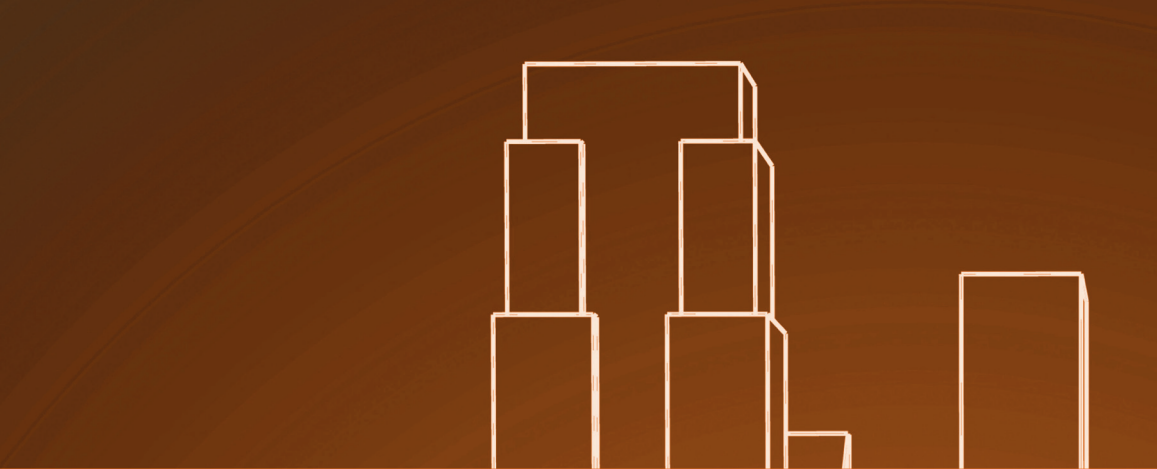




*Routledge Studies in Empirical Translation and Multilingual
Communication*

MULTICULTURAL HEALTH TRANSLATION, INTERPRETING AND COMMUNICATION

Edited by

Meng Ji, Mustapha Taibi and Ineke H.M. Crezee



Multicultural Health Translation, Interpreting and Communication

Multicultural Health Translation, Interpreting and Communication presents the latest research in health translation resource development and evaluation, community and professional health interpreting, and the communication of health risks to multicultural populations. Covering a variety of research topics in empirical health translation and interpreting, this advanced resource will be helpful for research students and academics of translation and interpreting studies who have an interest in health issues, particularly in multicultural and multilingual societies. This edited volume brings in interdisciplinary expertise from areas such as translation studies, community interpreting, health communication and education, nursing, medical anthropology and psychology, and will be of interest to healthcare professionals, language services in multilingual societies and researchers interested in communication between healthcare providers and users.

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**Edited by
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and Ineke H.M. Crezee**

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Preface

Meng Ji, Mustapha Taibi and Ineke Crezee

Multicultural Health Translation, Interpreting and Communication is one of the few books which integrate the latest research in (written) health translation and (spoken) health interpreting services in different geographical regions including the Asia-Pacific, North America, the Middle East and the EU, in response to the growing social demands for quality health services among multicultural migrant populations or the general public in these regions. This book is divided into three parts. Part I provides an overview of the growing health translation and interpreting fields as an integral part of national healthcare systems, especially in developed economies such as the USA, the EU, Canada, Australia and New Zealand, where we see strong and growing demands for quality and patient-oriented health translation and interpreting services. Part II offers three case studies illustrating the development of linguistically accessible and culturally effective health translation resources in Australia, New Zealand and the Middle East. Part III offers three representative case studies of health interpreting services for patients with special needs, i.e. sign language interpreters and mental health interpreters in the USA, Australia and the EU. Discussions throughout the volume point to similar directions in current health translation and interpreting research; that is, in order to develop, provide and monitor quality healthcare services for multicultural migrant and local populations, as well as patients with special needs, it is essential to identify, understand, prioritise and develop strategies to serve the practical needs of the targeted multicultural populations. The underlying argument and central claim of our collective effort in this volume is that there is a pressing need to move away from the traditionally prescriptive and instructional approach to health translation and interpreting toward the development of more culturally-effective and patient-centred health service models. Various innovative strategies and approaches to health translation and interpreting have been suggested and explicated in the chapters of the book. Allison Squires explores qualitative and quantitative models to gauge and assess the effects of medical translators and interpreters on the treatment outcomes. The quantitative approach was facilitated and enabled through the availability and increasing use of Electronic Health Records (EHRs). Shanshan Lin and Meng Ji illustrate the development of a

formalised framework for the integrated assessment of multicultural health translations. The patient-oriented and culturally-appropriate (POCA) health translation model they propose aims to fill in a persistent and costly gap in current health education and the prevention of chronic, life-style related diseases such as diabetes and cancers, the leading health risk and health burden in the country. Wei Teng explores new functional equivalence health translation models which reveal the subtlety, complexity and inter-personal efficacy of health translation and interpreting services. In a similar vein, Hala Sharkas explores the issue of health translation readability and accessibility by comparing distinct approaches to Arabic translation of patient information leaflets, and argues for the needs to develop new health translation models that accurately and effectively reflect the language and health literacy levels of the patients, as well as the cultural backgrounds of the intended users of the health translation resources.

Compared with health translation, the oral practice of health interpreting requires higher-level inter-personal interaction and a shared understanding of the role of health interpreters among the various parties involved in health interpreting services including healthcare providers, medical/health professionals, patients and institutional organisations. The three chapters in Part III provide empirical studies and/or high-level discussions around policy development in the growing research fields and service areas of health interpreting, especially sign language interpreting and mental health interpreting. These chapters concur in that health interpreting as an area of research and social practice faces important challenges, as well as providing opportunities to enhance the social visibility and role definition of health interpreters, their working relationships with patients and other stakeholders, and the impact of remote health interpreting technologies on inter-personal trust and quality control issues in health interpreting for patients with special needs.

This volume provides an easy-to-access and updated reading for students and academics working in the growing research field of health translation and interpreting. As the editors of this book, we hope it will provide a much-needed platform for the cross-fertilisation of ideas and research methodologies among health translators and interpreters, as well as the multiple stakeholders and multicultural healthcare providers who are concerned with the wide accessibility and cultural effectiveness of health translation and interpreting resources and services crucial to the sustainability of our modern healthcare systems in a large part of the world.

Part I

Health translating and interpreting in national healthcare systems



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1 Cross-cultural and cross-linguistic access to the healthcare system

Case studies from Seattle and Auckland

Ineke Crezee and Mele Tupou Gordon

1.1 Introduction and background

Aotearoa-New Zealand is a country in the southwestern Pacific Ocean which was originally settled by Polynesian migrants. New Zealand, like many other countries around the world, has experienced a significant influx of Non-English Speaking Background (NESB) settlers since the 1950s when the first significant numbers of Dutch migrants arrived looking for a new life. The Dutch settlers, who shifted to the use of English relatively quickly (Crezee, 2008, 2012), were followed by Polynesian-speaking migrants from Pacific nations such as Samoa and Tonga (Wong Soon, 2016; Wilson, 2017) who came to New Zealand looking for work and to give their children a brighter future. Immigrants from South East Asia followed in the 1990s. The 21st century has seen an influx of migrants from Mainland China and from the Indian subcontinent.

Today, New Zealand has a usually resident population of 4,242,048, according to the 2013 census (Statistics New Zealand, 2013). Auckland is its largest and most ethnically diverse city, with a population of approximately 1.42 million in 2013 (Statistics New Zealand, 2013). The official languages of New Zealand are English, Māori and New Zealand Sign Language. Mandarin, Cantonese, Samoan, Tongan and Korean are among the ten most in demand languages for interpreting services (Department of Internal Affairs, 2013). The fact that speakers of these languages often need language access assistance suggests that they may not have easy access to information about a health system which may be very different from that in their countries of origin, or to information about common health conditions.

In New Zealand, Pacific migrants are overrepresented in health statistics relating to both child and adult obesity, and in those relating to non-communicable diseases such as Type 2 Diabetes, hypertension and cardiovascular diseases (Ministry of Health, 2012, 2015). Studies have shown that health outcomes are affected by a wide range of non-clinical factors including cultural and linguistic barriers, lack of understanding of the healthcare system, general educational background and low levels of health literacy. Pacific people, and people living in more deprived areas, continue to be

among those with poorer health outcomes and more unmet needs for health-care (Ministry of Health, 2012, 2015). Adults in the most deprived areas also have “higher rates of most health risks including smoking, hazardous drinking, not eating at least the recommended servings of vegetables and fruit daily, physical inactivity and obesity” (Ministry of Health, 2015, key findings). Pacific people tend to live in the most deprived areas, and anecdotal evidence suggests that they may not attend appointments due to lack of transport and would benefit from more flexible and accessible options for accessing care. Failure to access care in a timely manner may lead to significant health issues later. Similarly, these patients may tell non-Pacific health providers what they think they want to hear – rather than what is actually going on – due to feelings of embarrassment (Tupou Gordon, pers. comm., 2018). This practice can lead to further problems later on if conditions remain untreated.

The New Zealand Ministry of Health (2006) also identified several health risks specific to the Asian population, including high rates of cardiovascular disease and diabetes, and a high risk of stroke amongst Chinese (Ministry of Health, 2006). Wong (2015, p. 3) suggests that “[s]tigmatisation, language barriers, lack of cultural competency and education in the New Zealand health system may all have contributed to this”. Wong (2015, p. 3) also points out that “the Asian ethnic group as a whole has lower rates of access to health services and healthcare utilisation, particularly the Chinese”. Such lower rates of healthcare utilisation include enrolment in primary health organisations (for primary healthcare), preventive screening services, disability support services, mental health services and access to residential care for the elderly (Jatrana & Crampton, 2009; Mehta, 2012; Wong, 2015). Women originating from the Indian subcontinent have higher rates of hypertension in pregnancy, while older Indian migrants are also more likely than the general population to suffer from high blood pressure.

Table 1.1 shows the ethnic breakdown of the Auckland population as per the 2013 census. Anecdotal evidence suggests a significant increase in the Asian population of Auckland between 2013 and 2018, although statistics from the 2018 census were not available to the authors at the time of writing.

Table 1.1 Ethnic breakdown of the usually resident Auckland population as per the 2013 census

<i>Percentage</i>	<i>Identifying as</i>
59.3	New Zealand European
14.6	Pacific Islander
23.1	Asian
10.7	Māori
1.9	Middle Easter/Latin American/African
1.2	Other
8	“New Zealander”

In 2013, 11.8% of the population in New Zealand identified themselves as of Asian ethnicity – a 33% increase since 2006. Statistics New Zealand (2013) projects this to further increase by 3.4% every year for the next decade. Notably, the majority of the New Zealand Asian population (65.1%) resides in the Auckland region (Statistics New Zealand, 2013).

In recent years a significant number of older follower migrants (Tang, 2017) have entered New Zealand under the Family Reunion policy.

The Statistics New Zealand definition of “Asian” includes people with origins in the Asian continent from Afghanistan in the west to Japan in the east, and from Mongolia south to Indonesia (Ministry of Health, 2006; Rasanathan, Ameratunga, & Tse, 2006). This definition encompasses East, South and South East Asian ethnicities, excluding people from the Middle East, Russia and Central Asia (Rasanathan, Craig, & Perkins, 2004).

1.2 The problem

In both Auckland and Seattle, the problem consists in new immigrants experiencing barriers to accessing the healthcare system, which could include but is by no means limited to barriers of a social, linguistic or cultural nature. In Seattle, Seattle Children’s Hospital is a highly specialised paediatric facility, with 15% of its patients coming from Limited English Proficient (LEP) families in 2013. Hospital figures for these patients showed higher than average no-show rates at appointments, higher levels of in-hospital stay and higher levels of readmission to the hospital. In addition, the hospital itself is large and difficult to navigate. The hospital offers on-site, telephone and video interpreting, with colour and themed nomenclature (Ocean, Forest, River, Mountain) to help families find their way through the hospital, but it appeared that LEP families were still experiencing barriers to do with a lack of transport, lack of (adequate) housing, lack of knowledge about their children’s condition and prescribed treatment and a lack of trust in healthcare providers.

In New Zealand, the problem was initially seen as one involving lack of language access and lack of informed consent. The “unfortunate experiment” (Coney & Bunkle, 1987) which saw a number of women unknowingly participate in a large cervical cancer experiment, without being informed that the theory behind the experiment was untested, led to a government inquiry led by Judge Sylvia Cartwright. The Cartwright inquiry recommended the use of trained healthcare interpreters and the widespread implementation of Informed Consent (Cartwright, 1988). The right to effective communication was enshrined in the New Zealand Health and Disability Act (Health and Disability Commissioner, 1996).

The three Auckland-based District Health Boards all established interpreting and translation services between 1991 and 2000 (Crezee, 2009). A special healthcare interpreter training course was first provided in 1990 by what was then the Auckland Institute of Technology (Crezee, 2009). Over the years, the

availability of trained healthcare interpreters in all community languages has remained patchy, with many spoken language interpreters choosing not to have specialised healthcare interpreter training but instead starting work in health (and legal) settings following a three month general “liaison” interpreting course.

In 2017, the New Zealand Ministry of Business, Innovation and Employment (MBIE) set out to develop language assistance policy and guidelines, with the input of a “whole-of-government” project steering group (Ministry of Business, Innovation and Employment, 2017). MBIE commissioned a national market assessment of the language assistance services market in New Zealand, with the aim of identifying a preferred model for delivering language assistance services across government departments. A set of standards was identified, based on that developed by the Australian National Accreditation Authority for Translators and Interpreters (NAATI), and vetted by New Zealand stakeholders, including the national body for translators and interpreters (NZSTI), agencies providing translation and interpreting services and service coordinators (Ministry of Business, Innovation and Employment, 2016; Immigration New Zealand, 2018).

This chapter will look at the current provision of services established to address health inequalities identified among Pacific and Asian patient populations in Auckland, with a specific focus on initiatives aimed to improve the utilisation of health services by the Asian population, and those aimed at improving health literacy and health outcomes among the Pacific population. Data was obtained by way of interviews with stakeholders in Auckland, New Zealand, and interviews with stakeholders and a Focus Discussion Group at Seattle Children’s Hospital (SCH) in Seattle, Washington. Services discussed in Seattle include the provision of bilingual navigators and health interpreters at SCH. Auckland services will include health interpreting services and outreach by health interpreters in the South Auckland area, Asian Health Services in the Northern and Western parts of Auckland, and health interpreting services in Central Auckland. Specific attention will be paid to work by Tongan health professionals working with (older) Tongan speakers across Auckland. The literature review section will look at language assistance services, including those provided by health interpreters and bilingual patient navigators and bilingual healthcare providers.

1.3 Literature review

Language access

The right to a competent interpreter has been enshrined in Right 5 of the 1996 New Zealand Health and Disability Commissioner Act which reads: “Every consumer has the right to effective communication in a form, language and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter” (Health and Disability Commissioner, 1996).

Countries have sought to monitor the quality of interpretation; for example, Australia instituted a National Accreditation Authority for Translators and Interpreters (NAATI, 2018), which now also provides specialist accreditation for those wishing to work in medical or legal settings (reference), and the US has certification programs for healthcare and legal interpreters at the national and state level.

Qualified healthcare interpreters facilitate communication between health professionals and health consumers whose “preferred language of medical care” is not the dominant language of the recipient society. The benefits of professional medical interpreters have been clearly demonstrated over the past three decades (Jacobs, Shepard, Suaya & Stone, 2004; Karliner, Jacobs, Chen & Mutha, 2007; Tsuruta, Karim, Sawada & Mori, 2013; VanderWielen et al., 2014; Hsieh, 2015; Villalobos et al., 2016).

Patient navigators

Over the past few decades, there has been an increasing recognition that language may not be the only barrier affecting health outcomes. Divergent levels of health literacy have been linked to non-compliance with prescribed treatment, a limited awareness of potentially life-threatening symptoms and the inability to know when to seek medical help or follow-up treatment. Other barriers include poverty, lack of internet access (Atkinson, Salmond & Crampton, 2013) and lack of transport. In 1990, Dr. Freeman initiated one of the first patient navigator programmes in the United States to help overcome barriers to cancer screening (Freeman, 1990). Currently patient navigator services are utilised across an ever-widening range of healthcare settings, and bilingual navigator programs have been set up not only to lower cultural and linguistic barriers to healthcare access but also to enhance health literacy in non-English speaking patient populations (Freeman, 2006, 2012; Freeman & Rodriguez, 2011; Meade et al., 2014; Genoff et al., 2016; Wells, Valverde, Risendal, Esparza, Ustjanauskas, & Calhoun, 2016). Charlot and colleagues (2015) concluded that minority women may benefit from having patient navigators of the same race and ethnicity and speaking the same language.

Bilingual navigators

Freeman and Rodriguez (2011, pp. 3539–42) define the principles of patient navigation as follows (emphasis added):

- 1 Navigation is a *patient-centric* health care service delivery model.
- 2 Patient navigation serves to virtually integrate a fragmented healthcare system for the individual patient.
- 3 The core function of patient navigation is the *elimination of barriers to timely care* across all segments of the healthcare continuum.

- 4 Patient navigation should be defined with *a clear scope of practice that distinguishes the role and responsibilities of the navigator from that of other providers.*
- 5 Delivery of patient navigation services *should be cost-effective* and commensurate with the training and skills necessary to navigate an individual through a particular phase of the care continuum.
- 6 The determination of who should navigate should be determined by the level of skills required at a given phase of navigation.
- 7 In a given system of care there is the need to *define the point at which navigation ends.*
- 8 There is a need to navigate patient across disconnected systems of care, such as primary care sites and tertiary care sites.
- 9 Patient Navigation systems *require coordination.*

Language-concordant services

Green, Ngo-Metzger, Massagli, Phillips and Iezzoni (2005) concluded that LEP patients were less satisfied with their care than other patients and that both interpreter-mediated interactions or interactions with language-concordant clinicians might be able to address such problems.

Cooper and Powe recommend that “health care system administrators organize the delivery of services to optimize providers’ ability to establish rapport and continuity in their relationships with ethnic minority patients” (2004, pp. 16–17). This chapter will describe two initiatives which involve Tongan health professionals working to help community members gain a better understanding of health conditions and the potentially dire consequences of not attending to these in a timely fashion.

Jih and colleagues (2015) concluded that patient-physician language concordance alone might not lead to improved uptake of preventive care services, based on their analysis of a population representative sample of LEP Latino and Asian patients. However, Parker and colleagues (2017) observed significant improvements in the control of blood glucose levels among LEP Latino patients with diabetes who switched to language concordant healthcare providers.

It is important to remember that language-concordant services may not be culture concordant. For instance, Spanish is spoken in Spain and in a wide range of different countries in South and Central America. In many cases Spanish will be the first language of the speakers, but in other cases it is the second language, Quecha or another native American language being a speaker’s actual first language. So while health providers may share a language with the patient, this does not mean that they share the same cultural, religious and health beliefs.

1.4 Method

Interviews were conducted in Seattle and Auckland in 2014 and 2017/2018 respectively, as well as a Focus Discussion Group with patient navigators at

Seattle Children's Hospital (SCH) in September 2014. Approval was obtained from the Ethics Committee at Auckland University of Technology and institutional review board approval was obtained from Seattle Children's Hospital.

In Seattle, interviews were held with patient navigators (PNs), the PN supervisor, the Director of the PN program, the hospital administrator, health interpreting service managers, and with providers (physicians and social workers) working with PNs. All interviewees were asked what they saw as the main difference between healthcare interpreter and navigator roles respectively.

In Auckland, interviews were held with managers of language- and culture-concordant services, health professionals providing care and advice in their own language and managers of interpreting services. The bilingual providers interviewed in Auckland were involved in the Tongan Health Society (Sosaieti Tonga Ki He Mo'uilelei), the Tongan Nurses Association and Asian Health Services.

Interviews were recorded and transcribed and a themed analysis was used to identify recurrent concerns.

In both Seattle and Auckland, interviews were conducted with staff involved in providing or coordinating bilingual healthcare provision, patient navigation and/or interpreting services. These will be described in some detail.

1.5 Findings

Health interpreting services

Auckland

New Zealand is divided into 20 District Health Boards (DHBs), each of which receives public funding from the New Zealand government to provide primary and secondary healthcare to the populations in their catchment areas. In New Zealand healthcare providers must comply with legislation which requires them to provide patients with a competent interpreter where practicable: Right 5 of the Code of Rights provided for in the (1996) Health and Disability Commissioner's Act, and Section 6 of the Mental Health Act, in relation to Compulsory Assessment and Treatment (Ministry of Health, 2018).

Since Auckland is New Zealand's largest and most ethnically diverse city (Statistics New Zealand, 2013), the three Auckland DHBs (Waitemata DHB, Auckland DHB and Counties Manukau DHB) look after the healthcare needs of very diverse populations.

In 1991, Counties Manukau DHB (then: South Auckland Health) was the first DHB to offer a healthcare interpreting service. Auckland DHB followed in 1998, and Waitemata DHB in 2000, offering both a translation and interpreting service (WATIS) and a special Asian Health Support Service (now Asian Health Services). All three DHBs provide health interpreting services, some over the phone, but mostly face-to-face. Counties Manukau DHB (CMDHB) also provides video remote interpreting services (Magill and De