Favoriser l'implantation de services d'interprétariat dans le réseau de la santé

Les outils disponibles dans la littérature scientifique

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Facilitating implementation of interpreter services in the healthcare network

Available tools in the scientific literature

François René de Cotret, doctorant en psychologie/postgraduate in Psychology
Yvan Leanza, professeur titulaire/full professor

École de psychologie
Université Laval
Québec, Canada

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1 Mesurer l'efficacité de l'implantation de services d'interprétariat/ Measuring the Effectiveness of Implementing Interpreter Services

1.1 Questionnaires – Usagers/Users

Questionnaire de l'alliance thérapeutique pour les migrants (QALM-PS) • QALM-PS

Boss-Prieto, O. L. (2014). L'interprétation en Suisse francophone: le cas de la communauté hispano-américaine. *Çédille: revista de estudios franceses*(4), 63-76

- Questionnaire auto-rapporté pré-testé non validé mesurant l'alliance thérapeutique entre différents professionnels de la santé et leurs patients.
  - Première section : Alliance avec le thérapeute
  - Deuxième section : Alliance avec l'interprète (pour les triades)
  - Troisième section : Évolution
- Construit sur la base d'une étude avec des migrants (Boss-Prieto et al., 2010) et inspiré par le SOFTA version patient, le WAI-S et The Penn helping alliance scales d'Alexander et Lubosky.
- La version espagnole du questionnaire[1] est disponible dans les pages suivantes.

Parte I. ***Alianza con el Terapeuta***

Las 19 afirmaciones que se encuentran en la pagina siguiente describen maneras diferentes de pensar y sentirse con relación a su terapeuta.

Terapeuta=profesional de la salud (ex : psicólogo(a), médico(a), partera, asistente social, enfermero(a), etc.)

Piense a la relación actual que tiene ***con su terapeuta*** y marque con una cruz la casilla que corresponda lo mejor posible a su forma de sentir. Hay 5 posibilidades:

1	Jamás
2	Raramente
3	Algunas veces
4	Frecuentemente
5	Siempre

No hay buenas ni malas respuestas. Gracias por marcar una casilla para cada una de las afirmaciones. Sus respuestas son anónimas y confidenciales. Si usted consulta en pareja o en familia, gracias por responder juntos (en lo posible) a un solo cuestionario.

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* Versión QALM-PS (juin 2009) © De Roten Y, Madera A, Boss-Prieto O, & Elghezouani A (2007). *Instituto Universitario de Psicoterapia, Asociación Appartenances y Universidad de Lausana*. Traducción en Español : Boss-Prieto O. La versión QALM-PS es una adaptación del QALM versión 1.0 (2007). Le QALM-PS está destinado a la evaluación de la alianza terapéutica en todo tipo de consulta con un profesional de la salud a diferencia del QALM versión 1.0 que es utilizado solamente en una consultación psicológica/psiquiatrica. Versión adaptada por : Boss-Prieto O., Universidad de Lausana.

[1] Boss-Prieto, O. L. (2013). The Dyadic and Triadic Therapeutic Alliance in Cross-Cultural Health Care: The case of Hispanic American Patients. (PhD), Université de Lausanne, Laussane, Suisse. Retrieved from http://serval.unil.ch

	Jamás	Raramente	Algunas Veces	Frecuentemente	Siempre
1. Siento que mi terapeuta me respeta	☐1	☐2	☐3	☐4	☐5
2. Estoy seguro(a) que lo que digo a mi terapeuta no sale de aquí	☐1	☐2	☐3	☐4	☐5
3. Aprecio mi terapeuta como persona	☐1	☐2	☐3	☐4	☐5
4. Me siento apoyado(a) por mi terapeuta	☐1	☐2	☐3	☐4	☐5
5. Tengo una buena relación con mi terapeuta	☐1	☐2	☐3	☐4	☐5
6. Sé lo que espero viniendo en consulta	☐1	☐2	☐3	☐4	☐5
7. Tengo la impresión que mi terapeuta me ofrece lo que necesito	☐1	☐2	☐3	☐4	☐5
8. Me siento seguro(a) con mi terapeuta	☐1	☐2	☐3	☐4	☐5
9. Mi terapeuta y yo colaboramos para fijar los objetivos de mi consulta	☐1	☐2	☐3	☐4	☐5
10. Pienso que mi terapeuta me ayuda	☐1	☐2	☐3	☐4	☐5
11. Tengo la impresión de ser aceptado(a) por mi terapeuta	☐1	☐2	☐3	☐4	☐5
12. Creo que mi terapeuta tiene los conocimientos y capacidades para ayudarme	☐1	☐2	☐3	☐4	☐5
13. Creo que la manera de trabajar mis problemas en terapia es correcta	☐1	☐2	☐3	☐4	☐5
14. Me siento cómodo(a) y relajado(a) en la presencia de mi terapeuta	☐1	☐2	☐3	☐4	☐5
15. Me gusta la actitud que mi terapeuta tiene conmigo	☐1	☐2	☐3	☐4	☐5
16. Sé que puedo tener confianza en mi terapeuta	☐1	☐2	☐3	☐4	☐5
17. Siento que mi terapeuta y yo trabajamos en un esfuerzo común para resolver mis problemas	☐1	☐2	☐3	☐4	☐5
18. Mi terapeuta y yo tenemos intercambios productivos	☐1	☐2	☐3	☐4	☐5
19. Siento que mi terapeuta me comprende	☐1	☐2	☐3	☐4	☐5

Parte II. ***Alianza con el Intérprete***

Atención : Si un intérprete esta presente durante su consulta, gracias por completar esta parte. Si no hay ayuda de un intérprete, pase directamente à la parte III en la página 4.

Gracias por indicar el tipo intérprete que esta lo mas frecuentemente presente en su consulta :

☐ Miembro de la familia (cuál: _____)
☐ Amigo o allegado
☐ Interprete profesional
☐ Empleado de la institución que trabaja en un oficio otro que la interpretación (ex : secretaria)

Si posible, gracias por escribir la lengua materna y el país de origen del intérprete: _____

Piense ahora a la relación actual ***con su intérprete*** y marque con una cruz la casilla que corresponda lo mejor posible a su forma de sentir.

	Jamás	Raramente	Algunas Veces	Frecuentemente	Siempre
1. Pienso que mi intérprete me ayuda	☐1	☐2	☐3	☐4	☐5
2. Tengo la impresión que mi intérprete me ofrece lo que necesito	☐1	☐2	☐3	☐4	☐5
3. Aprecio mi intérprete como persona	☐1	☐2	☐3	☐4	☐5
4. Creo que mi intérprete tiene los conocimientos y capacidades para ayudarme	☐1	☐2	☐3	☐4	☐5
5. Me siento apoyado(a) por mi intérprete	☐1	☐2	☐3	☐4	☐5
6. Siento que mi intérprete me comprende	☐1	☐2	☐3	☐4	☐5
7. Tengo la impresión que mi intérprete traduce adecuadamente todo lo que se dice en consulta	☐1	☐2	☐3	☐4	☐5
8. Siento que mi intérprete me respeta	☐1	☐2	☐3	☐4	☐5
9. Me gusta la actitud que mi intérprete tiene conmigo	☐1	☐2	☐3	☐4	☐5
10. Estoy seguro(a) que mi intérprete comprende bien todo lo que se dice en consulta	☐1	☐2	☐3	☐4	☐5
11. Pienso que mi consulta sería mas eficaz si yo no necesitara intérprete	☐1	☐2	☐3	☐4	☐5
12. Tengo una buena relación con mi intérprete	☐1	☐2	☐3	☐4	☐5
13. Me siento seguro(a) con mi intérprete	☐1	☐2	☐3	☐4	☐5
14. Estoy seguro(a) que lo que digo a mi intérprete no sale de aquí	☐1	☐2	☐3	☐4	☐5

	Jamás	Raramente	Algunas Veces	Frecuentemente	Siempre
15. Se que puedo tener confianza en mi intérprete	☐1	☐2	☐3	☐4	☐5
16. Siento que mi intérprete y yo trabajamos en un esfuerzo común para resolver mis problemas	☐1	☐2	☐3	☐4	☐5
17. Tengo la impresión de ser aceptado(a) por mi intérprete	☐1	☐2	☐3	☐4	☐5
18. Me siento cómodo(a) y relajado(a) en la presencia de mi intérprete	☐1	☐2	☐3	☐4	☐5
19. Mi interprete y yo tenemos intercambios productivos	☐1	☐2	☐3	☐4	☐5

Parte III. ***Evolución***

Atención : Si usted ha consultado este terapeuta dos veces o mas, gracias por completar esta parte. En caso contrario, usted ha terminado el cuestionario.

Espera usted un cambio psicológico y/o físico con sus consultas?
☐ Si ☐ No
Si su respuesta es afirmativa, gracias por completar esta ultima parte del cuestionario. Sino, ha terminado el cuestionario.

Las 6 afirmaciones siguientes se refieren a los cambios que usted pudo haber sentido en el transcurso de sus consultas. Marque con una cruz la casilla que corresponda lo mejor posible a su forma de sentir.

	Jamás	Raramente	Algunas Veces	Frecuentemente	Siempre
1. Siento que lo que hacemos en consulta me va a ayudar a alcanzar los cambios deseados	☐1	☐2	☐3	☐4	☐5
2. Mis dificultades han disminuido gracias a mis consultas	☐1	☐2	☐3	☐4	☐5
3. Gracias a estas consultas, veo mas claramente cómo podría ser capaz de cambiar/mejorar mi situación	☐1	☐2	☐3	☐4	☐5
4. Lo que hacemos durante las consultas me brinda nuevas maneras de ver/manejar mis problemas	☐1	☐2	☐3	☐4	☐5
5. En general, me siento mejor luego de una consulta	☐1	☐2	☐3	☐4	☐5
6. Los cambios observados en el transcurso de mis consultas corresponden a mis expectativas	☐1	☐2	☐3	☐4	☐5

Ha terminado el cuestionario. Muchas gracias por su apreciada colaboración !

Questionnaire – Gany et al (2007)

Gany, F., Leng, J., Shapiro, E., Abramson, D., Motola, I., Shield, D. C., & Changrani, J. (2007). Patient satisfaction with different interpreting methods: a randomized controlled trial. *J GEN INTERN MED, 22 Suppl 2*, 312-318

- "To assess satisfaction with physician communication/care, patients were asked (yes/no) if physicians listened to them carefully, if time spent with physicians was adequate, and if they would recommend their physician to a friend. They rated on a four-point scale how well they thought their physicians understood them, understanding of physician instructions and explanations, and overall quality of medical care, and on a five-point scale the level of respect."

- "For satisfaction with interpretation, patients were queried on a four-point scale about how well the interpreter understood them, how well the interpreter interpreted, and how well patient privacy was protected by the interpreting method. They were asked via a five-point scale about the level of respect from the interpreter. Patients were also queried (yes/no) about whether the interpreter listened to them carefully, whether they would recommend the interpreter used during the visit to a friend, and if they would recommend the method of interpretation to a friend." (p. 313-314)

Table 2. Satisfaction with Physician Communication/Care, by Interpreting Method

	Intent-to-treat Analysis (by randomization mode)		Actual Interpreting Method Received		
	U&C	RSMI	U&C Trained	RSMI	Language Concordant
n	364	371	165	175	751
Did your doctor listen carefully?					
Yes	324 (96)	336 (98)	145 (95)	165 (99)	697 (99)*
Did your doctor spend enough time with you?					
Yes	316 (94)	325 (96)	145 (95)	161 (98)	656 (96)
How would you rate your doctor in treating you with respect?					
Very well	213 (64)	242 (71)†	85 (57)	115 (70)‡	527 (75)*
How well do you think your doctor understood you?					
Very well	132 (39)	150 (45)	57 (37)	79 (49)‡	454 (64)*
How well did you understand your doctor's explanation of medical procedures and test results?					
Very well	125 (38)	128 (39)	52 (35)	62 (39)	404 (59)*
How well did you understand your doctor's instructions about follow-up care?					
Very well	125 (38)	134 (41)	48 (33)	60 (38)	436 (63)*
How would you rate your doctor overall?					
Very well	178 (54)	195 (59)	72 (48)	91 (56)	436 (63)*
Would your recommend your doctor to a friend?					
Yes	287 (95)	287 (95)	125 (94)	140 (97)	615 (96)
Overall, how satisfied were you with the quality of your medical care?					
Very well	155 (47)	169 (51)	72 (48)	93 (57)	396 (57)
Composite satisfaction with physician communication/care score					
Mean (SD)	0.478 (0.340)	0.514 (0.355)	0.436 (0.330)	0.518 (0.351)‡	0.628 (0.350)*

Table 3. Satisfaction with Interpretation, by Interpreting Method

	Intent-to-treat Analysis (by randomization mode)		Actual Interpreting Method Received	
	U&C	RSMI	U&C Trained	RSMI
n	364	371	165	175
Did your interpreter listen to you carefully?				
Yes	192 (99)	214 (98)	149 (99)	158 (99)
How would you rate your interpreter in treating you with respect?				
Very well	99 (51)	129 (58)	71 (48)	88 (54)
How well do you think your interpreter understood you?				
Very well	95 (48)	111 (50)	70 (45)	73 (45)
How well do you think your interpreter interpreted your visit with the doctor?				
Very Well	98 (50)	124 (56)	76 (50)	90 (55)
How well do you think this method of interpretation protected your privacy?				
Very Well	73 (38)	104 (51)*	52 (35)	74 (49)†
Would you recommend the interpreter to a friend?				
Yes	175 (97)	200 (97)	136 (96)	147 (99)
Would you recommend this method of interpretation to a friend?				
Yes	178 (93)	204 (96)	136 (94)	151 (97)
Composite satisfaction with interpreter score				
Mean (SD)	0.462 (0.368)	0.528 (0.393)*	0.449 (0.365)	0.502 (0.395)

Questionnaire – Schwarzinger (2012)

Schwarzinger, M., Cédiey, E., & Argant, S. (2012). *Usage et opportunité du recours à l'interprétariat professionnel dans le domaine de la santé : Analyse des pratiques d'interprétariat en matière de prévention et de prise en charge du Vih/sida, de la tuberculose et du diabète*. Paris, France

- Questionnaire de 50 questions, divisé en trois sections (caractéristiques du patient, consultation, communication avec le médecin).

7.1.5 Questionnaires patients avec enquêteur (après la consultation)

Questionnaire Patient

Le patient est vu SEUL immédiatement après la consultation médicale. Toutefois, si le patient n'a pas été vu en « screening » et qu'il est accompagné, la présentation de l'étude et du questionnaire peut être faite en présence de l'accompagnant, ainsi que le remplissage de la partie 1. Ce dernier devra par contre patienter à un autre endroit pour la passation du questionnaire avec le patient (parties 2 à 4).

Partie 1 : à compléter uniquement en l'absence de questionnaire de « screening »

1. Je vais tout d'abord vérifier que vous pouvez bien participer à l'étude. Avez-vous plus de 18 ans ?

|__| 1. Oui |__| 2. Non (=> exclusion de l'étude)

Si le patient est mineur, le remercier en lui indiquant que seuls les patients d'âge adulte peuvent remplir le questionnaire.

2. Etes-vous venu seul.e à la consultation aujourd'hui ?

|__| 1. Oui |__| 2. Non

3. [Si Non], La personne qui vous accompagne est-elle : " " ? *(plusieurs cases possibles, souligner l'accompagnant « principal », i.e. celui qui accompagne et traduit le cas échéant en consultation)*

|__| 1. Votre conjoint.e/partenaire |__| 2. Votre fils/fille

|__| 3. Un autre membre de votre famille |__| 4. Un.e ami.e |__| 5. Autre :

4. Est-ce qu'elle vous accompagne aussi en consultation ?

|__| 1. Oui |__| 2. Non

5. (Si oui), Est-ce que c'est parce que vous ne parlez pas assez bien le français ?

|__| 1. Oui |__| 2. Non

6 à 9. (questions à poser à tous les patients, y compris francophones, pour des raisons statistiques), Diriez-vous que :

(cocher une case par ligne)	Très bien	Bien	Un peu	Pas du tout	NSP
6. Vous comprenez le français à l'oral ?					
7. Vous parlez en français ?					
8. Lisez en français ?					
9. Ecrivez en français ?					

*Si l'accompagnant traduit lorsque l'on s'adresse au patient OU si le patient **comprend OU parle** "Un peu / Pas du tout / NSP", alors cocher Allophone = Oui :*

10. Evaluation enquêteur : le patient est-il allophone ?

|__| 1. Oui |__| 2. Non

11. [Si Oui], Pouvez-vous m'indiquer : quelle.s langue.s parlez-vous ?

_____

_____

12. Pouvez-vous me dire si vous êtes suivi dans le service depuis ?

|__| Moins de 3 mois [=> exclusion de l'étude] |__| 3 à 6 mois |__| 6 à 12 mois |__| 1 an et plus

Si le patient est suivi depuis moins de 3 mois, lui indiquer que seuls les patients étant suivis depuis plus de 3 mois peuvent participer à la suite de l'étude. Le remercier.

Pour les autres : proposer systématiquement aux patients allophones de participer à l'étude + compléter avec des patients francophones (jusqu'à 5 à 7 patients par vacations autant que possible).

Utiliser le support "affiche" traduit en 5 langues pour expliquer en quoi cela consiste.

13. Etes-vous d'accord pour répondre à un questionnaire portant sur votre compréhension de la consultation ?

|__| 1. Oui |__| 2. Non | **14. (si Oui) CODE de 1 à 5 :** |

Consigne : bien penser à communiquer le code au médecin pour appareiller les questionnaires médecin et patient.

Partie 2. La consultation

1. CODE (entre 1 et 5) :

2. Pouvez-vous dire comment s'appelle votre maladie ou votre problème de santé ? [réponse telle quelle du patient]

3. Codage "nom maladie" : *(à cocher uniquement si le patient mentionne les termes explicitement)*

|__| 1. Diabète |__| 2. VIH |__| 3. Sida |__| 4. Tuberculose

|__| 5. Hépatite chronique C/VHC |__| 6. Hépatite chronique B/VHB |__| 7. AUCUNE

4. Depuis combien de temps prenez-vous des médicaments pour votre maladie ou votre problème de santé ?

|__| 1. Moins d'un an |__| 2. Plus d'un an, préciser le nombre d'années : |__|__| ANS

5. Vous arrive-t-il d'oublier de prendre vos médicaments dans la semaine ?

|__| 1. Jamais |__| 2. Rarement (moins d'1 fois sur 10) |__| 3. De temps en temps (1 ou 2 fois sur 10)

|__| 4. Souvent (3 ou 4 fois sur 10) |__| 5. Très souvent (plus de 5 fois sur 10)

6. Aujourd'hui, est-ce que le médecin vous a prescrit des médicaments ?

|__| 1. Oui |__| 2. Non

7. [si Oui], A-t-il prescrit de nouveaux médicaments ?

|__| 1. Oui |__| 2. Non |__| 3. NC (c'est la première fois qu'il prescrit des médicaments)

8. [si Oui] Pouvez-vous me dire quel est le nom des médicaments prescrits aujourd'hui (qu'ils soient nouveaux ou non) ? [réponse telle quelle du patient]

9. Observation enquêteur : le patient a-t-il besoin de relire son ordonnance pour répondre ?

|__| 1. Oui |__| 2. Non

10. Codage "nombre médicaments" : indiquer le nombre de médicaments cités par le patient :

|__| 0 |__| 1 |__| Plus

11. Combien de fois par jour devez-vous prendre vos médicaments [réponse telle quelle du patient] ?

11 bis. Codage "prise médicaments" :

|__| 1 fois par jour |__| 2 fois par jour |__| 3 fois par jour |__| 4 fois ou plus par jour

12. Aujourd'hui, le médecin vous a-t-il prescrit des examens à faire pour la prochaine consultation (de sang, d'urine, radios, scanners ou autres) ? |__| 1. Oui |__| 2. Non

13. [Si médicaments prescrits à la question 7], Pouvez-vous me dire quels examens sont importants pour savoir si les médicaments sont efficaces/marchent bien ? [réponse telle quelle du patient]

14. Codage "nom examen" : *(à cocher uniquement si le patient mentionne les termes explicitement)*

|__| 1. Hémoglobine glyquée (diabète) |__| 2. Charge virale (VIH/Sida) |__| 3. CD4 (VIH/Sida)

|__| 4. Radio des poumons (VIH/tubercul.) |__| 5. Prélèvement à la recherche de myobactérie (tuberc.)

|__| 6. Aucun examen cité

15. Le médecin vous a-t-il fait des recommandations : [en service infectieux ou en CLAT] pour empêcher que d'autres personnes deviennent malades dans votre entourage / [en diabétologie] sur votre régime alimentaire ? |__| 1. Oui |__| 2. Non

16. [si Oui], Vous trouvez que suivre ces recommandations est :

|__| 1. Très facile |__| 2. Plutôt facile |__| 3. Plutôt difficile |__| 4. Très difficile

17. Par rapport à votre consultation d'aujourd'hui, quelle note entre 0 et 20 donneriez-vous à votre compréhension de ce que vous a dit le médecin ? |__|__|

Si besoin utiliser l'échelle graphique de 0 à 20 en demandant au patient de montrer où il se situe.

Partie 3. Communication avec le médecin (concerne uniquement les patients allophones)

18. Avez-vous pu communiquer directement avec le médecin ? |__| 1. Oui, en français |__| 2. Oui, en anglais

|__| 3. Oui, dans une autre langue = _____ |__| 4. Non, une autre personne a traduit la consultation

19. [si Non], Qui était cette personne ? [en clair] : .....

20. Codage "traduction consultation" : (partir de la description faite par le patient, affiner avec lui pour catégoriser)

|__| 1. Accompagnant |__| 2. Personnel de l'hôpital connu du patient |__| 3. Personnel de l'hôpital inconnu du patient

|__| 4. Interprète professionnel en présence physique |__| 5. Interprète professionnel par téléphone

21. [si 20 = 1, 2, 3], Etes-vous au courant qu'il existe des services d'interprétariat professionnel ? (expliquer : une personne dont c'est le métier et que l'on fait venir spécialement à l'hôpital pour traduire, ou qui traduit par téléphone) |__| 1. Oui |__| 2. Non

22. Dans vos consultations précédentes pour votre maladie ou votre problème de santé, est-ce qu'un interprète professionnel a déjà fait la traduction ? |__| Jamais |__| 1 fois |__| Plus d'1 fois

23. Si vous avez été hospitalisé pour votre maladie ou votre problème de santé, est-ce qu'un interprète professionnel a fait la traduction pendant votre séjour à l'hôpital ? |__| Jamais |__| 1 fois |__| Plus d'1 fois |__| NC (n'a pas été hospitalisé)

24. [si 20 = 1, 2, 3], Si pour votre consultation d'aujourd'hui votre médecin vous avait proposé un interprète professionnel, est-ce que vous auriez préféré cette solution ? |__| 1. Oui |__| 2. Non

Partie 4. Statistiques générales

« Avant de terminer l'entretien, je vais vous poser quelques questions pour les statistiques de l'étude »

25. A part le médecin que vous avez consulté aujourd'hui, avez-vous un médecin généraliste (référent) ? |__| 1. Oui |__| 2. Non

26. Avez-vous été vacciné contre la grippe saisonnière cette année ?
|__| 1. Oui |__| 2. Non, pas cette année |__| 3. Non, je ne me vaccine pas contre la grippe

27. De manière générale diriez-vous que votre santé est… : " " ?
|__| 1. Excellente |__| 2. Très bonne |__| 3. Bonne |__| 4. Mauvaise |__| 5. Très mauvaise

28. Actuellement, pour vos dépenses de santé, avez-vous…?

|__| 1. La CMU (Couverture maladie universelle) |__| 2. L'aide médicale d'état (AME)

|__| 3. La sécurité sociale (standard, y compris étudiants) |__| 4. Aucune couverture sociale

29. Et avez-vous une mutuelle [une couverture santé complémentaire, y compris CMU complémentaire] ? |__| 1. Oui |__| 2. Non

30. Quel âge avez-vous ? |__|__| ANS

31. Etes-vous né en France (métropole ou DOM-TOM) ou à l'étranger ? |__| 1. France |__| 2. Etranger

32. [Si étranger], Depuis combien de temps vivez-vous en France ? |__|__| ANS

33. Avez-vous votre Bac (ou équivalent) ? *(si besoin, expliquer qu'il s'agit d'un diplôme que l'on passe à la fin du lycée en France, vers l'âge de 18 ans)* |__| 1. Oui |__| 2. Non

34. [si Oui], Pouvez-vous préciser votre nombre d'années d'étude après le Bac ?

|__| 0 |__| 1 |__| 2 |__| 3 |__| 4 |__| 5 |__| + que 5

35. [si Non], Pouvez-vous indiquer jusqu'à quel âge êtes-vous allé à l'école ? |__| 1. Jamais |__| 2. Age : |__|__| ANS

36. Sexe de l'enquêté.e : |__| 1. Femme |__| 2. Homme

Remercier le patient.

Fin du questionnaire

Partie réservée à l'enquêteur

37. Remarques éventuelles (en excluant toute donnée qui pourrait permettre d'identifier personnellement le patient)

Quality of care through the patient's eyes–for migrants (Quote-mi)

Harmsen, J. A. M., Bernsen, R. M. D., Bruijnzeels, M. A., & Meeuwesen, L. (2008). Patients' evaluation of quality of care in general practice: What are the cultural and linguistic barriers? *Patient Education and Counseling, 72*, 155-162

- General satisfaction with the general practitioner (GP) measured by a report mark, a scale ranging from 1 (very dissatisfied) to 10 (very satisfied).

- [Language proficiency measure] was based on patients' self-evaluation of perceived proficiency (good, moderate or poor). These scores were highly comparable with the interviewers' (r = 0.82) and the GPs' assessments (r = 0.70).

- Perceived quality of care was measured using the 'Quote-mi' scale, which contains an ethnic-specific subscale and a communication process subscale. All quote-mi items were answered using a four point scale (low to high perceived quality).

Table 4
Percentage of "I agree" answers on the 12 Quote process-items, separately for the three levels of language proficiency

	Language proficiency			Total group
	Poor	Moderate	Good	
Your GP always				
1. Takes enough time to talk**	85	80	91	89
2. Talks with you seriously*	85	92	94	93
3. Keeps his promise	92	86	89	89
4. Is willing to talk about mistakes**	82	82	92	89
5. Is willing to talk about your problems***	80	83	93	90
6. Clearly explains your medication**	75	87	92	89
7. Explains the results of investigations	86	95	92	92
8. Gives opportunity for you to decide about treatment***	64	84	86	85
9. Refers to a specialist when asked***	67	83	93	90
10. Clearly explains what is wrong***	74	89	95	92
11. Explains the type and goal of treatment by himself	78	87	86	86
12. Interprets physical problems into psychological problems	70	65	74	72

Effect of language proficiency on process scale: see Table 3. $^{*}p < 0.05$; $^{**}p < 0.01$; $^{***}p < 0.001$; Chi-square tests.

Table 5
Percentages of "I agree" answers on the of 10 Quote-Mi items of the ethnicity scale, separately for the three 'cultural view' groups

	Patients' cultural views			Total
	Traditional	Trad./modern	Modern	
Your GP always				
1. Is prejudiced because you are a foreigner**	22	4	5	8
2. Gives you as much time as Dutch patients	84	93	90	91
3. Understands that you are accompanied by an interpreter**	96	93	71	90
4. Has consideration that (because of lack of language proficiency) you have difficulty in telling your story	89	89	80	88
5. Understands that you sometimes visit physicians abroad	82	80	79	80
6. Has informationbooklets in your language†	54	44	24	40
7. Calls an interpreter if you wish	69	62	36	60
8. Is interested in your culture	50	46	46	46
9. Understands that your problems are sometimes different from Dutch patients**	92	64	47	64
10. Has good knowledge about medication from abroad	46	50	42	46

Effect of cultural views on ethnicity scale: see Table 3. $^{\dagger}p < 0.1$; $^{**}p < 0.01$; Chi-square tests.

Questionnaire – Bagchi (2011)

Bagchi, A. D., Dale, S., Verbitsky-Savitz, N., Andrecheck, S., Zavotsky, K., & Eisenstein, R. (2011). Examining effectiveness of medical interpreters in emergency departments for Spanish-speaking patients with limited English proficiency: results of a randomized controlled trial. *Ann Emerg Med, 57*(3), 248-256.e241-244.

- "We used satisfaction measures that were appropriate for the ED setting."

- Adapted from questions from the Consumer Assessment of Healthcare Providers and Systems Hospital Survey (http://www.cahps.ahrq.gov).

Patient Satisfaction Survey

1. Did you receive any interpreter services during your visit?
   - Yes 1 Continue →
   - No 0 Go to Q.2 →
   - 1a. What type of interpreter services did you receive?
     - In-person interpreter—provided by hospital 1
     - Family member/friend interpreted for me 2
     - Interpreter on telephone—provided by hospital 3
     - Physician/nurse spoke my language 4
     - Other (specify) 5
     - Don't know d
     - Refused r
2. How easy was it for you to understand the things that were explained to you? Was it very easy, mostly easy, somewhat easy, not so easy, or not easy at all?
   - Very easy 1
   - Mostly easy 2
   - Somewhat easy 3
   - Not so easy 4
   - Not easy at all (did not understand) 5
   - Don't know d
   - Refused r
3. How satisfied were you with the way you and hospital staff were able to communicate? Were you very satisfied, somewhat satisfied, neither satisfied nor dissatisfied, somewhat dissatisfied, or very dissatisfied?
   - Very satisfied 1
   - Somewhat satisfied 2
   - Neither satisfied nor dissatisfied 3
   - Somewhat dissatisfied 4
   - Very dissatisfied 5

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Questionnaire – Green (2005)

Green, A. R., Ngo-Metzger, Q., Legedza, A. T. R., Massagli, M. P., Philips, R. S., & Iezzoni, L. I. (2005). Interpreter Services, Language Concordance, and Health Care Quality: Experiences of Asian Americans with Limited English Proficiency. *J GEN INTERN MED, 20*, 1050-1056

- Five questions assessing patients' perceptions of the quality of their communication with their clinician during the most recent visit.

Table 3. Communication- and Visit-rating Responses for Patients who Rated their Interpreters "Excellent/Very Good" Versus "Good/Fair/Poor"

Communication- and Visit-rating Question	Patients who Rated Interpreter Excellent or Very Good % (n=769)*	Patients who Rated Interpreter Good, Fair, or Poor % (n=570)*	Unadjusted Odds Ratio (95% CI)†	Adjusted Odds Ratio (95% CI)‡
Did the doctor or nurse you saw allow you enough time to explain the reason for your visit? (yes)	98.4	89.1	7.6§ (3.3, 16.9)	12.8§ (3.3, 50.1)
On your most recent visit, how much of the time did your doctor or nurse explain things in a way you could understand? (always)	78.6	40.4	5.4§ (3.8, 7.9)	3.6§ (2.2, 6.0)
Did you have any questions about your care or treatment that you wanted to ask but did not? (yes)	22.5	39.1	0.5§ (0.3, 0.7)	0.8 (0.4, 1.4)
Did you have any questions about your mental health, such as stress, anxiety, or sadness that you wanted ask but did not? (yes)	21.5	30.3	0.6§ (0.4, 0.9)	1.3 (0.6, 2.5)
Did the doctor or nurse that examined you give you as much information about your health and treatment as you wanted? (yes)	94.2	82.8	3.4§ (1.8, 6.3)	1.3 (0.5, 3.7)
Overall, how would you rate the health care you received at this clinic during this most recent visit? (excellent/very good)	80.5	17.8	19.1§ (12.3, 29.5)	4.8§ (2.3, 10.1)

**Weighted percentages using SUDAAN to account for sampling design.*
†Odds ratios use low-rated interpreter group as reference.
‡Adjusted for age, sex, education, primary language, English proficiency, time in U.S., health status, reason for visit, usual provider, rating of clinician.
§Statistically significant.
CI, confidence intervals.

Questionnaire – Shippe et al (2012)

Shippee, N. D., Pintor, J. K., McAlpine, D. D., & Beebe, T. J. (2012). Need, Availability, and Quality of Interpreter Services among Publicly Insured Latino, Hmong, and Somali Individuals in Minnesota. *Journal of Health Care for the Poor and Underserved, 23*(3), 1073-1081.

- Variables included self-reported need for interpreter services:
  - Availability of interpreter (0 = interpreter not always provided; 1 = always provided),
  - Items concerning whether enrolees usually had professional interpreters (1=yes, versus family/friend/other),
  - Consistent interpreters (1 = always have the same interpreter; 0 = do not),
  - Worry about interpreter confidentiality/privacy (1 = worry "a lot" about confidentiality; 0 = do not),
  - Three items addressing enrollee-assessed problems with the quality of interpreter mediated communication (i.e., whether enrolees felt that interpreters were helpful in the communication process).
    - How much does having an interpreter help you understand what the doctor is asking?
    - How much does having an interpreter help the doctor understand what you are trying to tell them?
    - How much does having an interpreter help understand what is being done?

    Responses were *None*, *A little*, *Some*, or *A lot*. Based on our interest in identifying any lack of quality, these variables were dichotomized, such that 0 = A lot of help and 1 = any response less than a lot of help. We also created a fourth, aggregated quality item, coded such that 1 represented any problem from the three original quality questions and 0 represented absolutely no quality problems reported.

Visit-Specific Satisfaction Questionnaire (VSQ) + Consumer Satisfaction Survey (CSS)

Gasquet, I., Villeminot, S., Dos Santos, C., Vallet, O., Verdier, A., Kovess, V., Hardy-Baylé, M. C., & Falissard, B. (2003). Adaptation culturelle et validation de questionnaires de satisfaction à l'égard du système de santé français. *Santé publique, 15*(4), 383-402.

- « Le VSQ est un questionnaire unidimensionnel de 9 items qui explore globalement la satisfaction pour la dernière consultation médicale. »

- « Le CSS (39 items) est un outil multidimensionnel qui aborde la qualité des soins médicaux et de la couverture maladie. Il présente les qualités psychométriques nécessaires pour être considéré comme un outil valide et fiable. Il a fait l'objet d'une large utilisation outre-Atlantique dans le cadre de la réflexion sur la planification sanitaire et la qualité de l'offre de soins. »

Questionnaire VSQ-VF

(dernière consultation médicale)

Modalités de réponses : Mauvais – Moyen – Bon – Très bon – Excellent

1. Le délai pour obtenir un rendez-vous.
2. La facilité pour joindre le cabinet par téléphone.
3. Le temps d'attente au cabinet.
4. Le temps que vous a consacré le médecin.
5. Les explications que le médecin vous a données sur ce qui a été fait au cours de la consultation.
6. La compétence du médecin (sérieux, conscience professionnelle, savoir-faire).
7. La manière d'être du médecin (courtoisie, respect, tact, gentillesse).
8. Cette consultation dans son ensemble.
9. La facilité d'accès du cabinet du médecin.

Questionnaire CSS-VF

Accès aux soins médicaux primaires (ASP)

Modalités de réponses : Mauvais – Moyen – Bon – Très bon – Excellent

1. Les horaires d'ouverture du cabinet de votre généraliste.
2. La facilité pour prendre rendez-vous par téléphone avec votre généraliste.
3. Le temps d'attente au cabinet de votre généraliste.
4. Le délai entre le jour de la prise de rendez-vous et le jour de la consultation chez le généraliste.
5. La possibilité d'avoir des informations médicales ou des conseils par téléphone de votre généraliste.
6. La possibilité de voir un médecin au moment où vous en avez besoin.
7. La facilité d'accès au cabinet de votre généraliste.

Accès aux soins médicaux secondaires (ASS)

Modalités de réponses : Mauvais – Moyen – Bon – Très bon – Excellent

8. La facilité pour se faire soigner par un médecin spécialiste.
9. La facilité pour se faire soigner à l'hôpital.
10. La facilité pour se faire soigner en cas d'urgence.

Compétence des généralistes et communication avec les généralistes (Comp-G et Com-G)

Modalités de réponses : Mauvais – Moyen – Bon – Très bon – Excellent

11. Le soin avec lequel les généralistes que vous connaissez vous examinent et la justesse de leur diagnostic.
12. La compétence et l'expérience des généralistes que vous connaissez.
13. Le sérieux avec lequel les généralistes que vous connaissez choisissent les traitements.
14. Les explications données par les généralistes que vous connaissez sur les actes médicaux et les examens.
15. L'attention que les généralistes que vous connaissez portent à ce que vous dites.
16. Les conseils de prévention que vous recevez des généralistes que vous connaissez pour rester en bonne santé.

Compétence des spécialistes (Comp-S)

Modalités de réponses : Mauvais – Moyen – Bon – Très bon – Excellent

17. Le soin avec lequel les spécialistes que vous connaissez vous examinent et la justesse de leur diagnostic.
18. La compétence et l'expérience des spécialistes que vous connaissez.
19. Le sérieux avec lequel les spécialistes que vous connaissez choisissent les traitements.

Communication avec les spécialistes (Com-S)

Modalités de réponses : Mauvais – Moyen – Bon – Très bon – Excellent

20. Les explications données par les spécialistes que vous connaissez sur les actes médicaux et les examens.
21. L'attention que les spécialistes que vous connaissez portent à ce que vous dites.
22. Les conseils de prévention que vous recevez des spécialistes que vous connaissez pour rester en bonne santé.

Possibilité de choix entre différents médecins (PC)

Modalités de réponses : Mauvais – Moyen – Bon – Très bon – Excellent

23. Le nombre de généralistes auprès de qui vous pouvez consulter.
24. La possibilité de consulter le généraliste de votre choix.
25. Le nombre de spécialistes, pour une spécialité donnée, auprès de qui vous pouvez consulter.
26. La possibilité de consulter le spécialiste de votre choix.

Qualités humaines des médecins (QH)

Modalités de réponses : Mauvais – Moyen – Bon – Très bon – Excellent

27. La gentillesse et la courtoisie des médecins.
28. L'intérêt que les médecins portent à vos problèmes de santé et à vous-même.
29. Le respect que vous portent les médecins et leur discrétion à votre égard.
30. La capacité des médecins à vous rassurer et à vous soutenir.

Satisfaction globale (SG)

Modalités de réponses : Tout à fait d'accord – Plutôt d'accord - Pas d'opinion tranchée - Pas vraiment d'accord – Pas du tout d'accord

31. Je suis très satisfait(e) des soins que je reçois.
32. Certaines choses pourraient être améliorées dans les soins que je reçois.
33. Les soins que je reçois sont pratiquement parfaits.
34. Je suis mécontent(e) d'un certain nombre de choses dans les soins que je reçois.

Couverture maladie (CM)

Modalités de réponses : Mauvais – Moyen – Bon – Très bon – Excellent

35. La capacité de votre couverture maladie à compenser vos dépenses médicales et vos pertes de revenus.
36. L'éventail des frais qui vous sont remboursés.
37. Le remboursement de vos frais de consultations.
38. Le remboursement de vos frais d'hospitalisations.
39. Le remboursement de vos dépenses de médicaments.

The Patient Satisfaction Questionnaire Short-Form (PSQ-18)

Marshall, G. N., & Hays, R. D. (1994). *The Patient Satisfaction Questionnaire Short-Form (PSQ-18)*. RAND. Santa Monica, CA, United States. Retrieved from http://www.rand.org/content/dam/rand/pubs/papers/2006/P7865.pdf

- The PSQ-18 contains 18 items tapping each of the seven dimensions of satisfaction with medical care measured by the PSQ-III: general satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with doctor, and accessibility and convenience.

- Here's the short form (p. 20-21 of the article). The article provides the long version also.

SHORT-FORM PATIENT SATISFACTION QUESTIONNAIRE (PSQ-18)

These next questions are about how you feel about the medical care you receive.

On the following pages are some things people say about medical care. Please read each one carefully, keeping in mind the medical care you are receiving now. (If you have not received care recently, think about what you would expect if you needed care today.) We are interested in your feelings, good and bad, about the medical care you have received.

How strongly do you AGREE or DISAGREE with each of the following statements?

(Circle One Number on Each Line)

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
1. Doctors are good about explaining the reason for medical tests	1	2	3	4	5
2. I think my doctor's office has everything needed to provide complete medical care	1	2	3	4	5
3. The medical care I have been receiving is just about perfect	1	2	3	4	5
4. Sometimes doctors make me wonder if their diagnosis is correct	1	2	3	4	5
5. I feel confident that I can get the medical care I need without being set back financially	1	2	3	4	5
6. When I go for medical care, they are careful to check everything when treating and examining me	1	2	3	4	5
7. I have to pay for more of my medical care than I can afford	1	2	3	4	5
8. I have easy access to the medical specialists I need	1	2	3	4	5

How strongly do you AGREE or DISAGREE with each of the following statements?

(Circle One Number on Each Line)

	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree
9. Where I get medical care, people have to wait too long for emergency treatment	1	2	3	4	5
10. Doctors act too businesslike and impersonal toward me	1	2	3	4	5
11. My doctors treat me in a very friendly and courteous manner	1	2	3	4	5
12. Those who provide my medical care sometimes hurry too much when they treat me	1	2	3	4	5
13. Doctors sometimes ignore what I tell them	1	2	3	4	5
14. I have some doubts about the ability of the doctors who treat me	1	2	3	4	5
15. Doctors usually spend plenty of time with me	1	2	3	4	5
16. I find it hard to get an appointment for medical care right away	1	2	3	4	5
17. I am dissatisfied with some things about the medical care I receive	1	2	3	4	5
18. I am able to get medical care whenever I need it	1	2	3	4	5

Questionnaire – Hadziabdic (2014) – Échantillon d'items/Item sample

Hadziabdic, E., Albin, B., & Hjelm, K. (2014). Arabic-speaking migrants' attitudes, opinions, preferences and past experiences concerning the use of interpreters in healthcare: a postal cross-sectional survey. *BMC research notes, 7*(1), 71.

- "A 51-item questionnaire with some additional background data questions was developed based on four previous qualitative studies […] concerning the use of interpreters in healthcare to ensure content validity."

- "When formulating questions, the results from the previous qualitative studies were organized into three different areas: questions related to the individuals' attitudes to the use of interpreters as a communication aid in healthcare (21 items); questions related to the individuals' attitudes to the professional and personal qualities of an interpreter in healthcare (19 items); and questions related to the individuals' attitudes to modes of interpretation and the types of interpreter in healthcare (11 items)."

- "Arabic-speaking persons responded to statements in the questionnaire by giving a rating on an ordinal 4-point Likert scale, ranging from 1 (strongly disagree) to 4 (strongly agree), i.e. the higher the values, the stronger the dimension of agreement." (p. 3)

Table 2 Questions concerning Arabic-speaking individuals' attitudes to the use of interpreters as a communication aid in healthcare

Variable	N	Agreed N (%)	Disagree N (%)	Mean ± Sd.
It is important that the interpreter helps you to find the way within health care to different consultations because it is difficult for me to read signs in English	53	51 (96%)	1 (2%)	3.9 ± 0.4
The interpreter helps me only with translation because I do not speak Swedish	53	50 (94%)	3 (6%)	3.8 ± 0.6
While I talk through an interpreter it is important to express myself clearly so the interpreter will be able to support me	52	48 (91%)	4 (8%)	3.7 ± 0.7
A nurse/physician always books an interpreter in advance when I need it	52	47 (87%)	5 (10%)	3.5 ± 0.7
It is difficult to guarantee that what I have said during the interpretation is made in confidence and that the interpreter will not spread it to others	53	45 (85%)	8 (15%)	3.3 ± 0.8
I prefer an interpreter who helps me with transport both before and after consultations in healthcare	52	36 (67%)	16 (15%)	3.0 ± 1.1
I always get a feeling of uncertainty while I talk through an interpreter because I do not know whether what I say is correctly translated or not	53	32 (60%)	21 (40%)	2.6 ± 1.1
I find that talking through an interpreter reduces intimacy between healthcare staff and me	51	30 (57%)	21 (40%)	1.9 ± 1.0
Talking through an interpreter makes me feel handicapped as I cannot speak Swedish	53	23 (43%)	30 (57%)	2.3 ± 1.2
I have not been in any situations in healthcare when booked interpreters have not turned up	51	23 (43%)	28 (53%)	2.4 ± 1.2
I always get a feeling of uncertainty while I talk through an interpreter because I do not know whether what I say is correctly translated or not	53	15 (28%)	38 (72%)	1.9 ± 1.0
The interpreter should not interpret literally and objectively	52	12 (25%)	40 (75%)	1.7 ± 1.2

Table 3 Questions related to the professional and personal qualities of an interpreter in the survey of Arabic-speaking individuals' attitudes to the use of interpreters in healthcare

Variable	N	Agree N (%)	Disagree N (%)	Mean ± Sd.
It is of no importance whether an interpreter is fluent in both languages	52	51 (96%)	1 (2%)	3.9 ± 0.4
It is important that an interpreter has a great ability to translate	52	51(96%)	1 (2%)	3.9 ± 0.3
An interpreter should show me respect	53	51 (96%)	2 (4%)	3.8 ± 0.5
It is important that an interpreter have training both in the language and the terminology used in healthcare	52	50 (94%)	2 (3%)	3.9 ± 0.5
It is important that the interpreter is neutral and impartial	51	48 (91%)	3 (9%)	3.7 ± 0.6
The interpreter's age is of no importance for the translation	52	41 (77%)	11 (21%)	3.1 ± 1.0
It is important that an interpreter talks the same dialect as me	53	40 (75%)	13 (25%)	3.3 ± 1.0
It is not important what clothes an interpreter wears and whether he/she is provocatively dressed	52	36 (68%)	16 (30%)	3.0 ± 1.3
It is not important what religion the interpreter belongs to	53	35 (66%)	18 (34%)	2.7 ± 1.2
It is important that I know what country the interpreter comes from	53	34 (64%)	19 (36%)	2.9 ± 1.2
I think that it is important to use an interpreter of the same gender as myself	51	31 (58%)	20 (38%)	2.8 ± 1.2
It is not important that the interpreter introduces him/herself to me before starting the interpretation session	53	16 (30%)	37 (70%)	2.0 ± 1.2
It is not important that an interpreter is trained	52	14 (26%)	38 (72%)	1.9 ± 1.1
It is of no importance to me whether the interpreter tells other people about what I have told the physician or nurse during my consultation in which he/she has interpreted	53	8 (15%)	45 (85%)	1.4 ± 0.9

Table 4 Questions related to modes of interpretation and the types of interpreter in the survey of Arabic-speaking individuals' attitudes to the use of interpreters in healthcare

Variable	N	Agree N (%)	Disagree N (%)	Mean ± Sd.
It is good to use an interpreter who has special training and who is employed by an agency	53	52 (98%)	1 (2%)	3.8 ± 0.5
I prefer to use a telephone interpreter during sensitive investigations	52	49 (92%)	3 (8%)	3.7 ± 0.7
I prefer to use an interpreter in place	52	46 (87%)	6 (13%)	3.3 ± 0.8
Bilingual healthcare staff are good to use as interpreters because they are already in place when interpreting is to be done	49	46 (87%)	3 (13%)	3.5 ± 0.7
There is no difference between using telephone interpreters and interpreters in place	52	34(64%)	18 (36%)	2.6 ± 1.1
Using a family member/friend as interpreter implies that I get support from family/friend at the same time as he/she translates	52	33 (62%)	19 (38%)	2.7 ± 1.1
I feel confidence in using a family member/friend as an interpreter more than an unknown person being an interpreter	52	28 (53%)	24 (47%)	2.5 ± 1.2
I prefer to use a family member/friend as an interpreter	53	25 (47%)	28 (53%)	2.4 ± 1.1
There is no risk that all information will not be translated when I use a family member/friend as interpreter	51	17 (32%)	34 (68%)	2.0 ± 1.1

Questionnaire – Bischoff et al (2008) – Description

Bischoff, A., Hudelson, P., & Bovier, P. A. (2008). Doctor–Patient Gender Concordance and Patient Satisfaction in Interpreter-Mediated Consultations: An Exploratory Study. *Journal of Travel Medicine, 15*(1), 1-5.

- "Patients and providers were asked to rate six aspects of communication during the consultation using a 10-point Likert scale:
  - the doctor's response to the patient's needs (not clear at all – very clear)
  - the doctors' explanations (not clear at all – very clear),
  - the doctor's respectfulness toward the patient (no respect – total respect)
  - the quality of communication in general (poor – excellent)
  - the overall consultation process (poor – excellent)
  - information provided regarding follow-up (poor – excellent)

- To assess the relationship between gender concordance and patient satisfaction in interpreter-mediated consultations, we analyzed only consultations with foreign language – speaking patients (N = 363, of the total 1,016 included in the larger study). The patients' language skills were assessed by the doctors. When the patient's mother tongue was a foreign language and his/her French was poor, then he/she was classified as foreign language speaking." (p. 2)

Questionnaire – Mahmoud et al (2014) – Description

Mahmoud, I., Hou, X., Chu, K., Clark, M., & Eley, R. (2014). Satisfaction with emergency department service among non-English-speaking background patients. *Emergency Medicine Australasia, 26*, 256-261

- "We developed a questionnaire in the English language and adapted the questions from the existing literature and validated questionnaires on patients' satisfaction.
  - Carrasquillo O, Orav EJ, Brennan TA, Burstin HR. (1999). Impact of language barriers on patient satisfaction in an emergency department. *J. Gen. Intern. Med., 14*, 82–7.
  - Woods SE, Bivins R, Oteng K, Engel A. (2005). The influence of ethnicity on patient satisfaction. *Ethn. Health, 10*, 235–42.
  - Norredam M, Mygind A, Nielsen AS, Bagger J, Krasnik A. (2007). Motivation and relevance of emergency room visits among immigrants and patients of Danish origin. *Eur. J. Public Health, 17*, 497–502.

- Two parts:
  - The first part, which solicited demographic information and the reasons for visiting the ED, was completed by the patient before treatment.
  - The patient was then asked to keep the questionnaire to fill out the second part, assessing patient satisfaction after treatment, before leaving the ED.

- The patients were asked to rate the questions about the ED staff's skills, compassion, courtesy and respect, communication, time with the doctor, the quality of the care they received and their overall satisfaction (five-point Likert scale : 1 = poor; 5 = excellent).

- At the end of the questionnaire, the patients were asked an open question about what they thought was the most important element of ED service.

- The procedure for answering the questionnaire was self-completion or a face-to-face interview for both parts. If required, a professional interpreter or a family member acted as an interpreter throughout their ED visit."

Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAHPS) – Description

Jacobs, E. A., Sadowski, L. S., & Rathouz, P. J. (2007). The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction. *Journal of General Internal Medicine, 22*(2), 306-311.

- "Satisfaction with the hospital stay was measured using the H-CAHPS, a previously-validated 24-item instrument available in English and Spanish. Participants completed the survey at discharge with the help of the research assistant (RA) or, if they were discharged outside of the RA's working hours, completed it over the phone in response to RA questioning, or mailed it in. We analyzed items from the H-CAHPS that would likely be affected by communication, including satisfaction with nursing care (4 items), satisfaction with physicians (4 items), and overall satisfaction with the hospital stay (2 items)." (p. 308)

Interpersonal Aspects of Care (IAC) – Description

Baker, D. W., Hayes, R., & Fortier, J. P. (1998). Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients. *Medical Care, 36*(10), 1461-1470.

- Five items from the IAC examiner scale that we thought patients could assess even if there were language barriers between the patient and the examiner :
    - Friendliness
    - Respectfulness
    - Concern for the patient as a person
    - Spending enough time
    - Making the patient feel comfortable

- Respondents were asked to say whether the provider, nurse, or clerk was *excellent*, *very good*, *good*, *fair*, or *poor*.

- The interpersonal aspects of care satisfaction score was determined by the mean score on the five satisfaction items described above (range from 1 = excellent to 5 = poor). The Cronbach's alpha reliability for this five-item scale was 0.86. To facilitate interpretation, we transformed scores using the formula [5 - mean/4] 100 to give a scale ranging from 0 (lowest satisfaction) to 100 (highest satisfaction).

1.2 Questionnaires – Fournisseurs de soins/Healthcare Providers

Représentation du rôle de l'interprète, version thérapeute

Goguikian Ratcliff, B., & Suardi, F. (2006). L'interprète dans une consultation thérapeutique : Conception de son rôle et difficultés éprouvées. *Psychothérapies, 26*, 37-49

- Questionnaire destiné à évaluer la représentation du rôle de l'interprète chez les thérapeutes.

1. Vous pensez que le rôle de l'interprète est d'être :

interprète

pas du tout — tout à fait

référent culturel

pas du tout — tout à fait

médiateur

pas du tout — tout à fait

co-thérapeute

pas du tout — tout à fait

2. Les consignes du groupe vis-à-vis de l'interprète sont suffisamment claires

pas du tout — tout à fait

3. L'interprète fait partie du groupe au même titre que les thérapeutes

pas du tout — tout à fait

4. L'interprète doit adhérer aux représentations étiologiques traditionnelles de la maladie et des soins

pas du tout — tout à fait

5. L'interprète génère un risque de malentendu supplémentaire

pas du tout — tout à fait

6. Le fait de ne pas pouvoir contrôler l'exactitude de la traduction vous pose problème

pas du tout — tout à fait

7. Il est important de pouvoir contrôler les interventions spontanées de l'interprète

pas du tout — tout à fait

8. L'interprète apporte du soutien au patient

pas du tout — tout à fait

9. Dans le cadre d'une prise en charge en ethnopsychiatrie la présence d'un interprète est toujours nécessaire

pas du tout — tout à fait

10. L'interprète se sent soutenu par le groupe

pas du tout — tout à fait

11. Le groupe doit se montrer en mesure de contenir la mobilisation émotionnelle de l'interprète

pas du tout — tout à fait

12. Veuillez mentionner 4 adjectifs (max.) qui illustrent les aspects positifs d'un travail avec un interprète

13. Veuillez mentionner 4 adjectifs (max.) qui illustrent les difficultés éventuelles d'un travail avec un interprète

Questionnaire – Safrin (2016)

Safrin, E. K. (2014). *La percepción del intérprete según los proveedores de servicios sanitarios en la ciudad fronteriza de San Diego, California.* (Trabajo fin de Máster), Universidad de Alcalá. Retrieved from http://hdl.handle.net/10017/2373

- Two surveys distributed to doctors and nurses at a hospital in San Diego, California.

Survey – Form B

1. **What language(s) do you know, other than English?**

2. **What level of proficiency do you have in the language(s)? (If applicable, circle more than one and indicate the corresponding languages.)**

Native / Fluent / Proficient / Conversational / Not sufficient for professional purposes

3. **Do you ever interact with patients in a language other than English? If so, how often and in which language(s)?**

4. **When a patient speaks a language other than English that you have a certain command of, do you prefer to carry out the visit in that language or do you prefer to use an interpreter? Why?**

5. **Have you ever had the experience of working with an interpreter in a language you were familiar with? (That is, you were able to understand some or all of what was said in the second language by the patient and the interpreter.) If so, what observations did you make about the interpreter, taking into account aspects such as accuracy, impartiality, etc.?**

Survey – Form A

Field/specialty: _____

Professional degree: MD / DO / RN / Other:_____ **Years in practice**: _____

1. **On average, how many times per month does an interpreter aid you in communication with your patients?**

2. **Are you proficient enough in another language so as not to require an interpreter?**
Yes / No
If Yes, what language(s)?
If Yes, please consider completing **Form B**.

3. **How often is the interpretation provided via telephone versus in person?**
   a. 100% telephone

b. 100% in person
c. 50% telephone, 50% in person
d. Usually telephone (approximate percentage: _____)
e. Usually in person (approximate percentage: _____)

4. How often does a professional interpreter provide the interpretation (regardless of whether via telephone or in person)?

Always Almost always Sometimes Rarely Never

5. How often is the interpreter untrained or a non-professional (e.g., a family member or acquaintance of the patient, a bilingual staff member at the hospital, etc.)?

Always Almost always Sometimes Rarely Never

6. How is the interpreter most often chosen?
a. I leave the decision up to the patient.
b. I suggest that we use a professional interpreter but allow the patient to decide.
c. I decide to use a professional interpreter regardless of the patient's preference.
d. Other (please explain briefly):

7. In your opinion, is a person's ability to speak both languages (English and that of the patient) sufficient in order to interpret? Why or why not?

8. Do you believe that interpreters should be required to fulfill a certain degree of professional education and training in interpretation or be accredited in order to work in a medical setting?

9. Have you participated in any training, courses, lectures, etc. on interpretation, intercultural communication, or related topics?: Yes / No
If Yes, please explain briefly:

10. Based on your experience with professional interpreters, how satisfied are you with their performance?

	Very satisfied	Satisfied	Somewhat satisfied	Not very satisfied	Not at all satisfied
Accuracy					
Impartiality					
Confidentiality					
Professionalism					

11. Based on your experience with untrained or non-professional interpreters (e.g., family members, bilingual staff), how satisfied are you with their performance?

	Very satisfied	Satisfied	Somewhat satisfied	Not very satisfied	Not at all satisfied
Accuracy					
Impartiality					
Confidentiality					
Professionalism					

12. Please list briefly any advantages or disadvantages of using a professional versus non-professional interpreter, or any observations you have made about the difference between the two.

13. In your opinion, what is the role of the interpreter?

a. To interpret all that is said faithfully and precisely, without omitting or adding information, leaving clarifications up to the patient and me.
b. To ensure comprehension by simplifying or summarizing statements made by both the patient and myself.
c. Other (please explain briefly):

Thank you for your time and consideration in filling out this survey.

Any additional comments are welcome on the reverse side of the page. Likewise, if you would be willing to participate in a **brief interview**, please provide an e-mail address or other contact information.

Questionnaire – Bischoff & Hudelson (2010)

Bischoff, A., & Hudelson, P. (2010). Communicating With Foreign Language–Speaking Patients: Is Access to Professional Interpreters Enough? *Journal of Travel Medicine, 17*(1), 15-20.

- Self-administered questionnaire, pretested but not validated, to examine attitudes and practices related to healthcare interpreting.

- Items (p. 16) :
  1. In which clinical service do you currently work? (Open-ended question)
  2. What is your current function at the hospital? (Open-ended)
  3. Please estimate the proportion of immigrant patients in your service in 2003. (Open-ended)
  4. Please estimate the proportion of patients with limited French proficiency in your service in 2003 (Open-ended)
  5. What is your mother tongue? (List of languages; more than one response possible)
  6. Were you born abroad? (Yes/No)
  7. Was one or more of your parents born abroad? (Yes/No)
  8. Are you ever asked to provide interpretation? (Yes/No)
  9. How often do you use interpreters (of any kind)? (Never, daily, once a week, once a month, a few times per year, I don't know)
  10. For about how many years have you been using interpreters (of any kind) in your work? (No. years)
  11. For about how many years has your institution been using interpreters (of any kind)? (No. years)
  12. Which of the following interpreting strategies do you use the most often, for each of the following languages? (Professional interpreters, Untrained volunteers, Bilingual employees (clinical and nonclinical), Patients' relatives/friends, I am my own interpreter (I speak this language))
  13. How do you rate the general quality of interpretation provided by the following persons? (Poor, satisfactory, good, excellent, I don't know)
      - Professional interpreters
      - Untrained volunteers
      - Bilingual employees (clinical and nonclinical)
      - Patients' relatives/friends
  14. Rate the following statements: (1 (false) to 4 (perfectly true))
      - With the use of interpreters…
        - Immigrants' autonomy is strengthened
        - Immigrants are better informed
        - Immigrants are not encouraged to learn the local language
        - Immigrants become dependent on interpreters
        - Immigrants are better informed about their rights

Questionnaire – Jacobs et al (2010) – Échantillon d'items/Item sample

Jacobs, E. A., Diamond, L. C., & Stevak, L. (2010). The importance of teaching clinicians when and how to work with interpreters. *Patient Education and Counseling, 78*, 149-153.

- "28-item questionnaire measuring the med students' knowledge, their attitudes and likelihood of future behaviour before and after the course.
  - The 28-item questionnaire was adapted from one developed by the Asian Health Coalition of Illinois to measure how their cultural competence curriculum impacted the knowledge of and attitudes towards cultural competency.
  - The instrument was modified to make all questions specific to working in the context of language barriers and we added several questions about their intended behavior when facing language barriers when encountering patients who did not speak English well.
  - In response to each item students circled one of five Likert scale responses: strongly disagree, disagree, unsure, agree, and strongly agree."

- Item sample in Table 1 (p. 151):

Table 1
Questionnaire items with significant improvement from pre-test to post-test.

	Direction of Change	P
Knowledge items		
The best place to have an interpreter sit is between you and your patient	Greater disagreement	<0.01
Family members and friends are usually the best people to use as interpreters	Greater disagreement	<0.01
It is inappropriate to use family members as interpreters	Greater agreement	<0.01
When speaking through an interpreter it is important to look at the doctor and patient	Greater agreement	<0.01
When speaking through an interpreter it is important to slow down and use short sentences	Greater agreement	<0.01
Attitude items		
It is easy to work with interpreters	Greater agreement	<0.01
Cultural competency is necessary to provide high quality health care services	Greater agreement	<0.01
The information I obtain using a trained medical interpreter is accurate	Greater agreement	<0.01
I think I will feel frustrated when caring for LEP patients	Greater disagreement	<0.01
I think I will find it rewarding to work with LEP patients	Greater agreement	<0.01
Future behavior items		
You will arrange for a professional interpreter to help you communicate with LEP pts	Greater agreement	0.04
You will ask patients to repeat back instructions	Greater agreement	0.05
You will take culture into account in pt care plans	Greater agreement	<0.01

Questionnaire – Papic & Rosenberg (2011) – Description

Papic, O., Malak, Z., & Rosenberg, E. (2011). Survey of family physicians' perspectives on management of immigrant patients: Attitudes, barriers, strategies, and training needs. *Patient Education and Counseling, 86*, 205-209

- Items not provided.

- 18 questions asking family physicians to identify the barriers they perceived to the care of immigrants, the resources and strategies they used to accommodate immigrant patients, as well as their training in immigrant care.

Questionnaire – Nápoles et al (2010) – Description

Nápoles, A. M., Santoyo-Olsson, J., Karliner, L. S., O'Brien, H., Gregorich, S. E., & Pérez-Stable, E. J. (2010). Clinician Ratings of Interpreter Mediated Visits in Underserved Primary Care Settings with Ad hoc, In-person Professional, and Video Conferencing Modes. *J Health Care Poor Underserved, 21*(1), 301-317

- Items not provided.
- Measures interpretation mode, quality of visit and clinician-reported patient characteristics.
- Five clinician-reported visit-specific outcomes: quality of interpretation, degree of patient engagement, quality of communication, visit satisfaction, and selfperceived understanding of the patient's cultural beliefs (surrogate for perceived cultural competence). The outcome measures consisted mostly of newly developed items based on the literature and developed by a multidisciplinary research team of adult medicine physicians and behavioral scientists, with review by clinicians at the targeted sites.
    - Quality of interpretation and degree of patient engagement were assessed with multi-item scales. We created new items from the perspective of the clinician that had face validity in terms of the functions of the interpreter in facilitating information exchange. The 4-item Quality of Interpretation Scale asked clinicians to rate, to the best of their knowledge, how well the interpreter listened to what the clinician had to say, explained what the clinician said to the patient, and helped the clinician understand what the patient said, as well as the overall quality of the interpretation for that visit (responses were: 1 = poor, 2 = fair, 3 = good, 4 = very good, 5 = excellent)
    - To assess patient engagement, we created new items from the perspective of the clinician that had face validity in terms of their importance to patient self-care behaviors. The 4-item Patient Engagement Scale asked how well the patient understood the information provided; the patient understood the clinician's recommendations; the clinician was able to elicit the patient's concerns; and the clinician was able to engage the patient as a partner in managing their health (responses were: 1 = not at all, 2 = poorly, 3 = fairly well, 4 = well, 5 = very well)
    - Quality of communication, visit satisfaction, and understanding of patient's cultural beliefs were assessed with single items. For quality of communication we asked, "In general, how would you rate the quality of the communication you had with the patient today?" (poor, fair, good, very good, excellent).
    - Clinicians reported on the patient's primary language, English-speaking ability, gender, age, global health rating, and level of emotional distress during the visit.

Questionnaire – Seeleman et al (2014) – Description

Seeleman, C., Hermans, J., Lamkaddem, M., Suurmond, J., Stronks, K., & Essink-Bot, M. (2014). A students' survey of cultural competence as a basis for identifying gaps in the medical curriculum. *BMC Medical Education, 14*(1), 1-10.

- Three competence domains:
  - *General Knowledge*. We developed eight multiple choice items to assess the 'general knowledge of ethnic minority care provision', and six multiple choice items to assess respondents' 'knowledge of interpretation services' (see Table 1 for examples). For both dimensions, the score was calculated as the sum of correct answers ('correct'=1 point, 'not correct' and 'do not know'=0 points; general knowledge range 0–8; knowledge of interpreter services range 0–6).
  - *Reflection Ability*. For culturally competent doctors, reflection is required for insight into one's own understanding of prejudice and cultural frames of reference. We included the Groningen Reflection Ability Scale (GRAS) in the questionnaire: a validated scale which measures respondents' general ability of personal reflection. The GRAS was developed to assess reflection ability in medical students and consists of 23 statements. Respondents rate their level of agreement with each statement on a five point Likert scale (1= totally disagree, 5= totally agree; see Table 2 for examples). Although the GRAS measures reflection ability in general, it includes various statements especially relevant with regard to cultural competence (e.g. "I am aware of the cultural influences on my opinions").
  - *Culturally Competent Consultation Behaviour*. In this domain we ask respondents to report their professional behaviour as doctors in medical consultations with ethnic minority patients. We defined culturally competent consultation behaviour of doctors as applying a patient-centred communication style with a focus on issues of specific importance in the care of an ethnically diverse patient population. The respondents report on their own behaviour in terms of what they do and/or how often. To this end, we developed:
    - two short case scenarios to assess respondents' behaviour in a) exploring patient perspectives, and b) interaction with patients of low health literacy level (see Table 1 for an example). Normative response options were determined, following recent literature [8,9]. Scores for these items ranged from 0–3 (summing the culturally competent answers).
    - an 11-item scale to assess how respondents explored patients' social contexts. This score was summed (75%= 3) and divided by 11 (range 0–3). In the results, all scores are also presented as a percentage of the maximum scores. Cronbach's alpha for the social context scale was 0.86 in this study.
    - 2 items about the frequency and type of interpreter used in the six months prior to this survey (e.g. professional interpreter, informal interpreter, patient's child older than 16; patient's child younger than 16). Because medical students during their rotation are not allowed to decide about professional interpretation without approval from their supervisors, we did not ask what they did, but what preference for type of interpreter they had.

Questionnaire – Brisset et al (2014) – Description

Brisset, C., Leanza, Y., Rosenberg, E., Vissandjée, B., Kirmayer, L. J., Muckle, G., Xenocostas, S., & Laforce, H. (2014). Language barriers in mental health care: A survey of primary care practitioners. *Journal of Immigrant and Minority Health, 16*(6), 1238-1246.

- A self-report survey assessing practitioners' experiences working with allophones.

- The survey instrument was developed by reviewing previous studies presenting descriptive data on practices with allophone clients and by requesting copies of the questionnaires used from the authors. Six questionnaires were obtained and used to develop a self-administered survey to address the study objectives.

- The final instrument consisted of 23 general descriptive questions exploring the resources available to mental health practitioners working with allophone clients, their use of each resource, their linguistic needs, their practices in working with interpreters (current practices, reported influencing factors, satisfaction and perceived advantages/difficulties) and their representations of the interpreter's roles according to Leanza's typology.

- Response choices for questions on perceived difficulties in working with allophone clients, linguistic needs, perceived satisfaction in working with interpreters and client's appointment keeping to treatment used a 5-point Likert scale (from 1 = ''not at all'' to 5 = ''extremely''); questions on perceived factors influencing the use of professional interpreting services used a 3-point Likert scale (1 = ''negative influence''; 2 = ''no influence''; 3 = ''positive influence''). For all other questions, participants indicated applicable items on a provided list.

Questionnaire – Kale & Syed (2010) – Description

Kale, E., & Syed, H. R. (2010). Language barriers and the use of interpreters in the public health services. A questionnaire-based survey. *Patient Education and Counseling, 81*(2), 187-191

- The questionnaire, originally developed and applied by linguist Mette Rudvin and colleagues in Italy [26], was translated and adapted for use as a tool for collecting data in this cross-sectional, descriptive study conducted in Norway.

- Its 36 questions were organized under three sections:
  - Section 1 focused on the need for language assistance and the use of interpreters;
  - Section 2 focused on the knowledge of how to cooperate with interpreters and the expectations of interpreters;
  - Section 3 focused on the competency needs of health professionals and their interpreters.

1.3 Questionnaires – Interprètes/Interpreters

Représentation du rôle de l'interprète, version interprète

Goguikian Ratcliff, B., & Suardi, F. (2006). L'interprète dans une consultation thérapeutique : Conception de son rôle et difficultés éprouvées. *Psychothérapies, 26*, 37-49

- À partir d'une série d'affirmations, les sujets doivent indiquer d'une croix sur une ligne de 10 cm allant de « pas du tout » à « tout à fait », dans quelle mesure ils sont d'accord avec chacun de ces énoncés. La réponse est mesurée manuellement en centimètres, au dixième près, l'extrémité « pas du tout » étant considérée comme la valeur zéro. On obtient pour chaque item un score allant de 0 à 100.

- Voici le questionnaire, disponible en page 48 de l'article de Goguikian Ratcliff et Suardi.

1. Dans quelle mesure vous êtes-vous senti dans un rôle de :

interprète

pas du tout — tout à fait

référent culturel

pas du tout — tout à fait

médiateur

pas du tout — tout à fait

co-thérapeute

pas du tout — tout à fait

2. Vous avez trouvé claires les attentes du groupe à votre égard

pas du tout — tout à fait

3. Vous-vous êtes senti membre du groupe pendant les séances

pas du tout — tout à fait

4a. Le groupe s'appuie sur des représentations culturelles traditionnelles

Vous étiez en accord avec ces représentations culturelles lorsqu'elles décrivaient la maladie

pas du tout — tout à fait

4b. Vous étiez en accord avec les représentations évoquées comme remède à la maladie

pas du tout — tout à fait

5. Vous avez trouvé le contenu des séances difficile à gérer

pas du tout — tout à fait

6. Vous vous êtes senti mal à l'aise en prenant connaissance de la vie privée d'un membre de votre communauté

pas du tout — tout à fait

7. Vous avez rencontré des problèmes de confidentialité par rapport au patient

pas du tout — tout à fait

8. Vous vous êtes senti soutenu par le groupe

pas du tout — tout à fait

9. Vous auriez souhaité des moments avec le groupe pour parler des émotions ressenties en séance

pas du tout — tout à fait

10. En voyant la situation du patient, vous avez pensé « ça peut m'arriver »

pas du tout — tout à fait

11. Veuillez mentionner 4 adjectifs qui illustrent les satisfactions de votre expérience « ethnopsychiatrique »

12. Veuillez mentionner 4 adjectifs qui illustrent les difficultés de votre expérience « ethnopsychiatrique »

Interpreter's Interpersonal Role Inventory (IPRI)

Angelelli, C. V. (2004). *Revisiting the Interpreter's Role: A study of conference, court, and medical interpreters in Canada, Mexico, and the United States*. Philaldelphia: John Benjamins Publishing Company

- A 38 items questionnaire « designed to measure the interpreter's attitudes towards the visibility/invisibility of the interpersonal role » and « for interpreters in the U.S.A., Canada and Mexico from all settings and language combinations » (p. 51).

- Subcomponents:
  - Alignment with the parties
  - Establishing trust with/facilitating mutual respect between the parties
  - Communicating affect as well as message
  - Explaining cultural gaps/interpret culture as well as language
  - Establishing communication rules during the conversation

- Angelelli, pp. 101… :

APPENDIX 1

IPRI Final Version

Respondent Information

(Please note that some questions may be worded in an unfamiliar fashion, because this questionnaire is intended for use in other parts of the world)

Part A
Please fill in the following information. Circle ALL the options that apply to you.

1- I identify myself as a:

A: community interpreter	D: medical interpreter	G: T&I student
B: conference interpreter	E: over-the-telephone interpreter	H: self-taught interpreter
C: court interpreter	F: interpreter (no qualifiers)	

2- Gender: M/F 3- Age group: under 20 20/29 30/39 40/49 50/59 60/69 over 69

4- Please indicate the amount of formal education you have had:

A: Less than High School	B: High School	C: Some College	D: College Graduate
E: Masters Degree	F: Doctorate		

5- Interpretation Education/Training:

5-1 Duration:

A: None	B: 1 or more workshops	C: Less than 1 semester
D: 1semester-1 year	E: 1–2 years	F: Over 2 years

5-2 Type:

A: Intensive course	B: Undergraduate courses/program
C: Graduate courses/program	D: Certification courses/program
E: On-the-job training	F: Practical experience interpreting for family, etc.

5-3 Education/training in the following types of interpretation:

A: community	B: conference	C: court
D: medical	E: over-the-telephone	F: general (no qualifiers)

6- Interpretation Experience:
A: Less than 1 year B: 1/3 years C: 3/5 years D: 5/10 years E: Over 10 years

7- In the past year, about how many times have you served as an interpreter in each of the following settings? (Enter approximate numbers on as many rows as apply)

Settings/Modes	Face-to-face	Non face-to-face
A: Community	times	times
B: Conference	times	times
C: Court	times	times
D: Medical	times	times
E: Over-the-telephone	times	times
F: Other (specify)	times	times

8- What is your total household annual income from all sources (Please circle one. Amounts are expressed in US dollars)

A: less than 20,000 B:20,000/30,000 C:30,000/40,000 D:40,000/60,000
E: 60,000/100,000 F: over 100,000

9- Working Languages (interpret into): _____

10- Working Languages (interpret out of):_____

11- Please comment on the interpreting that you have found more rewarding:

_____

_____

12- In most societies, there are more and less dominant/prestigious groups or subcultures, often defined by racial or ethnic heritage, country of origin, language background, etc. Within the context where you practice as an interpreter, do you identify more with a dominant/more prestigious or with a subordinate/less prestigious cultural group? (Please mark only one option with an "X").

_____ dominant/more prestigious
_____ subordinate/less prestigious
_____ sometimes one, sometimes the other (about half and half)
_____ does not apply

13- What term(s) would you use to describe the group (based on racial or ethnic heritage, country of origin, language background, etc.) with which you most closely identify?

Part B

The purpose of this questionnaire is to collect information about your work as an interpreter. Please answer the following questions from your own experience and perceptions. Please respond to each of the items using the following scale:

CD	SD	D	A	SA	CA
Completely disagree	Strongly disagree	Disagree	Agree	Strongly agree	Completely agree

Please circle the option that best represents your position. **Please respond in terms of your own perceptions and experience, rather than your general beliefs about the profession.**

1- As an interpreter, I should adhere to the conversational conventions established by the speakers	CD SD D A SA CA
2- During my work, I am careful not to change the tone used by the parties.	CD SD D A SA CA
3- My work as an interpreter has to be accurate; there is no room for guessing games on feelings and emotions.	CD SD D A SA CA
4- The greatest challenge is to maintain my second language, especially if it is not spoken in the country where I live.	CD SD D A SA CA
5- An interpreter is a professional who provides a service and has no voice in the interaction.	CD SD D A SA CA
6- I use the language variety of my place of origin during the interpretation.	CD SD D A SA CA
7- It is not my job to remind the parties whose turn it is to speak.	CD SD D A SA CA
8- Assuring the parties that they will be heard means conveying their emotions even if they are not expressed by words.	CD SD D A SA CA
9- During an interpretation I constantly check my position to be neutral.	CD SD D A SA CA
10- If a party's words are culturally inappropriate, I need to make her/him aware of that.	CD SD D A SA CA
11- If the parties do not respect each other, it is not my role to try to improve that situation.	CD SD D A SA CA
12- I only use my register and not that of the parties.	CD SD D A SA CA
13- The two parties will trust each other during the conversation neither more nor less than they would if they were communicating without an interpreter.	CD SD D A SA CA

CD	SD	D	A	SA	CA
Completely disagree	Strongly disagree	Disagree	Agree	Strongly agree	Completely agree

14- I never interrupt an interpretation to educate the parties on cultural differences.	CD SD D A SA CA
15- As long as the meaning is conveyed, the cross-cultural differences are not a problem.	CD SD D A SA CA
16- My work cannot begin until the less dominant party feels at ease with the more dominant one.	CD SD D A SA CA
17- If the parties want their feelings and emotions to get interpreted they have to express them in words.	CD SD D A SA CA
18- It is easier for me to establish trust with the party with whom I have more in common.	CD SD D A SA CA
19- I can only work with what has been expressed in words.	CD SD D A SA CA
20-If one party, unaware of the other's culture, commits a *faux pas*, I always compensate for that.	CD SD D A SA CA
21- My job, as an interpreter, is not to balance the power differentials that exist between the parties.	CD SD D A SA CA
22- While interpreting, it is simply impossible to be value neutral.	CD SD D A SA CA
23- As an interpreter, I am the only party to the conversation who can control the flow of communication.	CD SD D A SA CA
24- My job is not well done if the concerns of the less dominant party have not been explored throughout my interpretation.	CD SD D A SA CA
25- If there are cultural differences between the parties, the interpreter needs to iron them out before real communication can take place.	CD SD D A SA CA
26- I have the right to interrupt the parties whenever I need to, in order to assure smooth communication.	CD SD D A SA CA
27- When the interpreter is present to convey the meaning, the conversation can proceed on a culturally neutral stage.	CD SD D A SA CA
28- Even if I am working for both parties, I clearly give a voice to the weaker one.	CD SD D A SA CA
29- Sometimes interpreting tears is more necessary than interpreting the words that accompany them.	CD SD D A SA CA

CD	SD	D	A	SA	CA
Completely disagree	Strongly disagree	Disagree	Agree	Strongly agree	Completely agree

30- My job is to try to make sense of the emotional component and convey it as I interpret the words I hear.	CD SD D A SA CA
31- It is not always possible to maintain my professional stance.	CD SD D A SA CA
32- During my interpretations, my goal is to gain the less dominant party's trust more than the more dominant's.	CD SD D A SA CA
33- I do not need to interpret conflicts in values unless the parties specifically mention them.	CD SD D A SA CA
34- As an interpreter my role is to compensate for the power differentials between the parties.	CD SD D A SA CA
35- If one of the parties is disrespectful, part of my role is to compensate for that throughout the interpretation.	CD SD D A SA CA
36- My job is to educate parties on cultural differences to help them communicate in spite of them.	CD SD D A SA CA
37- It is not my job to try to read the parties' emotions or re-express them.	CD SD D A SA CA
38- As an interpreter, part of my role is to present my own voice during the interaction.	CD SD D A SA CA

Thank you very much for your time and cooperation!

PS: If you would agree to answer some further questions or would like to receive results of this study, please write your contact information.

____ I am willing to discuss these issues further

____ Please send me information about the results of the study

Name: _____

E-mail: _____

Ph: _____

Thanks again !

Questionnaire – Chesher et al (2001)

Chesher, T., Slatyer, H., Doubine, V., Jaric, L., & Lazzari, R. (2001). Community-Based Interpreting: The Interpreter's Perspective. In G. B. L. Brunette, I. Hemlin, & H. Clarke (Ed.), *The Critical Link 3: Interpreters in the Community*. Philadelphia: John Benjamins Publishing Company

- The survey was designed to « explore the characteristics of community-based interpreting and the profile of interpreters, to canvass interpreter' opinions about their work in community-based interpreting, to elicit the range of experiences interpreters have had in their practice and to seek definitions of this type of interpreting from practitioners. » (p. 276)

- Voici le questionnaire, disponible dans le document de Chesher et al en pages 277 et suivantes :

Table 1. Survey questionnaire on community-based interpreting

In responding to the questionnaire, please provide as much detail as you wish. Make sure you include the appropriate letter and number next to your answers (A1, A2 and so on).

A. Please give a few details about yourself:

A.1 Language(s) that you interpret from and into, in community-based settings.

A.2 How many years have you worked as an interpreter in CBI?

A.3 Considering all your interpreting work, do you work in CBI occasionally/most of the time/all the time?

A.4 In which country or countries?

A.5 Do you belong to an association of interpreters? Please give details.

A.6 (Optional) Your name and contact details (post, telephone, fax, or E-mail).

B. Context or settings — range of situations where CBI takes place:
(N.B. This survey does not include interpreting in court or legal settings.)

B.1 Describe where you usually go to interpret in community-based settings (for example, in a government service, medical clinic, migrant centre, school, office or business).

B.2 Give details about the kind of clients* for whom you interpret in CBI settings (for example, doctor–patient, teacher–parent group, welfare officer–refugee).

*"Clients" means: all the people you are interpreting for, in public sector or business settings.

C. Bookings and payments

C.1 Describe how you are usually booked for a CBI interpreting job and who makes the booking.

C.2 Does this involve interpreting face-to-face/by telephone/with microphone or tape-recorder/other?

C.3 When you interpret in this setting, how often do you receive payment? Never/sometimes/most of the time/always

C.4 When you receive payment, is the amount based on an hourly rate/on a certain fee for each assignment/on some other method; and is travel time paid for?

C.5 To give an idea of how your income compares with other professions, would the rates of pay for CBI in your country be closest to rates of pay for nurses/lawyers/electricians/bank clerks/cleaners/other? Please give details.

D. Standards and training

D.1 Please give details about any requirements about interpreting qualifications or minimum interpreting standards that are required by those who book you for CBI.

D.2 If some clients* require higher standards than others, please provide details.

D.3 In your opinion, are training and/or qualifications a prerequisite for CBI?

D.4 Give details about any training courses or other opportunities for interpreters in the district or country where you work, to develop, establish, maintain or improve CBI skills. Include course details (number of hours/years of training, qualification gained, course fees, accreditation or testing procedures and so on).

D.5 What do you consider are the most important components in preparation and training for CBI?

D.6 In which areas of CBI would you most like to have further training?

D.7 What do you do to maintain proficiency in the languages you work from and into?

E. Qualities and skills

E.1 What do you consider the most important qualities for successful CBI?

E.2 Describe any particular skills needed by interpreters in CBI situations. Give examples.

E.3 Do you consider that some people are more suited than others for CBI work? Why?

F. Your role, and expectations of clients*

F.1 How do you explain your role to clients?

F.2 In your opinion, what are the most important principles by which CBI interpreters should abide?

F.3 Do the same principles apply when you are interpreting in other settings?

F.4 What do you do when clients* (either language) ask you to provide advice?

F.5 What do you do if clients* ask you to negotiate or advocate for them?

F.6 Under what circumstances would you add information or leave anything out that has been said by any/either speaker?

F.7 Do your clients* expect you to adhere to any guidelines relating to manner of dress, wearing of veils or turbans, badges or religious symbols?

G. Mode of interpreting

G.1 Do you have a preferred mode of interpreting in CBI situations? Please give details.

G.2 Do clients* ever specify in which interpreting mode they want you to operate?

H. Working conditions, status

H.1 Are you aware of any differences in working conditions or other circumstances in CBI when compared with other types of interpreting?

H.2 In your opinion, does CBI rank equally with other types of interpreting?

H.3 In your experience, do clients* in CBI settings (either party) consider that this type of interpreting ranks equally with other types of interpreting?

I. Finally, could you give some thought as to how we can define the kind of interpreting work you do in the community?

I.1 Would you describe CBI as a distinct type of interpreting?

I.2 Can CBI be identified as a subcategory under the broader category of interpreting?

You are welcome to provide further details, anecdotes relating to your work, or other comments.

Questionnaire – Price et al (2012)

Price, E. L., Pérez-Stable, E. J., Nickleach, D., López, M., & Karliner, L. S. (2012). Interpreter perspectives of in-person, telephonic, and videoconferencing medical interpretation in clinical encounters. *Patient Education and Counseling, 87*(2), 226-232.

- "The interpreter survey was developed by study investigators based on prior studies of interpreter use and effectiveness in clinical settings. The survey took 10–20 min to complete, and included interpreters' age, race, ethnicity, birthplace, languages in which they interpret, education, interpreter training, and level of experience in medical interpreting." (p. 4)

- "To assess satisfaction with specific aspects of communication for each modality (in-person, telephonic, and VMI), respondents were asked to recall a recent encounter using that modality and to rate, on a 5-point Likert scale ("extremely satisfied"; "satisfied"; "neither satisfied nor dissatisfied"; "dissatisfied"; and "very dissatisfied"), their satisfaction with five specific aspects of patient–clinician communication:
  - "How satisfied were you with your ability to
    - Communicate what the patient had to say?
    - Communicate what the clinician had to say?
    - Establish rapport between the clinician and the patient?
    - Facilitate the clinician's understanding about the patient's social or cultural background?"
  - "Overall, how satisfied were you with the quality of the communication during this encounter?" (p. 4)

- "For each remote interpreting modality participants were asked to rate, on a 5-point Likert scale ("very well"; "well"; "adequate"; "not well"; "poorly"; "don't know") the modality's ability to facilitate communication for each of twenty-one common clinical scenarios. The list of scenarios was developed using author expertise and input from interpreter services managers at each site. Scenarios represented the range of common clinical encounters with respect to location (inpatient versus outpatient), acuity of illness, and information exchanged. They included new evaluations and acute care (nurse triage in the emergency department (ED); ED physician evaluation; new outpatient visit; urgent care visit; inpatient physician history and physical); follow-up/routine care (follow-up outpatient visit, pre-operative exam, routine daily hospital assessment, consent for minor procedure; inpatient nursing assessment, and outpatient nursing assessment); educational or psychosocial encounters (family meeting; consent for a complex procedure; inpatient nursing teaching; hospital discharge instructions; physical or occupational therapy; and case management/social work); and ancillary or administrative scenarios (patient checking in with a clerk; routine blood draw; radiology; financial services interview)." (p. 5)

1.4 Instruments – Institutions

Speaking Together Language Service Measures

Regenstein, M., Huang, J., West, C., Trott, J., Mead, H., & Andres, E. (2012). Improving the quality of language services delivery: Findings from a hospital quality improvement initiative. *Journal for Healthcare Qualitydoi, 34*(2), 53-63.

- A Delphi approach was used to select potential measures; two sets of expert review panels comprised of physician-managers of large hospital-based ambulatory departments and interpreter services managers at hospitals with substantial interpreter services resources rated proposed measures of language service (LS) quality based on defined evaluation criteria and selected five measures for pilot testing :
  - LS-1 : Patient screening for language preference
    - Through a screening question asking which language patients prefer to receive their healthcare in, as a means to identify LEP patients and to quantify demand for LS.
    - = The percent of patients who have been screened for their preferred spoken language.
  - LS-2 : Patients receiving language services from qualified providers
    - Receipt of LS for patients who need such services at the points of initial assessment and discharge.
    - For the purposes of this measure, we identified two instances in a patient's interaction with his or her provider during which adequate communication is absolutely necessary: during initial assessment and when receiving discharge instructions. Although there are other points in care in which language services may be necessary, we selected these two points as processes common to most patients in a hospital setting.
    - = The percent of patients with language needs who receive initial assessment and discharge instructions from assessed and trained interpreters or from assessed bilingual providers.
  - LS-3 : Patient wait time
    - Timeliness of LS delivery from the patient and physician/nurse perspective
    - = The percent of encounters where the patient wait time for an interpreter is 15 min or less.
  - LS-4 : Interpreter productivity
    - Efficiency in terms of use of interpreter services
    - = The percent of time interpreters spent providing medical interpretation in clinical encounters with patients.
  - LS-5 : Interpreter delay time
    - Timeliness of LS delivery from the interpreter perspective
    - = The percent of encounters interpreters wait less than 10 min to provide interpreter services to clinician and patient.

- The measures were tested and refined through the collaborative and are now included in the Agency for Healthcare Research and Quality (2009) National Quality Measures Clearinghouse.

- Based on the experiences of the participating hospitals, they identified eight strategies that may increase the likelihood of successful quality improvement work in LS (p. 61).

Instrument – Penka et al (2012)

Penka, S., Kluge, U., Vardar, A., Borde, T., & Ingleby, D. (2012). The concept of "intercultural opening": the development of an assessment tool for the appraisal of its current implementation in the mental health care system. *European Psychiatry, 27*, S63-S69.

- A tool to assess the status of "intercultural opening".

- "The German concept of "intercultural opening" is an approach to facilitating migrants' access to the health care system and improving the care they receive. […] "The assessment tool thus developed is the first one to evaluate the current status of "intercultural opening" in the community mental health care system in Germany from a broad perspective." (p. S63)

- "As the concept of "intercultural opening" is an expert-designed concept, in a first step, we used a web-based expert interview, based on a two-round consensus-oriented Delphi process to review the developed instrument for missing aspects of the instrument and, if possible, to shorten it." (p. S65)

- See next page for a copy of the tool, available in Penka et al's article (p. S68).

Item	Subpoints
1. Institution	*1.1.General information about institution (function, profession of interviewee etc.)* *1.2 Policy of institution (existing policy)*
2. Staff	*2.1. Number of staff in previous year* (divided by salaried employees, freelancers, trainees etc.) 2.2 Information about staff with migration background (divided by salaried employees, freelancers, etc; country of origin) 2.3 Job advertisements (in the last four years, migrants encouraged to apply, fi lled by migrant) 2.4 Occupational categories (number of staff per occupation, number of migrants per profession, number of employees without German citizenship)
3. Clients/ Patients general	3.1 Number of clients/ patients (number previous year, data base)
4. Clients/ Patients with migration background	4.1 Utilisation by migrants (subjective assessment of claims made by migrants, reasons) 4.2 Information about migration background (recording data relation to migration background, etc.) 4.3 Number of clients/ patients with migration background in previous year (number, data base)
5. Access	5.1 Access routes to institution (number of clients/ patients per each route, predominant routes by migrants
6. Aftercare	6.1 Aftercare (specialized aftercare protocols, inclusion of contacts with intercultural or migrant- specific facilities, description)
7. Migrant-specific offers	7.1 Migrant specific offers (existing migrant specific offers, description, reasons for (non-) existing)
8. Facilities and services	8.1 Offer of facilities and services (Non-German newspapers in public areas; multilingual door plates, inscriptions etc. in and outside of institution; rooms for religious practices; provision of suitable food according to religion etc.)
9. Linguistic communication	9.1 Language skills of staff (number and names of foreign languages and mother tongue of staff divided by occupation) 9.2 Linguistic communication with Non-German speaking clients/ patients (percentage of clients / patients care / treatment in German language not being possible; frequency of communication with the help of use of gestures, persons accompanying client/ patient, use of native-speaking employees, use of professional interpreter etc.) 9.3 Interpreters (work with interpreters, frequency of involvement, financing of interpreters, Reasons for non- involvement of interpreters etc.) 9.4 Cultural mediation (Provision of cultural mediation, description)
10. Continuing intercultural education, cultural competence and team-work	10.1 Continuing education on intercultural subjects, intercultural competence and intercultural team work (participation of employees in continuing education on these topics, encouragement by management to participate, employees regularly asked to participate etc.) 10.2 Intercultural competence (understanding of intercultural competence of interviewee, intercultural competence of staff etc.) 10.3 Intercultural team work (employees with migration background in charge of clients/ patients with migration background, existing tandem-.counseling etc.) 10.4 Case discussion (consideration of cultural and migration-specific aspects, frequency of taking into consideration, occupational groups taking part etc.) 10.5 Supervision (employees receiving supervision; frequency; occupational groups participating, consideration of subjects interaction with migrants etc.)
11. Survey of demand, demand planning	11.1 Quality control (employed measures, consideration of persons with migration background or migrant-specific topics, how)
12. Information	12.1 Information material and information paths (information leafl ets in various languages, client-/ patient- information in various languages, multilingual website, outreach activities in migrant community structures etc.)
13. Empowerment/ Participation of migrants	13.1 Contact person for migrants (existing contact point/ contact person for patients / clients in general, support of specific migrant- issues etc.) 13.2 Self-help groups (support of patients/ clients in finding or founding self- help group, support of migrants etc.)
14. Cooperation	14.1 Cooperation with institutions (existing cooperation, with whom)
15. Intercultural opening	15.1 Management Level (support/ promotion of intercultural opening by management, management interested in improving care/ treatment of migrants, person with migration background employed at management level etc.)
16. Goals reached	16.1 Services utilized by persons with migration background to equal degree as other clients/ patients
17. Outlook	17.1 Estimation with regard to equal access to psychosocial care compared to indigenous Germans 17.2 Kind of interaction generally liken to see in psycho-social care

1.5 Techniques – Mesure des coûts/Costs Measurement

Technique – Blanchfield et al (2011)

Blanchfield, B. B., Gazelle, G. S., Khaliif, M., Arocha, I. S., & Hacker, K. (2011). A framework to identify the costs of providing language interpretation services. *Journal of Health Care for the Poor and Underserved, 22*(2), 523-531.

- "This paper establishes a conceptual framework that identifies program costs, can be used across health care entities, and can be understood by administrators, researchers, and policymakers to guide research and analysis and establish a common ground for informed strategic discussion of payment and reimbursement policy. Using case study methods, a framework was established to identify costs and included determining the perspective of the cost analysis as well as distinguishing between the financial accounting costs (direct, indirect, and overheard costs) and the economic opportunity and subsequent utilization costs." (p. 523)

- "An important issue to clarify before attempting to identify costs is to understand the question being asked and the perspective of the analysis. What and whose cost is being evaluated or examined? The cost to a health care provider is different from the cost to a payer, and from the cost to a patient. The cost to society, different again, may include a net of all the cost perspectives plus intangible and opportunity costs. Researchers sometimes mix perspectives and conclude a study with a cost determination that actually includes costs from more than one perspective." (p. 525)

- Costs (p. 526…):
  - Financial accounting costs are the actual total costs (direct, indirect, and overhead) tangible and incurred by an entity/provider to provide services. Financial accounting costs are reported in the provider's financial statements to stakeholders and reflect the results of operations.
  - Direct costs to provide language interpreter service (LIS) are the costs directly associated with having interpreter services available and include the salaries and fringe benefits of the interpreters on staff, fees for contracting with external interpreters to provide services, and salaries and benefits of other key staff of the language services program. Other direct costs include the costs required to provide the LIS such as supplies, training costs, use of specific equipment such as speaker phones and video conferencing equipment, computer workstations, fees paid for written translations and signing services, and other similar costs.
  - Indirect costs and overhead costs benefit more than one unit of service (indirect), or more than one service or cost center (overhead), and must be allocated across the volume of units or all the provider's cost centers. Indirect costs, generally incurred at the department level, are associated with providing services and include costs of department management salaries or shared department computers.
  - …

Technique – Jacobs et al (2011)

Jacobs, E., A., Leos, G. S., Rathouz, P. J., & Fu, P. (2011). Shared networks of interpreter services, at relatively low cost, can help providers serve patients with limited english skills. *Health Affairs, 30*(10), 1930-1938

- "To provide the most relevant and comparable cost data, we calculated the average per minute and per encounter cost of providing interpreter services via the network for each language. To make these calculations, we collected data on all relevant costs and on the number and duration of all interpreted encounters during the study period."

- *Data and sources.* "These are the main costs accounted for in our calculations: hospital expenditures, including interpreter salaries, which were prorated by the time they were logged in as available to the network; bilingual bonuses for dual-role interpreters (people employed to serve in a primary role, such as nurses, who also serve as interpreters); manager salaries and time spent managing network activities; the cost of outsourcing to a telephonic interpreting service when a network interpreter is not available for videoconferencing; the annual network fee; and the initial investment to purchase equipment. The cost data came from Paras and Associates and the hospitals in the study."

- "The network administrator provided other necessary data, including the number of interpreted encounters provided and used by each hospital in each month; the duration of each of those encounters; the foreign language involved; and the time each interpreter spent interpreting for the network each month. The network paid the interpreters only for the time they were logged on and either interpreting or waiting to interpret for the network—not when they were providing in-person interpreting or other."

- *Cost Calculations.* "We calculated the average per minute and per encounter cost by dividing the cost each hospital incurred by the minutes and number of encounters they provided during the study period. We then calculated average per minute and per encounter costs for each language, for each hospital, and for the network overall. Using standard hospital accounting practices, we amortized the equipment start-up costs over five years. In addition, we prorated costs such as manager salaries and annual fees by the number of months of data a hospital contributed, so as to include only costs for the actual time period for which we had data on interpreted encounters." (p. 1930)

EXHIBIT 2

Number Of Interpreted Encounters In Network Hospitals And Mean Encounter Time And Cost, By Hospital

Hospital	Number of encounters	Mean encounter time (minutes)	Mean per minute cost	Mean encounter cost
A	15,415	10.5	$2.54	$26.69
B	3,747	11.4	1.55	17.71
C	2,108	9.9	1.67	16.52
D	3,106	11.5	2.35	27.02
E	1,860	13.9	8.72	121.18
F	15,134	10.7	1.67	17.83
G	8,178	9.6	2.22	21.32
H	2,924	10.3	1.48	15.28
Total	52,472	10.6	2.35	24.86

SOURCE Authors' analysis of study data. NOTE Costs are in 2007 or 2008 dollars, depending on the date of the encounter.

Technique – Hampers et McNulty (2002)

Hampers, L. C., & McNulty, J. E. (2002). Professional interpreters and bilingual physicians in a pediatric emergency department: effect on resource utilization. *Archives of Pediatrics & Adolescent Medicine, 156*(11), 1108-1113

- "A data form, attached to every patient chart at triage, required physicians to identify patients who met the following criteria: aged 2 months to 10 years, absence of chronic illness (defined as a history of immunosuppression or immunodeficiency, inborn error of metabolism, or ventriculoperitoneal shunt), and either a triage temperature of 38.5°C or higher or a complaint of vomiting or diarrhea. Physicians were also asked to assess the child's initial appearance ("well,""mildly ill,""moderately ill," or "toxic")."

- "We asked the treating physicians, who were blind to our study hypothesis, to determine whether, in their estimation, the patient's family could speak English. To identify encounters in which the physician was proficient in the non–English-speaking family's language, providers were then asked, "If not, did this create a language barrier for you?" If a barrier existed, they were asked to indicate whether a professional interpreter had been available. If an interpreter was used, they were asked to specify during which portions of the visit the interpreter was present (triage, history/physical examination, and discharge)."

- "Each visit was categorized into 1 of 4 groups: (1) visits in which the physician thought the family could speak English well enough to give a medical history (English-speaking cohort); (2) visits in which the family could not speak English but the treating physician could speak the family's language (non–English-speaking/no barrier cohort); (3) visits in which the family could not speak English and a professional interpreter was employed for at least a portion of the visit (non–English-speaking/interpreter cohort); and (4) visits in which the family could not speak English, the physician could not speak their language, and no professional interpreter was available (non–English speaking/barrier cohort). This cohort also included all instances in which nonmedical, ad hoc interpreters were used."

- "Following the visit, information was extracted from the records regarding demographics (recorded by registration personnel), resident level (postgraduate year of training), attending physicians, setting (main ED or on-site urgent care unit), initial vital signs, triage category, length of visit, laboratory and radiographic testing, and patient disposition (admission or discharge home)." (p. 1109)

Table 3. Adjusted Comparisons of Treatment for Non–English-Speaking Families*

Variable	No Barrier (n = 170)	Barrier (n = 141)	Interpreter (n = 239)
Use of intravenous hydration, OR (95% CI)	1.6 (88 to 2.9)	22 (1.2 to 4.3)	1.2 (0.70 to 2.1)
Likelihood of admission, OR (95% CI)	1.2 (0.56 to 2.4)	2.6 (1.4 to 4.5)	1.7 (1.1 to 2.8)
Likelihood of any testing, OR (95% CI)	0.77 (0.55 to 1.1)	1.5 (1.04 to 2.2)	0.73 (0.56 to 0.97)
Adjusted test cost, mean (95% CI), $†	18.11 (13.26 to 22.97)	22.27 (17.34 to 28.07)	20.23 (16.09 to 24.36)
Test cost difference, mean (95% CI), $	1.12 (–3.91 to 6.12)	5.73 (0.24 to 11.21)	3.24 (1.09 to 7.48)
Test cost difference, mean (95% CI), %	6.7 (–23 to 36)	34 (1.4 to 66)	19 (–6.4 to 44)
Adjusted length of visit, mean (95% CI), min‡	137 (125 to 148)	130 (118 to 143)	147 (137 to 156)
Length of visit difference, mean (95% CI), min	6.7 (–4.6 to 18)	1.8 (–8.8 to 16)	16 (6.2 to 26)

Technique – Jacobs et al (2007)

Jacobs, E. A., Sadowski, L. S., & Rathouz, P. J. (2007). The Impact of an Enhanced Interpreter Service Intervention on Hospital Costs and Patient Satisfaction. *Journal of General Internal Medicine, 22*(2), 306-311

- "Obj.: To provide data on the costs of failing to provide adequate interpreter services and measure the direct costs and cost-offsets of enhanced interpreter services use in the care of Spanish-speaking hospitalized patients."

- "Measurements: Patient satisfaction, hospital length of stay, number of inpatient consultations and radiology tests conducted in the hospital, adherence with follow-up appointments, use of emergency department (ED) services and hospitalizations in the 3 months after discharge, and the costs associated with provision of the intervention and any resulting change in health care utilization." (p. 306)

- "Costs were calculated using the average costs of care provided at the study institution in 2000, the most current year for which this information was available, and the costs of providing the interpreter service intervention during the study period. Both included overhead costs. The intervention costs include interpreter salaries, which were constant throughout the study, regardless of how many encounters were interpreted each day." (p. 308)

Technique – Jacobs et al (2004)

Jacobs, E. A., Shepard, D. S., Suaya, J. A., & Stone, E.-L. (2004). Overcoming language barriers in health care: costs and benefits of interpreter services. *American journal of public health, 94*(5), 866-869.

- "The data abstracted from the automated medical record system included demographic information and information about utilization of preventive, primary care, and emergency department services. For preventive services, our measure was the percentage of recommended services (appropriate for age and gender) received each year by each person. Measures of primary care utilization included annual number of health center office visits and phone calls, urgent care visits and phone calls, and prescriptions written and filled."

- "Cost data included both the direct costs of providing interpreter services and the costs of net changes in health care utilization that occurred after the new services were implemented. Direct costs included interpreter salaries, fringe benefits, and overhead costs."

- "The cost allocated to each health care service delivered before and after the new services were implemented was the average Medicaid fee-for-service payment in Massachusetts during the 2 years of the study. We used the costs to the Massachusetts Division of Medical Assistance to provide this organization with information about the impact of interpreter services on the cost of care for Massachusetts patients with limited English proficiency. The estimated net cost of medical interpretation per person per year in the interpreter service group included the cost of interpretation plus the net change in costs of health care utilization"

- "We compared receipt of preventive services, primary care, and hospital-based care and the cost of that care before and after adequate interpreter services were implemented. We compared changes in the interpreter service group with those in the comparison group by calculating the net mean difference (the change in the interpretive service group minus the change in the comparison group) and by modeling this difference in a linear regression model with the within-person difference as the outcome variable. (Within-person differences reflect the change in utilization and the cost of care for each person in the study both before and after implementation of the interpreter services.) In this manner, differences in absolute level of services or costs between the 2 groups attributable to measured or unmeasured characteristics were controlled." (p. 866-867)

Technique – Bischoff & Denhaerynck (2010)

Bischoff, A., & Denhaerynck, K. (2010). What do language barriers cost? An exploratory study among asylum seekers in Switzerland. *BMC health services research, 10*(1), 1

- "Data on costs were collected by the accounting office of the hospital administration and reflected consultations, diagnostic examinations (lab, x-rays, ECG, MRI etc.), medical interventions, patients' stays in the clinic, and medication."

- "Costs relating to professional interpreters are included in the costed items for clinic visits and are part of the "package" for asylum seekers. The costs are expressed per month..."

- "Data about language barriers were extracted from the patient records. We distinguished three categories: a) no reported language barriers between asylum seeker and physician, b) reported language barriers between asylum seeker and physician with the provision of interpreter services, and c) reported language barriers between asylum seeker and physician but no provision of interpreter services."

- "It was not mandatory for physicians to record language barriers in the patients' files. Language barriers were only reported, therefore, when the asylum seekers had serious health conditions and detailed communication was essential."

- "Other variables for this study included gender, age, the number of visits to the HMO, and the number of diagnoses."

- "The patients' utilisation of health care services and material was also assessed. This consisted of the sum of all the medical material used, the medications prescribed, and medical/nursing interventions." (p.2-3)

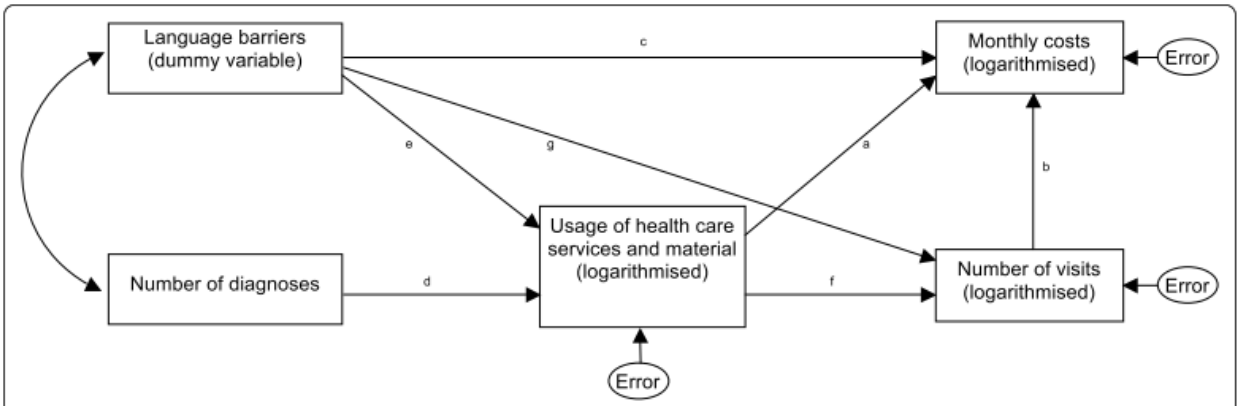


Figure 1 Theoretical framework used in the path analysis.

Technique – Schwarzinger et al (2012)

Schwarzinger, M., Cédiey, E., & Argant, S. (2012). *Usage et opportunité du recours à l'interprétariat professionnel dans le domaine de la santé : Analyse des pratiques d'interprétariat en matière de prévention et de prise en charge du Vih/sida, de la tuberculose et du diabète*. Paris, France

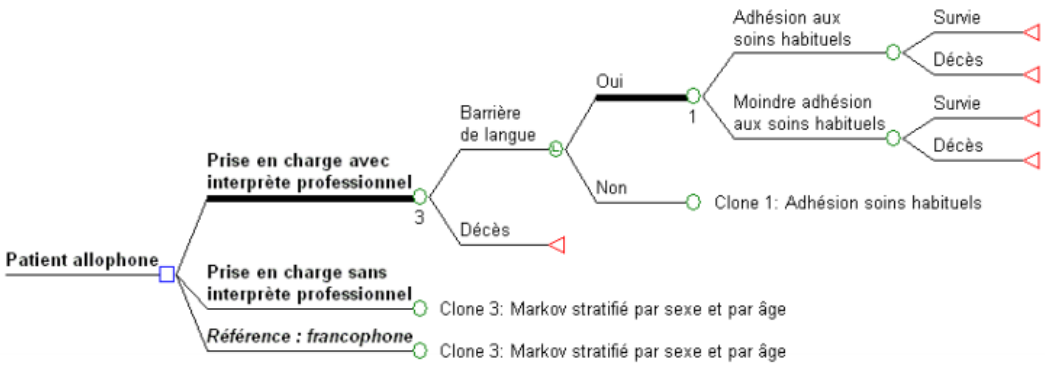
- « Nous avons orienté notre revue de la littérature sur les enseignements qu'ils apportent pour la réalisation d'une évaluation médico-économique des services d'interprétariat professionnel. »

  Voir Tableau 1.3.3.1.1 (Études sur l'interprétariat en santé mesurant un indicateur sanitaire et/ou de consommation de ressources) en page 14.

- Notre revue de littérature ne permet pas d'apporter la preuve de l'efficacité du recours aux interprètes professionnels pour les patients non-francophones en termes de morbi-mortalité. À défaut, l'évaluation médico-économique nécessite d'introduire des hypothèses permettant de mesurer l'efficacité de l'intervention en termes de morbi-mortalité. Nous avons choisi de construire cette mesure de façon indirecte en termes d'adhésion des patients allophones aux soins habituels des patients francophones. »

- « Dans notre projet, déjà limité par l'absence de preuve de l'efficacité du recours aux interprètes professionnels en termes de morbi-mortalité, nous avons choisi de construire un modèle médico-économique générique, simple et reproductible à partir d'un nombre limité d'hypothèses. »

- « Nous avons construit un modèle de Markov pour mesurer l'espérance de vie et le coût du recours à l'interprétariat professionnel pour les patients allophones dans la perspective de l'Assurance Maladie (figure ci-dessous). Le modèle est générique dans le sens où les hypothèses nécessaires à sa construction sont les mêmes quelle que soit la pathologie (diabète, VIH/SIDA, tuberculose) : seules les valeurs des paramètres spécifiques à la pathologie modifient les résultats. » (p. 21-22)



2 Autres outils/Other Tools

2.1 Formations pour les fournisseurs de soin/Healtcare Provider Training

Technique – Weber et al (2014)

Weber, O., Sulstarova, B., Reeves, D., & Faucherre, F. (2014). Promouvoir l'interprétariat communautaire en psychiatrie publique : une recherche action. *L'autre, 15*, 207-218.

- Favoriser un recours plus approprié aux interprètes communautaires, en deux volets (p. 210…) :
  - Clarification et simplification des procédures administratives.
    - « Directive révisée, validée par la direction hospitalière et à un guide pratique à destination des cliniciens, résumant les recommandations pour organiser et conduire les entretiens avec des interprètes professionnels. »
    - « Mise à disposition de ces outils sur l'intranet du DP-CHUV et par courriel. »

  - Module de sensibilisation des collaborateurs au travail avec les interprètes.
    - « Ce module ne se limitait pas à une action de communication des nouveaux documents de référence, mais devait permettre de faire émerger les résistances au changement des cliniciens et d'agir sur ces résistances par le biais d'une exploration et résolution de leur ambivalence. Dans ce sens, il s'inspirait librement de l'approche motivationnelle. »
    - « Le module visait également à rassurer les cliniciens par l'élaboration, dans une démarche dialectique, de stratégies propres à réduire les craintes de perte de contrôle dans les consultations triadiques. Il s'agissait en particulier de montrer que le rôle confié à l'interprète (« mot-à-mot », informations culturelles, etc.) peut, voire doit faire l'objet d'une discussion.»
    - Interventions de 45 et 90 minutes, séparées en en trois parties :
      - « Elles débutaient par une brève introduction théorique sur l'importance du travail avec les interprètes professionnels, les préoccupations et les difficultés dans ce domaine (…) et le droit/devoir des cliniciens à recourir à des interprètes. »
      - « La seconde partie, interactive et ludique, avait pour but de rendre les cliniciens conscients des difficultés possibles du travail en trialogue et des stratégies pour y faire face. Durant cette partie, entre une et trois scénettes vidéo étaient discutées avec les cliniciens. Conçues par les collaborateurs de l'équipe du projet « Psychiatrie et Migrants » et un comédien professionnel selon une méthodologie dérivée du Théâtre Forum, ces scénettes portent sur des difficultés courantes rencontrées en situation triadique. »
      - « La formation se terminait par la transmission de conseils pratiques pour le bon déroulement de l'entretien triadique et par la distribution du guide pratique susmentionné aux participants. »

Technique – Bereknyei (2012)

Bereknyei, S. (2012). *Fostering linguistic competency: A case for medical education for healthcare providers.* (Dr PH), University of California, Berkeley.

- 90 minute session for pediatric residents and 60 minute session for pediatric attendings.
  - A first systematic review to find out what are the current best practices in linguistic competency training and the effects on provider competence on patient, provider and systems outcomes.
  - A second systematic review to find out what are the communication and interpreters needs of healthcare providers and LEP patients.

- The workshop was designed to be informative and interactive as well as feasible to implement during a clinician's busy day.

- Specific components of the workshop are listed below (p. 47-50 for more details):

  1. Introduction to limited English proficiency (LEP) and the growing LEP population in the United States and California. Although there is a large proportion of the population in California who are LEP, a strikingly large number of LEP patients do receive inferior quality and access to care, resulting in health and healthcare disparities. LEP patients experience more barriers when accessing primary care services, and, when they are receiving care, have fewer services offered to them than their English speaking counterparts. Training physicians to work with interpreters can mitigate the effect of these barriers.
  2. Defining the terms "interpret" (to orally express a message from one language to another) and "translate" (converting written text from one language to another).
  3. Case study to determine current practices when interacting with an LEP family followed by a debrief. Prompt question "What would you do in your current practice to communication with this patient/family?"
  4. Discuss specific attributes of language interpretation standards nationally, statewide and at Stanford, as well as the responsibility of healthcare organizations on providing language services, as stated by the CLAS Standards(US DHHS, 2001).
  5. Discuss medical errors as they occur in the healthcare setting, provide real---life example of clinician ignoring "LEP status" of patient and resulting trauma from this mistake. Open up to group for discussion.
  6. Share tips on working with interpreters (relevant for in---person and for all modalities). Followed by role---play scenario with a Spanish---speaking mom, where a participant must explain a treatment plan to an actor playing the patient's mom with an interpreter present, another actor. The goal is to utilize the tips presented. Followed by a discussion from the participant, actors and participant observers. Debrief consists of additional tips to remember with in---person interpreters.
  7. Share tips on working with telephone interpreters. As before, one participant is asked to role---play a discussion on symptoms with a Russian---speaking teenager, with an actor playing the teenager and a real---life telephone interpreter is contacted for the presentation. This is followed by a discussion of tips and skills necessary for interacting with telephone interpreters.

8. Share tips on utilizing own non---English language skills. The final role---play incorporates a Spanish---speaking patient and requires a Spanish---speaking participant volunteer to discuss dietary changes and nutrition concepts to the family. The debrief incorporates additional tips on how to self---assess language abilities (for all languages, although the example was in Spanish) and utilize interpreters even when speaking in the patient's language.
9. Relay the interpreter's role on the healthcare team, ranging from "message converter" to "message clarifier" to "cultural clarifier" and finally, to "patient advocate" (California Endowment, 2007).
10. Share needs assessment research project results and lessons learned to emphasize relevance of the workshop on their LEP patient population and direct patient care.
11. Share resources at Stanford Hospital and Clinics as well as Lucille Packard Children's Hospital. Describe the functions of each and specific setting.
12. Final assessment, rate retrospective (before workshop) and post (after).

- The training developed for pediatric residents consisted of the following learning objectives, in order of appearance:
    1. Be able to explain current language standards and Stanford policy and applications to your practice;
    2. Discuss potential medical errors;
    3. Utilize communication tools to work effectively with trained interpreters;
    4. Know more about your LEP patient population;
    5. Recognize your language skills and potential limitations;
    6. Utilize available resources at Stanford to communicate with your LEP patients;
    7. Reflect how to teach, role model, and practice during patient care.

- The pediatric attendings module learning objectives were as follows, in order of appearance:
    1. Be able to explain current language standards and Stanford policy and applications to your practice;
    2. Discuss potential medical errors;
    3. Utilize communication tools to work effectively with trained interpreters
    4. Know more about your LEP patient population;
    5. Utilize available resources at Stanford to communicate with your LEP patients;
    6. Reflect how to teach, role model, and practice during patient care.

Technique – Jacobs et al (2010)

Jacobs, E. A., Diamond, L. C., & Stevak, L. (2010). The importance of teaching clinicians when and how to work with interpreters. *Patient Education and Counseling, 78*, 149-153.

- "The course is a one and a half hour teaching session in which all 2nd year medical students participate."

- "We developed and implemented this curriculum based on our experience working and collaborating with interpreters and community groups, previous research, and by following the guidance of professional organizations such as the National Council for Interpreting in Health Care a US-based health care interpreter policy and advocacy organization."

- "The course has four curricular components (p. 150 for more details) :
  - a trigger tape followed by discussion of the consequences of using untrained interpreters (10 min);
  - a didactic portion in which students are provided with best principles for choosing and working with interpreters (10 min);
  - a modeling session in which faculty members model how to effectively work with interpreters (10 min);
  - a role-playing session in which students have the opportunity to practice working with an interpreter. Because language and culture are difficult to separate, we also provide teaching on how to address cultural issues in an interpreted encounter (60 min)."

2.2 Formation pour les interprètes médicaux/Medical Interpreter Training

Technique – Ono et al (2013)

Ono, N., Kiuchi, T., & Ishikawa, H. (2013). Development and pilot testing of a novel education method for training medical interpreters. *Patient Education and Counseling, 93*, 604-611.

- A 3-day training program for medical interpreters.

- Core competencies determined by means of a systematic literature review to design and then test an interpreter training program : 2003-2010 (N=11) → Five core competencies.
    1. Maintaining accuracy and completeness
    2. Medical terminology and understanding the human body
    3. Behaving ethically and making ethical decisions
    4. Nonverbal communication skills
    5. Cross-cultural communication skills

- Description of the training program (p. 608) :

Table 3
Content of program for the intervention and control groups.

	Contents of intervention (intervention)	Contents of intervention (control)
Day 1	Pre-test/questionnaire [Lecture] What is medical interpreting? Frequently used phrases in medical encounters Code of ethics [Practical training] Quick response Note taking Medical interpreting: reception, medical interview	Pre-test/questionnaire [Lecture] What is business/liaison interpreting? Let's interpret: speech [Practical training] Quick response Note taking
Day 2	[Lecture] Introduction to anatomy Introduction to non-verbal communication Cross-cultural communication [Practical training] Shadowing Sight translation Medical interpreting: drug administration guidance	[Lecture] Introduction to communication Introduction to public speaking [Practical training] Shadowing Sight translation
Day 3	[Lecture] Terminology in hospital [Practical training] Reproduction/paraphrasing Transcription Interpreting informed consent Post-test/questionnaire	[Lecture] Voice of various interpreters Introduction to simultaneous interpreting [Practical training] Reproduction/paraphrasing Transcription Post-test/questionnaire