

“If you don’t understand what I mean....”

Interpreting in health and social care

Ludwien Meeuwesen and Sione Twilt (Eds.)

**European TRICC Project
International Handbook of Good Practice**



Universiteit Utrecht



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International Handbook of Good Practice

**European TRICC Project “TRaining in Intercultural and bilingual
Competencies in health and social Care”
(partners DE, IT, NL, TR, UK)**

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Preface

This international good practice handbook is the result of a period of four years of intensive cooperation between partners in five European countries. These partners are from Germany, Italy, the Netherlands, Turkey, and the United Kingdom. We found each other through our common interest in health and social care and in our wish to contribute to the improvement of migrant health care in European countries.

We first had meetings in a Grundtvig II Learning partnership, called BiCom – Promoting bilingual and intercultural competencies in public health. These meetings took place between 2005 and 2007.

The BiCom project was carried forward in a Grundtvig Multilateral project TRICC: “*TRaining in Intercultural and bilingual Competencies in health and social Care*”, to which this handbook refers to. Over these two years (2008-2010) training courses for different target groups were developed and successfully conducted by an interdisciplinary and international team.

All the training programmes have made use of the innovative educational methods of Forum Theatre.

This international handbook contains a description of all training given in the five countries. In addition to this, each country has published their national handbook of good practice, in their native language.

To cooperate together for so many years and in such a rich learning environment as this European consortium was a great joy. With this text we wish to share with others our experiences and hope to inspire many readers by learning about the training. We also hope to contribute to the dissemination of the good practice training for improving health and social care for migrant groups all over Europe.

Ludwien Meeuwesen and Sione Twilt

Utrecht, January 2011

Chapter 1 Introduction

Ludwien Meenwesen

This international handbook of good practice is about interpreting in health and social care for migrants and linguistic minorities¹, and therefore primarily about bridging the linguistic gap between patient and health care provider. It is meant for health care providers, teachers and policy makers. The book aims to offer a comprehensive insight into the issue of interpreting from the perspectives of the migrant patient, the interpreter, and the health care provider. It also aims to offer solutions and to stimulate the discussion on the health and social policy level.

Therefore, training for different target groups was designed, implemented and evaluated. This book contains detailed descriptions of this training, which was meant to overcome language barriers in health and social care. As a result, good access to high quality health care for migrants might be realized.

This work is the result of a European project, within the framework of the Lifelong Learning Programme. Linguistic and cultural differences make access to health care more difficult for migrant groups compared to indigenous groups in countries all over Europe. This might result in poorer quality of health care. Until now, a lot of attention has been paid to cultural differences, but oddly enough very little attention has been given to the linguistic differences (*e.g.* Bhopal, 2007; Helman, 2001; Kleinman, 1980). A principal requirement for good communication is that one speaks and understands each other's language. If this is not the case, it is necessary to bridge this language barrier by an interpreter. Why is this problem mostly negated and to little attention given to? What is the background and why is this case? What are the language barriers, and how can they be recognized? And most importantly: how can these problems be solved? These are some of the issues which will be covered in this handbook.

1.1 TRICC project and aims

A couple of years ago, these issues gave rise to representatives of multilingual migrant groups of four European countries discussing these matters of mutual interest. All of us regarded it as important and relevant to seek attention for the increasing phenomenon of bi- and multilingualism in Europe and the issue of interpreting. In western European countries hundreds of different languages are spoken by people of all kinds of minority groups (Dalby, 1999; Eversley *et al.*, 2010a). Bilingualism or multilingualism will become an enduring phenomenon, which will change our western society definitively. All kinds of social institutions and health and social care need to anticipate on this.

We maintained a Grundtvig II partnership for a period of two years. This network enabled us to meet each other three times a year, to discuss issues of mutual interest, to make an inventory of the needs of the important people involved in the health care process, i.e. the patients, the ad hoc and/or (in)formal interpreters, mediators and health care professionals (nurses, physicians, paramedical professionals, social workers). All these activities resulted in the successful completion of this network by publishing a booklet (Baylav *et al.*, 2007; *see also* www.bicom-eu.net).

¹ Hereafter abbreviated to 'migrants' although some migrants exclusively speak the language of the country they live in and some linguistic minorities are not migrants.

The project was continued in the TRICC-project called TRICC“*TRaining in Intercultural and bilingual Competencies in health and social Care*” which started in 2008 (www.tricc-eu.net). physicians, social workers, nurses, linguists, interpreters and mediators from Germany, Italy, the Netherlands (coordinator), Turkey and the United Kingdom participated in this project. Table 1 contains the aims of the project.

Table 1.1 Aims of the TRICC project

- **Enhancing bilingual and intercultural competencies of migrants, health care providers and interpreters;**
- Development, implementation and evaluation of training courses;
- Implementation of courses for any European minority group.

The heart of the project was the development, provision and evaluation of courses which will contribute in enhancing intercultural and bilingual competencies. This might enable several parties in the health care process in coping with bilingual situations in health and social care. Each country had their own preference in choosing a specific target group. Together, all groups were served as migrant patients, ad hoc interpreters, mediators, (in)formal interpreters, students, family physicians and nurses. The choice for a specific target group was motivated by national and and/or local policies with regard to interpreting in health care, and by having the necessary local and/or regional contacts. It also reflected the preferences of the participating countries’ companies or institutional contexts and each other’s specific expertise (*see* Chapter 2). Lastly, it was motivated by each other’s views on interpreting or how the local/regional situation was defined in terms of these views.

1.2 How to read this book?

Each country has written a *national* handbook of good practice. These handbooks contain all the details of the training which has been conducted in the participating countries (Ani *et al.*, 2011; Meeuwesen *et al.*, 2011; Cesaroni *et al.*, 2010; Eversley, 2010b).

The present *international* handbook contains an overview of all the national projects of the five countries. Some are more detailed than others. For additional information, the national handbooks can be consulted.

Chapter 2 of the international handbook contains relevant information from the five countries with regard to migration patterns and numbers, about official policy and standards with regard to interpreting. It ends with giving general background information about the issue of interpreting in health and social care.

Chapter 3 presents a description of the institutional context of the five European partners involved, their specific expertise, and the projects they have conducted.

Chapter 4 deals with Forum theatre as an important and innovative educational method.

Chapters 5 through 9 contain detailed information of each countries’ training, how it was developed, conducted and evaluated.

Chapter 10 offers the main conclusions in terms of techniques used, results and European added value, dissemination and recommendations for social and health policy.

Chapter 2 Migration and interpreting policies

Ludwien Meenwesen with contributions of all partners

Because of extended and ongoing migration in Europe, as elsewhere, professionals in health and social care increasingly see patients who have another mother tongue than the host countries' language. As at 2010, there are millions and millions migrants in Europe, coming from countries all over the world. What are backgrounds of the migrants in Germany, Italy, the Netherlands, Turkey and the United Kingdom? How large is the group in need of an interpreter? What is the governmental policy of these countries with regard to interpreting in health and social care? What is known from literature on (in)formal interpreting, interpreter roles, and what are the views if it comes to approaching language barriers? These are the questions that are dealt with in this chapter.

2.1 Migration backgrounds

In *Germany*, 8% of the total population are foreigners, whereas 19% have a recent or less recent history of migration (Statistisches Bundesamt, 2008). Over one third (37%) of the latter (15 566 000) come from Turkey, the Balkan, the Russian Federation, Ukraine, Kazakhstan, South and Southeast Asia, and the Middle East. About one quarter (24%) come from EU member states including Poland, Italy, Romania and Greece. Another 15% come from Africa, the Americas, Asia, Australia and Oceania.

Especially since the Immigration Act (*Zuwanderungsgesetz*) came into effect in 2005, the German government has put a lot of effort into promoting the integration of persons with a migration background into German society. A strong emphasis is put on the German language as a vehicle to integration. However, this is a development of recent years: for decades immigrant workers were not encouraged let alone required to learn German because they were expected to return to their home countries. Therefore, many immigrants, especially the first group mentioned above (37%), only have, if at all, a basic command of German which does not suffice in communicating with health care providers. This affects their access to good health care negatively.

In *Italy*, the number of immigrants has reached 4.330.000 people, which corresponds to 6,7% of the total population. Immigrants from Romania constitute the largest community in Italy, with 800.000 present. Albania (440.000) and Morocco (400.000) follow.

In the *Netherlands*, 20% of people are first or second generation migrants (CBS, 2010). This is over 3 million citizens, about half from western and the other half from non-western countries. The largest non-western groups of immigrants come from Turkey, Morocco, Surinam & the Antilles, and China. Over half of the group of non-western immigrants do not have sufficient Dutch language proficiency to communicate effectively with a health care provider. One in three consultations of non-western migrant patients in general practice is characterized by poor communication and misunderstanding, which results in lower patient satisfaction (Harmsen *et al.*, 2008; Harmsen, 2003). As a result, these patients have poorer access to health care, leading to lower quality care, which might negatively affect health care outcomes for migrant patients (Bhopal, 2007; Stronks *et al.*, 2001).

By far the largest ethnic minority in *Turkey* are the Kurds, who are estimated as making up between 15 and 20% of the population. Taken together, other much smaller minorities such as Circassians, Georgians and Bosnians account for around 12% of the population (Milli Güvenlik Kurulu, 2008). This ethnic breakdown, however, tells us little about the number of citizens who have no or limited competence in the sole official language, Turkish, and thus potentially face difficulties communicating in medical, legal and other settings. It is estimated that around a third of the Kurds in the Kurdish heartland of Eastern and South-Eastern Anatolia have limited or no competence in Turkish (Gürsel *et al.*, 2009). Other minorities (which are all much smaller than the Kurdish minority) could be said to have been assimilated more thoroughly, so that very few of their members have difficulty communicating in Turkish and only a small proportion can actually speak their ancestral language.

Since the 1990s, there has been a considerable increase in migration to Turkey, with figures given for the number of foreigners living in Turkey ranging between 150,000 and 1 million (Kirişci, 2003). While some of these are European ex-patriates, including pensioners seeking a warm place to spend their retirement, there are also refugees (mostly from Iraq, Iran, Afghanistan and North-East Africa) and (legal and illegal) migrant workers, largely from Eastern Europe and former Soviet Republics. Since Turkey currently only grants asylum to refugees from Europe, due to a geographical limitation it placed on its ratification of the Geneva Convention on Refugees (1951), non-European refugees in Turkey are seen as 'passers-through', who are expected to lodge applications for refugee status to the UNHCR's offices in Turkey and, if these applications are accepted, to move on elsewhere such as the USA, Scandinavia or Australia. The application process can take quite a long time, during which asylum-seekers are expected to stay in the towns to which they are assigned, where they are pretty much left to fend for themselves. In fact, Turkey is likely to drop its geographical limitation as part of its acceptance of European Union norms in the drive to gain admission to the EU, but this has not yet occurred. Whatever happens, members of non-Turkish-speaking migrant communities face difficulties accessing public services. If Turkey drops its geographical limitation, this is liable to spur even more immigration, bringing with it a greater need for interpreting and mediation services.

In the *United Kingdom*, 3.6% of its inhabitants have been born in the EU and 7.8% born in the rest of the world. If we look to which language is spoken by school pupils, it turns out that 89% is known or believed to be English, and 11% is other than English. As table 2.1 shows, 8 % of the population is from a Black or ethnic minority group.

If countries are compared, it becomes clear that Germany and Turkey have the largest absolute numbers of people from minority groups (*see* Table 2.1). It also shows that the Netherlands have the highest proportions of all countries. The data of the five countries are not directly comparable with each other, because they are based on different indicators. The number of immigrants from minority groups lies between 7% and 31%, about a group of 51 million people. If we suppose that $\frac{3}{4}$ of them have good proficiency in the host countries' language (e.g. the younger ones, immigrants from western countries, immigrants with good language proficiency) and $\frac{1}{4}$ not, then we are talking about a group of over 12 million people for the five countries. (These proportions are based on calculations for the Netherlands (Harmsen *et al.*, 2005a). There is no reason to believe that these proportions are different for the other countries.) These are very large numbers indeed.

Table 2.1 Immigrant groups of the five European countries, and percentages

Country & inhabitants	Immigrant and minority groups		Total %
Germany 82 million	- Turkey, Balkan, Russian Federation, Ukraine, Kazakhstan, South and Southeast Asia, the Middle East: 7% - Africa, the Americas, Asia, Australia and Oceania: 2.7%	EU member states: 4.5%	No specification 4.8% 19%
Italy 56 million	Other continents, largest groups from Romania, Albania and Morocco, 3.1%	Europe: 3.6%	6.7%
Netherlands 16,5 million	Nonwestern immigrants 11%, mostly from Turkey, Morocco, Surinam, the Antilles, China	Immigrants from western countries, 9%	20%
Turkey 75 million	Immigrants/ refugees, mostly from Iran, Iraq, Afghanistan, North East Africa, East European & Central Asian migrant workers, Western businesspeople and pensioners, c. 1%	Indigenous minorities c. 30% ; Kurds c. 18% + smaller groups of Circassians, Georgians, Bosnians etc.	31%
United Kingdom 61 million	Black and minority ethnicity 8%	Ethnicity white 92%	8%

All these people are confronted with language barriers in health and social care (or other social institutions), a situation which is not desirable at all and asks for a solution.

2.2 Official policy and standards

European countries differ from each other on health and social care policies how to realize good access to health care. How important it is to have good policy for migrant health care is illustrated in the Climbié case (*see* Box 2.1)

Box 2.1 The Victoria Climbié case

The Ivorian girl Victoria Climbié emigrated at young age via France to England. As a young child she was severely abused by her relatives. Her case was known at many official institutions, but nobody took responsibility in due time.

In earlier stages in the health care process, people in charge failed to talk with her directly, and in her own language, which was French. Nobody of the professionals who took care of her talked with her, they only talked with some of her relatives or some social care providers, who did not know her own story.

When she was in hospital, again nobody talked with her, and while she spoke French, they failed to think about a professional interpreter. Actually she died very soon, while she was that severe ill and abused.

The case became a national scandal, which showed how child protection care, hospital care, police etc. failed to prevent her from being murdered (by severe physical and sexual abuse). Because of this case, there came many trials, and change of health care routines (more cooperation etc.) took place.

But one thing hasn't still changed yet: that is the right of Victoria (as many others) to have an interpreter, i.e. the right to be heard in her own mother tongue.

This case shows how things can go completely wrong. If there had been an interpreter available, this could have made the difference between dying and living. Every country knows about specific cases where things went very wrong, because of language barriers. An example often reported is that of a young woman, who is accompanied by a male family member, who does the interpreting, and forces her to have an abortion. Most

examples we know are not that extreme, but they all have in common that language barriers hamper good access to health care.

Language barriers can obviously be bridged by the use of interpreters in health care. In some countries, patients' rights for interpreter services have been formalised. However, in daily practice, formal interpreters are not or too infrequently involved by health care providers. Patients can be harmed unintentionally. Some of the health care providers realize these problems, but because of time constraints they do not succeed in organizing a proper solution. Others might think that this group of people should learn the host countries' language as soon as possible, and regard the language barrier in health care as the patient's problem. But in general, care providers mainly lack adequate knowledge and awareness about how the language barriers manifest themselves, to what problems this might lead and how to solve them. This brings us to the question of what the respective countries' policies and standards on interpreting are.

In *Germany* there is no official policy regarding interpreting services in health care. While courts and some administrations use the services of professional interpreters and follow certain policies/laws in this context (e.g. to interpret in court, the interpreter needs to be sworn in), hospitals and private practices only rarely solve their linguistic problems with patients with the help of professional interpreting services. The necessity of bilingual health advocates is not yet recognized. The vast majority of health care providers solve their linguistic problems spontaneously, with the help of ad hoc interpreters, i.e. bilingual staff members (with or without a health care background) or relatives of the patient. These persons solve the problems of communication by spontaneous interpreting and try to mediate between physicians and patients (*see* Meyer & Bischoff, 2008).

Currently policy makers and hospital administrations and many health care providers are not very conscious of – or not willing to acknowledge – the fact that language barriers between patients and health care providers have a negative effect on the quality of health care for persons with insufficient German language skills. In general, the use of family members – including children – as interpreters is accepted by all parties as the lesser of two evils. The use of bilingual staff members as ad hoc interpreters is taken for granted. Several initiatives and institutions (including dock Europe e.V.) are trying to relieve this situation by offering training for ad hoc interpreters. However, without structural changes regarding official policies for interpreting in health care, this only provides a band-aid solution without actually curing the disease.

Italian legislation² promotes the recourse to cultural mediators in the health and educational sector, to guarantee the migrant population the access to qualitative services. A decree also assigns to local bodies the regulation of interpreters/cultural mediators qualification, training and employment in the different services.

Marche Region Government implemented the national guidelines with a law³ aiming at the migrants' integration. Cultural mediators are identified as the professional figures suitable to meet the migrants' needs and to guarantee them equal opportunities of access to the services.

But despite of the intention of legislation and the efforts some associations are making to promote the cultural mediators, health structures and schools continue to prefer informal and occasional interpreters. Different factors are at the root of this situation, the lack of cultural sensitivity towards migrants' issues and the lack of financial resources to activate

² L.D. (Legislative Decree, national level) 286/1998 “Unique text on immigration and on the foreigners conditions”.

³ L.R. (Regional Law, territorial level) 13/2009.

professional interpreting services being among the most important ones. Training is another important aspect because there is no national regulation standardizing the competencies a cultural mediator should have.

If migrant patients in the *Netherlands* have poor language proficiency, they have the right to make use of a professional interpreter. Health care providers can make use of interpreter services for free. These services are provided by an 'Interpreter and Translator Service' (called *Tolk- en Vertaalcentrum Nederland*; www.tvcn.nl) and paid by the Ministry of Health, Social Welfare and Sport (VWS). These are good and adequate services, but most health care providers are not very familiar with it. Although accessibility and availability of professional interpreters is mostly good, in daily practice these services are used very little. General practitioners for example mainly make use of informal interpreters, mostly family members or acquaintances of the patient (Twilt *et al.*, 2011). Reasons for not arranging a professional interpreter are mostly organizational or practical. Also, many patients prefer an informal interpreter, because they trust them more and/or they take the role of caretaker. However, the quality of the translation of the conversation is not always as it should be. Broadly, it can be said that the official policy is different from the daily routine in health care practice. The Dutch health care inspectorate regards the use of a professional interpreter as standard (*When interpreting? Fieldnorms for the use of interpreters in health care*). The use of family members is discouraged. With regard to children it is said: "Never use children as interpreters, except for emergencies, because they should not be charged with these kinds of responsible tasks" (IGZ, 2006). However, the use of informal interpreters, children included (beside the use of professional interpreters or no interpreters) is daily practice in Dutch medical care. It seems better to face this situation, to investigate the reasons and the impact, to discuss the ethics and ambiguities, and to give family members who do the interpreting for their relatives the credit and recognition for fulfilling this public and responsible task. Children as interpreters are extra vulnerable, the great responsibility they feel on their shoulders may lead to the phenomenon of *parentification*, where there is a switch of parental and juvenile roles. This might lead to traumatic effects for these children. Health care providers need to be reluctant to admit children doing the interpreting work. With regard to adult informal interpreters, who are often preferred by patients, we need to face the pros and cons of the use of formal and informal interpreting.

The *Turkish* state has done very little to remedy the problem of inadequate or non-existent communication between health-workers and patients, a problem which exists above all in the largely Kurdish-speaking East and South-East of the country and which affects women much more than it does men. For many years, the state tried to ensure that communication in health settings, as in all others, took place in Turkish. Signs on the walls of clinics and hospitals instructed citizens to 'speak Turkish' and, at the peak of the armed conflict in the East between the Turkish army and the separatist PKK, health-workers were punished for nonetheless trying to communicate with their patients using Kurdish. This said, up until the 2000s, relatively few health workers were of Kurdish origin or knew Kurdish, so a large proportion of medical interactions inevitably involved the mediation of a third, more-or-less bilingual person. A survey conducted by the Turkish Medical Association in 1994 reported that more than half of the doctors interviewed felt the need for such a mediator; unfortunately, it also noted that most doctors who relied on these *ad hoc* interpreters were unable to communicate effectively with their patients. In a later survey, carried out in the Diyarbakır region between 2008 and 2009, half of the doctors claimed that they were able to communicate with patients because they knew the language spoken by the patient (likely to be Kurdish or Turkish),

while slightly less than half admitted that they were reliant on the assistance of a member of staff or companion. As our own survey (*see* Chapter 3) implemented in Diyarbakır and Van in the summer of 2009 testifies, *ad hoc* interpreters are still widely used in Eastern and South Eastern Anatolia, but neither patients nor the interpreters themselves are satisfied with the processes or outcomes of interpretation. All in all, recourse to untrained *ad hoc* interpreters is extremely common in Eastern Anatolian hospitals and clinics, although there is now much greater tolerance of the use of Kurdish as a common language between patients and health-workers. It may be assumed that the use of *ad hoc* interpreters is common in other public health encounters where the patient has limited proficiency in Turkish, especially if the patient does not speak a *lingua franca* such as English or German.

On paper, people with insufficient Turkish proficiency do have the right to some degree of interpretation. Article 18 of the 1998 Regulation on Patients' Rights states that 'Information should be supplied to the patient in a comprehensible manner, using an interpreter if necessary...' This regulation, which is actually the only piece of Turkish legislation addressing the issue of language in health care, gives rise to many critical questions. What constitutes an interpreter? If 'interpreter' is to be understood as referring to a professional, as opposed to the usual untrained *ad hoc* mediator, who is supposed to arrange and pay for the interpreter? Furthermore, since the Regulation on Patients' Rights only mentions the right to interpretation in the context of the provision of information by health workers, does this mean that patients do not have the right to have their own utterances translated? Presumably these questions will remain open until legislation with more explicit and detailed measures is introduced, comparable, for example, to the Law on Criminal Procedure (2004), which stipulates that defendants, or victims of crime, who do not have sufficient Turkish to express themselves will be provided with a translation of the main points of the charges and the defence by an interpreter appointed by the court (Article 202) and paid for by the state (Article 324.5). Until similar legislation is enacted in the field of public health, it will be interesting to see if any actions are fielded by patients appealing to the Guidelines on Patients' Rights, since this will presumably promote a discussion on the ramifications of Article 18.

In the *United Kingdom*, one can look at the issue in several ways: , from the viewpoints of equality legislation, human rights and citizenship. The 1976 Race Relations Act provided for genuine occupational requirements (GORs) and genuine occupational qualifications (GOQs) which could include linguistic and cultural knowledge and skills. The Race Relations Act 1976 is being replaced by the Equality Act 2010 but at the time of writing the guidance on the new law is only in draft. The law and guidance make it clear that, for example, having a shared or distinctive language is neither a necessary nor a sufficient condition for being a 'racial group'. There is specific legal provision for the use of Sign Language for deaf people and legislation concerned with mental health (*see* Tribe, 2009 for example) and social care legislation also makes provision for independent advocacy and requires active involvement and understanding of the user.

The Race Relations Amendment Act (2000) placed specific duties on public authorities, among other things to make sure that the public have access to the information and services they provide. The specific Race Equality duties are now part of a more general *equality* duty. It has been assumed that providing translation and interpreting services and services sensitive to cultural and faith diversity are, if not required by law are at least permitted by law. It hasn't been generally tested. In relation to translation, the BBC reported that the Department of Health had told them: "*No legal advice has been taken. It is clear that there is an obligation to provide information that is clearly understood.*" (Easton, 2006).

The Human Rights Act prohibits discrimination on a wide range of grounds including ‘sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status’. (EHRC, 2010). The Act also says that everybody should have access to public services and the right to be treated fairly by those services (EHRC, 2010).

Under the right to a fair trial The Human Rights Act allows representation or an interpreter where appropriate. This includes the right to be informed promptly, in a language which he [sic] understands and in detail, of the nature and cause of the accusation against him (EHRC, 2010).

An immigrant living in the UK is applying for naturalisation as a British citizen or for indefinite leave to remain (settlement) has to take the Citizenship Test. They can only take the test if they demonstrate their proficiency in English. (Home Office, 2010)

With regard to *policy*, there have been expressions of views such as ‘Why don’t they learn English?’ among the public and in some sections of the media for many years. The translation of this into official policy is more recent: it begins with the Cattle report into disturbances in the north of England in 2001 which raised concerns about ‘parallel lives’ and a lack of English being a cause of segregation (Denham, 2001; Cattle, 2001). This was followed by the Commission on Integration and Cohesion which recommended that translation spending be redirected to English as a Second Language provision (COIC Annex D and Section 5.42). On the other hand the same report said:

“We recognise that language barriers can perpetuate inequalities. Taking health services as an example, if people don’t know how to access services, they may not get the care they need. Even if they get to the right doctor, without good English they might not get the right diagnosis – or understand it – and may not take the treatments prescribed There are clearly vulnerable groups who need particular support.” (COIC, 2007, p. 167).

At the same time as these negative stances on linguistic and cultural diversity, there have been many statements of policy and practice that have endorsed action to improve access to public services by provision of bilingual staff, mediators and provision to meet specific cultural and faith needs. For example, National Service Frameworks for Diabetes and Older People include specific references to language (Department of Health, 2004). In mental health, the stress has been on culture and race equality rather than language (Bhugra & Bhui, 2007). The new Government, elected in May 2010, acknowledges the need for the changes it is planning in the NHS ‘to tackle a range of issues, including support to patients with different language needs’. Culture is discussed in the context of choice within the Department of Health Equalities Impact Assessment of the proposed changes suggesting, for example, that the idea of exercising choice is not culturally familiar to some communities (DoH, 2010).

There are UK *standards* for most of the models of mediation in the UK (except informal and *ad hoc* interpreting) (e.g Tribe & Thompson, 2008; Royal College of Speech and Language Therapists, 2007; DoH, 2004; Tribe & Raval, 2003; Silvera & Kapasi, 2002). However:

1. None have statutory force
2. Even where they are in professional practice guidelines, they rarely form part of grievance or disciplinary procedures if they are not followed
3. They are often not implemented or monitored
4. More fundamentally, there is no consensus on what is good practice – nationally or at the interface between users and providers.

Based on the descriptions for the five countries, table 2.2 contains a summary of the results available so far.

Table 2.2 Official policy on interpreting in health care in five European countries

Country	Official policy	Services	Daily practice
Germany	No official policy for interpreting in health care	No official services NGOs	Mostly informal interpreters (family members) or ad hoc interpreting (in hospitals)
Italy	Formal right to use interpreters; No standardised professional interpreters curricula; Regional and local laws regulating the implementation of interpreting services in the health sector; Use of professional interpreters strongly encouraged	Local Health System; Municipalities	Poor use of the interpreting service, where it is active; Preference of informal and occasional interpreters.
Netherlands	Formal right to use interpreter; Professional interpreter is standard; Informal interpreting is discouraged; Children are not to be used as interpreters	Services of 'Interpreter- and Translator service' (TVcN) are for free; Paid by government.	Use of informal interpreters or ad hoc interpreting is widespread; also professional interpreters are used.
Turkey	Patients' rights legislation acknowledges the possible need for interpreting during the provision of information, without making any concrete promises or recommendations.	None	Widespread use of informal interpreters, including medical personnel and children; communication in Kurdish between doctors and patients is increasingly common
United Kingdom	No formal right to use interpreter in health care	Statutory and NGOs in health service	Use of professional interpreters and advocates common; Informal interpreting is not encouraged but is widespread; Children are used as interpreters.

As is clear from the cross national comparison, countries differ with regard to their policies, but mostly there is no formal right for patients to make use of an interpreter. The use of ad hoc and informal interpreters is widespread in all countries, even if countries' policy is to make use of professionals as an interpreter. Also in other European countries, like Ireland, the situation is mostly resolved without any interpreter, or with the help of informal or ad hoc interpreters (MacFarlane *et al.*, 2008). Often, the language barrier is regarded as a problem of the patient, who is supposed to learn as quickly as possible the host countries' language. Even if immigrants learn the new language, it is another thing to express themselves in the host countries language, if it is difficult to explain complex information, if the patient is emotional, if the situation is stressful etc. And what about the older people, refugees and undocumented people, not sure about their status?

In the case of nurses and other professionals who do a lot of *ad hoc* interpreting in hospitals, they are mostly not appreciated for that. Their interpreter work is not included

in their job description, while an official policy of the health care institutions or hospitals is lacking.

2.3 Resume of literature on (in)formal interpreting

We might conclude that countries differ in the health care policies regarding interpreting. In general, the use of professional interpreters is poorly facilitated by the national governments. As a consequence, the majority of immigrants from Western countries bring an informal interpreter (mainly family members or acquaintances) to the care provider, they talk without an interpreter being present, or medical staff relies on bilingual employees (Bischoff & Hudelson, 2010; Pöchacker, 2007). The reasons for using informal interpreters are mostly practical or organisational (Greenhalgh *et al.*, 2007). The literature on medical interpreting recommends the use of professional interpreters, because of fewer mistakes made as well as greater physician and patient satisfaction (Jacobs, 2006). Although studies on communication in informal interpreting are scarce (Aranguri *et al.*, 2006; Bührig & Meyer, 2004), there is a prevalent negative attitude regarding the use of informal interpreters in terms of it lacking professional standards and potentially resulting in greater miscommunication. Other researchers stress that informal interpreters contribute importantly to attaining trust between patient and physician (Greenhalgh *et al.*, 2006), or they point to the importance of their care taking role for the patient (Rosenberg *et al.*, 2008) or to the fact that young people who interpret for their relatives might be doing a very good job (Green *et al.*, 2005). Thanks to professional training, formal interpreters make fewer errors compared to ad hoc or informal interpreters, but patients do not always prefer professionals for interpreting, as a relationship of trust is at stake. When and why is the use of professionals desired and when and why will informal interpreting be preferred? Some of these issues will be dealt with in this book. It is necessary to gain more insight into the pros and cons of formal and informal interpreters (Meeuwesen *et al.*, 2011, 2010).

Table 2.3 contains definitions of names for several kinds of interpreters which are used throughout the book.

Table 2.3 Definitions of 'interpreter'

Professional interpreter:	A person formally educated to perform the job of interpreter, according to a code of ethics. An interpreter interprets orally, a translator translates by writing.
<i>Formal interpreter:</i>	<i>See professional interpreter.</i>
<i>Informal interpreter:</i>	Someone who is not trained as interpreter, but asked, usually by a patient, to join him/her and to do the interpreting work. Mostly they are family members or good acquaintances (like a neighbor or friend).
<i>Ad hoc interpreter:</i>	A person mostly having the same linguistic background as the patient, which is accidentally available and requested to interpret (e.g. nurse, physician, cleaner, secretary, other patient)
<i>Cultural mediator:</i>	A person who functions as a cultural broker between patient and care provider, he/she signals intercultural misunderstandings and tries to solve them. Has knowledge of norms and values of different cultures.
<i>Advocate:</i>	A person who takes action on behalf of another person that goes beyond facilitating communication, with the intention of supporting good health outcomes.

2.4 Interpreter roles

Interpreters may differ in the ways they interpret and the roles they take (Bot, 2005; Bolden, 2000; Wadensjö, 1992). Bot (2005) distinguishes two approaches on interpreting, the *translator-machine* model and the liberal *interactive* model as two poles of one continuum. In the first model the interpreter is present as a non-person who gives equivalent translations, while in the interactive model the interpreter takes an interactive stance towards the interpreter-mediated medical encounter, leading to an accumulation of tasks (e.g. providing equivalent translations, contributing to the structure of the medical encounter, functioning as a cultural broker, etc.). It appears that interpreters cannot always act like a translation-machine model – in fact, they tend to participate as a third interlocutor during the interaction. Wadensjö (1992) also states that the interpreter does not function as a translation machine, but rather participates in the interaction process on his own account. The interpreter roles might vary from translating literally to becoming the direct source, where the interpreter responds as an interlocutor in the discourse. In the latter case, no translations are being made, a dyadic communication takes place, where the interpreter is the direct source for the health care provider (Hasselkus, 1992). Hsieh (2006) makes comparable distinctions in terms of roles of translator machine, advocate for the patient, mediators. She points that the translator role is not realistic, and also stresses the importance of the interactive approach, resulting in many different roles, depending on the situation and the persons involved.

Health care providers expect interpreters to be not only translators, but to serve as cultural brokers and intercultural mediators (formal interpreters) or caregivers (informal interpreters) as well (Rosenberg *et al.*, 2007; Knapp-Potthoff & Knapp, 1987). Informal interpreters very often also have useful additional knowledge of the patient and his/her symptoms. According to the physicians, they can be helpful towards establishing a good contact with the whole family.

The strong point of a formal interpreter is that they are very keen on translating in as precise as possible in a professional way. The plus point of informal interpreters is that having context information about the patient might be quite relevant.

2.5 How to approach language barriers?

From the perspective of health care providers and policy makers, there are four main strands for approaching the issue of language barriers and the related issue of interpreting, with their corresponding views and attitudes.

1. *No problem.* This approach gives a strong accent on the non-existence of the problem: the language barrier is ignored, negated or, in the best case, regarded as a minor detail. There is complete ignorance of the issues, no knowledge of official policy, about rights and duties, quite low intercultural awareness and complexities in communication. The attitudes corresponds with fatal or naïve consciousness (Boal, 1979; Freire, 1972) characterized by comments such as “*that’s how it is*”, “*I have never thought about it*”, “*it is the migrants problem: they need to learn the host countries language*” or “*...are responsible by themselves for an interpreter*”. Also, views without nuance can be shared under this heading, like ‘*informal interpreting is always bad*’. Patients are not aware of their rights; health care providers are also not aware of patient rights about formal policy. Or even there is no formal policy at macro level how to deal with this situation. Health care providers mainly do not communicate (just observe), they communicate with

hands and feet or they expect the patient to solve the barrier by taking their own interpreter with them (mostly family members).

2. *Linguistic interpreting model.* In this model, health care professionals are obviously aware of language barriers, but they think that the only solution to the problem is the use of professional interpreters, who have professional training and are being paid for their job. They approach the problem mainly from the perspective of the western health care provider and have less feeling for or knowledge of norms and values other than their own. They are not aware of the importance of trust in the doctor-patient relationship, of the organizational constraints of having an interpreter available. A strong advocate of this view come from researchers and policy makers in the U.S. who claim that the use of professional interpreters is the only right solution. They are quite negative about informal interpreting (Jacobs, 2006). A closer look at the reasons behind it suggests that in the U.S. there is a strong culture of juridical claims in health care. Health care providers and hospitals fear that in the case of flaws they will be prosecuted. Of course, professional interpreting is also in the interest of patients. However in this model the motives to use informal interpreters are not examined, or the pros and cons of these different solutions. Also in the US the use of informal interpreters is widespread.
3. *Power model.* In this model, the issue is addressed from the starting point that structural power differences between individuals and groups in their different roles exist, e.g. between patient and professional, between members of different linguistic groups, between different groups of citizens in a society, e.g. indigenous majority language speakers and minority and immigrant groups . If we take the doctor-patient relation, we see that this relation has changed profoundly over the last 40 years. First there was the consensus model of Parsons (1951), which assumed a harmonious relationship where the physician is leading and the patient is following: the physician's role was characterized by high status and control *vis-à-vis* the patient. There is a normative pattern of trust: the physician will be attentive to the needs of the patient and will act in the patient's interests. The patient has to cooperate and to do everything the doctor advises to become healthy as quickly as possible. Later the discrepancy model of Freidson (1970) argued that there is an inherent discrepancy between the expectations of the patient and what the doctor can really offer. Only a part of the physician's control is used to advance the patient's interests; the physician also uses control to maintain his institutionalized authority. Both theories postulate an asymmetrical relation between doctor and patient, where the doctor is the leading party. In the latter one however, the patient is also regarded as an active partner in the interaction. More recent theories do stress the role of the patient even more. In approaches as the patient-as-consumer, or the patient centred approach, the role of the patient becomes gradually more pronounced. This has resulted in more patients' rights, such as being informed (informed consent). It is also expressed in concepts of 'shared decision making', which is *en vogue* currently in medical literature on doctor-patient relations. In this model, physicians are no longer highly respected 'professionals', and have lost power in favor of bureaucrats, health insurance companies, hospital managers. Mostly, doctor-patient relations have become much more egalitarian, although in the case of immigrants patient,

there is still more of a power relation compared to native patients (Meeuwesen *et al.*, 2006).

If we look at other roles, we see that citizens differ from each other, migrants experience more discrimination, are more often represented in socially poor neighbourhoods, have lower education attainment, wrestle with their identity and have problems of integration in the host's society. If society wants them to assimilate, they are expected to adjust themselves completely. If they are integrating they keep they are assumed to draw on the best of two cultures and try to combine these elements into a new way of life. If immigrants are unable or unknowingly expected to negate their linguistic background and to assimilate as quickly as possible, there is an imbalance between social groups. Overt or covert power structures stay flawless and are not subject to discussion. The long negated and not felt issue of the migrants' need for an interpreter can be seen as an expression of power structures. A process of becoming conscious of these power imbalances is the first step in changing relations in society, as well as relations in health and social care, e.g. the right to have an interpreter.

This concept of *empowerment* is not just relevant for migrant patients, but *mutatis mutandis* also for health and social care providers as well as (informal) interpreters. Often they feel unsure and experience stress in consultations with migrant patients, and are also hindered by cultural and linguistic barriers. Further they need to work under time pressure and available time to talk with patients is limited. If there is an informal interpreter available, the care provider can't understand both, and may lose control over the situation. This can result in feelings of powerlessness, especially if there is a lot of side talk between patient and interpreter. What do they communicate and what is translated for the care provider? The informal interpreter needs to deal with the agenda of the care provider and the agenda of the patient, which seems a tough job.

4. *The reality model*: a view that has increased in importance over the last years is to face reality and to find flexible solutions. This view strongly claims that a contextual approach is needed, and that conventional understanding of justice as neutrality (every patient the same treatment, regardless of background etc.) needs to be replaced by a concept of justice as evenhandedness (Carens, 2000). In this view, citizenship is open to multiple constructions and fair solutions grow out of practices which are considered to be just and beneficial. If immigrants are by whatever reason not able to master and to speak the host countries' language (e.g. to old to learn, short stay in new country, status unsure, etc.) they have the right to have an interpreter. This is seen as a basic right in order to enable good and effective communication. Sometimes this might be a professional interpreter, sometimes it might be an informal interpreter or otherwise, depending on the situation (trust issues, organisational issues, political reasons, etc.). The making of this choice needs to be considered every time again. Every situation is different. A consequence of the reality model is that one will face the possibility of training informal and ad hoc interpreters in a way that they might become professionalized in interpreting. This is also an example of empowerment, e.g. refugees becoming a professional interpreter.

For the purpose of this analysis, these four strands are demarcated from each other. In reality, they are much more overlapping with each other, as we will see in the description of the training in the chapters 5 through 9. The authors of this handbook mainly adhere to the approach of the *empowerment* and the *reality* model.

Before turning to the ins and outs of the conducted training, chapter 3 will give a short description of the five European partners, their expertise, their target groups, their choice of training.

Chapter 4 will pay attention to the innovative educational method of Forum Theatre. All training had in common that it made use of the several techniques of Forum Theatre, which is an experiential form of education.

Chapter 3 Partners and projects of five EU countries

Contributions of all partners

Five European countries participated in the TRICC project- Germany, Italy, Netherlands, Turkey and the United Kingdom (*see* Table 3.1). The partners collectively represent a diversity of disciplines and professions. The common starting point of the consortium was the development, provision and evaluation of training which aim to increase consciousness and competences of migrants and health care providers with regard to bilingualism and intercultural skills. Each country was free to choose their preferred target groups: patients, interpreters and/or care providers. The training for the different target groups had in common that they used Forum Theatre techniques. These techniques are based on the work of Augusto Boal from Brazil, who started a centre for theatre of the oppressed (*see* Chapter 4). This chapter gives a summary of each country's main activities in terms of target groups, research into the needs, and the training. The details are given in the chapters 5 through 9.

Table 3.1 Participants of the European TRICC-project

Country	Location	Organisation	Target group interviews	Target group training
DE	Hamburg	dock-europe e.V., training institute for adult learning; Hamburg University	Hospital nurses, ad hoc interpreters	Nurses, refugees, interpreters
IT	Ancona	COOS-Marche ONLUS, research & training department	Mediators, interpreters, physicians	Doctors, nurses, social workers
NL	Utrecht Rotterdam Amsterdam	Utrecht University; Erasmus University Rotterdam; University of Amsterdam	Family physicians, social care providers, informal interpreters, patients	Family physicians
TR	Istanbul	Boğazici University: Translation and Interpreting Studies	Patients, ad hoc interpreters	Students
UK	London	ppre research company; University College London	Patients, informal interpreters	Students, NGOs, managers and practitioners

3.1 Germany: Ad hoc interpreters

The colleagues from Hamburg focused on ad hoc interpreters – caregivers in hospitals as well as migrants and refugees interpreting in everyday/social contexts. The first group were nurses, most of them from Turkey, Russia, Greece, Portugal, and Bulgaria. The interviews conducted with this group revealed that it was often not clear what was expected of them in their role as interpreter. They are often confronted with so-called 'delayed' interpreting: first the patient communicates with the nurse, who later, and in another location, translates what was said for the physician. They also find it difficult to assess patient's level of understanding, i.e. their need for interpreting. Two-days training was provided for a group of 14 multilingual nurses. These migrant nurses are taking part in training (for 22 months) to obtain a degree so they can work as nurses in Germany. They are frequently requested to interpret ad hoc, although the hospital management has no policy with regard to interpreting which might facilitate their translating work. The aim of the course was to improve multilingual and intercultural competencies, to

empower them and to discover how to perform their role as interpreter. The training was not facilitated by hospital management, the participants followed the course in their own free time. The trainers made use of a variety of educational methods, like dialogue analysis, forum and image theatre, role play, discussion. Issues as ‘what does it mean to be a nurse and an ad-hoc interpreter at the same time?’ were central. The training proved to be successful in terms of consciousness raising, and partly in terms of empowerment.

A second training programme of three weeks was developed and provided for 12 multilingual refugees with little interpreting experience. The aim was self-empowerment with regard to their personal situation and goals, and finding out how to employ their language skills as community interpreters. The training provided participants with basic tools to facilitate ad hoc interpreting. It increased their knowledge, they were empowered by new forms of personal reflection and they gained insight how to establish themselves as community interpreters.

3.2 Italy: Mediators and health care providers

The largest groups of migrants in the middle-eastern part of Italy are from Albania, Romania, Turkey and Morocco. Six formal interpreters/mediators and four immigrants from the community were interviewed. They indicated that there often exists a cultural gap between health care providers and the needs of the patients. They often feel that their contribution to the communication is not valued by the patients and the doctors. Formal interpreters are often not trusted, but informal interpreters not always as well. Cultural differences are deeply seated and difficult to bridge, especially with regard to habits and care round pregnancy and giving birth. Because of these results, a training was developed not just for interpreters, but especially for health care professionals who haven't the slightest idea about migrant issues or about the impact of cultural and language barriers on the quality of care. Mediators indicate a need for more knowledge about official policy and regulations, supervision and case discussions, and prefer to have better contact with health workers to fine tune the interpreting work.

Doctors and psychologists were interviewed too; this confirmed that they had no knowledge and no commitment to interpreting. A culture of mediation is absent in the hospitals, and they don't realize the importance of good communication for the patients' healing process. Psychologists and gynaecologists are more aware than emergency care doctors.

A two day training programme was designed, mainly aimed to convince health care providers that mediation will be a solid solution to realize effective communication with migrant patients. There was a strong accent on improvement of skills and behaviour by using Forum Theatre techniques and case discussions under supervision. As an effect of the training, the participants became more aware of the positive effect of interpreters/mediators on the medical communication, and gained more insight in how to deal with these triadic communication situation.

3.3. The Netherlands: General practitioners

The Dutch focus in the project was on interpreted consultations in general practice. First, interviews were held with general practitioners (GPs) in order to gain insight into their knowledge, opinions, and experiences in relation to the use of interpreters when communicating with patients with poor Dutch language proficiency. Dialogical interviews were held with eleven general practitioners, all of them working in multicultural neighbourhoods in Rotterdam. The results show that GPs are barely aware

of interpreting issues and are mostly working with informal interpreters, which they prefer due to organizational advantages. Moreover they seem unaware of the official Dutch policy with regard to interpreting in health care. Working with child interpreters is regarded as undesirable, but seems to them inevitable at times.

To enhance knowledge, skills and awareness among GPs with regard to interpreted consultations, training was provided in the autumn of 2009 to 20 GPs in Rotterdam. To achieve the training aims, different educational tools were used: knowledge transfer, demonstrations, forum and image theatre, counselling, case discussions and interviews. Evaluation results show that the training was evaluated positively and the aims were mainly accomplished. GPs now know more about the official policy on formal interpreting and how to use the facilities in their practice. Moreover, they are more aware of interpreting issues and one out of three of them intends to adjust the way in which they coordinate conversations with an interpreter. With regard to the educational methods, the forum and image theatre were highly valued, because they created a comfortable and safe environment to experiment with new behaviour in identifiable situations of daily practice. Three months after the training, in depth interviews were held with five participants that showed that GPs see the interpreters' role as less self evident and are more aware of the different tasks and roles of the interpreter. Moreover, they are working more often with formal interpreters than before the training. It appears though that changing old habits (such as working with informal interpreters) is difficult and will take time. This is true not only for the GPs, but apparently for the patients and their interpreters as well.

Obviously, informal interpreters are often used in bilingual consultations in Dutch health care. It can be expected that this situation won't change in the future, so it is important to know what happens in these situations. Therefore, experiences and opinions of 15 young adults, who frequently work as an informal interpreter for their relatives, were obtained by in-depth interviews. Not only were their recent experiences explored, but also an inventory was made of their experiences with interpreting as a child. Results show that interpreting as a child is tougher and more aggravating than as a young adult. In both cases interpreting is regarded as an emotional burden. Moreover, discussing sensitive and taboo subjects like sex, death and life-threatening diseases is perceived as embarrassing and awkward. A positive aspect of interpreting for family members is the experienced satisfaction of being able to help the patient.

3.4 Turkey: Kurdish minorities in Anatolia

The main task of the Turkish partners was the 'cultural mirroring' of the input of the other TRICC partners. They provided very useful information about the Turkish health care system, its problems and challenges, as well as sharing accepted ideas about values, norms, emotions, status, respect, etc. Often, patients with life-threatening diseases are not informed openly about their condition, although such information is relayed to their relatives. There is a lot of medicine use, and many patients see a *good* doctor as being one who prescribes a lot of medicine. Physical examination is not always performed.

The Turkish partners decided to focus on the lack of interpreting services in public medical settings, which inspired them to go and interview members of Kurdish minorities at hospitals of cities in Eastern Anatolia, as well as in Istanbul. In the (south) eastern part of Anatolia, the language barrier is large, especially among women and the elderly: approximately a third of consultations are hindered by a language gap. Researchers working for the Turkish team interviewed 54 patients and 46 ad-hoc interpreters. Nearly all the patients interviewed were accompanied by a family member or another acquaintance, a phenomenon found throughout Turkey and not just in the

mostly Kurdish-speaking areas. The use of an interpreter was only believed to be successful in 25% of the interactions reported. According to the survey, patients would most prefer to have a Kurdish speaking doctor. In addition, there were some complaints that doctors don't understand the perspective of their patients who don't know Turkish. The ad hoc interpreters who were interviewed had not had any training in interpreting nor on medical issues. Indeed, the interpreters themselves said that they would prefer it if Kurdish-speaking doctors dealt with patients. Respondents also complained about a lack of educational material in languages other than Turkish. An online survey of doctors in the East of the country is currently underway.

As well as conducting research into *ad hoc* interpreting in Eastern Turkey, the Turkish team also ran two six-week modules in medical interpreting for postgraduate and undergraduate students at Boğaziçi University, using the language pair Turkish-English. The main training tools were role-playing, the writing and discussion of scripts for interpreted doctor-patient consultations, and a final exam intended to replicate an authentic medical situation requiring interpretation.

3.5 United Kingdom: Bilingual migrants and ad hoc interpreters

The UK project carried out interviews with three communities in East London, the Turkish, Bangladeshi and Somali.

In the Turkish community, 17 out of 53 participants said they needed an interpreter and stated that they used ad hoc interpreters regularly. 36 participants stated that they do *ad hoc* interpreting regularly for family, friends or neighbours at least once a month but in many cases, once a week. 16 interviewees who said that they interpreted on a regular basis were children under the age of 16 years.

46 out of 50 Bangladeshi patients interviewed used an interpreter. The majority (29) used a family member as an interpreter with smaller numbers using neighbours (14), friends (11) or interpreters provided by the NHS (17). Of a further group of 50 Bangladeshi people contacted, 41 said that they had carried out informal interpreting. 9 people had interpreted before they were sixteen years old.

Of the Somali community interviewees, 44 out of 50 patients had used an interpreter. More than a third had used a family member. However, unlike the other two communities, a higher proportion (60%) had used an interpreter provided by the NHS. 48 out of 50 people not contacted as patients had acted as interpreters but only three had done so below the age of 16.

The British team found that that the phenomenon of informal interpreting is far greater than expected. Children, but also the older people, often feel a moral pressure to interpret, and dare not to refuse. They feel quite responsible for their family members. It was clear that family members often preferred to keep interpreting in the family.

As a result of the needs assessment, the training programme was designed for, and delivered to, two broad target groups:

- Bilingual people from migrant or minority backgrounds already or potentially involved in healthcare mediation directly or indirectly;
- People responsible for taking care of migrants and minorities.

3.6 Common parts

The joint element of these various training courses is the attention paid to interpreter issues in health care, making visible what the problems are and findings solutions by applying several strategies. It is also to the partners to get it on the institutional and political agenda. All partners have conducted training, preceded by rounds of interviews,

to get an idea of the problems from three perspectives, i.e. the patient, interpreter and health care provider. The training is form of adult education and the main educational tools in common are derived from Forum Theatre. Last but not least, it is noteworthy that we have made ample use of each other's expertise. The UK introduced Forum Theatre to the consortium, and The Netherlands provided a Forum Theatre training for the European partners.

3.7 Methods of evaluation

The consortium paid a lot of effort to the evaluation methods for the training. Both quantitative and qualitative strategies were discussed and applied, depending on the aims, educational tools and target groups. Most countries preferred a combination of both strategies. For some training just using qualitative methods was more appropriate.

The partners were striving to get methodological coherence and to contribute to a transnational value to all the research and training activities. This was not achieved by using uniform prescribed strategies, but by making use of a multiple set of strategies - triangulation. Despite different emphasis on specific tools each country used it is striking that the final results of the research for needs and of the effect of the training show a coherent pattern, within countries as well as over countries. This validates the methods used to realise the aims of the project.

Table 3.2 contains the several strategies for evaluating the training of all countries. The results will be further discussed in the chapters 5 to 9.

Table 3.2 Evaluation matrix of training

	<i>Pre-interview qualitative</i>	<i>Pretest training quantitative</i>	<i>Training Group</i>	<i>Post-its/ Bull's eye, spider's web Qualitative</i>	<i>Posttest training quantitative</i>	<i>Evaluation Organization</i>	<i>Post interview qualitative</i>
DE	8		-Healthcare providers, 14 -Refugees, 12	Yes Yes			12
IT	16	28	- 28 doctors, nurses, social workers - 55 idem	Yes	27	78 quantitative	
NL	10	19	doctors, 19	Yes	19	19 quantitative	5
TR			Students, 23		23	4 qualitative	
UK	Minority communities, 153	Some courses	-Bilingual migrants -health/social care staff 102	Yes Yes	Some courses		Some courses

Chapter 4 Forum Theatre

John Eversley and Sione Twilt

The term Forum Theatre has already been mentioned several times in the forgoing chapters. This innovative method, which can be applied in educational and therapeutic contexts and which is the common educational method in the training, will be discussed here.

4.1 Background

Forum Theatre is a participatory theatre form, one of the elements of “*Theatre of the Oppressed*.” It was developed in Latin America by Augusto Boal as a way of working with theatre to tackle the overriding problems experienced by ordinary people. Significantly for the people working with minority language speakers it specifically developed in a context where people were described as ‘illiterate’ because they were unable to express themselves in a particular language, in this case Spanish – because Boal was in exile from his native Brazil in Peru and Chile (Boal, 1979).

It has been seized on, developed and adapted all over the world. Currently practitioners are applying it internationally in Health Promotion, Theatre for Development, Community action and development, work in prisons, in health, Theatre in Education (TIE) and schools work, Drugs and HIV awareness, Domestic Violence, with homeless people in participation processes and in many other areas. It has developed into various strands – though they are often intertwined – Legislative Theatre (policy-making), the Rainbow of Desire (therapeutic) and Forum Theatre (educational). Education in this context is used in the way that Paolo Freire used the term – “education as liberation” (Freire, 1972).

4.2 Theory

Forum Theatre explicitly draws on theories about the theatre and education. Often unconsciously it also draws on theories about policy-making and management of change. There are several key ideas:

1) *Oppression or Resistance*: Boal originally wrote in Portuguese. The term he used is usually translated as ‘Oppressed’. In Boal’s terminology, the word ‘Oppressed’ carries the notion of resistance rather than an accepted connotation of passivity or victimhood. He draws a distinction between the ‘Depressed’, the ‘Repressed’ and the ‘Oppressed’. The ‘Depressed’ person is crushed (for the time at least). The ‘Repressed’ is (literally or metaphorically) in front (e.g.) of a firing squad and it is too late. Boal reflects on the way in which people may be neither free nor externally repressed. Boal commented that after the visible, physical repression he had seen in Brazil:

In Lisbon , in Paris there appeared oppressions that were new to me - ‘loneliness’, impossibility of communicating with others’ fear of emptiness...I was ... asking, mechanically, ‘where are the cops?’. (Boal, 1995a)

The cops, he decided were in the head: hence the development of therapeutic techniques within Theatre of the Oppressed. The concept is very similar to that of Franz Fanon’s internalised oppression (Fanon, 1967). However, the ‘Oppressed’ is the person who

wants to do something. Boal's notion of oppressed incorporates the notion of 'bafflement' but also action.

2) *Language*: From his earliest experiments in Peru and Brazil, Boal was acutely aware of the way that language was a tool that could be used to reinforce or change power relationships. Physical imagery and photography have been used by Boal to overcome the restrictions of language. He says '...By learning a new language, a person acquires a new way of knowing reality and of passing that knowledge to others...' (Boal, 1979).

3) *Reframing*: Unlike role-play in which a 'part' is acted out as if there is a consensus on how the role is perceived, Forum Theatre specifically explores conflict. In this it takes after Goffman's understanding of human interactions (Goffman, 1986) and Schon and Rein's understanding of policy controversies (Schon & Rein, 1994). The techniques for reframing draw on the tradition of Bertolt Brecht of 'making the familiar strange – *Verfremdungseffekt*' (Willett, 1964).

4) *Reflection*: Core to Paulo Freire's approach to learning was that it needs to be drawn out of the learners by a process of reflection rather than drawn from the 'bank' of an "expert" (Freire, 1972). Forum Theatre came into being while working with Freire when a member of the audience went on stage after actors failed to convey the image on stage that she wanted them to. The transition from spectator to participation as 'Spectactors' is important. The idea that reflection is *more than a mechanical process* is also in management theory (Schon, 1991). Although it is not a conscious part of Boal's thinking, Schon's distinction between 'Espoused Theory' - what people think they are supposed to think – and 'Theory-in-Use' is a useful one.

Two techniques are particularly used by Forum Theatre to achieve this: extrapolation of everyday experience into the imagination and unrestrained context of theatre and the use of metaphors. Again this fits with management theory (Morgan, 1997).

5) *Transformation*: Reframing and Reflection are combined in Forum Theatre to '(re)construct reality' (Berger & Luckmann, 1972). The idea that small or everyday events can 'cause' much bigger transformations is shared with contemporary writers on the management of organisations and change (Morgan, 1997). 'Flux and transformation' have a much longer history (going back to Heraclitus) and wider applications in theoretical physics (quantum mechanics) with ideas of small changes being capable of setting off much bigger ones and post-Darwin biology with ideas of systems that are not separable from their environment – ecology or autopoiesis.

Forum Theatre's techniques for promoting transformation often involve small changes to what someone does or say which sets off a change in a train of thought or action.

4.3 The practice

A typical session begins with exercises and games aimed at initiating a playful, creative approach to what may be serious issues.

Then, a scenario or a set of images or tableaux is prepared by the group around what is of interest and importance to them. When the work is shown to an audience or worked within the group, everyone is encouraged to intervene to change the situation or resolve the problems. It is a theatre form that is entirely determined and developed through participation.

A classic Forum session involves the replacement of the principal character in a scenario, the one who represents the group, by members of the audience. Thus, take turns to be in

someone else's shoes and experience life through their eyes. This is called by Boal "pluralisation" and is central to the reflexive processes of Forum and Theatre of the Oppressed as a whole.

The "Spectators" practise or rehearse change by exploring the alternative courses of action open to the protagonist of the piece and carrying the experience through into everyday life.

A facilitator who becomes the "Joker" for the Forum, the enabler or mediator for the group, conducts the session.

The interactive structure is important within Forum Theatre: at some stage a dialogue takes place between the actors and the audience. This dialogue turns the spectators into actors. The participants look at a scene which is relevant and recognizable for them. A scene always consists of a problematic situation they want to change. The joker asks the audience what they have seen and asks them to join the scene and change the situation by playing their alternatives for the presented scene. In this way, the audience is able to try out different solutions and the actors show the consequences of their actions by reacting on the behavior of the person jumping in the scene.

An important contribution to creating a safe environment in which to explore possibilities is a non judgmental Joker. He or she has to invite the audience to show different behaviours and describes what is happening without judging. It is obvious that there is no ultimate solution for the situation given. This fact distinguishes Forum Theatre from traditional role plays, in which a certain norm has to be reached. The Joker creates an unprejudiced and safe environment, where participants can feel free to experiment with new behaviour.

Forum scenes always show aspects of power and powerlessness which may lead to oppression. The scenes mainly show interactions between people which may lead to feelings of powerlessness. These feelings may play a role for bilingual patients who don't feel heard, but also for health care professionals who feel they loose power in their consultations.

The nature of the society is reflected in its smallest cells. The great themes are inscribed in the smallest personal themes. (Boal, 1995b).

Image theatre is a supporting technique and is often used as a warming up for the actual forum scenes. Working with images allows the audience to communicate with their body. In this way, the participants get to know theatre without using words. This technique allows people to communicate with each other through images in space. Image does not only mean 'building a statue' but is also used in a transferred meaning of an image we make from something or someone. In several TRICC training events image theatre was used to create an image/statue of an interpreter and to discuss afterwards what these images say about the opinions and experiences of the audience about interpreters.

In sum, Forum Theatre offers people the opportunity to practice behaviour in a safe environment. It is practising for daily life. Direct feedback from the audience and the trainers deepens this process. Even when someone jumps into the scene, the audience remains actively involved by giving suggestions. The power of Forum Theatre consists of seeking different possibilities to improve certain situations instead of showing how well you behave.

Chapter 5 Good Practice – Germany

Ekpenyong Ani, Meike Bergmann and Ortrun Kliche

The diverse linguistic backgrounds of patients as well as hospital personnel, doctors and other healthcare workers have a great impact on the daily routine in the German healthcare system today. Very often there is no common language, therefore multilingual nurses, general hospital staff, patient's family members (including children) and friends routinely facilitate communication between patient and doctor by (spontaneously) taking on the role of an interpreter (Meyer & Bischoff, 2008). Although interpreting in these situations has become more and more common, there is little acknowledgement of the crucial role this plays in healthcare – not only in overcoming the language barrier but in actually providing patients with the appropriate medical care. After all, when language barriers impede communication between patients and healthcare staff/doctors, there are bound to be misunderstandings and delays, creating a higher risk for misdiagnosis or the wrong treatment or consultation. This situation is aggravated by the fact that multilingual individuals usually act as interpreters in addition to their regular jobs without extra time, pay or acknowledgement.

In order to support multilingual healthcare staff and other individuals who (need to) take on the role of interpreters, dock europe e.V. developed and conducted training for ad hoc interpreting for two different target groups (Ani *et al.*, 2011):

- multilingual healthcare providers in the hospital
- a diverse group of multilingual participants with refugee status.

5.1 Training for ad hoc interpreters in the hospital

The target group for this training was multilingual healthcare workers from various countries involved in a training programme in healthcare for migrant women provided by “Wege in den Beruf”/Passage gGmbH in Hamburg (<http://www.passage-hamburg.de/betriebe/wegeindenberuf/info.html>). The 22-month medical training in which these women are taking part in is geared to persons who have already completed a professional healthcare training in their countries of origin which is not completely recognised in Germany; they have good German language skills on B2-level (second intermediate level according to the Common European Framework of Reference for Languages – CEFR). The 14 participants came from 8 different countries and spoke at least 10 different languages, including Polish, Russian, Ukrainian, Filipino, English, Turkish, Albanian, Arabic, Farsi and Kyrgyz.

5.1.1 Goals of the training

The training developed by Ortrun Kliche was aimed at providing multilingual healthcare workers with basic tools to facilitate ad hoc interpreting in the hospital (Bührig *et al.*, 2010). Participants are encouraged to value their multilingual resources as an asset which is beneficial in social as well as professional contexts. The training is to help them make use of their competency and to create their own framework for interpreting and/or claim certain standards in the workplace. The training aims to raise the participants' awareness of the role of the ad hoc interpreter – the role the health carers themselves attribute to the interpreter as well as the role that is assigned to her/him by patients and doctors.

Finally, the training is aimed at raising awareness of the significance of interpreting in healthcare and the need to implement an official, salaried interpreting service in hospitals.

5.1.2 Identifying training needs

What kind of support do multilingual professionals/individuals need when they act as interpreters besides their work as health carers, social workers or public officials? How best do we benefit from multilingual competences and how can they be acknowledged in an adequate way? How should training for ad hoc interpreting in hospitals, administration and social services be designed? To find answers to these questions, guidance for interviewing multilingual health carers developed by Birthe Pawlack (Bührig et al., 2010) was adapted to fit dock europe's target group. The interviewees were eight healthcare providers with diverse backgrounds (i.e. Turkish, Russian, Russian-Ukrainian, Russian-Greek, Portuguese, Iranian). The questions they were asked included:

- What is their experience with interpreting in their everyday work?
- What went well in these situations and what was not satisfactory for everyone involved?
- What are critical everyday problems for interpreters in the hospital?
- What do patients and doctors expect of them as interpreters?
- What needs for training can the interpreters themselves identify?
- What competences need to be promoted and trained so that interpreting assignments can be managed successfully for everyone involved?

In general, the interviews showed that multilingual employees have a high disposition to offer their services as interpreters. Some interviewees explained their motivation with the positive memories they had of the time when they first came to Germany and friends or relatives supported them by assisting with the language. Apart from that they thought they could empathise with someone who has little command of the German language and feels insecure because of this.

"(...) I want to know a bit more about the illness. After all, the parents could ask me something about it afterwards. And then I don't know. And you don't want to have to tell them, 'No, I don't know. No idea.' So I do give it some thought and look things up and get the information so I can say something about it."

The interviewees also mentioned doubts, for example concerning their own proficiency in German, if their interpreting is good enough and who is legally responsible if a patient gets the wrong treatment or consultation due to an interpreting error. One interviewee remarked that she sometimes doesn't feel she has another option, that she is obliged to interpret because she has certain language skills and no one else will do it.

"When you know how much work needs to be done on the ward, then you think it will be stressful to take more time for interpreting, 'I have work to do. There are people waiting for me.' That's when you already set out thinking, 'Oh, hopefully it's not going to take that long.'"

As a result of the interviews that Ortrun Kliche and Meike Bergmann conducted, the following training needs were identified and integrated in the curriculum:

- Development of the role of the ad hoc interpreter;
- Interpreting in a triad setting (patient, interpreter, doctor);
- So-called distance or delayed interpreting (patient and doctor are not in the same location, so the interpreter translates from one to another in a time-displaced mode);
- Interpreting for patients with limited command of the German language (who may therefore wish to add their own views or may correct the interpreter);

- Responsibility and liability (for example: what happens when a patient claims essential information was not interpreted or not communicated correctly?).

Apart from these specific needs, the training addresses more general needs:

- Improving interpreting skills;
- Enhancing personal competencies of communicating clearly, being self-assertive and setting boundaries by defining one's role as an interpreter;
- Knowledge about the German healthcare system as well as that of the patients' respective country of origin;
- Improving knowledge of technical/official terminology in the native language as well as the target language;
- Raising awareness for gender-related factors.

5.1.3 Training methods and modes

The methods and modes used during the training included facilitator's inputs, warm-ups, group discussions, brainstorming, dialogue analysis, workgroups, role-play, Forum Theatre. The application of some of the methods is described in more detail below.

Analysing Transcripts and Tutorial Films: The participants were provided with an excerpt of an authentic (German – Turkish) interpreted dialogue and were asked to analyse it (Bührig & Meyer, 2009; Bührig, 1996; Meer, 2009). The participants were very observant and “found” all the translation mistakes as well as certain interpretations and content-related changes the interpreter had made. The participants discussed the interpreter's role, e.g. how he relates to the patient and from this derived guidelines for the role of the ad hoc interpreter.

In another session, the participants watched a 10-min tutorial film – *Trialog* (Pickel *et al.*, 2003) in which the patient is accompanied by an interpreter to the doctor's office. The participants watched the film several times and were asked to analyse the roles and responsibilities of the doctor, the patient and the interpreter with the aid of questions. Notably, the participants had the least observations concerning the interpreter. They were, however, very critical of the interpreter's role and observed her body language as well as what was translated and what was left out.

Forum Theatre (Boal, 2010): *Forum Theatre* involves a group of actors acting out a scene to make a problematic situation visible. The scene is acted out in such a way that the problems are obvious to the audience. There is a “Joker” who acts as a mediator between the actors and the audience. After the scene, he or she asks the audience, “What did you see?” and listens to their suggestions for better solutions. When the scene is acted out again, spectators, now spect-actors, can stop the scene, take the respective actors' place and act out their way of handling the situation. If their solution isn't accepted by the audience, another spect-actor can jump in.

The participants were asked to exchange “typical” interpreting stories that are concise and characteristic in a positive or negative way. They then related or acted out these situations with (potential) conflicts. In one situation, a patient asks a nurse who speaks her language about the medication she has been given. The nurse does not know how to translate the specialist term and needs to check with the doctor. This was a good example of delayed or distance interpreting.

In another session, the participants were asked to conceive three scenes focusing around problems that may arise in the following settings: a) Triad setting with patient, interpreter and doctor all seated, b) Interpreting during the doctor's round in the hospital (patient in bed, doctors and interpreter standing), c) A health carer interpreting back and forth between the patient in the hospital room and the doctor in her office (distance/delayed interpreting).

The method of Forum Theatre was employed by asking the participants to act out the scenes and then asking the “spect-actors” the crucial question “What did you see” and giving them the opportunity to change outcomes by jumping into the role of the respective interpreter. The group found “crunchpoints” in each setting and these were re-enacted by participants jumping in.

5.1.4 Training results and evaluation

The evaluation directly after the training revealed that participants felt they had greatly profited from the training and were eager to learn more. Some stated that the training had boosted their self-esteem and they felt more confident in their multilingual competencies. The training also gave participants the opportunity for exchanging their experiences in ad hoc interpreting and this helped them develop individual role-models for interpreting. Participants said they had gained a better, more realistic understanding of the possibilities and limitations of interpreting. They also learned that certain structural conditions are necessary for their work as individual ad hoc interpreters to be successful. Five months after the training, a second evaluation session was conducted with 12 participants (at Albertinenschule in Hamburg). However, only three trainees had actually interpreted in the meantime. Nevertheless, participants repeated they had become more self-assured after the training. One important statement made during this session was that the training was not only useful for ad hoc interpreting but that the communication skills (e.g. transparency) practiced in the training were applicable in many other work situations.

5.1.5 Ideas for the future

The interviews conducted with health carers reflect the tremendous strain employees in healthcare are under. Many complain about a lack of time to give patients the attention they need and to do them justice. When they described situations in which they had to interpret as well as take care of their normal workload, the daily pressure they were under became clear. Staff shortage and permanent strain on the job call for structural changes that do not lie in the personal responsibility of individual employees.

At the end of the training, the participants made several recommendations to the hospital management concerning working conditions for multilingual health carers who interpret for doctors and patients. These recommendations will be useful in advocating standards for interpreting in the hospital and structurally integrating ad hoc interpreting in healthcare. They should also prompt hospital administrators to regard language support as an aspect of patient care.

Another idea is to set up a focus group in which healthcare professionals working as ad hoc interpreters can exchange experiences and talk about case studies.

5.2 Training for ad hoc interpreters – People with refugee status

The target group for this training were people with multilingual resources but little interpreting experience. The group consisted of 12 participants recruited by the Hamburg Centre for Refugees (Flüchtlingszentrum Hamburg – <http://www.fluechtlingszentrum-hamburg.de/index.php>). They came from diverse backgrounds regarding their nationalities, professions and ages. They had good German language skills on B1-level (first intermediate level according to the Common European Framework of Reference for Languages). Between them, they spoke at least 9 languages, including Farsi, Spanish, Armenian, Romany, Twi, English, Russian, French, and Dari.

5.2.1 Goals of the training

Based on the concept applied in the first training events, dock europe e.V. developed the concept for ad hoc interpreting further to fit the needs of this new target group. The goal of the 3-weeks training is self-empowerment and giving participants an orientation as to how they can employ their language skills as community interpreters. For this target group, special emphasis was put on self-empowerment since the participants experience a great deal of discrimination and marginalisation on the basis of interdependent factors such as race, gender and their status as refugees (in some cases only a so-called “Duldung” – an exceptional leave to remain). One section of the training focuses entirely on self-empowerment and communication skills to raise the participants’ awareness for their personal situation and goals. One aim is deconstructing the identity of “refugee” in the dominant society and analysing and processing the impact this has on one’s self-esteem (Eggers, 2010).

Analogous to the training for healthcare providers, this training is aimed at providing participants with basic tools to facilitate ad hoc interpreting in diverse settings – administration, courts, police, schools, hospitals, at home, on the street etc. Participants are encouraged to value their multilingual resources as an asset which they can possibly make use of professionally. The training also aims at raising the participants’ awareness for the role of the ad hoc/community interpreter.

5.2.2 Training needs

At an introductory meeting conducted before the actual training, prospective participants expressed the following training needs:

- Improvement of language skills;
- General introduction to ad hoc/community interpreting;
- Defining one’s position in interpreting situations – neutral, empathetic, partial etc.;
- Professional orientation;
- Empowerment.

5.2.3 Training methods and modes

The first week of empowerment included biographical narratives geared towards critical self-evaluation in order to experience and understand the relationship between the individual and society as something that can be shaped (Kinder et al., 1999). The key method used was Forum Theatre in connection with Living Sculpture or Image Theatre. Image Theatre is a series of techniques that allow people to communicate through images and spaces. The method involves individuals or groups creating a “living image” or “statue” to communicate a certain message or to illustrate a problem in a nonverbal way. The message can be varied by changing certain positions or expressions.

The first week also included an introduction to communication blockages and active listening.

The second and third week of the training concentrated on interpreting skills. In the second module participants were provided with an overview regarding the tasks of an interpreter and could develop their personal concept of an “ideal interpreter”. Forum Theatre and role plays were used to examine the different potential roles of the ad hoc interpreter and to identify conflicts that can arise in the interpreting situation. Since the training focused on interpreting in a broad variety of situations, participants came up with all kinds of interpreting settings ranging from a situation in a police station to ad hoc interpreting in an embassy or a pharmacy. Acting out the scenes helped identify problems related to societal power structures. It became clear that not only the patient or client who does not speak German is in a vulnerable position but also the interpreter

with a precarious status. The participants used Forum Theatre to try out different ways of dealing with this imbalance. One key question was if the interpreter should be “neutral” or partisan.

In the third week participants were provided with information regarding practical aspects of interpreting: official and specialized terminology; writing letters and e-mails; interpreting on the phone; accessing further training; networking. The centrepiece of the last week was a discussion with a community interpreter from KiFaZ Schnelsen (a community centre for families), who came to visit the class. Participants were able to ask questions about the work of a community interpreter ranging from organisational and financial aspects to questions concerning specific problems and strategies.

5.2.4 Training results and evaluation

At the end of the training all participants gave the feedback that they had gathered a lot of new information. Many said they had profited especially from the self-empowerment sessions which they experienced as a completely new way of personal reflection. One participant felt generally inspired to learn more and to “do something” with her life.

The combination of talking about personal issues, looking at structural problems such as racism and exploring one’s personal and professional position by taking a closer look at ad hoc interpreting encouraged participants to tap into their language resources, to look for new ways to continue their (professional) education or to establish themselves as community interpreters.

These participants also said they had gained a better, more realistic understanding of the possibilities and limitations of interpreting. They also learned that certain structural conditions are necessary for their work as individual ad hoc interpreters to be successful.

5.2.5 Ideas for the future

In the final session of the training participants were provided with information on a further training for ad hoc interpreters, the online course “Dolmetsch-Führerschein” – <http://www.dolmetscher-treffen.de/pdf/ausschreibung-aug10.pdf>. At least one of the participants took part in this online training successfully. The course takes place regularly, the next was scheduled to run in December 2010.

One important political goal for this target group with refugee status or even just a “Duldung” is for them to have access to a work permit. Without a permit they are barred from working and cannot be paid for interpreting. Once this is possible, there will be a higher motivation for institutions or public sponsors to fund training for refugee ad hoc or community interpreters.

5.3 Conclusion

One of the goals of the training dock europe e.V. designed was to support multilingual individuals in their daily struggle to accommodate a number of tasks simultaneously – for example as health carers who have to attend to patients and interpret for them at the same time. This goal was definitely achieved in the training conducted so far. With the tools and skills they learned in the training, participants felt empowered in the different roles they take on and better equipped to handle (or even deny) the diverse expectations they are confronted with.

The success of the training on an individual level, however, does not hide the fact that multilingual workers in health and social care are often taken for granted and exploited. They are expected to render their interpreting services free of charge to save institutions time, trouble, and money. The fact remains that makeshift interpreting without even minimal training, without a definite framework, without accommodation and time,

without standards and without (financial) appreciation may sometimes cause more damage than it avoids.

Providing training for ad hoc interpreters is just one step. What needs to be done on an institutional level is to design policies and implement structures that facilitate communication in a multilingual setting. This would include setting up (external) interpreting services (Wesselmann et al., 2004) as well as training multilingual professionals for the extra job of interpreting in their respective fields.

Chapter 6 – Good practice - Italy

Francesca Cesaroni, Silvia Coltorti and Claudio Sdogati

6.1 The Italian context

The Italian legislation recommends the support of cultural mediators to facilitate the interaction of migrant people, especially in the education, juridical and health sectors, delegating the implementation and regulation of proper mediation services to the local bodies. In compliance with the national legislation, Marche Region issued rules promoting the implementation of mediation services to facilitate the migrants' integration and their access to the public services. Consequently, some local administrations have implemented interpreting and mediation services in areas where the migrants' attendance is particularly critical, as hospitals, health districts and schools.

For the TRICC project purposes, COOSS decided to involve the Hospital of Jesi – a small town near Ancona - a particularly interesting experimentation site because of the following reasons:

- a renewal process of the company policies is in progress, with the aim to meet the new needs caused by demographic, social and cultural changes;
- a mediation service has existed within the hospital since 2003.

To formalise the involvement and collaboration of the Hospital in the research and training activities, an agreement was signed with the Local Health Unit of Jesi (hereinafter ASUR 5).

6.2 The interview results

The COOSS Marche research aimed to investigate the quality of the health services provided to migrants in the hospital of Jesi, with particular focus on the communication and the cultural competencies aspects. The purpose was to concentrate on the *mediators* and to identify their training needs. Six cultural mediators coming from different countries (Brazil, China, Morocco, Albania, ex-Yugoslavia and Congo) were interviewed, with the twin objectives of knowing the difficulties they meet in the performance of their job and to gather their impressions and experiences in the interaction with the health personnel. The main critical issues and priorities emerged from the analysis have guided the project staff in the design of an innovative and tailored training initiative.

Methodologically, the interviews were based on guidelines aimed at understanding the interviewees' motivation to practise their profession, their training and educational background, the training needs, the critical aspects of their job, their direct experiences and possible suggestions. The interviewees were encouraged to talk freely, leading the discussion back to the basic topics when it tended to diverge from the research key points.

To widen the research overview, four migrants were interviewed, either, in their double role of patients and/or informal interpreters. They came from the former Yugo-slavia, Congo, Bangladesh and Nigeria. The interviews aimed to discover their direct experiences with formal and informal interpreters, their experience, if any, as informal interpreters and their perception of the Italian health services. They were also asked if they considered their bilingualism a positive value capable of turning into future opportunities.

The analysis of the interviews with the *mediators* provided useful indications both in terms of difficulties & criticalities and suggestions & good practices. With respect to the *difficulties*, the interviewees indicated to experience a sense of exclusion and lack of consideration on the part of health personnel; they felt somehow marginalised by the health staff members. The mediators are not part of the service they are such a relevant part of. The feeling that health personnel don't properly understand the contribution the mediators bring to the communication clearly emerged: health staff appear to be scarcely aware of the negative effects bad communication can have in the care performance. This is evident, for example, with pregnant women from African or Asian countries: they are reluctant to accept the treatments and the procedures envisaged by the Italian protocols, because they don't know them and they appear so different from the ones they are used to. On their part, the health staff demonstrate low sensitivity towards their patients' cultural traditions, contributing to more difficult dialogue and making diagnoses and therapies more challenging.

As for the *suggestions* on how to improve the service and to guarantee qualitative care, the mediators insisted on the importance to prepare the mediation in advance, to have time to know the patient, to create a friendly and trustful atmosphere, and to decrease the uneasiness stemming from dealing with private and sometimes very intimate aspects. They expressed their need for periodic meetings with the health staff, to promote inclusion and better relationships, and among mediators, to compare their experiences and to discuss their difficulties, especially when complex and painful situations have to be faced.

At the organisation level, they underline the importance of fixing some days when a mediator works alongside the doctor; such a modality would encourage the patients to go and book visits on these days, allowing better planning of the visits and limiting the number of emergencies. It has to be stressed that the management of the emergencies is one of the most critical difficulties the mediators meet in the performance of their job.

A final suggestion, strictly linked to the local administration under consideration, is the need to give the mediation service higher visibility, as its existence is still unknown to many of the hospital departments.

Turning the above results in training requirements, the mediators wish:

- To improve their competences in the management of the relations with the patient, particularly when complex and very personal problems have to be dealt with;
- To improve their relations with the health staff;
- To update their knowledge on central topics for a cultural mediator, as, for example, the juridical aspects;
- To have opportunities for supervision and comparison, both with their colleagues and the health personnel.

The interviews with *migrants* provided a double feedback:

- as *patients*, they confirmed the negative feeling of living in a country whose language you can't speak, and of having to trust informal interpreters. None of the interviewees had ever been supported by a formal mediation service. Nonetheless, all declared to have had good care and for free;

- as *informal interpreters*, the majority of the interviewees declared to have acted this role for friends or relatives, and to have liked the experience, as it allowed them to feel useful.

All migrants consider bilingualism a value which, in the long term, might turn into working opportunities, especially in the cultural mediation area.

6.3 *A change of mind.....*

The initial idea was to analyse the mediators' needs and to design a tailored and coherent training initiative on them, but the results emerging from the research forced the working group to reflect on the relevance of such a plan. The analysis highlighted that the obstacles to effective communication came more from the health professionals than from the mediators. Promoting the culture of mediation and intercultural dialogue among the health professionals seemed to be a challenge worth facing, and a new research phase was started, involving the health professionals working in the hospital departments attended by a high number of migrants, i.e. gynaecology, general medicine, first aid, paediatrics and planning clinic.

A new round of interviews was planned and aimed to identify the main critical issues the health professionals meet in the interactions with their migrant patients, and to know if they had ever used formal or informal interpreters. Six health professionals were interviewed: 2 psychologists, 1 gynaecologist, 1 doctor of general medicine, 1 doctor from the first aid department, 1 paediatrician.

The results confirmed that the majority of the interviewees did not know about the mediation service, even though it has been running within the hospital for some years. Only the professionals working in the departments close to the mediation service premises said they knew and used it. It has to be noted, however, that the concept of "mediation" was often confused with that of "translation": the prevailing assumption was that a technical translation of medical terms is enough to guarantee good health care. It is evident that the concept of "cultural mediation" is therefore degraded to a technical exercise of translation, while it implies cultural issues as well. Such a narrow vision of cultural mediation might be detrimental to the care service quality.

The health professionals admitted to have sometimes solved an urgent situation by calling a patient's friend or relative as an interpreter. They acknowledge that this is not the best practice, since these informal interpreters, being emotionally involved, might distort communication. The testimony of the gynaecologist is illustrative, she told the case of her pregnant patients from Asia or Africa: when they are accompanied by their husbands or, sometimes, by their children, the communication is laconic and limited to yes/no answers, with all the power in the hands of the person who understands and speaks Italian. When, on the other hand, the mediator is present, the women speak freely, ask for clarifications, showing a trustful and collaborative attitude.

Many of the interviewees indicated to have involved their patients' children in interpreting situations because of lack of alternatives, but they all acknowledge it is a mistake, as children it is too heavy a responsibility for their age.

6.4 *The international workshop on Image and Forum Theatre*

While performing the research activities, the project staff analysed the possible training methods to experiment with the different targets in the different countries, with the aim to find a common method adaptable to different contexts. The Image and Forum Theatre was selected, being a well known method in the Netherlands and the United Kingdom, but less familiar to the other partners. To allow the partners and their future trainees to familiarize with this method, an international workshop on Image and Forum Theatre was held on the 3rd of July 2009 in Utrecht, directed by Kees Deenik of the HoutenBeenTheatre (www.houtenbeentheater.nl). The Italian team attending the workshop consisted of two doctors from the Hospital of Jesi, the coordinator of the Mediation Service, an educator working at the First Acceptance Centre for migrant children without parents, and the Italian coordinator of the TRICC project.

The participants practised the Image and Forum Theatre activities themselves. The purpose of the workshop was to send the participants back home with the knowledge and the courage to use the techniques themselves.

6.5 *Towards the definition of a training programme*

The workshop experience convinced the project staff to implement the method in a training for the health professionals of the Jesi Hospital, while being aware of the challenges and the uncertainties of such an innovative, interactive and atypical technique . The method seemed particularly suitable to sensitize the health professionals to intercultural communication issues, to stimulate them to reflect on their own behaviours towards their patients and to introduce the concept of cultural mediation. The training was assigned to a theatrical company, whose experience in theatre-based education guaranteed a professional performance by qualified people. The participants to the international workshop transferred their knowledge to the actors, agreed with them the Forum Theatre scenes to be performed, supported the actors during the performance, in particular during the discussion with the audience, and one of them acted as the Joker (facilitator).

The working group decided to include a second training day, based on more traditional methods, to provide a theoretical approach to the cultural mediation concept and to propose the analysis of real cases (*see Cesaroni et al., 2010*).

6.6 *The training programme*

Once the training methods and their contents were defined, the selection process of the participants got started. Coherent with the criteria used for the research, it was decided to involve the health professionals working in the departments with the highest attendance of migrant patients, i.e. gynaecology, general medicine, first aid, paediatrics and planning clinic. Some social workers and educators from COOSS Marche, working in the services to migrants, were involved as well.

As the Forum Theatre method advises a maximum number of 15 participants, it was decided to limit the “pilot group” to 30 persons and to repeat the training on two different days. A second training day followed, which consisted of an analysis of cases. The pilot group agreed to take part in both training days.

To make the training initiative more attractive and to motivate the health professionals to participate, the course was accredited to achieve ECM (Educazione Continua Medici) credits.

The training programme was structured as follows:

Image and Forum Theatre – 11th and 12th March, 2010 (8 hours/day)

In the morning session, the theatre company led about 20 games/activities to break the ice, to make participants know each other, and to communicate through images rather than through words. The objective was to lead participants to reflect on their expressive and relational abilities and on their resistances. After lunch, the Forum Theatre session took place. The actors proposed two different interactions between migrant patients and a doctor, involving an informal interpreter in the first case and a formal one in the second. Both the scenes highlighted, and deliberately exaggerated, ambiguous behaviours on the doctors’ part towards the patient and the interpreter. Dr. Adamo, who had participated in the International Workshop in Utrecht, acted as a Joker, stimulating the discussion about the meaning and the implications of the behaviours interpreted by the actors first, followed by the audience.

The scenes proposed during the Forum Theatre, as well as the participants' interventions as spect-actors in the scenes, were video-recorded and included in a CD, attached to the TRICC Italian Handbook (Cesaroni *et al.*, 2010). The participants had been previously asked to sign an informed consent form for this purpose.

Analysis of cases - 25th March, 2010 (8 hours)

This training day was deliberately open to a wider number of participants: 55 persons attended the event (the pilot group included), the majority doctors, nurses and social workers.

The training was led by Dr. Vacchiano, a psychologist and anthropologist well known at national and international level for his publications on migration issues (Vacchiano, in press; Taliani & Vacchiano, 2006; Vacchiano, 2005). The trainer briefly introduced the cultural mediation concept and the communication difficulties in the health sector, before proposing the most participative part of the day, i.e. the analysis of cases, introduced by the vision of the Forum Theatre scenes. Three different cases were presented and the participants, divided into groups, were asked to elaborate a strategy to manage and solve them. These strategies were presented and discussed by the total audience in the final plenary session.

6.7 Evaluation – methods, tools and results

The project partnership devoted great attention to the evaluation of the training initiative, choosing methods and tools allowing qualitative and quantitative analysis of the results. The main evaluation objective was to measure the impact of the training on the participants, both in the short and in the medium term. Evaluation also aimed at assessing the participants' satisfaction towards the initiative.

Evaluation of the training impact

To guarantee methodological coherence and a transnational value to the activities carried out in the different countries, the partners suggested a common evaluation strategy allowing a future comparison of data. A 17-item questionnaire was designed, meant to allow for a quantitative analysis (answers between 1 and 5 on a Likert scale).

The questionnaire included 4 macro-areas, each corresponding to a training objective (see Table 6.1):

Table 6.1. Four macro areas of questionnaire

<i>Macro-area</i>	<i>Training objective</i>
Knowledge	Increasing the learners' knowledge in terms of cultural mediation, rules and related services
Competence	Improving the learners' competence in the interaction with migrant patients
Awareness	Sensitizing the learners on the difficulties the migrant patients meet because of language and cultural barriers
Behaviour	Making the learner reflect on the behaviours they adopt towards their migrant patients, and on the possibility to correct them.

The questionnaire included a number of questions common for all the partners, and some other specific questions each partner included because of their relevance to the territorial area and/or the specific target.

The evaluation enabled to measure any changes in the learners' knowledge, attitudes and behaviours after the training course. The questionnaire was therefore filled out by the learners twice: once before the training and once at the end of it. The differences in the values of the answers give an indication of the training impact.

The results were initially analysed at the individual item level. These analyses showed that the participants' knowledge of the mediation service, of the procedures to access and use it and of the difference between formal and informal interpreter had increased. It was also evident that the training had triggered doubt about the correctness of the learners' usual behaviours towards migrant patients. To get an idea of the aims realised, analyses on subscale level were performed. Table 6.2 contains the results. In the last column, p-values are given. If the p value is $<.05$, this means that the different scores between pre- and posttests are statistically significant, i.e. not based on coincidence. It is evident that there is a significant increase in knowledge, skills and behaviour (tendential), but not so with regard to awareness. Nonetheless, the awareness score was higher than the other ones in the first questionnaire: this might be interpreted that the learners were aware of the problems already, but lacked knowledge and skills, which increased significantly after the training.

*Table 6.2 Pre- and posttest measures on subscale level**

<i>Subscales</i>	Pre-test	Post-test	t-value	p-value
Knowledge (5 questions)	2.8	3.4	- 2.483	.016
Competence (2 questions)	2.7	3.3	-2.642	.011
Behaviour (3 questions)	2.8	3.2	-1.640	.11
Awareness (7 questions)	3.5	3.8	-1.394	.17
Total (17 questions)	3.1	3.5	-2.497	.016

**) scores were between 1 (most negative) and 5 (most positive)*

Evaluation of the participants' satisfaction

This kind of evaluation aimed to assess whether the learners had appreciated the proposed methods and contents. As the training initiative was officially accredited, a standard structured questionnaire provided by the Ministry had to be used, and was submitted to the participants at the end of each training day. The analysis of data revealed an extremely high satisfaction score with respect to organisation, content, methods and trainers for both the days. The Forum Theatre method, reached the highest scores in the Likert scale.

An additional qualitative evaluation was proposed for the Image and Forum Theatre training: at the end of the day, participants were asked to express the experience with a single word written in a post-it: the terms used confirmed the very high satisfaction for the proposed method. They expressed their feedback in word like “wonderful, enriching, fantastic, extraordinary, happiness, emotion, trust, participation, respect” and a lot of “thank you”.

Follow-up

The evaluation activities ended with a follow-up phase: 6 months after the end of the training, the participants of the pilot group were contacted to be interviewed again. The guidelines for the interviews were based on the previous questionnaire items. The objective was to verify the training long-term impact, specifically if it had affected the participants' working practices and behaviours towards their migrant patients. For this follow up, 14 out of 30 participants were available for the interviews. Their answers revealed that:

- the communication problems with the migrant patients are still a reality, mainly due to

- the difficulty to understand their family, social and cultural context, which easily gives way to misunderstandings;
- the importance of working with a formal mediator/interpreter to make the communication more reliable and effective is acknowledged. Nonetheless, the use of informal interpreters persists, especially when urgent situations occur and there is no time to look for a formal interpreter;
 - the use of the mediation service has increased in those departments less burdened by Urgent cases;
 - the informal interpreters can offer a partial and distorted translation, but their emotional closeness to the patient continues to be seen as valuable;
 - their prejudices and behaviours have been analysed after the course, and their working modalities sometimes modified. Nonetheless, the enthusiasm aroused by the course soon faded because of the problems making their daily work with the migrant patients difficult, even frustrating;
 - further training is wanted, with diverse content according to the departments needs and characteristics;
 - training should be provided to GPs, as they often improperly send their patients to the hospital;
 - the appreciation for the course was confirmed, especially for its innovative and experiential aspects.

6.8 Final considerations

Planning tailored and high quality services, promoting innovation, managing new and complex social phenomena, facing changes, are imperatives that migration has brought to the attention of managers, policy makers and administrators involved in the planning and provision of health and social services. Multiculturalism is a recent phenomenon in Italy, particularly in our regional area, and it has been modifying the relationships within the society. The established and familiar habits of Italians nationally and locally need to be modified and adapted to this new multicultural reality.

The health professionals' working methods and relationships with patients need to be updated accordingly, and proper tools to acquire intercultural competences should be made available. The professional educational curricula do not incorporate the enhancement of cultural competences among their disciplines: tailored educational interventions should therefore be planned to help health staff to increase their cultural competencies, to acknowledge the individual diversities, and to see migrant patients as an enriching opportunity more than an inconvenience. Focusing on the centrality of the human being should be the starting point, and not the application of a generic "ethical label" to the company policy.

Increasing the cultural competences in the health professionals requires therefore the organisation of short courses for them: the TRICC experience is a valid and concrete example in this sense. The training initiative experimented in Jesi indicated the effectiveness of a participative and highly interactive method, as the Image and Forum Theatre is, in meeting these educational needs.

Chapter 7 Good practice – the Netherlands

Hans Harmsen, Ludwien Meeuwesen, Barbara Schouten and Sione Twilt

The Netherlands developed, provided and evaluated training for a group of general practitioners (GPs). We used cultural knowledge and methods which were already available from the work of Hans Harmsen (2003; Harmsen *et al.*, 2005b), and adapted it for the training on interpreting. In this chapter an overview is given of the needs of the group of GPs and of the design and evaluation of the training which was given in the fall of 2009.

7.1 Needs of target group

To assess the needs for training, 11 GPs were interviewed working in multiethnic areas in Rotterdam. Results showed that GPs frequently worked with informal interpreters and had ambivalent feelings about their experiences (*see also* Schouten *et al.*, 2008). Most of them were not aware of the Dutch official policy regarding the use of (in)formal interpreters. Furthermore, they seemed to lack the skills to coordinate interpreted consultations in an effective way. The GPs stated that various methods could be helpful to change their behaviour. According to them, the most important method consisted of actively practising conversations, for example through role play. Other useful and educational training methods mentioned were the exchange of experiences, the use of videos, discussing cases and transferring knowledge. It was striking that a substantial number of the respondents were not able to indicate their training needs with regard to interpreted consultations. A possible explanation might be that these consultations are normally held on an unconscious level. The results showed that GPs were unaware of interpreting issues and were not aware of the possible problems which may occur when working with interpreters. In sum, among the GPs there was a need for more knowledge about interpreting policies and possibilities, and about educational tools which will give insight and awareness in interpreting issues; especially they like to practise new behaviour. The interview results were used to design the training.

Apart from interviewing GPs, two other groups were questioned as well. These are social care providers and informal interpreters. Four social care providers, working in a multiethnic area in Amsterdam, were interviewed to gain insight into their knowledge, attitudes and experiences in their work with bilingual patients. The group consisted of a psychiatrist, a psychosocial nurse, one psychomotor therapist and a social worker. The results show that all of them use and prefer working with formal interpreters. In fact, working with an informal interpreter is regarded as aggravating by most of them. Sometimes it seems unavoidably hard to work with family members who translate for the patient, because it ‘overcomes’ them and most of them therefore feel they can’t say no. Furthermore, the respondents all say that they are responsible for arranging an interpreter; this is contrary to the opinions of the interviewed GPs who think that the patient is responsible for arranging an interpreter. Finally a few social care providers doubt the reliability of some formal interpreters and therefore prefer to work with the same interpreter who they trust completely.

Halfway through the project it was decided to interview young adults to make an inventory of their recent and early experiences as (child) interpreters for their relatives. Results from interviews with 15 respondents show that interpreting as a child is tougher and more aggravating than as a young adult. In both cases interpreting is regarded as an

emotional burden. Moreover, discussing sensitive and taboo subjects like sex, death and life-threatening diseases is perceived as embarrassing and awkward. A positive aspect of interpreting for family members is the satisfaction experienced in being able to help the patient (Zendedel, 2010).

7.2 Description of the training

7.2.1 Introduction

Based on the needs of the target group and insights from literature, training was designed for GPs to enhance their knowledge, attitude and skills on interpreting issues. The training was called “*Do we speak the same language?*” *Bridging language barriers in general practice*. Twenty GPs working in multi-ethnic areas in Rotterdam participated in the training. These doctors are confronted daily with language and cultural barriers in their surgery.

7.2.2 Aims of the training

The first aim of the training was to increase the GP's *knowledge* on Dutch law, regulations and possibilities regarding formal interpreting. Secondly, the training aimed to enhance *awareness* with regard to the needs and difficulties of bilingual patients, the role of the interpreter and reflection on the GP's attitude and practice which are culturally determined. Finally, participants were trained to improve their *skills* in dealing with interpreted consultations.

To achieve these aims, different educational tools were used: knowledge transfer, demonstrations, counselling, case discussions and interviews. An important element of the training was the use of Forum and Image theatre to experiment with new behaviour in a fun and safe environment. These sessions were performed by the ‘HoutenBeenTheater’, a training company specializing in theatre techniques, based on the ideas of Augusto Boal (Babbage, 2004; Boal, 1995a; 1979).

7.3 Organisation of the training

The training consisted in total of 12 hours: one training day (8 hours) and one feedback evening (4 hours), and was held in a conference center in Rotterdam. The period between the meetings was one month (29.10.2009 – 01.12.2009). To develop the training, several experts were involved: researchers and teachers on intercultural and bilingual communication experienced GPs and Forum Theatre experts. These experts came together on a regular base to discuss the content and organization of the training. During the training, assistance was given by informal and formal interpreters and professional actors.

7.4 Programme

The training day was the heart of the training and consisted of an interactive programme in which theory and practice were combined. During the feedback evening the main aim was to reflect on the integration of the new learned behaviours in daily practice. The complete programme was as follows:

PROGRAMME TRAINING ‘ ”DO WE SPEAK THE SAME LANGUAGE?” BRIDGING LANGUAGE BARRIERS IN GENERAL PRACTICE” ‘.

Training day

Morning

- Start and welcome/Pretest
- Collagescenes
- Interview with a GP, specializing in intercultural communication
- Image theatre
- Presentation about formal interpreting in health care
- Demonstration Telephone interpreter

Afternoon

- Presentation about cultural differences in general practice
- Forum Theatre: Working with interpreters I
- Presentation about communication with informal interpreters
- Forum Theatre: Working with interpreters II
- Preparation feedback evening
- Evaluation and closure

Feedback evening (5 weeks later)

- Start and welcome
- Presentation about interviews results GPs
- Case discussion
- Experiences informal interpreter
- Evaluation/Posttest and closure

Different educational methods were used to achieve the training aims: theatre techniques (collage scenes, image theatre, and Forum Theatre), knowledge transfer (presentations by experts), case discussion, demonstrations and sharing experiences. An explanation of the implementation of the methods is given below. The sequence of it is slightly different than in the original programme.

7.5 Theatre techniques

7.5.1 Collage scenes

During the collage of different scenes, three actors were playing the role of doctor, interpreter and patient. By doing so, the problems that may arise when working with interpreters were shown to the participants. The audience saw, for example, an unmotivated informal interpreter who makes translation mistakes. Subsequently they saw an over worried informal interpreter and at last a formal interpreter who functions as a ‘translation machine’. In just a few minutes the essence of the problems in interpreted consultations is shown. The actors also acted as three children who complain about their translating duties for their parents. They are arguing about who has to join the parents during their visit to the doctor. Finally the audience saw a scene in which the prejudices of working with interpreters were shown by three GPs who say ‘patients just have to learn Dutch’ and ‘interpreters never translate everything, working with them is too complicated and it takes too much time’.

After the collage scenes were shown, the participants were invited to react on what they saw and to share their opinions about and experiences with interpreters. The GPs were immediately responding with examples, stories and prejudices about interpreting issues. After this discussion it was clear there is a problem, so the next step in the training was to seek for solutions.

7.5.2 *Image theatre*

Image theatre is a technique which enables people to communicate by creating images in space, without the use of words. Image is not only used by means of a statue but can also be seen in a more figurative way, like creating an (ideal) image of something or someone. During the training participants were asked to create an image of an interpreter. They worked together in groups of four people and made an image of an informal or formal interpreter.

The created images reveal how the participants think about interpreters. The different statues were being discussed and it became clear how the parties are involved in the interpreting process. It was interesting to discuss about who is who in these images. After the discussion the image-makers were invited to share the story behind their image. Then, suggestions were given to change the positions of the people in order to make the image stronger or weaker. The discussion created new image-forming and may lead to a change of opinion.

7.5.3 *Forum Theatre*

During the training two forum scenes were performed which are characteristic for interpreted consultations in general practice. After playing and repeating the first scene, the participants had the opportunity to jump into the scene and to play the role of the GP.

The first scene showed a GP consultation in which the doctor finds a lump in a patient's breast after performing a physical examination. He shares his diagnostic findings with the informal interpreter, but the GP suspects not everything is being translated. He questions whether or not to call a formal interpreter and shares this with the informal interpreter in a non-strategic way. She is obviously not amused and feels unappreciated which leads to a firm discussion and eventually to an awkward closure of the consult without the diagnosis being understood by the patient. Two problems are central in this scene: 'How to tell bad news through an informal interpreter?' and 'When and how to switch from an informal to a formal interpreter, without insulting the former?'. Privacy and intimacy issues were also discussed when working with an interpreter during a physical examination.

The GP invites the patient to another room for the physical examination. Her niece, who joins the patient as an informal interpreter, takes this opportunity to send some text messages with her mobile. Every now and then, the GP asks a question and the niece answers, a bit distracted by her phone. Obviously she does not understand each question while she is in another room, not being able to see what the GP is doing.

"Stop!" yells someone from the audience. Different participants jump into the scene to try and make this consultation work. Where do you position the informal interpreter during the examination? What about privacy? During what examinations is an interpreter allowed to be physically present? What if the interpreter is a boy?

The second forum scene is situated at a so called GP point - a weekend service. The doctor doesn't know the particular patient or the interpreter. The central question here is: "Does the GP takes enough time to explain the structure of the medical conversation and the 'rules' when working with an interpreter and to give the opportunity to both patient and interpreter to react on it?". In the initial scene the GP starts the medical history immediately and the conversation quickly results in wrong translations, side talk activity and a dominant interpreter. The actual complaint of the patient remains unclear. After the scene is shown, the participants have the opportunity to jump in the scene when it is repeated. When they see something which they don't like, or would have done

differently themselves, they yell ‘stop’ and are invited to take the place of the doctor and show their solution. When someone wants to interrupt again to try a different approach, another switch of roles takes place. The other actors (patient and interpreter) remain in their roles and respond to the behaviour of the new doctor.

7.6 Description of knowledge transfer

In order to give GPs more insight in how to work with interpreters and to make them more aware of interpreting issues, different presentations are given in which the transfer of knowledge is the main aim.

7.6.1 Official interpreting service

GPs are barely aware of the law and regulations regarding the official interpreting policy in Dutch health care. During the first presentation this national policy is being explained and attention is paid to what extent it can be transferred to the organization policy of GPs. The role and profession of a formal interpreter is being clarified and the participants are being informed about the law and regulations regarding patients who do not speak the dominant language. Live interpreting as well as telephone interpreting is illustrated and the latter is also demonstrated. Finally, attention is paid to the structure of an interpreted conversation and to the aspects that should be taken into account by care providers (e.g. give short pieces of information at a time).

7.6.2 Cultural differences

Cultural influences have an unconscious impact on our lives. Since culture affects the conception of health, sickness and therefore the needs, communication and expectations towards health care, it is necessary to make the GPs aware of cultural differences (Kleinman, 1980).

Insights in one’s own cultural baggage and that of the patient is crucial to communicate effectively. Knowledge about these different cultures helps to comprehend them and to search for creative solutions to bridge them. A lot of models are designed to comprehend different cultures. In our training the model of Pinto (2002) is chosen because of the practical relevance for health care providers. A distinction is being made between fine grained cultures with prescribed group rules for behaviour, and rough grained cultures on a more individual basis, allowing a broader range of behaviour. Pinto developed a three-step-model to give insight in and facilitate intercultural communication. First, the doctor needs to reflect on his own cultural and professional norms, secondly he needs to reflect on the patient’s norms and the final step consists of searching for a solution which is suitable for both parties. Obviously it is not always possible to bridge the cultural barriers, but it is important to keep on communicating about the differences in order to understand each other. This takes much effort from the doctor, as well as the patient.

7.6.3 Communicating with informal interpreters

During this presentation, examples of consultations with informal interpreters are discussed in which communication difficulties become clear. These consultations between Turkish patients, GPs and informal interpreters were audio taped and analyzed with regard to miscommunication, changes in translations and side talk activity (in which one of the participants is excluded from the conversation). The interpreted talk was translated into Dutch, which made it possible to understand what is actually happening in the interaction between patient and interpreter. Therefore, these examples illustrate (the cause of) miscommunication very well. Moreover it offers GPs a clear insight into how they can influence the progress of the conversation and how difficult it is to

communicate with a third person and in two languages. Most fragments are very recognizable for the GPs, because they are derived from real consultations. Practical recommendations are given and discussed, based on the fragments, which the participants could afterwards use during their skills practice (Forum Theatre).

7.7 Demonstration how to make use of interpreting service

During the training day a live-demonstration is given of the telephone interpreting services of the Dutch Interpreting and Translating Centre (Tolk- en Vertaalcentrum Nederland, TVcN).

The group is gathered around the telephone with the trainer who plays the doctor and a Turkish colleague who plays the patient. A real life demonstration takes place, in which the different stages of the consult are illustrated. Afterwards, the opportunity is given to the participants to ask questions to a professional interpreter. They want to know how the interpreter feels about her tasks, if she perceived difficulties, how the conversation went and what she advises. The discussion with the interpreter was very enlightening for the audience, especially because it gave insight into the thoughts and emotions of the interpreter during the consultation.

7.8 Discussion of cases

The feedback evening took five weeks after the training day took place, which gave the participants the possibility to reflect on the way they applied the newly learned behaviour in their daily practice. Before the meeting, some GPs provided case material to discuss difficult situations which occurred in their work. The following case illustrates the effect of the first training day very well.

“I have learned very much in the training, and it was useful in daily practice. A Moroccan woman of 35 years old came nearly every week and she had a lot of physical complaints, which varied per consultation. With the help of a professional interpreter it became clear to me that a good friend of her died of cancer. This friend also consulted the GP with a lot of complaints but the diagnosis for cancer came too late. So my patient worried a lot about having cancer and she was afraid that her diagnosis was missed. By talking with her this patient became sensitive now for a psychosocial approach of her fears.”

Each problem or question was discussed and an analysis of the problem was made by the trainers and participants. Afterwards, recommendations were given to deal with similar situations.

7.9 Exchange of experiences

Sharing experiences was a central theme during the feedback evening. Each participant has had experiences with interpreted consultations, some positive and some negative. Many of the GPs say they practice these consultations different than before the training day, for example by working with a telephone interpreter. Others experience the conversations with the presence of an interpreter different than before the intervention. Awareness of the (role of the) interpreter resulted in a different approach of the consultation.

Besides these mutually shared experiences, the floor was given to an informal interpreter who translated for her mother on a regular base. She was invited by the trainers to share her experiences with interpreting at the GP office. The participants were given the opportunity to ask questions about the impact, difficulties and benefits of her role as a family interpreter.

7.10 Evaluation of the training

To determine the short- and long-term effect of the training several evaluation methods were applied.

7.10.1 Methods

Two quantitative methods were used. First, a pre and post test questionnaire consisting of 17 items about knowledge, attitude and skills was filled out by the participants. After the training, an additional questionnaire was used to evaluate the organization and the trainers.

Qualitative methods were also used. After the training day the participants came up with a 'free association' written on post-it notes. Furthermore, they were asked to deliver cases on working with interpreters for the feedback evening. These case descriptions contain reflections on the daily practice after the knowledge and skills acquired during the training day. After the feedback evening there was an evaluation on organization, content and trainers by applying the 'Bull's eye method'. This method is based on a visualization technique in which the opinions of the participants are immediately clear and can be discussed. At last, three months after the total training semi-structured interviews were conducted with five participants.

7.10.2 Qualitative evaluation

The quotes from the 'free association' showed that the participants were satisfied about the organization, the content and the trainers. Participants appreciated the combination of theory and practice and the approach of the **HoutenBeenTheater** (Forum Theatre) was highly valued. Some participants have their doubts though about working with formal interpreters in daily practice due to time and organizational constraints.

The results of the feedback evening were mainly positive as well. Six participants provided cases in which the awareness and change of behavior was clearly visible. An example was given of a Moroccan patient who visits the GP practice on a regular basis with diverse somatic complaints. After the training, a GP decided to call for a formal interpreter to facilitate the next consult. By doing so, the true cause of the patient's complaints became clear in a highly efficient way, which resulted immediately in an adequate diagnosis and treatment strategy.

"I had an older Moroccan lady as a patient. She used to come to the consultation with a friend of her. I never liked those consultations, because the complaints never ended and no matter what I tried, there was always another complaint and more pain. The lady talked a lot using excessive gesticulation. I never succeeded in understanding her complaints and tried to break off the consultation as fast as possible, sending her home with a recipe for one of her many complaints. Once, some time after receiving the training, the lady visited me again. Her friend was not with her and I decided to call the interpreter service. They picked up fast and after some minutes of talking I got a clear complaint description, without any unnecessary body language. The consultation was shorter and both I and the patient were satisfied with the result. The patient took both of my hands and thanked me extensively. After this, we always use professional interpreter service."

When performing the Bull's eye evaluation nearly all participants were satisfied about the atmosphere in the group. The majority was satisfied about the organization. Regarding the content, it was suggested to bring in more diversity in the evening programme.

At last the interviews with five participants showed the effects long term. All the GPs stated that since the training they are more aware of the role of the (in) formal interpreter, they have gained more knowledge about the official interpreting policy and they try to work with a formal interpreter more often.

7.10.3 Quantitative results

With regard to the organization, it turned out that the information about the training was mainly regarded as sufficient, the location was fine, the training material was good, the presentations were inspiring and informative, the HoutenBeenTheater was very inspiring and the sketches were quite recognizable.

The pre and post training tests showed interesting results. On all three dimensions a substantial learning effect was achieved (*see* Table 7.1), especially regarding knowledge, but also on attitude and behaviour.

Table 7.1: Effect training on knowledge, attitude and skills/behaviour

Statements	Pretest N = 17	Posttest N = 14
1. I am familiar with the law and regulations concerning interpreting.	1.8	4.4 *
2. I am familiar with the interpreting facilities in the Netherlands.	2.9	4.1 *
3. I work with the interpreting facilities of the Translation Centre (Tolk- en Vertaalcentrum Nederland) on a regular basis.	1.8 †	2.6 †
4. I expect an interpreter to translate literally.	3.8	4.2
5. Besides translating, I expect an interpreter to be a cultural mediator.	2.8	3
6. I think it is the patient's responsibility to arrange an interpreter.	2.8	3
7. It is my responsibility as a physician to arrange an interpreter.	2.8	3.8 *
8. I adjust to a conversation with an interpreter.	3.5	4.1 *
9. I mainly work with informal interpreters.	3.8	4.4 †
10. Usually, I am satisfied with the work of informal interpreters.	3.1	3.6 †
11. I mainly work with formal interpreters.	2.4	1.8
12. Usually, I am satisfied with the work of formal interpreters.	3.2	3.9 †
13. I explain the patient the task of the interpreter.	2.4	3.2 *
14. It is easy for me to explain to the patient what the task of the interpreter is.	2.6	3
15. I discuss with the interpreter about his/her task.	2.5	2.9
16. It is easy for me to discuss with the interpreter about his/her task.	2.8	3.3
17. I discuss with my colleagues about how to work with interpreters.	1.3	2.1
Subscales		
Knowledge (3 items: 1, 2, 7)	2.3	4.2 **
Attitude (7 items: 4, 5, 6, 10, 12, 14, 16)	3.0	3.5 *
Behavior (7 items: 3, 8, 9, 11, 13, 15, 17)	2.5	3.0 *

Legend: 1= totally disagree, 2= somewhat disagree, 3=neutral, 4= somewhat agree, 5= totally agree.

t-tests: † p<0.1; * p < 0.05; ** p < 0.01

As an effect of the training, GPs know more about the law and regulations regarding the use of formal interpreters. Moreover, they are aware of the difficulties in interpreted consultations and 1/3 of them intends to adjust the way in which they coordinate conversations with an interpreter.

In contrast with the qualitative results, working with formal interpreters happens less. This can be explained by the fact that GPs did not always know who these formal interpreters were. Before the training they regarded other professionals (e.g. cultural representatives, migrant social workers) as formal interpreters. After the training, the term of formal interpreter was strictly applied to professional interpreter of TVcN.

Three months after the training was finished, interviews were conducted with five GPs to determine the training effects long term. These results point in the same direction as the quantitative data. The GPs said to have gained more knowledge regarding the

possibilities of inviting formal interpreters to medical consultations with bilingual patients. This causes a change of behaviour which is shown in the fact that GPs make more use of telephone interpreting and in the fact that GPs inform colleagues about this possibility. After the training, the GPs regard the interpreting tasks as less self evident and they seem to be more aware of the roles and difficulties of the interpreter.

However, it appears that changing old habits (e.g. working with informal interpreters) is rather hard for both the GPs and the patients and their interpreters. This process of changing habits will take time.

In sum, the interview results show that there was an effect on a long term as well. GPs are more aware of interpreting issues and experiment with changing old patterns in consultations with language and cultural barriers.

7.11 Conclusion

The training is evaluated positively and the aims are largely accomplished. The GPs have gained more knowledge about (in)formal interpreters, are more aware of language and culture barriers and in some cases this has also resulted in a change in behavior like working with formal telephone interpreters more often.

The learning effects on knowledge, attitude and behaviour after the training, confirm that it was a good training design and that there are possibilities for implementation. Therefore, the same training can be conducted for doctors in other work settings and locations in the Netherlands. Furthermore, plans are being made to use the same training design and adjust it for other care providers (e.g. social workers, nurses, paramedics) in order to create more awareness about interpreting issues in a wider context. Finally, it is important to bring the language and cultural barriers in health care to the attention of a broader audience. Results of our research and training will be used to focus on solutions for the bilingual and multicultural problems on a political, social and scholarly level.

Chapter 8 Good practice - Turkey

Ibrahim Dereboy and Jonathan Ross

8.1 Medical interpreting training at Boğaziçi University

The training conducted by the Turkish partner in TRICC comprised a six-week (18-hour) module on medical interpreting. This module was incorporated, at different times, into two compulsory courses offered by the Department of Translation and Interpreting Studies at Boğaziçi University, Istanbul: a course on Community Interpreting within the department's undergraduate degree in Translation and Interpreting Studies and a course on Dialogue Interpreting taken by students attending the MA in Conference Interpreting, a programme connected to the EU-accredited European Masters in Conference Interpreting. The undergraduate and postgraduates modules followed roughly the same order, although the undergraduate course (taught in November–December 2009) and the postgraduate course (taught in April–May 2010) inevitably had to be designed slightly differently due to the differences between the two target-groups in terms of age and language-level as well as the dissimilar sizes of the two groups.

The trainees in the module taught to undergraduates were 23 Turkish-speaking students in the sixth semester of their degree, which concentrates on the language pair Turkish–English. The undergraduate students in our department certainly rank among the most gifted linguists in the country, and they are generally in the top-100 scorers in the Turkish university entrance exam language section. However, since the Turkish educational system unfortunately places little emphasis on productive language skills, our students are often very anxious about speaking English, a situation barely rectified during the university's English preparatory program or even in the course of the degree. All the same, the students invariably have sufficient competence in English to be potentially effective interpreters (at least in the consecutive mode), and by the time they come to the Community Interpreting course they have taken several courses that could assist them in the activity of interpreting in medical settings, such as introduction to translation, technical translation, on-sight interpreting and consecutive interpreting.

The four students who attended the (postgraduate) course in Dialogue Interpreting had even stronger potential as medical interpreters. For one thing, they were at least ten years older than their undergraduate counterparts, perhaps more familiar with medical problems and processes, more mature, and more adept at communicating in traumatic or problematic situations. In addition, they had a higher level of awareness, fluency and accuracy in English, which they needed in order to be accepted onto the MA program in the first place. Although none of the students who attended the dialogue interpreting course had had an undergraduate academic background in translation—three were graduates of Language and Literature departments, one a computer engineer—by the time they took the course in Dialogue Interpreting they had taken eight courses in the theory and practice of consecutive and simultaneous interpreting.

To be frank, few of the students attending either of the modules will have the opportunity to become full-time medical interpreters and thus make use of what they learned and experienced during the course: there are currently no professional interpreters employed in the Turkish public health service, and there are relatively few full-time openings in the private health sector, even though medical tourism and medical coverage for ex-pats are quite developed in Turkey. All the same, it is quite likely that at some point students will be called upon to interpret on an *ad hoc* basis, a situation which many students had already experienced. We have also had students in the past who, after

graduating, have worked as community and medical interpreters in English-speaking countries. Finally, given the expansion of medical tourism facilities and the increasing popularity of Turkey as both a retirement home for Europeans and a destination for refugees from Asia and Africa, it is not out of the question that medical interpreters with English will later be more in demand. In other words, while our trainees will probably have less chance to benefit from the training than will the participants in the training conducted by our partners in TRICC, the training we have offered will certainly not be in vain.

According to the official course description, the undergraduate course in Community Interpreting is supposed to provide students “Training in the skills of interpreting (English-Turkish, Turkish-English) for the social services and in legal, medical, business settings”, as well as “Familiarizing students with the diverse demands of dialogue interpreting.” The description for the postgraduate course is quite similar. Although the emphasis of both courses is on practice, our department is a department of Translation and Interpreting *Studies*, so we like to give our students some exposure to research and research methodologies in the field of community interpreting, while also ensuring that they become acquainted with more theoretical writing on the subject. Prior to taking the module on medical interpreting, all the students had had six weeks of lessons in which they had read and discussed about various aspects of community interpreting, including the following:

- (Problems of) Defining community interpreting and its differences from other types of interpreting
- History of community interpreting
- Sub-fields of community interpreting
- The (ideal and actual) position of the community interpreter vis-à-vis the service provider and the client, e.g. the issues of neutrality, advocacy, etc
- The different actions of the community interpreter within the triad, such as ‘literal translation’, asking for clarification, explanation & explicitation, smoothing, restoring communication, etc
- Issues of pragmatics and register
- Ethical principles, e.g. accuracy, confidentiality, impartiality, professionalism
- Good practice, e.g. pre-interview briefing to both parties, positioning, effective note-taking.

In small groups, the students had done a number of simulations involving an interpreter, such as an interaction between a Turkish police officer, a British tourist, an angry Turkish citizen accusing the tourist of urinating in public, and an English-speaking Turkish passer-by whom the police-officer asks to interpret. Students had also focused on another sub-field of community and dialogue interpreting, about which they had done some terminology work, prepared presentations, and enacted role plays. In the case of the undergraduates the topic was public housing in the UK; for the postgraduates it was liaison interpreting concerning Turkish-British business relations in the citrus-fruit and textile sectors.

The specific aim of the medical interpreting module was to help students to be in a better position to deal with any *ad hoc* or professional medical interpreting tasks they might face— more precisely, to motivate them to act confidently and responsibly, and with maximal conformity to international professional norms. (At present, in Turkey there are no official codes of best practice or ethics for medical interpreting.) To this end, the modules were planned in such a way as to draw the attention of students to the ethical and cultural aspects and problems of medical interpreting, as well as to the more linguistic aspects such as terminology and discourse, and then to give students practice in coping with these aspects. The module was planned and taught by two people: Dr Jonathan Ross (JR), an English native-speaker working as a full-time lecturer in the

department, with four years' experience of teaching Community Interpreting, and Dr İbrahim Dereboy (ID), the Turkish head-doctor of the university's medical centre, who had experience of working as a freelance medical interpreter in the UK.

8.2 Training programme

The modules consisted of four main parts, culminating in a final exam, which shall be described further on.

(1) General introduction to medical interpreting (week 1)

We started the module by eliciting students' thoughts about, and experiences of, the particular challenges of interpreting in medical settings. This was followed by the modelling of a situation intended to highlight particular challenges of medical interpreting. While ID was a Turkish doctor, JR played the role of an English ex-pat in Turkey who had come to consult the doctor about a venereal wart acquired during a sexual encounter with a prostitute. The conversation was interpreted by a volunteer student who had not been briefed about the patient's complaint. This scenario brought to the fore issues such as the possible uneasiness of interlocutors (including the interpreter) about discussing intimate, sexually-related matters, the difficulties posed to the interpreter by the doctor's use of highly technical jargon and the patient's recourse to slang and euphemism, as well as technical aspects like the interpreter's unsureness about how to position himself during the consultation.

After a class discussion on the modelled situation and the interpreter's performance, JR drew attention to the existence in some countries of standards of best practice and codes of ethics for professional interpreters, adding that no such standards had been established in Turkey, where public-sector medical interpreting had not yet reached any degree of institutionalisation. As an example of a set of standards, the 'National Standards of Practice' (2005) developed by the (US) National Council on Interpreting in Health Care (www.ncihc.org) was outlined and subjected to a critical evaluation by the class (*see* Table 8.1).

While the students were encouraged to derive some guidance from the Standards, which seemed to offer clear answers to some questions they had about "What should I do if...?", we were also keen to draw attention to the grey areas and potential contradictions within the Standards. To give one example, the first of the 32 standards states that "The interpreter renders all messages accurately and completely, without adding, omitting or substituting". The ethical principle linked to this statement, however, notes that "Interpreters strive to render the message accurately, conveying the content and spirit of the original message, taking into consideration the cultural context." A question that might arise here is how the interpreter can give consideration to the cultural context without adding anything to the message.

Table 8.1 National standards of practice*

Standard	Related ethical principle
Accuracy	The interpreter strives to render the message accurately, conveying the content and spirit of the original message, taking into consideration its cultural context.
Confidentiality	The interpreter treats as confidential, within the treating team, all information learned in the performance of their professional duties, while observing relevant requirements regarding disclosure.
Impartiality	The interpreter strives to maintain impartiality and refrains from counseling, advising or projecting personal biases or beliefs.
Respect	The interpreter treats all parties with respect.
Cultural Awareness	The interpreter continuously strives to develop awareness of his/her own and other (including biomedical) cultures encountered in the performance of their professional duties.
Role Boundaries	The interpreter maintains the boundaries of the professional role, refraining from personal involvement.
Professionalism	The interpreter must at all times act in a professional and ethical manner.
Professional Development	The interpreter strives to continually further his/her knowledge and skills.
Advocacy	When the patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem.

*) 32 standards grouped under 9 headings, each corresponding to an item in the NCIHC's Code of Ethics (2004). Source: www.ncihc.org

(2) Focus on discursive and cultural aspects of medical interpreting (week 2)

At the end of week 1, students had been assigned to read two academic articles on linguistic and discursive aspects of medical interpreting:

- 1) Jan Cambridge (1999). Information loss in bilingual medical interviews through an untrained interpreter. *The Translator*, 5, 201-19.
- 2) Bernd Meyer (2001). How untrained interpreters handle medical terms", in Ian Mason (ed.), *Triadic Exchanges: Studies in dialogue interpreting* (pp. 87-106). Manchester: St. Jerome.

These were summarised and discussed in class and their practical implications debated. Then the focus turned to the place of culture and cultural differences in medical encounters. As a lead-in to this topic, JR introduced the online "Cultural Reference Guides" prepared by the Ohio State University Medical Centre to make health workers more aware of specific needs, perceptions and behaviours of patients from minority communities (see example in Box 8.2).

It was stressed that such guides could easily encourage essentialist thinking and stereotyping and prevent health workers from considering the individual patient with a minority background as an *individual*. All the same, the categories used in the Cultural Reference Guides ('Language', 'Spiritual / religious practices', 'Communication', 'Food practices', 'Family', 'Health practices', 'Death / dying') provide a handy framework for thinking about characteristics common to (or stereotypes attributed to !) members of certain communities as well as discussing differences within societies and social groups.

After we discussed the rights and wrongs of such documents, the class was split into five groups, one of the above-mentioned categories was assigned to each group, and the groups were given around half-an-hour to brainstorm for aspects of Turkish culture related to this category that an interpreter might need to explain to an English-speaking doctor faced with a patient from Turkey. The points emerging from the brainstorming were shared and discussed.

Box 8.2 Example of a cultural reference guide

Cultural Reference Guide: Amish

This is intended as a staff reference for use as a starting point for understanding care for those of different cultures. Always talk with your patient and their family to learn about his/her particular beliefs and practices to avoid stereotyping. There can be large variations in beliefs and practices even within a given family. Be respectful of the uniqueness of each person you care for at OSUMC. See “Resources & References” for sources for this information.

Language: **English and Dutch**

Spiritual/Religious Practices

- _ **Belief that one must live life purely and free from influences.**
- _ **Religious beliefs do not prevent surgery, blood transfusions, anesthesia or dental work.**
- _ **Organ transplant is allowed, but not the heart. Children may have a heart transplant at birth (before baptism).**

Communication

- _ **If a phone call is made, it is an emergency. Do not place on hold or try to call back.**
- _ **Most seek permission from the church for health care, because church pays for health services.**
- _ **Tell patients about discharge—transportation must be arranged.**
- _ **Education usually limited to 8th grade**

Food Practices

- _ **Many use kitchen gardens or raise crops. Foods are canned.**
- _ **High exercise agrarian lifestyle means few worry about high-fat or high cholesterol foods.**
- _ **Food is affected by Amish order. Old Order Amish prefer basic foods- whole grain breads, few sweets, and balanced vegetable protein intake. New Order Amish may shop at local grocery stores.**

Family

- _ **Husband and wife share decision making for health.**
- _ **If family chooses to refuse treatment, talk about disability. Disability is a greater concern than death.**
- _ **High value is placed on child rearing, not economic gain.**
- _ **Women wear white head covering when married, black when single.**

Health Beliefs

- _ **Define health as someone who has good appetite, looks physically well and is able to do rigorous physical labor.**
- _ **Faith healings, herbal remedies. May see chiropractor before medical doctor.**
- _ **Use Western med only in emergency. Do not seek preventative treatment or birth control.**
- _ **Only want experienced doctors.**
- _ **When giving meds, remember they may have trouble keeping things cold.**
- _ **Like herbal remedies and vitamins.**

Death/Dying

- _ **Death is a chance to “be one” with God. There is refusal for autopsy. Preference is to die at home. Will not refuse home health care for end of life issues. Yet, will be rationed to consider community’s finances.**

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Source: <http://medicalcenter.osu.edu/PatientEd/Materials/PDFDocs/CulturalRefGuides/Amish.pdf>

(3a) Undergraduates: *Simulations and presentations* (weeks 3 and 4)

The third week’s class began with short simulations of interpreted medical encounters. In the previous week, students had been asked to think of common minor medical ailments from which they or people they knew had suffered. Now they were placed in

groups of three and had to take it in turns to play the role of a Turkish or English-speaking patient who was suffering from this ailment, a doctor, and an interpreter. JR and ID went around the class, listening in on the simulations, answering questions, and commenting on the performance of the three role-players, especially the interpreter. After general problems emerging from the simulations had been discussed by the whole class, students (working in pairs) gave informative research presentations on topics related to medical interpreting that had been allotted at the very beginning of the module. The topics were

- Legal responsibilities of medical and other interpreters according to laws and guidelines abroad
- Comparison of the Turkish and UK health systems
- Traditional medical practices in Turkey
- Remote (i.e. video & telephone) interpreting in medical settings
- Medical tourism and interpreting in Turkey
- Characteristic features of doctor-patient communication.

(3b) Postgraduates: *Simulations, presentations and terminology work* (weeks 3 and 4)

The simulations were conducted in a similar matter to those in the undergraduate course, and each of the students gave a presentation. Due to the small size of the class, there was time to do additional activities, and we planned to exploit this by working on the then very topical theme of *swine flu*. In week 2, the students had been asked to look at a very extensive Turkish-language PowerPoint presentation on swine flu prepared by a doctor in the university medical centre, to find and note down English equivalents for the Turkish terms they identified, and to produce a glossary on swine flu. In the class in week 3, the students were asked to carry out on-sight interpreting (into English) of an English-language text on swine flu prepared by the World Health Organisation. Having thus reinforced their knowledge of the substance and terminology of swine flu, the students were asked to role-play three situations involving an interpreter:

- An adult English-speaking patient reports to a Turkish-speaking doctor with symptoms of swine flu
- A drug representative for a foreign company selling a vaccine for swine flu has a meeting with a group of Turkish citizens about the pros and cons of the vaccine
- A Turkish-speaking mother in London asks her English-speaking doctor how to protect her child from catching swine flu

(4) Scripted dialogues and glossaries (weeks 5 and 6)

The fifth week's lesson began with a discussion of three scholarly articles on cultural issues in health care and interpreting, the first of which was of particular relevance to the matter of interpreting for Turkish-speakers:

- 1) Schouler-Ocak, M. *et al.* (2008). Cultural factors in the diagnosis and treatment of traumatised migrant patients from Turkey. *Transcultural Psychiatry*, 45, 652-670.
- 2) Kaufert, J.M., & Putsch, R.W. (1997). Communication through interpreters in healthcare: Ethical dilemmas arising from differences in class, culture, language, and power", *The Journal of Clinical Ethics*, 8, 71-87.
- 3) Mirdal, G.M. (1988). The interpreter in cross-cultural therapy", *International Migration*, 26, 327-334.

We then moved on to an activity intended to enhance students' medical terminology and familiarity with the discourses exhibited in medical encounters between English-speaking doctors and Turkish-speaking patients, and vice-versa. In week 3, students in the undergraduate class had been divided up into groups of 3 or 4 and each group was 'assigned' one of eight relatively common medical conditions: Irritable Bowel Syndrome,

Acid Reflux, Hay Fever, Panic Attacks, Polycystic Ovary Syndrome, Type 2 Diabetes, Torn Meniscus, and Cystitis.

(Students in the postgraduate class completed the task individually, with each student working on two medical conditions.) For week 5, every group (every individual student in the postgraduate class) had to prepare a glossary of 20 Turkish-English pairs of terms related to the condition assigned to the group, together with a script for an interpreted encounter between a doctor and a patient with symptoms of this condition (Box 8.3).

Box 8.3 Sample of an MA student's script for an interpreted doctor-patient interaction (Author: Cem Ülgen)

IRRITABLE BOWEL SYNDROME – HASSAS BAĞIRSAK SENDROMU (SPASTİK KOLON)
(P) Patient : 48 years old, female, from a village in Central Anatolia. Has had the syndrome for a month now.
(D) Doctor: Swedish, 57 years old, male, a visiting professor in a reputable university hospital in Istanbul.
(I) Interpreter

D: So, how can I help the lady? What is her complaint about?
I: Doktor bey size nasıl yardımcı olabileceğini soruyor, şikayetiniz neydi?
P: Tercüman hanım, Türk doktor yok muydu acaba? Benim durum biraz karışık da...
I: She is asking me whether or not there is a Turkish doctor she could see as her situation is a bit complicated.
D: Please assure her that it will not make a difference. We are all sworn caregivers.
I: Emin olun, hiçbir şey fark etmez. Hepimiz yeminli tıbbi görevlileriz.
P: (squeamish) Hiç olmazsa bir hanım olaydı?
I: Can't I see a female doctor?
D: Listen, I am the only one in right now. She will have to make do with me.
I: Şu anda müsait bir tek ben varım. Benimle yetinmek zorundasınız.
P: Peki... Aaa, şimdi... Benim derdim büyük abdestimle ilgili – Tercüman hanım ben utanırım, anlatabileceğim bir kadın yok mu acaba?
I: My problem is with my bowel movements. Can't I speak to a woman doctor? I feel ashamed.
D: There is no need to be ashamed ma'am. We all have bowel movements. It's an indispensable part of life. What is the problem?
I: Utanmanıza hiç gerek yok han'fendi. Hepimiz büyük abdest yaparız. Hayatın vazgeçilmez bir parçası bu... Sorunuz nedir?
P: Yaklaşık bir aydır düzenli yapamıyorum doktor bey. Bazen kabız oluyorum, günlerce çıkamıyorum tuvalete, bazen de sürekli ishal oluyor, tuvaletten çıkamıyorum.
I: I haven't been having regular bowel movements for almost a month now. At times I am constipated for days and at times I get diarrhoea and can't leave the bathroom.
D: Hm, well, do you also have abdominal pain? Before, during or after your bowel movements?
I: Peki karın ağrısı da çekiyor musunuz? Tuvaletten önce, sırasında veya sonrasında?
P: Evet oluyor, özellikle yaparken. Bazen o kadar şiddetli ağrıyor ki bayılacağım sanıyorum.
I: Yes, I do. Especially when I am in the process. Sometimes the pain is so sharp that I feel as if I'll faint any minute.
D: Have you had any illnesses before your complaints began?
I: Peki şikayetleriniz başlamadan evvel herhangi bir hastalık geçirdiniz mi?
P: Hayır ciddi birşey yoktu.
I: No, nothing serious.
D: What have you done to cure it for the month you had complaints?
I: Şu bir ya boyunca herhangi bir tedavi gördünüz mü?
P: Hayır da bizim köyde ayran yapılır çok güzel, karın ağrısı çektiğimi duyunca bana devamlı ayran içirdiler. Ama hiç bir değişiklik olmadı. Hatta daha bile kötü oldu.
I: They make very good ayran in our village so when I came down with the complaints they made me drink a lot of ayran. But it didn't change a thing. In fact, it made it worse.
D: Hmm, well you could be lactose intolerant you know? This sounds like IBS to me, and people with lactose intolerance are quite susceptible to the syndrome.
I: Laktoz hassasiyetiniz olabilir. Bahsettiğiniz şikayetler hassas bağırsak sendromunu

çağırıştırıyor ve laktoz hassasiyeti olanların bu sendroma kapılma olasılığı yüksek.

P: Laktoz ne ola doktor bey? Anlamadım.

I: What is lactose, doctor? I don't understand.

D: Sensitivity towards milk and dairy products. You might be allergic to them.

I: Sütü ve süt ürünlerine karşı bir duyarlılık durumu. Belki de bu ürünlere alerjiniz vardır?

P: Valla doktor bey ben süt de sevmem yumurta da. Küçükken zorla yedirirlermiş, sonra vücudumda acaip lekeler çıkarmış, o yüzden bıraktırmışlar.

I: Well, doctor, I don't like milk or eggs. They used to force it down me but my body would come down with strange rashes so my parents stopped giving it to me.

D: Well this could be a reason though since you don't eat them anymore, I don't see why you should come down with IBS.

I: Bu bir sebep olabilir ama halen bu ürünleri yemiyorsanız hassas bağırsak sendromu için geçerli bir neden olmayabilir.

D: How about celiac disease? Have you had anyone diagnose you with it?

I: Peki ya çölyat hastalığı? Daha önce böyle bir tanı kondu mu size?

P: Çekyat hastalığı mı? O ne doktor bey?

I: I don't know what this is.

D: Well it's a disease that's caused by a reaction to gliadin, a gluten protein.

I: Gliadin'e yani bir gluten proteinine alerjiyle gelişen bir hastalık.

P: Bahsettiğiniz şeyleri bilmiyorum ben.

I: I have no idea what you're talking about.

D: It is basically found in wheat, gliadin I mean.

I: Gliadin genelde buğdayda bulunur.

P: Yok, buğday hep tüketiriz, bir sorunum olmadı henüz buğdayla.

I: No, we consume wheat all the time; I haven't had any problems yet.

D: Well, that rules that out.

I: O halde bu da yeterli bir sebep değil.

P: Doktor bey, Allahaşkına bana bir çare. Ne yapmam gerekiyor? Hiç bir işimi halledemez oldum. Ağrıdan, tuvalete girip çıkmaktan bıktım artık!

I: Doctor, find me a cure for the love of God. What do I have to do? I am completely incapacitated. I am sick and tired of the pain and the frequent trips to the bathroom.

D: Don't worry; you'll get through this. But first, I need you to take some tests and see a dietician. You need to get your stool tested. Also, the dietician will tell us if you've been eating properly and what you can eat to feel better.

I: Merak etmeyin, bunu atlatacaksınız. Ama önce sizden bir test yaptırmanızı ve bir diyetisyenle görüşmenizi istiyorum. Önce bir dışkı testi yaptırın. Diyetisyen de size düzgün beslenip beslenmediğinizi ve daha iyi hissetmek için neleri yemeniz gerektiğini anlatacaktır.

P: Çok teşekkür ederim doktor bey, söylediklerinize uyacağım.

I: Thank you very much doctor, I will do as you say.

During the classes in weeks 5 and 6, the various groups/students presented their glossaries and then performed the dialogues they had drafted. Feedback on these glossaries and scripts was given immediately and the trainees were asked to revise and resubmit their scripts. They were also supposed to share the second draft of their glossaries and dialogue scripts with their other classmates, via an online group that had been set up for the class.

Exam (week 8)

Since the modules took up a large proportion of formal university courses, it was necessary to grade students' effort and achievement. This was a module on medical interpreting, so it seemed appropriate to assess the actual performance of students as interpreters, in addition to their other classwork and assignments. For this reason, we designed the exam format of an interpreted consultation between the Turkish doctor, ID, and either JR, who played the role of various male patients, or another female colleague. The students came to the consultations in pairs, and the exam-consultations were videoed with the consent of the students, to provide a record of students' performances and to furnish material for future research and training. Each student had to interpret for a patient presenting symptoms of one of the conditions covered in weeks 5 and 6,

except for the condition they had worked on for their dialogue and glossary. The students' performances were graded according to the criteria of general interpreting performance, terminology, and use of English, the latter criteria being included due to our department's aim of maximising students' proficiency in this foreign language.

8.3 Evaluation – outcomes

Since the Turkish partner in the TRICC project was primarily responsible for cultural mirroring and was focusing on conducting innovative research into the extent and characteristics of informal interpreting in Turkey, it was not until late on in the project that we considered appraising the training we provided anyway in such a structured manner as our other partners were doing. Having said this, we learned a lot from the methods used by our partners, from the discussions of these methods at the various TRICC meetings, and from the feedback we received about our program when we presented it at the TRICC meeting in Hamburg (22-24 January 2010). Because the training was not the central component of our contribution to TRICC, we did not conduct any pre-training testing or elicit any evaluation right at the end of the training. A feedback form was prepared and distributed to all the students in the class, asking them to list things they had learned during the module and things they would have liked to learn more about, to identify aspects of the module from which they think they had or had not benefited, and to suggest ways of improving the module. Unfortunately, very few (4) students returned their forms, presumably because the form was emailed out immediately following the training, which happened to be the end of term, when students were busy with exams. All the same, the four responses were generally positive about the training, and the things students claimed to have learnt concurred with the aspects of medical interpreting we had been wanting to emphasise, such as medical terminology in different registers in both languages—an element students still wanted to learn more about—, communication-crisis-management skills, and the need for the interpreter to explain their role to the patient and doctor before the consultation.

If we incorporate the overall exam performance of students into our evaluation of the training, this performance can be said to reflect well on both the students and the module. All students in both courses passed the exam, with the average grade in the undergraduate course being 78.5% (a grade judged “Fair to Good” according to Boğaziçi's official grade descriptors) and in the postgraduate course 86%. (To provide concrete examples of ‘good practice’, recordings of some of the highest performing students in the two classes are included in the accompanying CD). Students mostly managed to maintain effective communication between the doctor and patient, and only in the case of a few students did we witness poor interpreting seriously affecting the flow of information between the patient and the doctor. Impressively, all the students started their exam-slot by briefing the patient and the doctor about the ground rules for the consultation (e.g. by warning both that he/she would translate everything that was said and by requesting them to address each other directly), and by and large students displayed very professional and ethical behaviour, such as correcting themselves once they had misinterpreted and making an effort to uphold transparency, by informing one party about what they had been talking about with the other.

8.4 Ideas for the future

Judging from the exam and the feedback received, it would appear that the training met its objectives. In future training for other students at Boğaziçi, some changes might be

made to the choice of presentation topics (a request repeated by several students), and more attention might be paid to terminological issues. An even more exciting prospect, which would also correspond more to actual social needs in Turkey, would be to offer a shorter and modified version of the module to bilingual (Turkish and Kurdish) citizens who frequently serve as informal interpreters (see section 3.4). While such a version could incorporate the points stressed in the current module (e.g. the importance of the interpreter's briefing, of transparency and responsible and ethical behaviour) and use some of the same methods and materials (the "National Standards of Practice", the "Cultural Reference Guides", simulations, glossary preparation), in order to deal effectively with terminological and discursive issues we would need to collaborate with a Kurdish speaker with medical knowledge. Furthermore, depending on the educational backgrounds of the trainees, it might be necessary to remove some of the more 'academic' components (e.g. the presentations and readings), although the useful insights they provide would have to be rendered by other means.

Chapter 9 Good practice - United Kingdom

Akgul Baylav and John Eversley

9.1 Aims of training

The aim of the training was to develop and enhance the intercultural and bilingual awareness and competencies of informal and ad hoc interpreters, healthcare providers and students.

9.2 The participants

There were five groups of participants:

1. *Staff and volunteers from Non Governmental Organisations (NGOs) and a Primary Care Trust (NHS Tower Hamlets):* Most of these participants were from the Somali and Bengali/Sylheti linguistic communities. They were bilingual and used their dual language skills in their work as paid employees or volunteers interpreting for people they generally did not know. Crucially they were not recruited or trained as interpreters. A few were refugee health professionals from their own countries seeking alternative employment in the UK. Three were not bilingual but were interested in linguistic and cultural issues relevant to the multi-cultural community they were working in (i.e. East London).
2. *A group of students at a further education college on health and social care related courses leading to Higher Education.* They were bilingual in a variety of languages. They were called on to interpret as informal volunteers for friends, family, neighbours.
3. *Nursing students:* They were not specifically identified as a group of bilingual students but half spoke more than one language and some had been called on to use a language other than English. The significant issues of mediation for them were cultural and faith capability and competences.
4. *Imams (mostly) of Bangladeshi origin:* prayer leaders at mosques in Tower Hamlets. They were called on primarily as linguistic mediators but also to give health related advice and information from an Islamic perspective appropriate to the Bangladeshi community.
5. *Health and healthcare managers and practitioners* who were specifically interested in issues of Islam and Health – language was not a central preoccupation.

In total 102 people took part in the various events (Table 9.1).

Table 9.1 Participants in TRICC UK training

Group	Further information	Numbers
1. Tower Hamlets College	Access course students	7 learners
2. Health Trainers	Bilingual staff working for NHS Tower Hamlets	Two courses: 1) 8 learners 2) 11 learners
3. Women's Health & Family Services	Bilingual staff working for NGO	18 learners
4. Refugee Women's Association	Bilingual staff working for NGO	6 learners
5. City University	Graduate Entry Adult Nurses in training	8 participants
6. Tower Hamlets Council of Mosques	Imams (advisers to informal and <i>ad hoc</i> interpreters)	17 participants
7. NHS – Tower Hamlets	Clinical leaders (users of informal and ad hoc interpreters)	27 participants
Total		102

9.3 Needs

Exploration of the participants needs and expectations reinforced the observation that informal interpreting was a widespread practice but more importantly the need to equip staff and students with strategies to handle it professionally and skilfully. A recurring theme amongst all the target groups and training programmes was how to maintain boundaries without causing offence or appearing rude to either patient or the clinician. Many participants stated that saying “no”, refusing people in authority (due to age, seniority or status in society) was difficult, almost unacceptable, in many of their cultures.

9.4 Specific aims of training

Each of the courses had specific aims.

NGOs, Health Trainers and Further Education College:

- To enhance learners’ language and cultural competencies;
- To familiarise learners with terminology of the public agencies they will be working in;
- To train learners in community interpreting skills and techniques;
- To raise learners’ awareness of culture-specific issues around health;
- To raise learners’ awareness of public services and a range of health and social care settings;
- To train learners in collecting, collating and analysing relevant local information.

City University, nursing students:

- To explore issues of communication with healthcare students currently undertaking professional training;
- To enhance their own understanding of cultural competency;
- To understand how communication is mediated through culture and faith;
- To develop an understanding of, and an awareness about, how their own values; culture and beliefs can impact on their decisions about patient care.

Health managers and practitioners and Imams:

- To explore the issues of cultural, faith and linguistic mediation for Muslims in Tower Hamlets including the relationship between culture and faith
- To increase their knowledge of how Islam might impact on healthcare and specifically the role of Imams
- To promote concordance between health care providers and public health promoters on the one hand and users or populations to maintain and improve health and make health care effective.
- To encourage employers, schools, colleges, universities and mosques to work together to enhance capabilities.

9.5 Organisation of training

The training was organised by associates of *ppre, Community Interest Company*, a not-for-profit research and education company. *ppre* associates have been involved in research and development around equalities and specifically issues of language and culture and healthcare for many years.

Partners: Each training course or event was organised with an external partner. The partners were:

- Three community based organisations - Women's Health and Family Services, the Refugee Women's Association and Tower Hamlets Council of Mosques
- Two education bodies – Tower Hamlets College – a further education college and City University, School of Community and Health Sciences which trains nurses and other health professionals
- NHS Tower Hamlets - a Primary Care Trust in East London
- Making Training Work, a training organisation which undertook to arrange accreditation of training through the Open College Network.

9.6 Learning Methods

The overall learning strategy of the programme followed the approach of Paulo Freire – based on experiential learning and drawing out the knowledge of the participants rather than treating them as bank customers making withdrawals from the 'bank' of educators (Freire, 1972). This was done by using participants' personal experiences and local examples.

With the NGOs, the Health Trainers and Further Education students, it was possible to incorporate the use of Forum Theatre. For the other groups it was felt that time was too limited to use Forum Theatre. Role plays were extensively used, however.

Case studies and examples were used with all groups – examples are given in Box 9.1.

The participants were encouraged to bring real life cases to the training. The emphasis given to maintaining confidentiality gave them confidence that 'what was said in training stayed in training'. As such the training groups were able to explore each other's examples of work situations that they had found challenging – framing the problems and the solutions. Several participants anecdotally commented that they had been looking for the 'right answers' and realised this wasn't always possible. They also said they would talk to colleagues more about finding solutions to challenging interpreting scenarios in the workplace after witnessing how discussing cases could assist so positively rather than struggling on their own.

Small group work was used with all groups (except the Imams). A gentle sense of competition was often used to encourage the learners to participate actively and "perform well" in their teams.

Discussion triggers of various kinds were used- watching and discussing a training DVD for example. This was used with the NGOs to prepare for and to structure/conduct an interpreted consultation. Group work centred on "What happens when different parties interpret – advantages and disadvantages of having friends/family members, including children, and professional community interpreters to interpret for a service user who does not share the same language and culture with the providers of services." This proved to be particularly useful in highlighting different aspects within the social and cultural context of interpreting.

For the longer courses different exercises were used, such as "*Designing the ideal interpreter*" and quizzes on various aspects of interpreting and on ethical issues of interpreting. The participants found short scenarios using a quiz format both enjoyable and challenging.

Most of the 'community' participants (bilingual and non bilingual learners) both lived and worked locally and were therefore familiar with the backgrounds, living conditions and aspirations of their communities and clients. Many of the community workers, volunteers and health trainers were second and third generation migrants. Most of the Imams and some of the students were first generation migrants.

What would you do if you were an interpreter and:

1. The client gave you some information and told you to keep it confidential
2. The client gave you information which was not relevant to the question asked by the professional
3. The client swore or said offensive words
4. The Professional said something to you during an interview and told you not to pass the message on to the client
5. The professional said something which showed that s/he does not understand the requirements of the client's culture
6. The professional asked you to interpret in Arabic, your first language is Persian but you understand some Arabic
7. You have been asked to attend a psychiatric ward with Mr B who is having an appointment with his psychiatrist. Due to his mental health problems and stress, Mr B keeps rambling on emotionally and incoherently

Case studies used with health managers and practitioners:

- (1) Mr Sarwar, a 49 year old Bangladeshi taxi driver, suffered a stroke two years ago, which has left him with a major right-sided weakness of his arm and leg. He has a minor speech impediment and incontinence. He continues to smoke 25/day, stating that he will stop "when Allah wills." Of at least equal concern to his GP and neurologist is that his compliance with statin therapy and aspirin are poor. What can be done to help him quit smoking and improve compliance?
- (2) Rachna, a 15-year old GCSE student makes an appointment to see her school nurse. Tearfully, she confides that she might be pregnant as her last period was four months ago. The only other person she has told is Katrina, a classmate. The pregnancy test is positive. What issues might it be helpful for the school nurse to be aware of?
- (3) Mrs Begum, a 24 year old recent migrant from Bangladesh, consults for the third time with problems of aches and pains in her arms and legs, poor sleep and tiredness all the time. Suspecting a diagnosis of depression, the GP prescribes an anti-depressant and arranges a review four weeks later. At review, she is no better. Why might this be the case?
- (4) There is a local recruitment drive to try and recruit a more diverse nursing and allied health professional workforce (i.e. dieticians, physiotherapists and occupational therapists, etc). There is a particular need for female practitioners who can communicate effectively with the high proportion of Bengali-origin patients. What factors should those planning the recruitment drive take into account?
- (5) Jamal, a 13 year boy consults with his father to ask about whether he should fast. Looking through his medication history reveals that he has been getting through an average of two blue (reliever) inhalers a month, suggesting poor asthma control. His father also expresses concern that he is not doing well at school and spends too much time sleeping.
- (6) Mr and Mrs Malhotra attend the antenatal clinic following a pre-natal diagnosis of a major congenital anomaly. They have three other children, one of whom has severe cerebral palsy. Mr Malhotra went to discuss the problem with the local Imam who said that "He will pray for the family and that everything will be fine, Inshallah." The issue of a termination comes up in the discussions with the obstetric staff. Reassured, Mr Malhotra is unwilling to contemplate a termination. In contrast, Mrs Malhotra appears apprehensive. She says little in the consultation. What issues is it important for the obstetric/midwifery staff to be aware of?
- (7) Mr Akmal, a 37 year old shop-keeper attends to enquire if it is ok for him to go on Hajj. Reviewing the notes, you notice that his diabetes tends to be poorly controlled. He is obviously overweight, but otherwise appears in reasonable health. What should you advise him?
- (8) The local health promotion team have had a three month run of weekly outreach work trying to promote cardiovascular health. This has centred on the opportunity for drop-in sessions after Friday prayers at mosques throughout Tower Hamlets. At a debrief meeting one month into the campaign, the health promotional teams express concerns about the "complete lack of interest". Why might this be the case? Should they abandon the campaign? What might they do differently?

We did not specifically ask the health managers and practitioners about their backgrounds but some volunteered that they were not familiar with the backgrounds of many of their patients.

The backgrounds of the participants influenced the learning methods. For all the informal and *ad hoc* interpreters the issue of recognition of their skills was important. Therefore accreditation was built in. Accreditation requirements influenced learning methods. For example, the second and third generation migrants understood and spoke English and their respective community languages but they were less confident and capable in writing in a community language and therefore in compiling specialist terminology in a second language. They needed to do this to compile a Bilingual Glossary in Public Services for the accredited Unit. Those who anticipated difficulties in writing their assignments were offered the option of transliterating or reading it onto a tape. It was felt that all the groups needed some didactic input but this was generally organised as a response to needs identified by the participants. Inputs included:

- a) Theoretical issues such as Modes and Models, Skills and Techniques of Interpreting, Issues relating to Interpreting – e.g. verbatim vs. summary, first vs. third person interpreting, confidentiality, dependency/detachment/boundaries, intervention skills as well as legal and ethical aspects of interpreting (NGOs);
- b) Background to the social, organisational context, professional contexts and approaches to mediation (College and University students, health managers and practitioners);
- c) An introduction and some insights into notions of authority and the core beliefs and pillars of Islam (health managers and practitioners).

9.7 Forum Theatre in the UK project

The aims of using Forum Theatre were to bring about reflection on the relationship between the theory and practice of *ad hoc* interpreters. The objectives were:

- To evaluate and consolidate the learning so far;
- To look at power relationships;
- To review participants' approaches in dealing with them;
- To explore a range of solutions.

Using Forum Theatre: Forum Theatre was used with the further education students and the NGOs and NHS health trainers.

At the beginning the participants were not very clear about what they were there for, as the process is hard to envisage for people with no previous experience of Forum Theatre. Each workshop was introduced by a set of ground rules agreed by participants. One of the facilitator's ground rules is always "have a go!" which, when agreed to by a group, can boost confidence and motivation to join in.

The first Forum Theatre event (for further education college students) did not allow time for reflection. Later events (generally lasting about five hours) allowed the participants to explore the metaphorical nature of their experiences and stories. This involves using image and theatre, made by the group, to see their own experiences in relationship to others', to "pluralise" those experiences so that each acquires a significance greater than it has singly. This is both a reflexive and a creative process and combines the advantages of both.

Introductions

The groups were asked at the outset to name their roles in their work and then to deconstruct them in terms of their capacities and capabilities; for example: translator, listener, negotiator, empathiser, holder of boundaries etc.

Games

Following this, two games, *Zip Zap Boing!* and *123!* encouraged spontaneity, fun and opened up the potential for surprising, unanticipated discoveries. The image games and, always, a blind exercise called simply Follow the Sound, fuelled a reflexive process around issues of how to respond both to vulnerable others and to a vulnerable self. Examples of all the exercises used in Forum Theatre are given in Box 9.2.

Box 9.2 Forum Theatre Exercises

Hypnosis

1. In pairs. Hand 4-6 inches from and parallel with partner's face. Keeping the distance is the main focus;
2. Partner follows the hand wherever it leads;
3. Leader to move at a reasonable speed, not so fast that impossible to follow.
4. Try to stretch and develop the capabilities of the partner. Stay with your hand: if you explore floor level, keep your head and shoulders level with the back of your hand.

Follow the sound

1. Partners A and B;
2. A agrees a guide sound with B: needs to be of the voice rather than mechanical like a click;
3. B shuts eyes and follows sound. Only moves when she can hear sound;
4. A leads and becomes more elusive, loud, soft, far, near, stops etc.
5. This can be done as a rainforest exercise or with some kind of a journey in mind e.g. guiding round obstacles;
6. It's a trust exercise and requires the blind person to be attended to and kept from collision also to be challenged in a way appropriate for that individual;
7. Swap over.

Go towards

1. Partners. Shake hands, eyes closed, step back an agreed number of steps.
2. Eyes closed, find handshake again.
3. Go further away, repeat a few times.
4. Embrace; step away, and as above.

Occupy the space

1. Ask group to walk fast round the room covering the space evenly: if you see a space move into it, cover gaps.
2. Ask group to move round room briskly looking into each other's eyes neutrally and holding the gaze: glance and keep moving.
3. Ditto, acknowledging each other, with big smiles.
4. Ask ditto but this time to look and quickly look away.
5. Ask half the group to hold gaze, the other half to avert eyes after quick glance.
6. Swap round.
7. Group as it walks, takes on the character of a service provider/power holder, a service recipient; briefly finding and holding the intuited characteristics, walking like them, sitting like them etc.
8. Deconstruct, discuss, name with the group.

Discussion

Deconstruct these exercises with the group. Why do we enjoy power so much? Do we all? What was it like to be the person led? The leader? How did it feel? What did you think? How differently did people behave from how you expected? What did you have to do to adapt? What does it remind you of? How do these feelings relate to your work?

The experience of these games referred directly and indirectly back to the roles/capacities session and raised questions about the relationship between values and practice, which were followed through as the workshop progressed.

Images

The warm up exercises used are described in Box 93. A transitional image exercise, *Occupy the Space*, brought the experiences of exercising or being on the receiving end of, power relations, having to trust or be trusted into the room through evoking both physical and cognitive recall.

From this process of the embodying of ideas and experiences in a general way, participants divided into small groups of 3 or 4 and each created a “snapshot” image of an actual moment when they had experienced an obstacle to realising their intentions. They did this in the first instance in silence without explaining the image to the others. They showed the images unexplained, to the whole group. Group process of projecting meaning onto ambiguous images helps recognition of ambiguities and exploration of differences and convergences. Themes of power, anxiety, confusion, puzzlement, desire for action, aspiration, commitment, passion for change emerged.

Scenarios

Groups were next asked to get back together, explain the images and select one to convert into a scenario, with improvised dialogue, for working as a Forum Theatre piece with the whole group.

The scenarios were very diverse. Two groups, independently from each other, chose scenes about family relationships in the Bengali community. It emerged that those scenes, which at first sight did not relate to the work they were doing, were in fact strongly connected to the participants’ work. In families, parents’ power over children in marriage and education, and men’s power over women, can lead to problems around mental health and happiness. These things affected group members and their clients. Not only that, but people’s learned behaviour at home might affect their reaction to power in the outside world.

Others chose to work on scenes with doctors and patients or with service users they were working with. The themes around work showed the gap between values and practices where people’s ethical aspirations do not percolate through to their practice. Interactions become “automatic”, over-determined by everyday habits, assumptions and practices and by box ticking and under resourced work cultures.

An example of Forum Theatre in use as part of the TRICC project is in a DVD on YouTube (Moarefvand, 2010).

9.8 The programmes

First: NGOs, Health Trainers and Further Education College (Groups 2, 3 and 4 in Box 9.1.) (20 hours each, including the Forum Theatre session).

The training was led by Akgul Baylav with input from Gita Malhotra and Frances Rifkin (facilitating the Forum Theatre).

The training covered:

- *What is interpreting?* It is about modes of interpreting, models of interpreting, legal issues, ethical issues.
- *Knowledge and Skills in interpreting:* Importance of language and culture in communicating in health settings; general/specialist terminology (including own language); planning and conducting the interpreted consultation
- *Experience of Interpreting:* Categories of issues (e.g. confidentiality); reconciling

personal and family and community priorities; power relationships with users and service providers; managing and coping strategies.

- *Interpreting in communities*: knowledge of communities (own and others); feelings towards communities (own and others); inequalities in society; understanding of community dynamics as it relates to their job and function (formal/informal).

Second: City University (4 hours ; Group 5 in Box 9.1)

- Self assessment of students knowledge: Statements about Interpreting
- Icebreaker exercise: students counting 1-2-3 monolingually, then bilingually, then trilingually
- Aims and expectations of the day
- Student experiences
- Types of mediation: Language, communication, knowledge and power.
- Summary, conclusions and evaluation: repeating analysis of statements about interpreting.

Third: Health managers and practitioners (3 hours; Group 7 in Box 9.1)

- In advance of the workshop, all attendees were asked to identify at least one pressing issue relating to the impact of faith and Islam in their sphere of health work
- Setting the scene and context with an examination of the factors that can act as barriers to access to healthcare and healthy living for black minority ethnic and refugee communities (John Eversley)
- Presentation by a local Mawlana (Islamic scholar) Mawlana Shams Adduha Muhammad describing core thinking and beliefs in Islam including notions of authority and where these come from-
- Professor Aziz Sheikh, Professor of Primary Care Research and Development at Edinburgh University: brief introduction to the history of Muslims in the UK and what is and is not known about the health profile and experiences of Muslims in the UK
- Collation of list of issues for health managers and practitioners and responses by Professor Sheikh and Mawlana Shams
- Discussion of Case Studies (See Appendix One) and responses by Professor Sheikh and Mawlana Shams
- Evaluation using 'Spider's Web' tool

Fourth: Imams (2 hours; Group 6 in Box 9.1)

- Invitation to Imams to discuss what they thought the relationship between health and Islam is, followed by free ranging discussion covering
- Theology focusing on the example of the Prophet
- Putting Islam into practice in the UK
- The role of Imams
- Diet and Exercise
- Mental health and well-being.

Professor Sheikh, Mawlana Shams and John Eversley asked questions and offered observations but there were no formal presentations.

9.9 Evaluation of training

NGOs, PCT and Further Education College (Groups 1 – 4):

The training was evaluated in five ways (see also Eversley, 2010b):

1. A recap from the previous session at the beginning of the second and third sessions;
2. Conventional assessment for threefold evaluation: baseline, at the end of formal training and one month after the end of the training;
3. One day session in Forum Theatre to evaluate and consolidate the learning to date;
4. Facilitators' own reflections and discussions;
5. Informal verbal feedback from the learners and their line managers helped the Facilitators to gauge the level of satisfaction (and anxiety) of the learners throughout the courses.

Feedback. Direct feedback from the participants was invaluable. Individual learners repeatedly said that they were “*enjoying the course*”, “*learning a lot*”, “*they had no idea that it would be so difficult but also worthwhile*”, they are “*now aware of the equalities perspective of interpreting and bilingual advocacy*”. Some of the managers also informally reported that “*they are getting a very positive feedback from their team members*” and “*everyone is enjoying themselves*”. Finally, one manager said, “*The atmosphere in the office has changed. There is more buzz now – They (team members) talk more, they discuss more and they help each other more!*” and “*They are almost revitalised, helping each other to complete their assignments*”.

Qualitative evaluation. The more formal evaluation took place at three moments: (1) At the beginning of the training to get a baseline of the participants' experience and competencies in interpreting; (2) At the end of the training the questions to assess the immediate impact of the training; (3) After three months, the participants were asked follow up questions about the medium term impact.

The results broadly (details are given in Eversley, 2010b) were that although the participants felt that they were doing a good job before hand, they had a number of concerns. Immediately after the training and three months after they felt the training had addressed those concerns. The result seems to be both that they were doing more interpreting and feeling that they could say ‘No’ to doing it more easily. In the language of the analytical framework for the project, the training seems to have addressed both capability (including confidence) and competence.

Evaluation using Forum Theatre The Forum Theatre sessions also presented opportunities for evaluating and consolidating learning, with three main objectives: (a) To look at power relationships; (b) To review our approaches in dealing with them; (c) To explore a range of solutions.

Whatever their background, as group members began to identify and then “re-rehearse” their behaviours and practices, they became more able to analyse and characterise the problems and to propose alternative ways of working, to consciously explore the ethics and values behind what was needed. The move from “good feelings” to an ethical practice became possible. Their confidence increased and particularly in two of the workshops, participants began to allow their personalities a freer range, to trust themselves to think, reflect and act.

Participants talked freely about how they felt about Forum Theatre and what they got out of it. The participants from NGOs comments included:

- *Listening is important otherwise you may lose out on important clues*
- *Images can help shape and create*
- *Non verbal communication very important*
- *Importance of reflecting and correcting*
- *You can change the situation*
- *Acting liberates, Conflict issues etc can be acted out and you know what it means better by putting*

yourself in other's shoes
- We did have a go and it was fantastic/ enjoyable!

The Tower Hamlets College students used the Forum Theatre session to evaluate what they had learned. They said that interpreters needed to

- Be flexible in approach but accurate in detail
- Learn from mistakes
- Not to touch without permission
- To reflect on situation and own performance
- Know boundaries of role and competence
- Be sensitive
- Recognise the power of the interpreter and that the interpreter has power to change things
- Understand the complexity of Language and that speaking to the health professional and to the client is different; the importance of moving from technical to simpler language, depending on the level of the client
- Know that the interpreter can talk to the client privately at any point confidentially
- Each case has a different level of complexity
- Know the interpreter often has to work with uncertainty and unpredictability.

City University (Group 5): *Evaluation of the event took place in three ways:*

1. *Quantitative evaluation* Learners were asked to re evaluate the impact of the workshop by completing the same questionnaire that had been used at the start of the day (*see Eversley, 2010b*); Table 9.2 contains the items.

Table 9.2 City University workshop statements about interpreting

(Promoting cultural and linguistic competences; 29 September 2010)

To what extent do you agree with the following statements?

1 = Totally disagree 2 = Somewhat disagree 3 = Neutral 4 = Somewhat agree 5 = Totally agree

1. I am familiar with the law and regulations concerning interpreting	1	2	3	4	5
2. I am familiar with interpreting facilities in the UK	1	2	3	4	5
3. I expect an interpreter to translate literally	1	2	3	4	5
4. Besides translating, I expect an interpreter to be a cultural mediator	1	2	3	4	5
5. I think it is the patient's responsibility to arrange an interpreter	1	2	3	4	5
6. I understand the difference between informal and informal interpreters	1	2	3	4	5
7. I am usually satisfied with the work of interpreters	1	2	3	4	5
8. I explain to the patient what the task of the interpreter is/ It is easy for me to explain to the patient what the task of the interpreter is.	1	2	3	4	5
9. I would discuss with the interpreter about his/her task. It is easy for me to discuss with the interpreter about his/her task.	1	2	3	4	5
10. I discuss how to work with interpreters with my fellow students	1	2	3	4	5

1 = Totally disagree 2 = Somewhat disagree 3 = Neutral 4 = Somewhat agree 5 = Totally agree

Space for comments

Again they were asked to what extent they agreed with a range of statements, with the opportunity of providing written comments as well. All the students reported a positive shift in their understanding of both the law and regulations concerned with interpreting and of interpreting facilities available locally. Several students reported that they had little or no experience of working with interpreters to date in their work as student nurses and therefore only answered 'neutral' on a set of questions both before and after the workshop.

Of particular note was that as a result participation in the workshop, which focused on understanding how power, knowledge and communication operate and impact on

delivery of healthcare, almost all participants in their 'after' responses expected the interpreter to also act as a cultural mediator, possibly demonstrating an understanding of the complexities of language and power.

After the event none of the participants thought that it was the patient's responsibility to organise an interpreter if they needed one. They all thought that it was the responsibility of the clinician or the service as "patients had a right to be understood". Finally, as a result of the training programme, the majority of respondents also identified an improved understanding of the difference between formal and informal interpreting.

2. *Qualitative feedback from students* At the close of the day, participants were asked to say one thing that they would take away from the day or would like to comment on. Below is a summary of the comments made:

- *I definitely feel more informed about this agenda of interpreting informally*
- *I've realised that there is more than one way of looking at something*
- *I think I will be try to be more open minded when I am with a patient especially in the community where we are going to for our next health placement*
- *Some of my own perceptions about why patients do what they do have been challenged.*
- *I think I need to give proper thought to cultural issues and try and understand why a patient is behaving they are – a way that might not be familiar to me.*

3. *Lecturer feedback* When the training was complete the university lecturer who had taken part also gave feedback to the training facilitators indicating the following:

- The students evaluated the session positively and were really looking forward to using the knowledge acquired in their practice;
- The lecturer felt that the training had provided the learners with the right information to work on becoming patients' advocates.

Health managers and practitioners (Group 7)

'*Spider's web*' (see Eversley, 2010b): Almost all indicated they had found the seminar very interesting and relevant to their work. 22 out of 27 indicated the seminar had been what they expected and a similar number stated they had found it useful.

Seven out of the 27 participants had also provided more detailed written feedback. Interestingly the comments almost exclusively reflected a desire for further sessions on looking at issues of faith and cultural competency and a call for more support, as illustrated in the sample below:

- *I would welcome further discussions, maybe by our individual organisations, to look at the case studies more closely and get more idea on how to deal with difficult situations. A lunchtime forum would be better for GPs*
- *Would be good to set up a multidisciplinary group across Tower Hamlets to better tackle these challenges*
- *It would be helpful to have a named contact at the London Muslim Centre / Council of Mosques for clinicians and managers to consult in specific questions for assistance guidance or sign posting*
- *Is there scope for one of the Protected Learning Time education slots for clinicians at Mile End Hospital?*
- *But who should we consult on [regarding] medical issues if there is such variety of advice from imams?*
- *Am very interested in Islam and health and social impacts on lesbian and gay and bisexual Muslims and also on older adults in rehabilitation.*
- *Has helped with raising these issues of faith in teaching students.*

A DVD of the presentations and the discussion has been made which will be used in further work with practitioners and managers. A short version of it will available on YouTube so that anyone searching for material on Health and Islam can find out about more (see also below).

Imams (Group 6):

Evaluation of the session with the Imams was planned, using the Spider's web. However, it did not take place. The discussion went on longer than expected and the Imams had to leave hurriedly for afternoon prayers.

A DVD of the discussion has been made which will be used in further work with the mosque. A short version of it will be available on YouTube so that anyone searching for material on Health and Islam can find out about more.

9.10 Accreditation

The training programme for NGOs and Tower Hamlets College was a reduced version of longer 20 week Community Interpreting course accredited by a UK awarding body, the Open College Network (OCN). The university students' session was part of the 'Communication Skills' section of the core curriculum.

The completion of an assignment towards a Unit accredited by Open College Network on "Creating a Bilingual Glossary" was a distinctive, innovative aspect of the training programme.

Chapter 10 Interpreting in health and social care into perspective

Ludwien Meeuwesen and Sione Twilt

10.1 Summary

In European health and social care, language barriers frequently exist between care providers and patients due in part to continuous migration. The TRICC-project was focused on developing training courses for different target groups in health and social care in order to enhance their intercultural and bilingual awareness and competencies. The training courses were designed for health care providers (physicians, nurses and social care providers, managers, key informants), informal interpreters (medical staff, family members or friends of the patient) and students (medical and interpreting studies). The total project period was two years, from December 2008 to December 2010.

The aims of TRICC were:

- 1) Enhancing bilingual and intercultural competencies of migrants, health care providers and interpreters;
- 2) Development, implementation and evaluation of training courses;
- 3) Implementation of courses for any European minority group.

The TRICC-consortium consisted of five European partners (DE, IT, NL, TR and UK) who have experience in different fields, such as academic research, education, training and health care practice. Social, cultural, medical and communication scientists, linguists, public health care experts and health and social care providers have been exchanging, expanding and combining their knowledge and experience in order to develop, provide and evaluate the training courses.

To gain insight into the needs of the different target groups for the training, screening and in-depth interviews were held with patients, care providers (physicians and nurses), medical students and informal interpreters. The results were used to create lists of needs for different target groups and to design the content of the training.

Different training programmes or workshops were developed during the project. This training was conducted for general practitioners (NL), for ad hoc interpreters, i.e. hospital nurses and refugees (DE), for health and social workers (IT), for students of interpreting studies (TR), and for healthcare students, health practitioners, imams and staff (informal interpreters) from NGO's (UK). All countries used Forum Theatre as a central training technique, as well as knowledge transfer, counselling and role play (*see national handbooks: Ani et al., 2011; Meeuwesen et al., 2011; Cesaroni et al., 2010; Eversley, 2010b*).

The evaluation results showed that the impact on and benefits for the target user groups have been quite substantial. By creating greater awareness, knowledge and skills in interpreted medical consultations, communication will be more effective. Immigrant patients will receive better care, because care providers are able to transfer their message more effectively and interpreters are more capable of doing their translating tasks. On a meso-level, these benefits might lead to less miscommunication in the health care system, which in turn implies better access to health care and better quality of care for immigrant patients. These effects are relevant in contributing to a better health care policy on interpreting in health care, national and international. In the end, it might contribute to a better political climate in European countries with regard to health and social care for non-European immigrants, and in that sense it might contribute to better integration or social cohesion of immigrants in host societies.

10.2 Contextual approach

Generally, the use of formal interpreters is regarded as 'best practice' to bridge language barriers. Nevertheless it is obvious that the choice for an interpreter depends on the specific situation and the wishes of the patient. As we saw in section 2.4 there are different strands on how to approach the issue of language barriers. These were the 'no problem' attitude, the linguistic interpreting model, the power model and the reality approach. The *negation* of the issue was not so much the case, and if it was at hand, it was more an issue of 'not knowing', a gap in knowledge among health and social care providers. Mostly, the training participants already realized that there are communication problems because of language barriers, and they were eager to learn more. They generally viewed the *linguistic interpreting* model as important contribution to resolving the issues and recognized and valued professional interpreting services.. This view is most clearly expressed in the approach of Turkey, by conducting courses on medical interpreting for students, and in the Dutch case, where exercises in making use of a professional interpreter were part of the training programme. The *power* model can be seen more or less in each country. This is reflected in the use of Forum Theatre methods, which aim to give the powerless groups a voice. The approach is recognized by using terms as *empowerment* of migrants, refugees, but also empowerment of interpreters and health care providers.

With regard to the *reality* model, reality is faced and flexible solutions are strived for, depending on the specific context. We therefore think a *contextual* approach with regard to interpreting issues is needed, in which flexible solutions are being strived for, depending on the specific situation. This means that realistic choices are being made by care provider and patient based on their needs and possibilities. The use of a good interpreter is (cost) effective and efficient, which leads to better care and therefore less visits to the care provider (Bischoff & Denhaerynck, 2010). It is better to invest in the first consultation with an interpreter, in order to shorten the visits afterwards because a good translation enables an accurate diagnosis. Some patients will be better off with a formal interpreter, whereas others will benefit from an informal interpreter (e.g. family member or close friend). Sometimes the care provider will have to search for an ad hoc solution like asking a bilingual colleague to facilitate the consultation. It becomes clear that according to us each patient has a right to a specific, contextual approach in bridging the language barrier.

10.3 Policy

Migration has become a permanent process in Europe, as elsewhere in the world. Because of the importance of interpreting, governments of all European countries need to invest in interpreting, to give patients the right to have an interpreter, and to (continue to) provide interpreter facilities for care providers. Further, health and social care organisations are recommended to make provisions for their employees to work with interpreters, like making policies about bridging language barriers and providing proper equipment (telephone with loudspeaker).

Within interpreted consultations, special attention to the use of children (under the age of 16 years) as interpreters is needed. This is not to be tolerated, since they are vulnerable and the responsibility that comes along with the task is too much for them. It can often lead to parentification which may cause traumatic experiences.

10.4 Training the trainers

Since the training as described here turned out to be effective, it is recommended that the concept of the training is transferred to other target groups in social and health care (e.g. physicians, nurses, paramedics, social workers, therapists). The training offers useful knowledge and skills to transform powerless feelings with regard to language barriers into powerful performance in a fun way. Forum Theatre activates the participants because it is not prescriptive and therefore invites the audience to experiment with new behavior in a safe and non judgmental environment. Training involving the use of this technique is adequate for all professions in health and social care and beyond.

Not only can Forum Theatre be used for interpreting issues, but for a great number of subjects (like creating rapport, improving listening skills, shared decision making etc.). At the moment, plans are being made to develop and implement these courses for countries across Europe.

All these forms of 'best practice' will hopefully find their way to teachers from secondary and higher vocational education and universities. In that way Forum Theatre can be implemented in a broad domain.

10.5 From informal to formal interpreting

When migrants come to countries in Europe, they generally learn a new language. Some of them will come to realize the profit of multilingualism. This can inspire them to investigate their informal interpreting qualities and to increase them through education. What may have been an obligation to family members at first can now be done professionally: formal interpreting. Another option for them is to use their bilingualism in their own profession, as the training in DE and UK has shown.

In several countries, this approach can be adopted within 'civic integration courses' for migrants. Attention can be paid to the surplus of multilingualism and to how these qualities can be used for different targets and in various settings. This will also contribute to the integration of migrants in society. As citizens of all European countries will become bi- or multilingual (Grosjean, 2010) there is a large reservoir of linguistic capital which offers a great opportunity to make use of it.

10.6 Professional interpreting

Obviously it is equally important to train formal interpreters in facilitating bilingual conversations in health and social care. More information can be given about translating medical terms and the structure and procedures of medical consultations.

Apart from this, as we have these large numbers of people all over Europe who are in need of good interpreters, it is also necessary to have enough vocational schools and universities to train a new generation of interpreters. At the moment, the demands for professional interpreters are far greater than can be fulfilled. Therefore, educational policy should be keen on creating more departments for interpreter and translation studies at vocational schools and universities.

10.7 Contribution to EU policies

This project contributes in several ways to the Lisbon objectives and priorities regarding the European striving for an 'economy of knowledge'.

All the activities of the project, and especially the developing and testing of training, will contribute importantly to cultural and bilingual awareness of the different target groups. The widespread practice in Europe of *ad hoc* and formal interpreting in health care will be enhanced and professionalised, leading to a better understanding between health and social service providers and their clients (users).

These innovative training courses will lead to intercultural dialogue between different ethnic groups in Europe, as well as between different professional groups and lay persons. All these instances may lead to an increase in intercultural understanding and because of that to a greater social cohesion in the long run.

The training for the different target groups creates an open learning environment: for the professionals, the quality of their lifelong training activities will increase, by creating an efficient vocational training opportunity. Forum Theatre is an effective and active training technique which gives informal learners a voice, contributes to lifelong learning in a fun way within a safe environment.

By providing informal training opportunities for members of minority groups, the level of education of the immigrants may be improved considerably; these opportunities can help them to professionalise and to validate informally acquired skills. Encouragement of the development of bilingual skills will contribute importantly to the immigrants' self-awareness and self-esteem, and hence may contribute to social cohesion and integration. Immigrants whose informal competencies like mother-tongue and cultural know-how are appreciated and valorised are more eager to assume responsibility in the hosting country and feel part of it.

10.8 Plans for the future

It has been proved to be very enriching to work together in a European consortium. The added value is first of all to learn from each other's expertise. During partner meetings and online discussions experiences have been shared and new strategies are being developed for European goals. Interdisciplinary work with different countries and different organizations has broadened the view of each participant in the project and results in products with a great and rich diversity. Turkey especially has had a central role in holding up a cultural mirror by reflecting on how intercultural and bilingual health care issues are dealt with in a country somewhat on the margins of Europe. All these activities contribute to enriching the knowledge of each partner in a very substantial way.

After the project period actions will be continued to consolidate and to disseminate the training courses. There are already contacts with organisations (university hospitals) and foundations who might take over the concept of the training. They have a suitable context to provide and sustain the training after the project ends. By writing and distributing the handbooks on best practices in training on intercultural and bilingual competencies in health and social care, these training methods, which have proven to be effective, can be used across Europe for many different target groups (doctors, paramedics, nurses, social care workers, therapists, medical students etc.)

10.9 Conclusion

In conclusion, we can say that language barriers in health and social care can be bridged by a good interpreter. It is important to understand each other and to build a relation of trust between patient, interpreter and care provider. The use of interpreters involves more than just a transfer of information; above all it has to do with trust and mutual respect. Patient satisfaction is not only determined by medical-technical solutions but also by a good communicative approach. Care providers are more satisfied with their

work when they can build a good relation or *rapport* with their patients. In this respect, getting the message across makes all the difference.

10.10 Recommendations

Some of the main recommendations of the TRICC project are formulated as follows:

- 1) Empowerment of informal interpreters is important. Providing this group with training on how to use (or when not to use) their bilingual competencies empowers them and they can be acknowledged for their (mostly taken for granted) task as an interpreter for their relatives. This recommendation is in line with the European focus on Lifelong Learning.
- 2) Development of national and European policies on interpreting/language barriers in health and social care is needed. Policies differ due to various national politics, but perhaps an attempt can be made to create some kind of European pact in future projects/networks.
- 3) It is needed to relate the effects of the TRICC training (or other training focusing on improving intercultural medical communication) to health outcomes. By doing so possible evidence can be found to convince governments and health insurance companies to provide interpreter facilities on a regular base.
- 4) Existing networks on migrants should be addressed in order to focus on overcoming language barriers in health and social care. The final conference of TRICC was held within a large European network (COST Action Home, on migrant health care). This led to an inspiring exchange of information and experiences. Moreover, new networks could be incorporated dealing with language barriers and interpreting in social and health care, thus resulting in recommendations for European policies on this issue.

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www.bicom-eu.net

Website of the same European consortium that cooperated in BICOM – Promoting bilingual and intercultural competencies in public health. In BICOM, the TRICC-project was prepared.

www.cost.esf.org

Website COST (European Cooperation in Science and Technology) is one of the longest-running European instruments supporting cooperation among scientists and researchers across Europe.

See ISCH Action IS0603 „Health and Social Care for Migrants and Ethnic Minorities in Europe (HOME)“ (*Prof. dr. David Ingleby*).

www.dolmetscher-treffen.de

An online course “Dolmetsch-Führerschein”.

www.exmaralda.org

Website of DiK-Korpus: ‘Dolmetschen im Krankenhaus’ (Bühlig & Meyer (2009)).

www.fluechtlingszentrum-hamburg.de

Hamburg Centre for Refugees (Flüchtlingszentrum Hamburg).

www.houtenbeentheater.nl

Website of theatre specialized in post academic education of professionals in first line health care.

www.medicalcenter.osu.edu

Website containing reference guidelines (Amish).

www.ncihc.org

National Council on Interpreting in Health Care (US).

www.theatreoftheoppressed.org

Website Forum Theatre of Augusto Boal.

www.tricc-eu.net

Website of a European consortium TRICC (Training in Intercultural and bilingual Competencies in health and social Care) with the aim to develop and conduct training in intercultural competencies in health and social care.

www.tvcn.nl

Website of the Tolken Vertaalcentrum Nederland (Dutch Interpreter and Translation Center).

TRICC

Training Intercultural and Bilingual
Competencies in Health and Social Care