to gather demographic information and a basic history of their use of health and language services. A total of 16 focus group interviews were conducted involving a total of 86 people. The Vietnamese focus groups involved 23 people, who arrived in Australia between 1979 and 1994 and were aged between 41 and 80. The Italian focus groups involved 20 people, who arrived between 1952 and 1981 (with 75% of people arriving before 1971) and were aged between 52 and 87 (with 75% over 65). The Iraqi focus groups involved 24 people, who arrived between 1995 and 2004 and were aged between 19 and 66. The South Sudanese focus groups involved 19 people who arrived between 1997 and 2005 and were aged between 26 and 59.

In each community, two of the focus groups involved men only and two of the focus groups involved women only. Focus groups were conducted in the geographic regions where people from a particular community mostly lived. The Italian and Iraqi focus group interviews were conducted in the northern region of Melbourne. The South Sudanese and Vietnamese focus groups were conducted in the southern and western regions of Melbourne. Focus groups were also structured to include some of the major religious or cultural differences within some communities. Two of the Iraqi focus groups involved the Iraqi Muslim community and the other two focus groups involved the Iraqi Christian-Assyrian community. Focus groups in the South Sudanese community involved the Cholok, Nuer, Dinka and Equatorian groups. Of course, many other differences exist within these communities that were not reflected within the focus group structure or were not specifically prioritised in the recruitment strategy.

The focus group interviews were conducted by the bilingual co-researchers in Vietnamese, Italian, Iraqi Arabic and Sudanese Arabic. The principal researcher, who spoke only English, listened in and asked follow up questions through interpreters engaged for each session.

**Verification**

The main findings were verified in a second round of focus group interviews in each community. The verification interviews involved a smaller number of participants who had attended the first group of interviews.
Participants who spoke little or no English, and who did not have access to the support of English speaking family members, said that use of a professional interpreter was the only way that they could receive effective healthcare.

The Findings
The Findings

Introduction

In the twelve months prior to being interviewed, participants utilised a wide range of health services. These included General Practice (GP), dental, podiatry, radiology, emergency department, ultrasound, endoscopy, ophthalmology, cardiology, diabetes education, nutrition, optometry, audiology, oncology, radiography, child and maternal health, paediatric, health screening (non specified), breast screen, district nursing, neurology, pathology, rehabilitation, orthopaedic, plastic surgery, mental health and disability services.

Participants accessed these services in community health, hospital and private settings.

When using these services, participants communicated with health professionals who did not speak the participant’s preferred language by:
- using a professional interpreter
- using a family member to interpret
- ‘getting by’ without any interpreting assistance.

When using these services, particularly when consulting a GP, participants also consulted a health professional who spoke their first language or who spoke a language in which the participant was more fluent than English.

Most participants had adopted all of these communication practices when using health services in the twelve months prior to the focus group interviews.

Why participants used interpreter services in a health setting

Most participants said that using a competent, professional interpreter was the best way to communicate fully with a health professional and that full communication was essential in enabling a participant to both access health services and receive effective, quality health care. Participants said that professional interpreters enabled both the health professional and the participant to understand the nuances of each other’s questions, answers and explanations. Participants also said that without this mutual understanding, health consultations could be ineffective, a waste of practitioner and participant time, or could have dangerous or traumatic consequences.

Participants stressed that professional interpreting services were particularly important in a health setting because they enabled the participant to understand and express the complex language used in a health setting, such as words used to describe symptoms, physiology, diagnosis, procedure and treatment.

The main reasons participants gave for both preferring and choosing to use language services in a health setting were to:
- ensure both basic and thorough understanding
- ensure essential information wasn’t missed
- reduce anxiety
- to enable privacy and full understanding and to reduce embarrassment around private or serious health issues.

Each of these reasons is elaborated on the following pages.
'To understand what is going on'
Participants who spoke little or no English, and who did not have access to the support of English speaking family members, said that use of a professional interpreter was the only way that they could receive effective healthcare. Participants often explained their need for an interpreter by relating the bewildering and ineffective experiences they had had when accessing a health service without an interpreter and without the support of family.

_I went to have some blood tests. The person doing the test was asking me questions but I couldn’t understand anything. There was no interpreter. I couldn’t ask for one because I don’t speak any English. Some days later they called me on the mobile. He was talking in English. I tried to get someone off the street to listen and translate but the doctor just kept talking, talking and then hung up the phone. I don’t know how to get the results of my tests._

Participants from every community related similar experiences to the one above. These participants often:
- did not have family members who spoke English
- had family that spoke English but were too busy to accompany the participant to health services
- had no adult family members at all. This was particularly the case with participants who were single mothers and newly arrived to Australia
- believed it inappropriate to use family members, particularly their children, as interpreters.

‘So I don’t miss important information’
Many participants, particularly those that had basic English language skills or those who could access the support of bilingual family members, said that they preferred to use a professional interpreter to ensure that no essential information was missed by either the health professional or the participant. These participants repeatedly said that their English language skills were not adequate to communicate in a health setting.

_Even though I speak a bit of English I need an interpreter because I don’t know the words that are important when going to the doctor._

_When I first went to the doctor I had an interpreter but the doctor said I didn’t need it. I would prefer one because I can’t understand medical terms._

_I am asked to interpret for my uncle when he goes to the doctor. I don’t want to but I have to because I have to show him respect. It is better if a professional does it because they do it better and they are accountable if there are any mistakes._
Many participants also said that their bilingual family members were not effective interpreters because they were either emotionally involved or did not competently speak either English or the participant’s first language. Participants repeatedly said that when visiting a health professional without a professional interpreter, whether with family or on their own, they felt anxious about whether they and/or the health professional had fully understood each other. When talking about the importance of using a professional interpreter, many participants related their experiences of situations where the health practitioner or the participant had missed important information.

I was told that I had to wait three months for an interpreter by the... specialist’s receptionist. I couldn’t wait that long because I was in pain so I took my son with me. At the second visit I was shocked when they took me into the surgery rooms for an operation. I started to panic. I didn’t know what was happening. I was in pain and I was panicking. They said they told my son last time. But he is not an interpreter and he missed that information... It was a very scary experience for me.

I went to the dentist. I brought my family along to help me understand. I thought I was getting a filling but they pulled my tooth out. This was against my will.

[after the baby was born] they asked me if I wanted an injection to stop having babies or something. There was no interpreter. I didn’t really understand. I called my husband in and we decided not to have it. We didn’t really understand what they were offering us.

Participants said that ‘missed information’ often involved ‘medical terminology’. When participants said ‘medical terminology’ they were usually referring to the words surrounding symptoms, diagnoses, physiology, medical procedures and treatment. Participants explained that they, or their family members, often knew medical terminology in their own language but not in English. Conversely, participants said that sometimes family members could understand English medical terminology but were not always able to translate into the participant’s preferred language. A small number of participants said that their low levels of education meant they were not able to understand medical terminology in either English or their own language.

In 2001, my 4 year old son had anal discharge and bleeding. I took him to the hospital. No interpreter was available at the time. It was very difficult for me to explain with my poor English. I know the name of his problem in my language but not in English... he did not get the right treatment.

Our children don’t speak good Assyrian so they can’t interpret what the doctor is saying to us, particularly the medical terms.

I took my daughter to interpret for me when I had an eye operation. She couldn’t understand what the doctor said. Our kids don’t have experience in a medical setting – it is much better to have an interpreter.
Many participants said that when family members acted as interpreters, in certain circumstances, they edited or restricted the communication between the participant and the health professional. Participants said that this editing or restricting of communication often occurred when a family member wanted to protect the participant or was too embarrassed to communicate the information. Participants repeatedly emphasised their preference to fully communicate; to be told ‘the truth’ or to tell the health professional whatever they thought was relevant.

The doctor at the hospital explained to me that I am at high risk of getting tuberculosis. The news was scary but I was glad the interpreter was there as a family member or friend would not have told me this information at once.

It is embarrassing for my son or daughter to interpret. My kids say ‘Mum! You shouldn’t say all these private things to the doctor’. So I feel embarrassed. I feel frustrated. I say to my children that I want them to interpret what I say but they refuse. So I prefer a professional interpreter.

Children can down play the severity of our condition to prevent us from worrying, at least with an interpreter we are told the truth.

Not all participants believed their families edited information. A small number of participants said that they trusted their family member, more than the interpreter, to tell ‘the truth’.

A smaller group of participants were happy for their family members to protect them from information through editing what the health professional said. However, these participants stressed that they wanted to know ‘the truth’ eventually.

‘So I feel less anxious’

Some participants said that the anxiety caused by not being able to communicate in a health setting was detrimental to their health. Some participants described interpreting services as beneficial to their health and well-being.

When I speak through an interpreter to the doctor I feel more relaxed. I feel less anxious. I am in a country that is not mine. Once I have talked it is very good. The interpreter keeps the secrets I tell. We have a proverb that says that if the person is happy psychologically this is half the treatment. Once we communicate through an interpreter, we feel less stress. We trust them. It improves our psychology. Without the interpreter we can’t communicate with the doctor and we feel more stressed.

‘For delicate matters and when I really need to understand’

Almost all participants, even those who routinely used family to interpret, preferred to use a professional interpreter when the health consultation involved a matter that the participant viewed as private or embarrassing, such as sexual, mental or serious health issues. However, a very small number of participants, mostly from the South Sudanese community, felt more embarrassed about such issues in the presence of the interpreter than they did in the presence of their family, although this did not always mean that these participants chose to use a family member to interpret instead of an interpreter. Often the need to communicate fully outweighed the embarrassment this group of participants felt in the presence of an interpreter.
While most participants said that full, detailed communication in a health setting was important in every circumstance, there were some circumstances in which participants thought communication more important than in others. Examples include where the participant consulted a health professional in a crisis situation, or about a matter that the participant considered particularly serious, or if the health matter concerned the participant’s children or spouse. It was in these situations that participants believed it particularly important to use a professional interpreter.

‘A professional interpreter is the best way to communicate, only if...’

While most participants said using a professional interpreter was the best way to communicate with a health professional, these participants invariably added an important qualifier, i.e. that the interpreter should be highly skilled, highly professional and trained in medical interpreting. As participants placed so much value on both the health professional and participant being able to fully understand each other, particularly in relation to ‘medical terminology’, participants wanted interpreter services that were able to competently facilitate thorough communication. Participants often commended interpreters they had used in the past who appeared to be trained in health interpreting, maintained professional boundaries, and were meticulous about interpreting everything the participant and health professional said to each other. However, participants also related many experiences involving the confusing, frustrating and, sometimes, traumatic consequences of what participants saw as less than competent interpreting services. These issues are further elaborated upon on pages 24 and 25.

Why participants did not use interpreter services in a health setting

When asked why they did not use interpreting services in a health setting, participants gave the following reasons:

- Interpreting services were not available in a particular setting
- Waiting times were excessive and/or lack of coordination between health services and interpreter services made interpreter services unreliable
- Health service providers refused to engage an interpreter and insisted the participant communicate without assistance or use family to interpret
- The participant preferred to consult a health professional who spoke the participant’s first language or a language in which the participant was more fluent than English
- The participant chose not to request an interpreter because the participant believed that communication was not important in certain situations
- The participant felt too embarrassed or uncomfortable to ask for an interpreter
- The participant preferred to use a family member to interpret for them.
These reasons are elaborated below.

‘They said there was no interpreter’

Participants repeatedly said that interpreting services were simply not available, or very rarely available, at particular types of health services. Participants said that when services were not available, they were forced to attempt to communicate without assistance or to use a family member to interpret for them. Participants said that the two most common types of health services where interpreting services were not, or rarely, available, were emergency departments and specialist services. Some participants also said that interpreting services were difficult to access when they were using in-patient hospital services.

Participants repeatedly said that the lack of interpreter services in emergency departments, specialist services, and in-patient hospital services led to ineffective appointments, unnecessary confusion and anxiety and an inadequate level of care. Participants frequently said that it was when visiting emergency departments, specialist services or when an inpatient in hospital, that communication was particularly important. This was because when accessing these services, participants said that they were often in crisis, and/or highly anxious, and that an inability to communicate compounded the stress of the situation and made a positive health outcome less likely.

When participants were informed that interpreting services were, in fact, available in many of these settings (see conclusion) they often expressed surprise and frustration. Upon hearing this information, many participants said they wanted detailed information on where, and under what circumstances, interpreters were available so that they could insist that a particular service engage an interpreter. Participants also stressed the need for this information to be made available to their particular communities.

Participants’ experiences and views about the purported lack of availability of interpreters in emergency departments and specialist and in-patient services are outlined below.

Emergency Departments

Participants said that when they had requested an interpreter at an emergency department they were told that interpreting services were not available at that service. Participants repeatedly echoed this participant’s comment:

*There are no interpreters in emergency. We would be much more confident if interpreters were available. Even if the emergency department know you are coming they don’t arrange an interpreter.*

Only one participant in eighty six said they had used a professional interpreter in an emergency department. One participant said that an emergency department had used a hospital security guard to interpret for her.

The lack of professional interpreting services in emergency departments was a source of significant concern to participants. Participants repeatedly described situations where they, and their families, went through triage, sat in the waiting area and saw a doctor without:

- understanding what was said to them
- being able to describe to emergency department staff why they were in emergency
- being able to ask questions about the treatment they were receiving.
Participants said that the inability to communicate caused them significant distress, particularly when they were unsure about why they were waiting or if they, or their families, had been adequately assessed. Participants frequently said that the inability to communicate when taking a child or grandchild to emergency was a particularly distressing experience. Participants believed that the inability to communicate whilst in emergency departments resulted in inadequate assessments, longer waits than English speaking patients, and inadequate treatment. The following quotes from participants highlight the dissatisfaction expressed about their level of care in emergency departments.

My granddaughter is 4 years old. She had a big operation in her stomach and sometimes she cannot eat. Sometimes if she eats she needs her stomach cut open again. One night she had high fever. We took her to the hospital. We stayed there between 3am and 9am. We were just in the waiting room. There was no interpreter. She was not seen by anyone. She was then taken to another hospital for an operation. This was a very dangerous case - so dangerous that she needed an operation. The doctors at the second hospital were very upset about why she wasn’t seen straight away when she went to emergency.

I had poisoning. I went to emergency. I couldn’t communicate. They did nothing for me but gave me Panadol. I was pregnant. They were only concerned about the foetus. They scanned to see if the foetus was alright. They didn’t care about me. They just sent me home with Panadol. So I asked a friend of mine and she gave me the tablets she takes and I was alright.

Some participants from the Iraqi Muslim and Vietnamese communities believed that emergency departments discriminated against particular ethnic or religious groups. These participants believed particular ethnic or religious groups waited longer in emergency than did the rest of the community.

I think there is racism at emergency. When my child had very bad stomach pain, I came in at 10pm. After that time many other people came in and went out but no-one called my child. At 3am I looked around and only two black haired people were sitting there. One was my child. Perhaps it is because we are Muslim.

Participants said the lack of interpreting services in emergency departments meant that the participant was forced to take family members with them, placing extra pressure on their families.

My wife fell and a night-time GP said she should go to emergency. I had to wait from 10pm to 1am, my child had to stay there with me because there is no interpreter at emergency. My child had to work in the morning.
Specialists

Many participants said that interpreter services were rarely available when consulting a specialist. Participants described ‘specialist’ services as cardiology, ophthalmology, radiology, health screening, oncology, neurology, orthopaedic surgery and plastic surgery. Participants also termed ‘specialist’, any health service (excepting GPs) that operated from a ‘private clinic’, including some physiotherapy, optometry, pathology and audiology services. Many participants said that although they had rarely received interpreter services when consulting a specialist in a hospital setting, they were still much more likely to receive interpreter services in this setting than when consulting a specialist outside of a hospital setting. A small number of participants said that when they had regularly seen a particular specialist at a particular hospital, they had mostly been provided with an interpreter.

Participants said that not only did specialist services tell participants that interpreters were not available, but they often explicitly told participants to bring a family member with them to interpret. Some participants reported that some specialists said that an interpreter could be arranged but only if the participant paid for it. Participants often expressed frustration at the lack of interpreting services available when consulting specialists. Participants said that having access to interpreters when using specialist services was particularly important because specialists often used technical language and were thus particularly difficult for the participant, or their family member, to understand. Participants said that having access to interpreters when using specialist services was also important because participants often consulted specialists about serious health issues where the participant needed to both give the specialist detailed information and clearly understand what the specialist was asking and telling them.

> When I see a specialist, there is no interpreter. I want one very much but they will not provide one.

> I went to an eye doctor. He wouldn’t provide an interpreter. I was angry and frustrated because I couldn’t explain the problem to the doctor.

> I have a breast exam every two years and there is no interpreter even though they have given me the appointment already. My relative has to come with me to help my English.

Hospital in-patients

Some participants said they were not able to access interpreters when they were ‘on wards’ when in hospital.

> I was lucky when I was in hospital because there is no Vietnamese interpreter but I speak Chinese and there was a Chinese nurse.

> When I stayed in hospital there was no interpreter. I couldn’t understand any of their questions.

As was the case with specialists, some participants said that hospital staff often insisted on using the participant’s family to interpret.

> I was in hospital for five days. Every day I asked for an interpreter. Every day they did not give me an interpreter... they told me that they don’t have one. When the doctor came for his rounds he asked me if I had any children at home who can interpret through the telephone. My son-in-law then interpreted through the phone. Many times my son-in-law was not home, then the doctor asked me ‘how about other children?’ But they all were at work... Once, I had a pain in my lower abdomen. I pressed the emergency button, later a nurse came and I told her about my pain but she didn’t understand me. Luckily my son came to visit and could explain. They found that the urine line was twisted. If it was too late to find out the reason for the pain, my bladder would have broken and I would have died.
When participants did access interpreter services when in hospital they valued the service highly.

I had malaria and I was in hospital for a week. Every day I had an interpreter with me to explain what the doctor said. It was very important and useful. I don’t have relatives to support me in Australia other than my children.

‘Too long to wait’ / ‘Sometimes an interpreter and no doctor and sometimes a doctor and no interpreter’

Many participants said that they often chose not to ask for an interpreter because the waiting time to receive interpreting services was excessive. Rather than wait, many participants said they ‘made do’ without assistance or relied upon, what they often saw as the inadequate interpreting skills of family members. In fact, waiting time was the most common reason participants said they did not use interpreters.

I prefer to have an interpreter but I usually take my husband because the waiting times are so long. But I feel more at ease with the interpreter but sometimes I just can’t wait. There is no choice if you want an early appointment.

When participants talked about waiting times they were usually talking about two different kinds of waiting times.

1) If participants wanted to arrange a medical appointment, and have interpreting services at that appointment, participants said they had to wait much longer for a medical appointment than if they booked the appointment without an interpreter.

In a public hospital we had to wait for one month until an interpreter was available.

I was told I had to wait three months for an interpreter by the specialist’s receptionist so I took my son.

I realise that if I don’t need an interpreter they will give me an early appointment and if I need an interpreter they will give me a late appointment. I have to wait for a long time.

I had a bad back pain and needed access to physiotherapy. Because I had to wait so long to see the physiotherapist with an interpreter, I decided it wasn’t worth it. I just stayed at home and put up with the illness.

2) Participants said they often had to wait many hours when they had booked an interpreter for a specific appointment because the interpreter was late. Participants said interpreters were often delayed at other appointments at the same service or had been delayed at another service.

I had an eye operation and I asked for an interpreter. We waited for a long time, myself and my husband, and the interpreter did not come. So my husband just managed to interpret for me and then I went for the operation.

I accompanied my wife to the doctor when she suffered strong period pain. I only went to support her. We waited 6 hours for an interpreter. It was very difficult.

I often go to the hospital outpatients. I always book an interpreter in advance. However, many times the interpreter is not there. Once my appointment was booked at 10am. I had to wait until 2pm. I asked the doctor why I had to wait so long. He said there was a shortage of interpreters. Afterwards I took my child for interpreting then we saw the doctor very quickly.
Participants also said that when an interpreter did show up on time to their appointments, the health professional was often running late. When this happened the interpreter sometimes had to leave for another appointment before the health professional was available. Participants, who had access to bilingual family members, said that they often brought family members with them just in case this occurred.

‘The doctor said no. They told me to use my family’
Participants said that some health professionals refused a participant’s request for an interpreter and insisted that the participant manage on their own or use a family member to interpret. Participants said that this was most common amongst specialists (see pages 21 and 22) and GPs. While most participants regularly consulted GPs who spoke their language of choice, when they consulted a GP who did not speak their language of choice, participants said they were rarely provided with an interpreter. Some participants said that this was because some health professionals thought a participant’s English was ‘good enough’ or the health professional did not want to provide interpreting services due to inconvenience or cost.

Some doctors don’t believe that you need an interpreter. They say you speak good enough...
if you say ‘hello-good morning’, they say you don’t need an interpreter.

I have asked for an interpreter but my GP won’t get an interpreter. She uses a dictionary. She wants to encourage me to speak English. I would understand her better with an interpreter.

When I know (that a GP won’t get an interpreter) I book a double appointment so I can try and understand. They prefer me to have a double appointment than booking an interpreter for me.

They don’t do it because it would take time and time is money. They don’t want to pay.

‘I like a doctor who understands me’
Most participants did not use an interpreter when they consulted a GP because participants mostly consulted GPs who spoke their preferred language, or a language they understood better than English. Over 90% of Italian and Vietnamese participants consulted a GP who spoke Italian or Vietnamese. Approximately 80% of Iraqi participants visited Arabic speaking GPs, although long waits for these GPs meant that sometimes Iraqi participants said they were forced to consult a non-Arabic speaking GP. The Sudanese participants said that they would prefer to consult a GP who spoke their languages of choice but there were no GPs who spoke their first languages (Dinka, Bari, Chulok and Nuier). Sudanese participants also said there very few GPs who spoke Sudanese Arabic. About 60% of Sudanese participants saw an Arabic speaking GP but some described communication problems due either to the participant’s poor Arabic language skills or difficulties understanding the GP’s particular dialect of Arabic.

Most participants said that they preferred to consult a health professional who spoke their preferred language. Some said they preferred to consult a health professional who spoke their language of choice rather than consult a health professional with an interpreter.

I can express everything and the doctor can understand everything immediately. Using an interpreter it is not always correct.

Others said that they preferred to consult a health professional who spoke their language of choice only because they were not always able to access interpreters when consulting health professionals who did not speak their preferred language.
Some doctors don’t believe that you need an interpreter. They say you speak good enough... if you say ‘hello-good morning’, they say you don’t need an interpreter.

‘I didn’t need one’
Some participants chose not to request an interpreter because they believed that communication was not important in certain situations. Situations where participants believed communication unimportant usually involved routine and regular appointments, such as having a dressing changed or a long term prescription renewed.

‘I don’t like to ask’
Some participants said they felt uncomfortable asking for interpreting services. These participants said they were much more likely to use interpreting services if the services were offered to them rather than if they had to request interpreting services. Some of these participants said they felt uncomfortable asking for interpreting services because they didn’t want to be, or appear to be, a drain on government resources.

I worry about it being too much money for the government. I feel embarrassed to ask all the time. My husband has chronic asthma and needs a lot of medical help. I feel embarrassed asking for an interpreter all the time.

‘My family is better’
Participants said that on some occasions they didn’t use an interpreter, when interpreters were available at a particular service, because they preferred family to interpret for them. As discussed above, this was usually because the participant did not want to wait for an interpreter or they feared that an interpreter would not be able to attend the appointment at the last minute.

However, a minority of participants (approximately a quarter of Italian participants, a third of the Sudanese participants and a quarter of Iraqi participants) preferred a family member to interpret for them because they felt more comfortable with family members than they did with an interpreter. These participants valued the emotional and material support (transport to appointments, assistance filling out forms etc) that family members provided when they came to interpret. These participants also highly valued a family member’s involvement in their healthcare, particularly when family members could advocate for participants or assist participants in making decisions. These participants also said they felt uncomfortable talking about their private health concerns in front of an interpreter. This was either because they did not trust that the interpreter would keep their confidentiality or that they did not want the interpreter hearing their private concerns, even if the interpreter kept confidentiality. Some participants also believed that family members made better interpreters because family had the participant’s welfare at heart. Most of these participants still used interpreter services but usually as a last resort when family were unavailable. However, this group of participants did also occasionally use interpreting services as a first choice. This was usually when the health matter was something they wished to keep private from family or they thought the consultation particularly important and did not want to risk family members misinterpreting.

For some participants, a preference for family members did not mean they used them. As this participant explains:

I prefer a family member over an interpreter. Health is a family affair. It is only because our families don’t speak English that we use interpreters. We like to take the ones we trust.
The Findings

Participant views on the effectiveness of existing interpreting services in a health setting

Participants said that the effectiveness of existing interpreting services in a health setting were compromised by the following factors:

- Pressure on existing interpreting services and lack of coordination between health and interpreting services
- Varying levels of accuracy in interpreting services
- Provision of interpreting services in languages, or dialects, other than the participant’s preferred language
- Provision of interpreting services by interpreters who were of a different gender than the participant
- Varying standards of professional conduct.

Each of these factors is elaborated below.

Pressure on existing interpreting services and lack of coordination between health and interpreting services

Many participants said that interpreting services appeared over-stretched and interpreters appeared over-committed. Participants said that this impacted negatively on the quality of communication that the participant had with the health professional and, hence, the effectiveness of the health service. Participants said that interpreters often left appointments before the appointment was finished, walked in and out of appointments, interrupted appointments by responding to pagers and phones, arrived late to appointments, or simply didn’t arrive at all. Participants also said that when the interpreter was present at the appointment they often appeared hurried and stressed. Participants said that when this occurred they felt uncomfortable asking questions of the health professional because they didn’t want to delay the interpreter. Others said that they thought the interpreter could not interpret accurately due to a lack of concentration. Participants also said that when the interpreter interrupted their appointments the participant found it difficult to focus on the communication with the health professional.

_They seem too busy... when they are interpreting, suddenly, their machine rings, ‘bip bip’, then they have to use the desk telephone, then they sit down to continue the interpreting... then bip bip again... there are up to three interruptions in each appointment. Many times this happens... then sometimes the conversation hasn’t finished and they say sorry, then leave in a hurry. This makes me lose my trust. I am worried whether they interpret accurately._

_Many times I want to ask more questions but they [the interpreter] show they are in a hurry. This stops me from asking more questions... I am going to ask a question and she is already at the door._

Participants said that they thought these problems were caused by the demand for interpreter services outweighing supply, but also because interpreting services and health services were poorly coordinated. Many participants said that either the interpreter or the health professional was running late, making it very difficult for the two services to synchronise. As one participant commented, ‘sometimes there is a doctor and no interpreter and sometimes there is an interpreter but no doctor’.
Varying levels of accuracy in interpreting services

Participants repeatedly stressed that to be effective, interpreting services needed to act as a conduit for all that a health professional and participant said to one another. Participants, without exception, said that to accurately interpret was the most important aspect of an interpreter’s role.

[An interpreter] should interpret everything that the doctor says, not what they think we need to know.

An interpreter should never summarise.

Participants said that inaccurate interpreting led to misunderstandings, mistakes and, often, a reduced quality of healthcare.

Participants said the accuracy of the interpreting, and hence the effectiveness of communication, varied markedly from interpreter to interpreter. Participants highly commended interpreters who meticulously interpreted everything the health professional and participant said to one another. Participants also spoke particularly highly of interpreters who were trained in medical interpreting. On the other hand, participants were very concerned about what they perceived to be the inaccurate interpreting practiced by other interpreters.

When I first arrived in Australia my language was very poor and I had to rely entirely on interpreters and I had complete faith the interpreter would convey all that I was saying. After being in Australia for a few years my English language improved and I realised that not all the information you and the doctor say gets through the interpreter. We need accurate information.

I talk a lot to express exactly what I think and feel, but the interpreter interprets this very short. Sometimes I talk very short and the interpreter interprets this very long.

Participants said they believed that when interpreters interpreted inaccurately it was either due to a lack of skill or because the interpreter wanted to edit or simplify what the health professional or participants said to each other.

Some participants said that some interpreters actively tried to restrict what the participant was saying to the health professional by either not interpreting everything or reprimanding the participant for what the interpreter perceived as inappropriate talk for a health setting.

I know one interpreter in particular who, when we try to get an explanation from the doctor or add something he says, ‘I won’t interpret this part’.

I had one interpreter who didn’t interpret everything I say and then yelled at me ‘why do you speak too much?’

I don’t like it when the doctor says a lot, but then the interpreter just says one short sentence like ‘generally he is going to die soon’.
The Findings

Participants found inaccurate interpreting very frustrating and anxiety-provoking. Participants said that when they observed an interpreter inaccurately interpreting they were concerned that the interpreter would edit out something that was of importance to the participant’s healthcare. Some participants were so concerned about this issue that they had asked interpreters, who they thought were interpreting inaccurately, to leave the appointment or requested that a particular interpreter not be engaged in the future. Participants said that inaccurate interpreting impacted negatively on their confidence in interpreting services in general.

When we realised that this [the interpreter was not interpreting accurately] was happening, I insisted that they were never booked for my family again. We need the interpreting service but we fear they will not convey the message.

I have used interpreters for many years because of a work cover injury. I must say that only once I found myself in the situation where the interpreter interpreted incorrectly what I was saying to the doctor. Fortunately I understood sufficient English to realise that he misinterpreted me. I immediately informed the doctor that what [the interpreter] told him was incorrect and because of that I would prefer to speak to the doctor without the interpreter. Ever since I have been suspicious of interpreters and listened carefully.

Many participants said that it was around medical terminology that the most inaccurate interpreting occurred. Many participants also said that the effectiveness of the health consultation was vastly improved when an interpreter was trained in medical interpreting.

Most of the time even Dinka or other Sudanese Arabic interpreters would never know the medical terminology to describe to the doctor. When you try and explain the pain and the issue the interpreter doesn’t know how to describe the name of the condition or the symptoms in English. So the interpreter tries to explain it to the doctor in simple English and this results in most cases in the doctor not understanding.

I fear mistakes being made. When interpreters don’t know terminology it doesn’t inspire confidence. Medical terminology is very important, often we know other words but we need interpreters in a health setting because we can’t understand the terminology the doctor uses.
Provision of interpreting services in languages, or dialects, other than the participant’s preferred language

Participants said that the effectiveness of interpreting services was reduced when participants were unable to access an interpreter who spoke their preferred language or dialect. Some participants, particularly the South Sudanese and Iraqi participants, said they were often provided with interpreters where they understood little of what the interpreter said. These participants said the level of understanding they had in these instances was inadequate for them to communicate effectively with the health professional concerned.

South Sudanese participants

South Sudanese participants said it was rare that they were able to access an interpreter who spoke their native languages (Nuer, Dinka, Cholok and Bari). Participants said that there are very few interpreters who speak these languages and that the few that are available are much in demand. Participants repeatedly stressed the importance of an increase in the number of interpreters (men and women) who spoke Nuer, Dinka, Cholok and Bari.

South Sudanese participants said they were often provided with Arabic interpreters as a second option. Participants said that the provision of Arabic interpreters to their community presented some problems. Most people said that when the interpreter spoke anything other than the Sudanese dialect of Arabic, understanding was very difficult, if not impossible.

When I went to the hospital I asked for a Dinka interpreter. They didn’t have one and brought me someone from Egypt. I didn’t understand him. I had to guess. There is a very big gap between Sudanese Arabic and Egyptian Arabic.

Participants said that even with Sudanese Arabic it was difficult for some people in their community to understand because not all of the South Sudanese community were fluent in Sudanese Arabic.

I accompany my mother-in-law to hospital. She is diabetic. They brought us an Iraqi interpreter. It was very difficult to understand. The doctor would speak to the interpreter in English, The interpreter would speak to me in Arabic - I didn’t understand him very well - and I then interpreted for my mother-in-law [who doesn’t speak Arabic] in Nuer. The next time they arranged a Nuer interpreter for us. It was much better. We could understand.

When we have a Nuer interpreter it is very good. It is harder with Sudanese Arabic. I can understand about 70% if I concentrate hard. I can’t really understand... Egyptian Arabic at all.

Iraqi participants

The Iraqi Muslim participants also stressed the need for interpreters to speak a dialect of Arabic they understood. These participants repeatedly said that appointments were a waste of time when they were provided with an interpreter who spoke a dialect of Arabic that they couldn’t understand.

The Iraqi Christian participants echoed these statements, but like the South Sudanese, many participants spoke Arabic as a second language. Some of these participants found Arabic difficult to understand and preferred an interpreter who spoke Kildanean.
The Findings

**Italian participants**

Some of the Italian participants also experienced some problems with dialects. Some Italian participants said that they could understand the Italian that most interpreters spoke but they couldn’t always speak it. This meant that unless the interpreter understood the participant’s particular dialect, the interpreter sometimes misunderstood, and misinterpreted, what the participant was trying to communicate to the health professional.

**Provision of interpreting services by interpreters who were not of the same gender as the participant.**

Many participants, both men and women, said that the effectiveness of the health consultations could be compromised when the interpreter was not of the same gender as the participant. Many participants said they felt uncomfortable talking about health in the presence of an interpreter who was not of the same gender. Participants repeatedly said that when they had used an interpreter who was not of the same gender, they had often refrained from telling the health professional some symptoms or from asking particular questions. This was particularly the case for health issues that the participant considered sensitive, such as sexual health issues.

*Before my prostate operation they got a female interpreter. It was a little embarrassing. The interpreter was embarrassed too.*

*When a man interprets, there are some things I am too embarrassed to say.*

Some participants felt less concerned about the gender of the interpreter when they were consulting a health professional about health issues that they considered less sensitive. However other participants, particularly those participants from the Iraqi Muslim community, had a strong preference for always having an interpreter of the same gender.

Participants from the South Sudanese and Iraqi communities said there were very few female interpreters available in their preferred dialect/language. This meant that female participants from these communities did not communicate certain health issues to health professionals.
Varying standards of professional conduct

Many participants said it was very important that interpreter services ensured that their interpreters maintained a high standard of professional conduct. These participants appeared to derive the benchmark for these standards from their more positive experiences of using interpreters. Participants thought it important that interpreters refrain from saying things to the participant that was outside their role as a conduit between participant and health professional. In particular participants believed it was important that interpreters refrain from making any comments or judgements about the participant. Participants most valued interpreters who were respectful, maintained their professional boundaries and were compassionate.

Interpreters need to have good will, they shouldn’t think they are bestowing their clients a favour.

Interpreters should have the same respect and courtesy for the patient as they show the doctor.

They should be impartial and not look down on us.

Participants gave examples of times that they thought interpreters had not maintained their professional conduct. The following three examples are typical:

Sometimes they want to tell you about their life story - about how they came to Australia rather than interpret for you.

Sometimes their behaviour is very authoritarian. When I took my child for an operation, the female interpreter said to me with a slowly talking voice ‘How long have you been in Australia? 7 or 8 years? Why can’t you speak English!’ She spoke to me like I was simple.

The specialist told me I needed a hysterectomy... When the specialist left the cubicle the interpreter said my condition was due to ‘too much sex’. I was embarrassed and outraged and told him to mind his own business.

Participants stressed that instances, such as those described above, were the exception rather than the rule. Yet most participants had one or two anecdotes of this sort where they described feeling humiliated or angry at the unprofessional conduct of an interpreter.

Some participants wanted to be able to complain about such experiences but did not know how.

We need to be able to complain if an interpreter has bad manners - we don’t know which company employs them so we don’t know where to complain.
Factors that assist or deter CALD consumers in accessing language services

Participants described many factors that assisted them to, or deterred them from, accessing language services. Participants, also spoke about factors that they believed would assist or deter other members of their communities in accessing language services. These factors are summarised below.

Factors that assist CALD consumers in accessing language services

- Readily available interpreting services (minimal waiting times)
- Punctual and reliable interpreting services
- Well coordinated and integrated health and interpreting services
- Readily available interpreting services in the participant's preferred language and preferred gender
- Interpreters who can interpret accurately, particularly medical terminology
- Being provided with an interpreter who can speak the participant's language and dialect well
- Health services offering a participant an interpreter, rather than a participant having to request one
- Administrative systems that ‘flag’ a participant's language needs every time they make an appointment
- Health services that encourage family involvement in a participant's health (in support role not interpreting role)
- Participant being able to assess when they need an interpreter rather than a health professional assessing whether a participant needs an interpreter (this was raised only in relation to a health professional assessing a participant as not needing an interpreter when the participant believed they did need an interpreter not a health professional insisting they use an interpreter when a participant did not think they needed one)
- High professional standards amongst interpreters, particularly in the areas of impartiality, accuracy, confidentiality, respect and compassion
- Knowledge about how to access interpreter services and in what settings they are available
- Knowledge about the role of interpreting services and how to effectively use them.

Factors that deter CALD consumers from accessing language services

- Long waiting times for interpreting services
- Unreliable and late interpreting services
- Poorly coordinated health and interpreting services
- Inaccurate interpreting services
- Lack of availability of interpreters in the participant's language of choice
- Lack of availability of interpreters in the participant's gender of choice
- Being provided with an interpreter who does not speak a language well or speaks a different dialect
- Lack of availability in particular settings: specialists, emergency departments and in-patient hospital services
- Health services refusing to arrange interpreting services
- Health professionals overriding consumer's requests for interpreting service eg. on the basis that the participant's English is good enough
- Lack of information about the interpreter's role, their professional boundaries and codes of conduct
- Bad experiences with interpreting services in a health setting
- Fear that the interpreting services are not accurate or confidential
- Lack of information about how to access an interpreter, where interpreters are available and consumer rights in relation to interpreters.
Participants’ priorities for change

Participants were asked about their views on how interpreting services in a health setting could be improved. The following participant suggestions are not in order of priority:

- Increase the number of interpreters (particularly ‘in-house’ interpreters)
- Increase the number of interpreters who speak:
  - Dinka, Bari, Nuer and Cholok (South Sudanese)
  - Kildanean (Iraqi)
- Ensure that there enough male and female interpreters so that consumers are able to use an interpreter they are comfortable with
- Provide interpreting services in emergency departments and specialist services
- Provide more interpreting services at GP and hospital in-patient services
- Decrease waiting times associated with interpreting
- Ensure interpreters are trained in health interpreting if they are working in a health setting
- Better coordinate health and interpreting services
- Ensure that health services always ask about a consumer’s language needs (Do they need an interpreter? If so, which language, which dialect, which gender?)
- All health services should adopt the system (seen in some services) where a participant’s language needs are flagged on their file for future bookings
- Implement a way in which participants can give feedback or complain about interpreting services in a health setting
- Implement a community education campaign that includes:
  - How to request an interpreter in a health setting
  - Where, and in what settings, interpreters are available
  - How to make the most out of using an interpreter in a health setting (eg. what you do if you don’t understand, how to get assistance filling out forms)
  - Participant rights and entitlements in relation to interpreting services in a health setting
  - How to give feedback or make a complaint about an interpreting service
- Provide scholarships and actively recruit interpreters from the communities.
The Findings

Differences between newly arrived and established communities

As discussed in the method section of this report, participant responses were remarkably similar across the four communities. However, the most significant difference between participants who were from more recently arrived communities and those from more established communities was that newly arrived participants had little or no English speaking networks or no family networks at all. This meant that when language services weren’t provided to these participants, these participants often utilised health services without being able to communicate at all. Newly arrived participants frequently described situations where they were relying on family members to interpret who had only marginally better English than the participant had themselves. Participants said this led to ineffective and confusing encounters with the health system. Many of the male participants from the South Sudanese and Iraqi communities said they were often pressured by language services to interpret for their wives and children. These participants said that their English language skills were only marginally better than those of their wives or children and were not adequate for interpreting in a health setting. These participants described the experience of interpreting for their families as extremely stressful and frustrating.

However, while the lack of English speaking networks was consistently raised as an issue with the Iraqi and South Sudanese communities, it was also raised as an issue with many of the older Vietnamese participants. Some older Vietnamese participants also said they had no English speakers in their families. Other Vietnamese participants had English speaking family members but these family members were often too busy to accompany participants to appointments.

The other major difference between newly arrived and more established communities concerned access to GPs who spoke the participant’s language of choice. For the Italian and Vietnamese communities, bilingual GPs were an important link with the rest of the health system, forming a major role in referring and orienting consumers to the health system as well as assisting consumers to understand their interactions with the rest of the health system. Bilingual GPs played a similar role for South Sudanese and Iraqi participants but these GPs were much in demand, difficult to access and often did not speak the participant’s language of choice. For example, the Sudanese participants saw Arabic speaking GPs because there were no GPs who spoke their preferred languages. As discussed in the report, the Sudanese spoke Arabic as a second language, with some participants only speaking Arabic marginally better than English. In these cases, bilingual GPs were less effective in providing a health setting where participants could communicate easily.

Another major difference between newly arrived and more established participants was that newly arrived communities were often provided with interpreters who did not speak their preferred language/dialect. This meant that participants were often trying to communicate through an interpreter who spoke a language they could only partially understand or communicate in. Newly arrived participants said that there were very few interpreters available who spoke their language/dialect of choice. Newly arrived communities also reported a lack of female interpreters who spoke their preferred language/dialect. This meant that women participants often felt unable to discuss certain issues with health professionals.
Conclusion

One of the most consistent themes that emerged from the findings was the high value that participants placed on communication in a health setting.
One of the most consistent themes that emerged from the findings was the high value that participants placed on communication in a health setting and the clear and direct connection participants made between communication, effective healthcare and positive health outcomes. Participants said that language services, when of a high standard, provided participants with the means to fully communicate with health professionals. For participants, full communication involved listening, asking questions, discussing issues, advocating for themselves and their families, as well as communicating in the very specific language used in a health setting. Participants believed this communication was fundamental to obtaining positive health outcomes for themselves and their families. Participants repeatedly said that when communication in a health setting was ineffective or non existent, either because interpreting services were not provided or because interpreting services were of an inadequate standard, contact with the health system became confusing, ineffective and, sometimes, dangerous and traumatic.

Understanding the value that participants placed on communication is pivotal to understanding participants’ preferences, actions and choices surrounding language services in a health setting. Participants mostly preferred to use a professional interpreter over a family member, even when they were more comfortable with a family member, to ensure that communication was effective. This was particularly true in situations where the participant believed the health matter to be serious, an emergency, private or embarrassing. However, while many participants preferred to use a professional interpreter they often chose to use a family member to interpret. Participants usually, but not always, chose to use family to interpret because they:

- were not provided with interpreting services
- had to wait too long for interpreting services
- felt uncomfortable asking for an interpreter
- feared language services would be unreliable, delayed or inadequate.

While most participants highly valued the support of their families, they often described communication facilitated by family as limited or compromised. For other participants the option to use family to interpret was not available. This was particularly the case for participants from newly arrived communities who often had no English speaking family members and sometimes no families at all.

Participants’ value of, and preference for, full communication also appears to be at the heart of the strong preference participants expressed for using bilingual health professionals. Most participants believed that full communication with a bilingual health professional was both reliable and effective.

Participants believed that the current level and standard of language service provision appeared to compromise the effectiveness and quality of healthcare that participants and their families received. Participants said that when they attempted to access health services they experienced prohibitively long waits for interpreting services. When attending pre-booked appointments, participants often found language service provision inconsistent or unreliable and health and language services often poorly coordinated. Participants also found interpreting services varied in quality and sometimes the interpreter was unable to effectively interpret in a health setting. When accessing some services, particularly emergency departments, specialist or in-patient services, participants were often denied language services altogether. These barriers often forced participants to use what they saw as inadequate communication means such as family members or ‘getting by’ without assistance. This led to confusing, ineffective and traumatic interactions with the health system. This aspect of the findings raises some pressing questions about the quality of health care being delivered to Victoria’s diverse community.
Perhaps one of the most concerning and puzzling issues that arose from the findings is that it appears that participants have been denied access to interpreter services even when interpreter services may actually have been available. For example, many emergency, specialist, inpatient and GP services do have access, within certain resource constraints, to interpreters. However, participants consistently said that when using these services they were often either actively discouraged from using language services or informed that interpreting services were simply not available. If participants were actually informed that interpreter services were simply not available, then they were not only denied access to interpreting services but were explicitly misinformed about the availability of these services. Further, in these situations, participants said that health services often actively encouraged them to use family members as interpreters, a practice discouraged in Victorian government policy regarding language services. The apparent commonplace practice of using family to interpret or using no interpreting assistance at all also raises questions about how, in the absence of communication, health professionals are ensuring that duty of care requirements and legal obligations around informed consent are being met. This aspect of the findings, amongst others, suggests a gap between Victorian government policy regarding language services and language service provision in a health setting. This gap needs further investigation and intervention in order to ensure that consumers are receiving the full benefit of available services and to ensure that all health services are complying with government policy.

While the research raises some urgent issues concerning the under utilisation of available language services in some health settings, the research findings also suggest a lack of availability of language services in other settings. The excessive waiting times, overstretched services and the varying quality of language services described repeatedly by consumers suggest a lack of availability of appropriately skilled interpreters. The findings suggest that both the quantity and quality of existing services are not always adequate to meet the needs of CALD consumers. This appeared to particularly be the case with regard to language services in newly arrived communities.

As well as raising concerns about the gap between Victorian government policy regarding language services and issues of supply and utilisation, the findings also highlighted a lack of information available to consumers. Participants repeatedly said that they needed more information about when and where interpreters were available, how to access them and what actions to take when interpreter services were denied or inadequate. Participants said they needed this information so that they could better advocate for themselves and their families. Participants also said that they were willing to make complaints but needed clear information about where and how to make complaints or give health and language services feedback about the provision of language services in a health setting.
Understanding the value that participants placed on communication is pivotal to understanding participants’ preferences, actions and choices surrounding language services in a health setting.

Recommendations
Recommendations

On the basis of these research findings, CEH makes the following recommendations:

1. That DHS, in conjunction with the relevant Government agencies, ensures that there is an increase in the utilisation and availability of appropriately qualified interpreters in health settings.

2. That DHS investigates the reasons why interpreters may be under-utilised by health professionals, particularly in emergency, specialist, in-patient and GP services.

3. That DHS undertakes consultation to determine the best way to establish a ‘language services in health’ consumer advocacy body (or capacity in an already existing service) that:
   a) Assists CALD consumers to make complaints through the relevant channels
   b) Can arrange language services for consumers who want to make complaints
   c) Provides culturally relevant and accessible information on how to make complaints
   d) Provides consumers with advocacy support in order to make complaints
   e) Provides a central point where consumers can make complaints about services who refuse to provide interpreters
   f) Monitors themes and trends in consumer complaints
   g) Provides policy advice
   h) Conducts a regular, state-wide review that seeks consumer perspectives on language service provision in the health system.

4. That DHS in conjunction with Victorian Office of Multicultural Affairs (VOMA), investigate strategies to increase the number of interpreters (particularly female) that speak newly arrived community languages, including Dinka, Bari, Nuer and Cholok (South Sudanese), Kildanean (Iraqi), Sudanese Arabic and Iraqi Arabic.

5. That DHS develop and implement a system for ongoing monitoring and reporting on interpreter utilisation that specifically identifies usage in emergency departments and specialist, GP and in-patient services.

6. That both health services and language services providers ensure internal complaints mechanisms are more accessible and are promoted to consumers.

7. That DHS and health providers ensure that health service provision complies with Victorian Government policy regarding language services, particularly in relation to using family as interpreters.
Recommendations

8. That health service providers, health professional peak bodies and key stakeholders in the private sector improve the delivery of their language services to ensure the needs of CALD consumers are met. This may include:
   a) Providing interpreters who are of a gender and speak a language/dialect of the consumer’s choice
   b) Decreasing waiting times for access to interpreters
   c) Ensuring timely, uninterrupted consultations
   d) Improving coordination between health service and language service appointments
   e) Improving organisational systems that indicate consumer language needs and ensuring language service provision at all critical service points

9. That health service providers and health professional peak bodies improve ongoing training to all staff in relation to using interpreters in a health setting. Training should place particular emphasis on improving the quality of communication between practitioners and consumers, duty of care requirements, and respect for consumers’ rights in relation to language services.

10. That the Victorian Government and language service providers ensure that interpreters working in health settings meet minimum standards, including accreditation at NAATI Level 3 and are experienced in, or trained to develop specialist skills for, interpreting in health settings.

11. That language service providers seek and take into account consumer perspectives and complaints when monitoring service quality.

12. That interpreter training providers and language service providers ensure that interpreter education and training places particular emphasis on improving accuracy and working sensitively with consumers in a health setting.

13. That DHS implement community education strategies to improve/increase consumer knowledge in relation to language services including:
   a) How to arrange for an interpreter in a health setting
   b) Where, and in what settings, interpreters are available
   c) How to make the most out of using an interpreter in a health setting
   d) Participant rights and entitlements in relation to interpreting services in a health setting
   e) How to give feedback or make a complaint about interpreting services
   f) Information on the professional code of conduct for interpreters
Appendices - Summary of Project Findings in Italian, Vietnamese and Arabic
Sommario delle risultanze del progetto

Il Centro per la Cultura l’Etnicità e la Salute (Centre for Culture Ethnicity & Health) (CEH) ha condotto un progetto di ricerca dall’ottobre al dicembre 2005. Abbiamo parlato con ottantasei persone che fanno parte delle comunità vietnamita, italiana, irachena e sud-sudanese di Melbourne. Le opinioni, idee ed esperienze che queste persone hanno condiviso con noi ci hanno aiutato a capire:

- come può essere migliorato il servizio interpreti in un contesto sanitario
- in che modo viene colpita l’assistenza sanitaria che le comunità d’immigrati ricevono quando gli interpreti non vengono resi disponibili

Questo rapporto, Servizi linguistici nel sistema sanitario del Victoria: Prospettive di utenti culturalmente e linguisticamente differenti, illustra le risultanze delle nostre discussioni con le comunità vietnamita, italiana, irachena e sud-sudanese e le raccomandazioni che CEH propone per migliorare la qualità dei servizi. Riportato qui sotto vi è un sommario di ciò che le persone ci hanno detto riguardo gli interpreti nel contesto sanitario. Abbiamo anche incluso alcune citazioni dirette.

Le esperienze della gente sugli interpreti nei servizi sanitari

Le persone hanno detto che gli interpreti sono molto importanti quando si fa visita ad un servizio sanitario. Le persone hanno detto che gli interpreti hanno permesso loro di fare domande, dare informazioni e capire quello che l’operatore sanitario dice loro, specialmente la terminologia medica.

Quando sono andato dal dottore per la prima volta avevo un interprete ma il dottore ha detto che non ne avevo bisogno. Preferirei averne uno perché non capisco i termini medici.

Le persone hanno detto che usare gli interpreti è il modo migliore perché l’operatore sanitario e la persona comunichino l’uno con l’altro, e ciò a tutto vantaggio della loro assistenza sanitaria.


Le persone hanno detto che gli interpreti sono particolarmente importanti quando si fa visita ad un operatore sanitario riguardo ad un problema di salute delicato (come un problema di tipo sessuale) o riguardo ad una questione molto grave.
Le persone hanno riferito molte esperienze di quando non potevano avere accesso ad un interprete. Queste esperienze sono spesso paurose o frustranti e portano ad un’assistenza sanitaria di cattiva qualità.

Mi fu detto che dovevo aspettare tre mesi per un interprete dalla segreteria dello specialista in … . Non potevo aspettare così tanto perché avevo dolore e così portai mio figlio con me. Alla seconda visita rimasi scioccata quando mi portarono in sala operatoria per un’operazione. Cominciai ad essere colta dal panico. Non sapevo cosa stava succedendo. Soffrivo e ero fatta prendere dal panico. Loro mi dissero che lo avevamo detto a mio figlio la volta precedente. Ma lui non è un interprete esperto e non aveva afferrato quelle informazioni … è stata un’esperienza davvero spaventosa per me.

La maggior parte delle persone ha detto che preferisce usare un interprete ma che spesso sceglie di utilizzare un famigliare per fare da interprete o di arrangiarsi da solo perché avrebbe dovuto aspettare troppo, non gli è stato fornito un interprete, non si sente a suo agio nel richiedere un interprete o ha paura che l’interprete non sia affidabile, venga in ritardo o non sia molto bravo.

Mi è stato chiesto di fare da interprete per mio zio quando deve andare dal dottore. Non voglio farlo, ma sono costretto perché devo mostrargli rispetto. Sarebbe meglio che fosse un professionista a farlo perché lo farebbe meglio e è tenuto a rendere conto di ogni suo errore.

Le persone hanno detto che apprezzano il sostegno dei famigliari ma che spesso essi non sono in grado di fare bene da interpreti.


Le persone dicono che non ci sono abbastanza interpreti nei servizi sanitari, particolarmente nei servizi di pronto soccorso, nei servizi specialistici e nelle corsie degli ospedali.

Non ci sono interpreti nei servizi di pronto soccorso. Saremmo molto più a nostro agio se fossero disponibili degli interpreti. Anche se il personale del pronto soccorso sa che stai arrivando, non pravvede a far venire un interprete.

Le persone hanno detto che gli interpreti non sono sempre molto accurati o sensibili e ciò significa che la qualità dell’assistenza sanitaria erogata a loro e alle loro famiglie non è molto buona.
Conosco un interprete in particolare che, quando noi cerchiamo di chiedere qualche spiegazione al dottore o di aggiungere qualcosa, ci dice: ‘non tradurò questa parte’.

Le persone hanno detto che è molto importante che sia fornito loro un interprete che sappia parlare bene il loro dialetto.

Le persone hanno detto di avere bisogno di maggiori informazioni su quando e dove sono disponibili gli interpreti, come avere accesso a loro e come fare un reclamo se non è stato fornito loro alcun interprete.

Vogliamo essere in grado di lamentarcì se un interprete è maleducato – non sappiamo quale società li impiega, quindi non sappiamo con chi reclamare.

**Punti di vista delle persone su come i servizi interpreti in un contesto sanitario potrebbero essere migliorati**

- Incrementare il numero degli interpreti (particolarmente quelli ‘residenti’)
- Incrementare il numero degli interpreti che parlano Dinka, Bari, Nuer e Cholok (sud-sudanese); e Kildanean (iracheno)
- Assicurarsi che ci siano abbastanza interpreti maschi e femmine, in modo che gli utenti possano usare un interprete col quale siano a loro agio
- Fornire servizi interpreti nei pronto soccorso e nei servizi specialistici
- Fornire più servizi interpreti presso i medici generali e i servizi ospedalieri per degenti
- Diminuire i tempi d’attesa associati col servizio interpreti
- Assicurarsi che gli interpreti abbiano una preparazione specifica in campo sanitario, se lavorano in un contesto sanitario
- Coordinare meglio i servizi sanitari e quelli d’interpretariato
- Assicurarsi che i servizi sanitari chiedano sempre agli utenti quali bisogni abbiano relativi alla lingua (Hai bisogno di un interprete? Se la risposta è sì, quale lingua, quale dialetto, di che sesso dovrebbe essere l’interprete?)
- Tutti i servizi sanitari dovrebbero adottare un sistema nel quale i bisogni degli utenti relativi alla lingua siano evidenziati nel loro incaricamento, in modo che siano presi in considerazione per prenotazioni future
- Assicurarsi che esista un modo in cui gli utenti possano dare il loro feedback o lamentarsi dei servizi interpreti in un contesto sanitario
- Organizzare sessioni informative per le comunità che forniscano informazioni sui diritti e su come concordare un appuntamento e come fare un reclamo
- Fornire borse di studio per gli interpreti e reclutarli attivamente dalle comunità
Raccomandazioni

Che il governo del Victoria:

1. Si assicuri che ci sia un incremento nell’utilizzo e nella disponibilità di interpreti qualificati in un contesto sanitario.

2. Indaghi perché gli interpreti non vengono utilizzati dai pronto soccorso, dagli specialisti, dai servizi per i degenzi e presso i medici generici anche quando essi sono disponibili.

3. Scopra qual è il modo migliore per istituire un servizio che aiuti le persone che utilizzano i servizi interpreti a fare un reclamo quando non sono soddisfatti del servizio.

4. Incrementi il numero degli interpreti (specialmente di donne interpreti) in tutte le lingue ma particolarmente in Dinka, Bari, Nuer e Cholok (sud-sudanese); Kikondean (iracheno) Arabo sudanese, Arabo iracheno.

5. Sviluppi un sistema per controllare quanti interpreti vengono utilizzati nei pronto soccorso, dagli specialisti, dai servizi per i degenzi e presso i medici generici.

6. Si assicuri che i servizi sanitari si attengano alle norme e alle linee di condotta relative agli interpreti, specialmente nel non utilizzare membri della famiglia come interpreti.

7. Lavori coi servizi interpreti per assicurarsi che gli interpreti impiegati in un contesto sanitario siano sensibili, professionali e comprendano la terminologia medica.

8. Organizzi sessioni informative per la comunità per migliorare la loro conoscenza su come fare richiesta di un interprete, dove sono disponibili gli interpreti e sui diritti delle persone nell’ambito dei servizi sanitari.

Che i servizi sanitari e quelli linguistici:

9. Informino le persone su come possono fare reclamo se non sono soddisfatti del servizio.

10. Si assicurino che venga fornito un interprete della lingua e del sesso richiesto ogni volta che ce n’è bisogno e che gli appuntamenti vengano tenuti in orario e non siano interrotti.

11. Si assicurino che gli addetti sanitari abbiano un adeguato addestramento per migliorare il modo in cui comunicano con le persone, e si assicurino di fornire sempre un interprete ogni volta che ce ne sia bisogno.

12. Interpellino le comunità sulle loro esperienze con gli interpreti in un contesto sanitario, in modo da sapere dove è necessario apportare miglioramenti.

13. Si assicurino che gli interpreti abbiano un adeguato addestramento in modo che essi siano accurati e sensibili.
Tóm lược kết quả đề án

Trung tâm Văn hóa Sắc tộc & Sức khỏe (CEH) đã thực hiện đề án nghiên cứu từ tháng Mười đến tháng Mười Hai 2005. Chúng tôi nổ lực chinh phục 68 người thuộc cộng đồng Người Việt, Ý, Irắc và Nam Tư ở Melbourne. Nhờ những quan điểm, ý kiến và kinh nghiệm do những người này chia sẻ, chúng tôi đã xác định được:

- cách thức có thể cải thiện dịch vụ thông dịch trong khung cảnh y tế
- dịch vụ chăm sóc sức khỏe đáng cho các cộng đồng di dân bị ảnh hưởng như thế nào khi không cung cấp thông dịch viên

Bản báo cáo Dịch vụ Ngôn ngữ trong hệ thống y tế Tiêu biểu Victoria: Cái nhìn của người sử dụng có nguồn văn hóa và ngôn ngữ đa dạng (Language services in Victoria’s health system: Perspectives of culturally and linguistically diverse consumers), giải thích kết quả của những buổi thảo luận với cộng đồng Người Việt, Ý, Irắc và Nam Tư ở CEH dựa ra để cải thiện chất lượng của các dịch vụ. Dưới đây là bản tóm lược những điều đã chứng minh cho chúng tôi biết về thông dịch viên trong khung cảnh y tế. Nói chung, chúng tôi còn thiếu nguồn văn hóa những lời trình bày của họ.

Kinh nghiệm của dân chúng về thông dịch viên tại các dịch vụ y tế

Dân chúng cho biết thông dịch viên là yếu tố rất quan trọng khi họ sử dụng dịch vụ y tế. Dân chúng cho biết nếu có thông dịch viên họ có thể đặt câu hỏi, cung cấp thông tin và hiểu những gì chuyên viên y tế nói, đặc biệt là thuật ngữ y khoa.

Khi tôi đi khám bác sĩ lần đầu tiên, tôi có thông dịch viên nhưng bác sĩ nói là tôi không cần thông dịch viên. Tối muốn có thông dịch viên bởi vì tôi không hiểu thuật ngữ y khoa.

Dân chúng cho biết sử dụng thông dịch viên chuyên nghiệp là cách tốt nhất để chuyên viên y tế và người sử dụng dịch vụ có thể nói chuyện với nhau và có lợi nhất cho việc chăm sóc sức khỏe của họ.


Dân chúng cho biết thông dịch viên là điều đặc biệt quan trọng khi đi gặp chuyên viên y tế về vấn đề sức khỏe thế nhỉ (ví dụ như vấn đề sức khỏe tình dục) hoặc về vấn đề rất quan trọng.
Dân chung chia sẻ nhiều kinh nghiệm khi họ không được thông dịch viên. Những kinh nghiệm này thường rất đằng sợ hoặc bức minh và dân denen tin rằng chăm sóc sức khỏe thiếu sót.


Da ső dân chung cho biết họ thích sử dụng thông dịch viên chuyên nghiệp nhưng thường quyết định sử dụng người nhà làm thông dịch viên hoặc ra mạng tự nói chuyện để switched vo không thể chờ quá lâu, vi không được cung cấp thông dịch viên, vi ngắn ngại không dầm yêu cầu có thông dịch viên hoặc vì sợ thông dịch viên không đằng tin cậy, tríst recept không ngơi lắm.

Tôi đươc nhờ làm thông dịch viên cho bác/chủ của tôi khi bác/chủ ấy đi khám bác sĩ. Tôi thấy ngắn ngại nhưng phải vậy lôi để tôi sự kinh trọng với bác/chủ ấy. Nếu thông dịch viên chuyên nghiệp làm việc này thì tốt hon vi họ thông dịch giỏi hơn và chịu trách nhiệm nếu có điều gì sai sót.

Dân chung cho chúng tôi biết là họ có tư trở giúp của gia đình nhưng thông thường người nhà không thể thông dịch giỏi được.

Để cho con trai hoặc con gái tôi làm thông dịch viên là điều không ngẫu ngứng. Con tôi nói ‘Mẹ, Me không nên nói những điều riêng tư này với bác sĩ’. Do đó, tôi cảm thấy ngẫu ngứng. Tôi cảm thấy bức bối. Tôi nói với con tôi rằng tôi muốn nó thông dịch nhưng gi tôi nói nhưng chúng không chịu rằng tôi. Vì vậy tôi thích sử dụng thông dịch viên chuyên nghiệp hơn.

Dân chúng nói là các dịch vụ y tế không có đủ thông dịch viên, nhất là các dịch vụ khẩn cấp, dịch vụ chuyên khoa và tại các khu bệnh nhân trong bệnh viện.

Tại khoa cấp cứu không có thông dịch viên. Chúng tôi sẽ cảm thấy tự tin hơn nếu có thông dịch viên. Cho dù khoa cấp cứu biết bệnh nhân dạng trên đường đi đến hô ván không chịu sắp xếp thông dịch viên.

Dân chúng nói là thông dịch viên có lúc không dịch chính xác hoặc tự nhiên và điều này có nghĩa là chất lượng của việc chăm sóc sức khỏe của dân thân và gia đình thường thường không có chất lượng cao.

Tôi biết một thông dịch viên này, khi chúng tôi muốn bác sĩ giải thích điều gì hoặc muốn nói thêm, ông ta nói ‘tôi không dịch phần này’.

Đàn chúng nói điều quan trọng là họ được sử dụng thông dịch viên nói đúng phương ngữ của họ.

Đàn chúng nói họ cần biết thêm chi tiết về nơi nào có thông dịch viên và thời gian nào, cách để được sử dụng thông dịch viên và cách thức nếu khiếu nại nếu không được cung cấp thông dịch viên.
Chúng tôi phải có thể nếu nhiều người mới thông dịch viên có phong cách không tốt - chúng tôi không biết họ làm cho công ty nào, do đó, không biết phải nếu nhiều người với ai.

Quan điểm của dân chúng về cách có thể cải thiện dịch vụ thông dịch trong khung cảnh y tế

- Tăng nhận số thông dịch viên (nhaft là thông dịch viên ‘nội bộ’)
- Tăng nhận số thông dịch viên nói tiếng Dinka, Bari, Nuer và Cholok (Nam Sudan); và Kildanean (Irák)
- Bảo đảm có đủ thông dịch viên nam và nữ để người sử dụng có thể được sử dụng thông dịch viên nào họ cảm thấy thoải mái
- Cung cấp dịch vụ thông dịch cho khoa cấp cứu và các dịch vụ chuyên khoa
- Cung cấp thêm dịch vụ thông dịch tại các phòng mạch bác sĩ toàn khoa và dịch vụ nội trú bệnh viện
- Giảm bỏ thời gian chờ đợi liên quan đến thông dịch viên
- Bảo đảm thông dịch viên được huấn luyện về kỹ thuật thông dịch y tế nếu họ làm việc trong khung cảnh y tế
- Điều hợp tốt hơn giữa dịch vụ y tế và thông dịch viên
- Bảo đảm các dịch vụ y tế luôn luôn hài lòng người sử dụng về nhu cầu ngôn ngữ (Hơ có cần thông dịch viên không? Nếu cần, ngôn ngữ nào, phương ngữ nào, phải tính nào?)
- Tắt cờ các dịch vụ y tế nên có hệ thống ghi nhận nhu cầu ngôn ngữ của người sử dụng trên hồ sơ của họ cho những lần hẹn trong tương lai
- Bảo đảm người sử dụng có cách thức để động góp ý kiến hoặc than phiền về dịch vụ thông dịch trong khung cảnh y tế
- Tổ chức chương trình giáo dục cho các công dân để cung cấp thông tin về quyền hạn và quyền lợi, cách yêu cầu được sử dụng thông dịch viên và cách nếu thiếu nhân
- Cập nhật bổ sung và tích cực tuyên thông dịch viên từ các công dân
Đề nghị

Chính phủ Tiểu bang Victoria:
1. Báo đảm sẽ tăng mức sử dụng và nhân số thông dịch viên chuyên nghiệp trong khung cảnh y tế.
2. Xem xét lý do việc sao khoa cấp cứu, dịch vụ chuyên khoa, bệnh nhân nằm viện và các dịch vụ toàn khoa không được sử dụng thông dịch viên đủ có sẵn.
3. Tìm cách thức tốt nhất để thành lập dịch vụ giúp người sử dụng các dịch vụ thông dịch nếu thiếuتسجيل khi họ thấy bất mãn về dịch vụ đó.
4. Tăng nhận số thông dịch viên (đặc biệt là nữ thông dịch viên) trong tất cả các ngôn ngữ, nhất là tiếng Dinka, Barie, Nuer và Cholok (Nam Sudan), Kildanean (Irâc), A râp Xuâng, A râp Irâc.
5. Phát triển một hệ thống để biết có bao nhiêu thông dịch viên được sử dụng tại khoa cấp cứu, dịch vụ chuyên khoa, phòng mạch bác sĩ toàn khoa và dịch vụ bệnh nhân nội trú.
6. Báo đảm các dịch vụ y tế chấp hành các điều lệ và chính sách về thông dịch viên, đặc biệt là việc không dùng người nova làm thông dịch viên.
7. Hợp tác với các dịch vụ thông dịch để bảo đảm các thông dịch viên làm việc với các dịch vụ y tế đều biết lesthi, chuyên nghiệp và am hiểu thuật ngữ y khoa.
8. Sắp xếp chương trình giáo dục cộng đồng để nâng cao kiến thức của công chúng về cách hồi xin thông dịch viên, nơi nào có thông dịch viên và quyền lợi được sử dụng thông dịch viên tại các dịch vụ y tế.

Các dịch vụ y tế và dịch vụ ngôn ngữ:
10. Báo đảm cung cấp thông dịch viên đúng ngôn ngữ và phải tình mơi lần cần thông dịch viên và thông dịch viên phải đi đúng giờ và không bị gian đoạn khi thông dịch.
11. Báo đảm nhân viên y tế được huấn luyện đúng mức để cải thiện cách thức giao tiếp với công chúng và báo đảm họ luôn luôn cung cấp thông dịch viên nếu cần.
12. Hỏi các công điệu về kinh nghiệm của họ về thông dịch viên trong khung cảnh y tế để biết cần phải cải thiện về phương diện nào.
13. Báo đảm thông dịch viên phải được huấn luyện đúng mức để họ thông dịch chính xác và biết thế thì.
التوصيات

أن تقوم حكومة ولاية فكتوريا بـ:

(1) التأكد من زيادة استخدام وتوفر مترجمين للشفه على المهن في المجالات الصحية.
(2) النظر في أسباب عدم استخدام الترجميين الشفه في أقسام الطوارئ والخدمات المختصة، ومع المرضى المقيمين والأطباء العامين حتى عندما يكونون متوافرين.
(3) البحث عن أفضل طريقة لإنشاء خدمة تساعد المشاركين الذين يستخدمون الترجميين الشفهيين لتقديم شكاوى عندما لا يكونون راضين عن الخدمة.
(4) زيادة عدد الترجميين الشفهيين (السما المترجمة) في جميع اللغات ولكن بشكل خاص في الدنكا والباري والنوب والشلكو (جنوب السودان) والكلدانية (العراق) واللغات العربية السودانية واللغة العرقية.
(5) تطوير نظام يظهر عدد الترجميين الشفهيين الذين يتم استخدامهم في أقسام الطوارئ والخدمات المختصة والطب العام والمرضى المقيمين.
(6) التأكد من التزام الخدمات الصحية بالقواعد والسياسات الإجرائية المتعلقة بالمترجمين الشفهيين، لاسيما بالنسبة إلى استخدام أفراد العائلة كمترجمين شفهيين.
(7) العمل مع خدمات الترجمة الشفهية للتأكد من أن المترجمين الشفهيين المعين في الخدمات الصحية هم حساسون ومحترفون وفهمون المصطلحات الطبية.
(8) الترتيب لتوظيف إجبارية لتحسين معرفة الناس بكيفية طلب مترجم شفهي ومكان توافر الترجميين الشفهيين وحقوق الناس في الحصول على مترجم شفهي في الخدمات الصحية.

آن تقوم الخدمات الصحية وخدمات اللغات بـ:

(9) اطلاع الناس على ما يستطيعون القيام به لرفع شكاوى إذا لم يكونوا راضين عن الخدمة.
(10) التأكد من تأمين الترجمين الشفه في اللغة والجنس الصحيحين في كل مرة يحتاج المرء إلى مترجم وكذلك التأكد من إجراء الواجبات في حينها وعدم مقاطعة سيرها.
(11) التأكد من أن عمل الصحة لديها مدربي تدريبا لإقناع الترجمين الشفهين في الصيغ التي يتواصلون بها مع الناس والتأكد من أنهم يوافقون دائما متراجما شفهيا عند الحاجة.
(12) الاستفسار من الجهات عن تجاربها مع الترجمين الشفهيين في الخدمات الصحية بحيث يعرفون أن تدعم الحاجة إلى التحسينات.
(13) التأكد من أن الترجمين الشفهيين مدربين تدريبا لافتا بحيث يكونون دقيقين.
نحتاج إلى القدرة على الشكوى إذا كان سلوك المترجم سيئاً - لا نعرف الشركة التي توظف المترجمين وهكذا لا نستطيع الشكوى.

آراء المشاركين حول كيفية تحسين خدمات الترجمة الشفهية في الأوضاع الصحية

- زيادة عدد المترجمين (لاسيما المترجمون المقيمين)
- زيادة عدد المترجمين الذين يتحدثون الدنوكا والبالي والتوير والشلوك (جنوب السودان)/ والكلدانية (العراق)
- التأكد من وجود عدد كاف من المترجمين الذكور وإناث بحيث يتثنى لأصحاب الحاجة استخدامهم على راحتهم
- توفير مزيد من خدمات الترجمة الشفهية في أقسام الطوارئ والخدمات المتخصصة
- توفير مزيد من خدمات الترجمة الشفهية في عيادات الطبيب العام وفي خدمات المرضى المقيمين في المستشفيات
- خفض فترات الانتظار المتعلقة بالترجمة الشفهية
- التأكد من أن المترجمين الشهفيين مدربون في الترجمة الصحية إذا كانوا يعملون في المجال الصحي
- تبسيط أفضل لخدمات الصحة والتراجم الشفهية
- التأكد من قيام الخدمات الصحية دائماً بالسواحل عن الاحتياجات اللغة للشخص المعني (هل يحتاج إلى مترجم شفهي؟ إذا كان الأمر كذلك، فأي لغة وأي لهجة؟)
- وجوب تبني الخدمات الصحية لنظام يبرز الاحتياجات اللغوية للشخص المعني في ملقى بهدف الحجوزات المستقبلية
- التأكد من وجود طريقة يستطيع فيها الشخص المعني الإدلاء بتعليقاته أو الشكوى عن خدمات الترجمة الشفهية في المجال الصحي
- توفير التوعية الاجتماعية للجالسات بما يؤمن المعلومات حول الحقوق والمستحقات وكيفية الترتيب لترجم شفهي وكيفية التقدم بشكوى
- توفير المنح الدراسية والتوظيف الناشط للمترجمين الشفهيين من صنف الجاليات
في ذلك الوقت، كانت هناك ثلاثة أشهر للحصول على مترجم شفهي من قبل مكتب استقبال الطبيب الاحترافي. ولم استطع الاستماع لفترة هذه الائتمان لأنني كنت أكتب، في زيارة الثانية صممت عندما اختتني إلى غرفة الجراحة للاستماع لفترة. لم يعرف ماذا كان يجري، وكانت أغلب الأحيان مارجة. قالت لهما في البداية أنني ليس مترجمًا ولم ينتبه إلى هذه المعلومات. لذا كانت تخرج مفيدة جدا بالنسبة لي.

قال معظم الذين شاركوا أنهم يفضلون استخدام مترجم شفهي محترف ولكنهم غالباً ما كانوا يختارون استخدام أحد أفراد العائلة ليترجم لهم أو يتوارون أمرهم بأنفسهم لأنهم لم يستطعوا الانتظار طويلًا جدا، ولم يتوفر لهم مترجم أو لم يرتاحوا لطلب مترجم أو كانوا خائفين أن يكونون أثناء إجبارهم ألا يأتوا أو لا يكونون جيدًا.

طلب مني أن أترجم لحي عندما يذهب إلى الطبيب، أنا، ليس لدينا ثم يكون ضرر لذلك لأنني على أن أظهر احترامي له. من الأفضل إذا قام مترجم بذلك لأنه يفعل ذلك بشكل أفضل، ويتحمل المسؤولية إذا ارتكب خطأ.

أكد أن المشاركين قد تكون مؤزرة عائلاتهم وتمكن عائلاتهم غالبًا ما تكون غير قادرة على الترجمة بشكل مهني.

ومن المعروف أنني أو ابني أن أترجم، لأقدم يقولون يا ماذا! لا ينبغي عليك أن تقولي هذه الأشياء للطبيب. فأشياء بالحريج، وأشياء بالإحباط. أقول لأولادي أريدهم أن يترجموا ما أقوله ولكنهم يرفضون، لهذا أفضل مترجم محترف.

راجح المشاركون إنه لا يوجد متورجون بالقدر الكافي في الخدمات الصحية، لذلك في خدمات الطوارئ، والخدمات المتخصصة، وفي أجهزة المستشفيات.

لا يوجد متورجون في الخدمات الصحية، نحن أكثر ثقة إذا كان المترجمين متواشين، حتى لو كان قسم الطوارئ يعرف أننا قادم فإنه لا يعرف أي مترجم.

أشار المشاركون أن المترجم لا يكون دائماً ضيفًا جددًا أو حساسًا وهذا يعني أن نوعية رعايتهم الصحية والرعاية الصحية لعائلاتهم غالبًا ما تكون غير جيدة جدا.

أعرف مترجم واحداً بالتحديد عندما تحاول الحصول على تفسير من الطبيب أو إضافة شيء يقول: لن أترجم هذا الجزء.

أعرب المشاركون بالقول إنه من الأهمية مكن أن يتوفر لهم متورج يتحدث لهجته بدقة.

قال المشاركون إنهم بحاجة إلى مزيد من المعلومات حول متى يتوفر المتورجون وكيف يصلون إليها وكيف يرفعون شكوى إذا لم يتم توفير متورج لهم.
خلاصة نتائج المشروع

نظم مركز الصحة وتعدد الثقافات (CEH) مشروع بحث في أكتوبر / تشرين الأول 2005 في المتاحف الأولى. وقد تحدثنا إلى ستة وثمانين شخصًا من الجاليات الفينيقيانية والإيطالية والعراقية ومن جنوب السودان في مليون. وقد ساعدتنا الأراء والأفكار والتجارب التي شاركنا فيها هؤلاء الناس في تحديد:

- كيفية إمكانية تحسن خدمات الترجمة الثقافية في الأوضاع الصحية
- كيفية تأثر الرعاية الصحية التي تلتها جاليات المهجرين عندما لا يتم توفير الترجمين الشفهيين

يشرح هذا التقرير المعنى للخدمات الطبية في النظام الصحي بولاية فكتوريا. أثرت المستعدين المتتوريين معًا وقاعدة مبادئًا مع الجاليات الفينيقيانية والإيطالية والعراقية وجنوب السودانية، والتوصيات التي نوصي بها مركز الصحة وتعدد الثقافات لتحسن نوعية الخدمات. وفقًا لموجز الأمور التي أخبرنا المسجلون في البحث بها حول المترجمين الشفهيين في مجال الصحة. وقد أخذنا على ذلك بعض الكلام المثير مباشرة.

تجارب المشاركين في البحث مع المترجمين الشفهيين في الخدمات الصحية

قال المشاركين إن المترجمين الشفهيين مهمون جدًا عند القيام بزيارة طبية صحية. وأضاف المشاركون إن المترجمين الشفهيين يمكنهم من طرح الأسئلة وإعطاء المعلومات، وفهم ما يقوله أخصائي الطبيعة، لاسيما بالنسبة إلى المصلحات الطبية.

عندما ذهبنا إلى الطبيب لأول مرة كان معي مترجم شفهي ولكن الطبيب قال لي إنه لا يحتاج إليه. ولكننا أفضل أن يكون معي مترجم لأني لا أستطيع أن أفهم المصلحات الطبية.

وأكد المشاركون إن استخدام المترجمين الشفهيين هو أفضل طريقة للتواصل بين أخصائي الصحة والشخص المعني وهو أفضل شيء لرعايتهم الصحية.

عندما أتحدث إلى الطبيب من خلال مترجم شفهي أشعر بالراحة أكثر، ودرجة أقل من التوتر، خصوصًا وأنا في بلد جديد. ومن ثم تحدثنا إلى أنجح واحدًا بأن المترجم يحتفظ بالأسرار التي أصح عليها وأشعر بالراحة عندما استطيع الإفصاح عن أني يجلد في نفسي. وفي تفاوتنا مثل يقول إذا كان الشخص سعيدًا نشأ في هذا هو نصف الطبيعة وأعدنا التواصل عبر المترجم نشعر بقلق أقل. فإننا نشاط المترجمين. وهذا يحسن نفسنا وبدون المترجم الشفهي لا نستطيع التواصل مع الطبيب ونشعر بتوتر أكبر.

قال المشاركون إن المترجمين الشفهيين مهمون بشكل خاص عند زيارة أخصائي الصحة بشأن مشكلة صحية حساسة (مثل مشكلة الصحة الجنسية) أو بشأن حالة خطيرة جدا.

وأدى المشاركون في العديد من التجارب المتعلقة بوقت الحصول على مترجم شفهي، وغالبًا ما كانت هذه التجارب مخفية أو مبهرة أو أسست عن رعاية صحية رديئة نوعية.
Other resources available from the Centre for Culture Ethnicity & Health include:

**Reports**
- Language Services: Good Practice in the Victorian Health and Community Sector
- Consumer Participation and Culturally and Linguistically Diverse Communities

**Resources**
- Assessing the Need for an Interpreter
- Bilingual Staff Roles and Organisational Supports
- Communicating with Clients with Low English Proficiency
- Culturally Inclusive Health Assessment
- Recruiting Bilingual Staff
- Reviewing Existing Translated Materials - Checklist
- Translating Health Promotion Materials into Community Languages
- A Practical Guide to CALD Consumer Participation
- Making Focus Groups Culturally and Linguistically Appropriate

To access electronic copies of any of these resources, please visit [www.ceh.org.au/resources/resbyceh.html](http://www.ceh.org.au/resources/resbyceh.html)

**Training Workshops**

We also offer organisational training workshops in the following areas:
- Consumer Participation and Culturally and Linguistically Diverse Communities
- Cross Cultural Communication
- Culturally Inclusive Health Promotion
- Inclusive Health Assessment
- Palliative Care and Cultural Diversity
- Valuing Cultural Diversity

For further information on our training program, including our annual calendar of training, please visit [www.ceh.org.au/education](http://www.ceh.org.au/education)