Interpreting in Healthcare Settings

Community-based training for interpreters working in healthcare and medical settings

Student Handbook
2019

THE INTERPRETER'S LAB™
Be a Better Interpreter

The Interpreter's Lab

Discover, Learn, Share, Meet

The Interpreter's Lab is an interpreter education program that trains interpreters to work in community, healthcare and legal settings

This Handbook is provided as a study guide for the Interpreting in Healthcare Settings Short-term Training Series provided by The Interpreter's Lab ™ and Shifting Pictures. It is not intended as a stand-alone training manual. This Handbook may only be used as a supporting document to the 30-hour Interpreting in Healthcare Settings delivered by The Interpreter's Lab™.

Contact Information:

Shifting Pictures

1424 Commercial Drive

Vancouver BC

V5L 3X0

admin@interpreterslab.org

www.interpreterslab.org

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The World of Community Interpreting

Introduction

Interpreters have been around for a very long time. Records show that some the "oldest documented accounts of training and employing interpreters are from 2500 BCE, from the southern province of Egypt where Egyptians and Nubians met regularly."[i] However, it was not until the 1950's that interpreting was formalized with a professional title designation championed by the Association Internationale d'Interprètes de Conferénces (AIIC), which came into existence at that periodii. Changing migration patterns experienced later in the decade shaped a linguistic and cultural diversity now found within many nations, which in turn fostered the development of new brand of interpreting known as community or public service interpreting.

Community Interpreting was initially an ad-hoc response to these changing linguistic and cultural demographics and one that was provided informally by family members (including children), friends, and untrained/untested bilingual staff or volunteers. As it progressed and advanced as an acknowledged profession, Community Interpreting began to draw much attention from scholars interested in understanding this new locus within the profession. As a field of practice that was conducted in the community instead of the conference booth, Community Interpreting adopted many of the central tenets of conference interpreting given the absence of any other guiding set of principles. However, transposing a set of rules from one end of the interpreting continuum to the other resulted in a decontextualization of the practice by ignoring the realities of the field, a neglect of practitioners that were left to face ethical dilemmas without sound guidance, and relinquishing of the profession to definitions from external influences.

In Canada, Community Interpreting largely came to existence in the late 20th century when migration patterns began to shift, and organizations responded to the broadening linguistic and cultural diversity through the provision of informal language services. The rise of Community Interpreting has been an "institution-led field" - one in which the needs of the institutions were primary and the requirements of the profession secondary[iii]. This genesis may be at the core of why it has taken so long for Community Interpreting to achieve equal status as a member of the established language industry, even though it is one of the fastest growing areas of interpreting. However, the landscape of Community Interpreting is rapidly changing as new certification schemes and improved awareness and recognition of the Community Interpreter are evidenced.

Interpreters are generally freelance contractors that work either directly for the service providers that require language services, but more commonly contract their services through a brokerage that procures work, assigns the interpreters and then takes a margin off of the fees they charge for the interpreter's services. In fact, most government contracts for language services are only awarded to agencies, both non-profit and business, so it is impossible for an individual interpreter to secure steady, long-term contracts of this nature and there can be drastic differences in how interpreters are treated from one agency to the next.

However, there are universalisms in community interpreting, one being ethics and standards of practice. Standards of Practice are guidelines that describe expected conduct and behaviour in a field or practice or profession. These standards may be enforced by governments, legislation or laws, or by professional membership bodies. In Canada, most interpreter services providers, and indeed this course, rely on the National Standards Guide for Community Interpreting Services as a framework for standards and ethics.

The Role of the Interpreter

What is the role of the Community Interpreter? An interpreter, in any situation, is a language or communication facilitator that acts as a conduit for 2 or more people who do not speak the same language. The primary role of the interpreter involves the **oral rendering** from one language into another without changing content, meaning, register or tone. The main purpose of interpreting is to facilitate understanding in communication between people who speak different languages.

An interpreter:

- Is a language assistant
- Is fluent in two or more languages
- Understands their limitations
- Does not advocate for either party in an interpreting session
- Does not let personal opinions enter into their work
- Maintains a current knowledge of vocabulary and terminology
- Does not offer counseling nor advice

An interpreter is more than a bilingual person. An interpreter is part of a larger professional network and is obligated to adhere to standards of conduct defined by ethical principles. Interpreters are also responsible to their peers and must act in a professional manner at all times to safeguard not only their own scope of practice but the integrity of the network of professionals that span the globe. Does that sound like a heavy obligation? It is, but it is also a reasonability that can be embraced with confidence and satisfaction through careful practice and continued competence.

Interpreters are also responsible to the people whom they serve: the minority-language speakers that come as clients to consume services; the professionals and practitioners that serve the community; and the agencies with which they work. So, while it may seem that interpreters work in isolation, they are actually connected to a broad scope of people.

Interpreting in healthcare settings is a division of what is called Community Interpreting. Community Interpreting, or Public Service Interpreting as it is called in the UK and EU, is "*bidirectional interpreting that takes place in the course of communication among speakers of different languages. The context is the provision of public services such as healthcare or community services and in settings such as government agencies, community centres, legal settings, educational institutions, and social services*" (National Standards Guide for Community Interpreting Services, 2010, Canada).

What distinguishes Community Interpreting from other settings is a number of different factors:

- It is bidirectional
- It is dynamically situated within the context
- It demands interpreters be more aware of the potential for ethical dilemmas
- It is done as a single practitioner, and not in team

Interpreting Techniques and Modes

Interpreters work in different modes, which is about the interpreters how the interpreter relays the message from source to target language. The different modes are used in different settings.

Simultaneous Mode

The interpreter begins to interpret the message while the speaker is still talking. The interpreter keeps a few words behind the speaker.

Consecutive Mode

The interpreter waits for the speaker to pause and then accurately interpreters what the speaker has said. Usually allows for a few sentences of information to be spoken before pausing.

Sight Translation or Sight Interpreting

The interpreter renders written script into oral language from one language to another.

Chuchotage (whispered)

Similar to simultaneous but done in whispered mode to one or two people only.

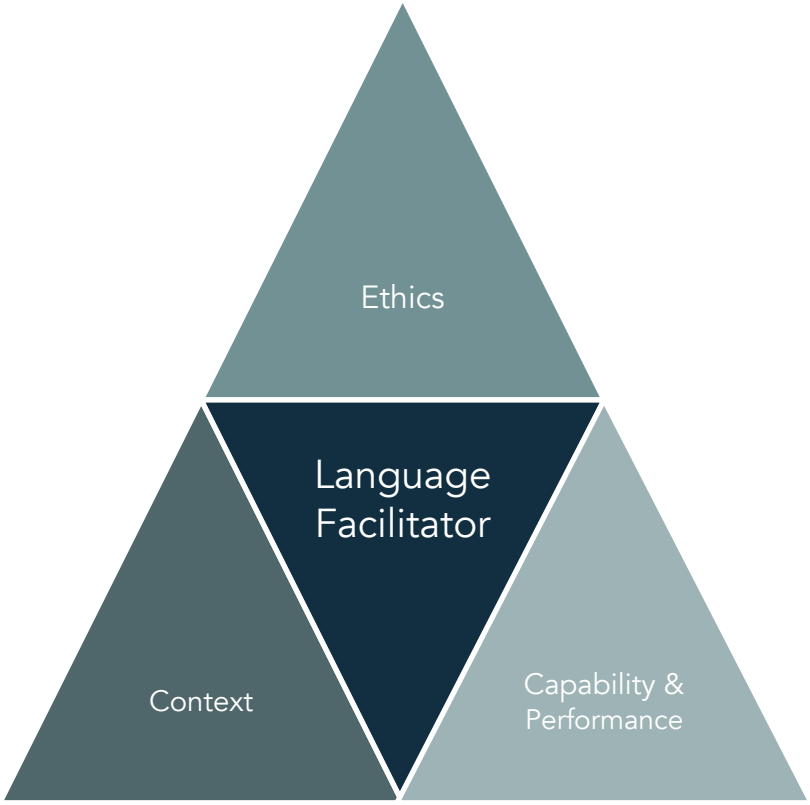
Settings and Styles for Interpreting

Interpreting happens in a variety of different settings. While Community Interpreting is perhaps the oldest form, it is the most recent to join the professionalization rank. When people think about interpreting they often envision booths, headsets, microphones, and a large auditorium or perhaps a United Nations conference room. But interpreting happens everywhere. From the smallest community based office to the largest conference rooms. Below is a listing of different settings and styles for interpreting.

- Conference Interpreting
- Court Interpreting
- Diplomatic Interpreting
- Business Interpreting
- Community Interpreting
    - Public services
    - Healthcare
    - Legal
    - Education
    - Correctional services
    - Etc.

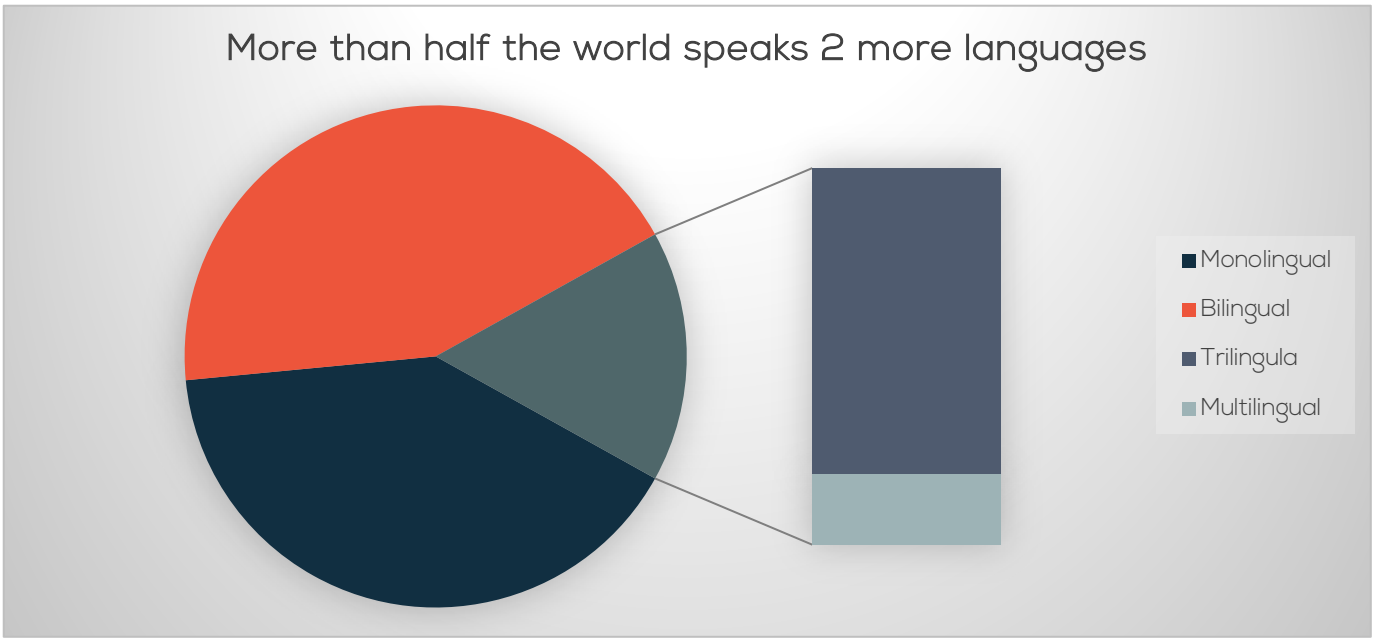
The Competent Interpreter

The Community Interpreter is a composite of elements that come together to form the competent interpreter. Interpreters are more than just words and language. The Competent Interpreter, as opposed to the bilingual person, is comprised of knowledge, skills, traits, and competencies that distinguish them from non-interpreters. We call these competencies the Core Competencies because they are the CORE of what makes a great interpreter. \



1. Ethics guide the profession according to principles and values
2. Context refers to the understanding and knowledge of the setting in which the work is done
3. Capability and Performance refers to the knowledge of theory and skills that allows an interpreter to perform

DID YOU KNOW…



Monolingual: A person who only knows one language is monolingual (40% of world population)

Bilingual: A person who is able to speak two languages especially with *equal fluency* (43% of world population)

Trilingual: A person that speaks three languages *fluently* (13% of world population)

Multilingual: A person who speaks more than two languages, but used often for four languages or more (3% of world population speak more than 4 languages)

Polyglot: Someone with a high degree of proficiency in several languages (less than 1‰ of world)

Interpreting Core Competencies

The National Standards Guide to Community Interpreting Services (NSGCIS)

The NSGCIS was developed in 2007 through a pan-Canadian partnership, led by the Healthcare Interpretation Network in Toronto, Ontario. It was updated in 2010, and was one of the foundational documents for the first ISO published standard in interpreting – **ISO13611:2014 – Interpreting – Guidelines for community interpreting**. The NSGCIS is a professional ethics document, premised on guiding values.

The NSGCIS defines 47 standards of conduct, organized by ethical principles. This guideline standard document also delineates 4 core competencies:

1. Interpreting Competence
2. Linguistic Competence
3. Interpersonal Competence
4. Research and Technical Competence

These core competencies provide are the underpinnings to interpreting learning, interpreter studies and interpreter conduct.

Linguistic Competence

Linguistic competence includes the ability to comprehend the source language and apply this knowledge to render the message as accurately as possible in the target language.

The interpreter shall:

- Have an in-depth knowledge and understanding of his/her working languages and the required range of language registers.
- Have knowledge of subject areas and relevant terminology.
- Must be able to deal with obscenities and render them accordingly in the target language. The interpreter must also be able to understand cultural stigmas without assuming the role of advocate or cultural broker.

Interpreting Competence

Interpreting competence comprises the ability to interpret a message from one language to the other in the applicable mode. It includes the ability to assess and comprehend the original message and render it in the target language without omissions, additions or distortions. It also includes the knowledge/awareness of the interpreter's own role in the interpreting encounter. The interpreter shall:

- Have active listening skills and strive to improve them through self-training.
- Have good memory retention skills.
- Be able to take notes during the interpretation assignment to ensure accuracy of the information given.
- Be able to mentally transpose and verbalize into the target language

Interpersonal Competence

Interpreting is interaction with many people in various situations. Interpreters must be able to perform their duties and tasks demonstrating competent interpersonal skills.

The Interpreter shall:

- Have strong communication skills.
- Be polite, respectful and tactful.
- Be able to relate well to people.
- Have good judgment.
- Must be punctual.
- Must be able to work with limited supervision and be organized.
- Must be articulate
- Must be assertive in his/her work without being overconfident.
- Must be able to cope with stress during and after the assignment.
- Must be dedicated professional.

Research and Technical Competence

Research competence includes the ability to efficiently acquire the additional linguistic and specialized knowledge necessary to interpret in specialized cases. Research competence also requires experience in the use of research tools and the ability to develop suitable strategies for the efficient use of the information sources available.

Ethics and Standards of Conduct for Community Interpreters

Ethics and Professional Standards for Interpreters

Ethics are a branch of philosophy that concerns itself with morals, moral judgement and morality. Philosophy has divided these into three areas of study: meta-ethics, which explores the larger question of where ethics come from and what they signify; applied ethics, which explores issues that are complex and controversial, and; normative ethics, which is concerned with the practical side of regulating or guiding right and wrong.

Morality is conduct that is either judged to be right or wrong, good or bad. But there are larger questions. Where do our definitions of right and wrong come from? Who decides? On what basis is conduct judged? What are the implications or consequences of judgement?

Values and Ethics

Our ethics and ethical approaches to life are driven by our personal values. Personal values are a set of guidelines that help delineate good from bad, right from wrong, and beautiful from disagreeable, among other beliefs. Values are internalized, vary from individual to individual and can change over the course of an individual's lifetime. Values are a complicated topic that connects to issues of individual cognition, personal experiences, and cultural influences – but there are some important points to note about values:

- They are individual
- They motivate and dictate behaviour and thoughts
- They are often hidden, and operate within individuals like silent drivers
- They are not always congruent or clearly obvious
- They are not universal rules
- Values operate on a spectrum
- Shared cultural or societal values are often reflected in political, social and religious institutions
- Values can be individual, organizational or cultural.
- As an interpreter, knowing your own core values, the values that motivate you, is a critical component of success.

Ethical Decision Making – "it depends"

"Although codes of ethics and standards of practice rule that interpreters must be neutral, this task may be more easily said than done. It is no simple feat to escape the social processes to which all individuals are continuously exposed" [iv]

Community Interpreters work in isolation, which is why it is critical that ethical codes of conduct, in essence the "rules", are fully understand not only in theory, but also in *practice*. As Dean and Pollard state (2011, pg. 155), "interpreting is best understood as a practice profession rather than a technical profession." What they mean by this is that interpreters are often in situations that are dynamic, and decisions maybe contextually driven, and values based. As with the previous activity on cheating, we saw that the context in which the

action is situated may affect the decision taken depending on *preconceived values or beliefs about right and wrong and the burden of the consequence(s) as an outcome of that action*. Once again referencing Dean and Pollard (2011, pg. 156): "Interpreting students receive a mixed message when educators assert a non-contextual, rule-based approach to ethics while simultaneously responding to both ethical and translation questions with "It depends" – an obvious reference to the centrality of context in decision making." We cannot rely on the "it depends" approach in interpreting, but rather provide interpreters with tools to effectively, and contextually, apply the professional standards of conduct and rules of the role. We are at a transitional place with these thoughts in interpreter education. Until we have achieved a set of standards that are more guiding rather than directive, what we can best do is learn and integrate the standards in a way that fit the setting. This means to build critical thinking skills to navigate through ethical dilemmas.

In interpreter-mediated encounters, especially in community interpreting, interpreters are frequently confronted with choices, and are required to make decisions where the choices appear equally undesirable. Sometimes it is very easy to make a decision, maybe because you are more comfortable with one choice over the other, but other times it is not so easy. Ethical dilemmas can present major challenges for interpreters, and interpreters must question themselves: from what perspective are you viewing the issue? Are you looking at it from your personal values, from your professional values, from societal values, or from what perspective?

Consider this….

1. What is an ethical dilemma?

2. Can you think of any ethical dilemmas? Perhaps something that has happened to you personally, or something you've heard or seen in the media?

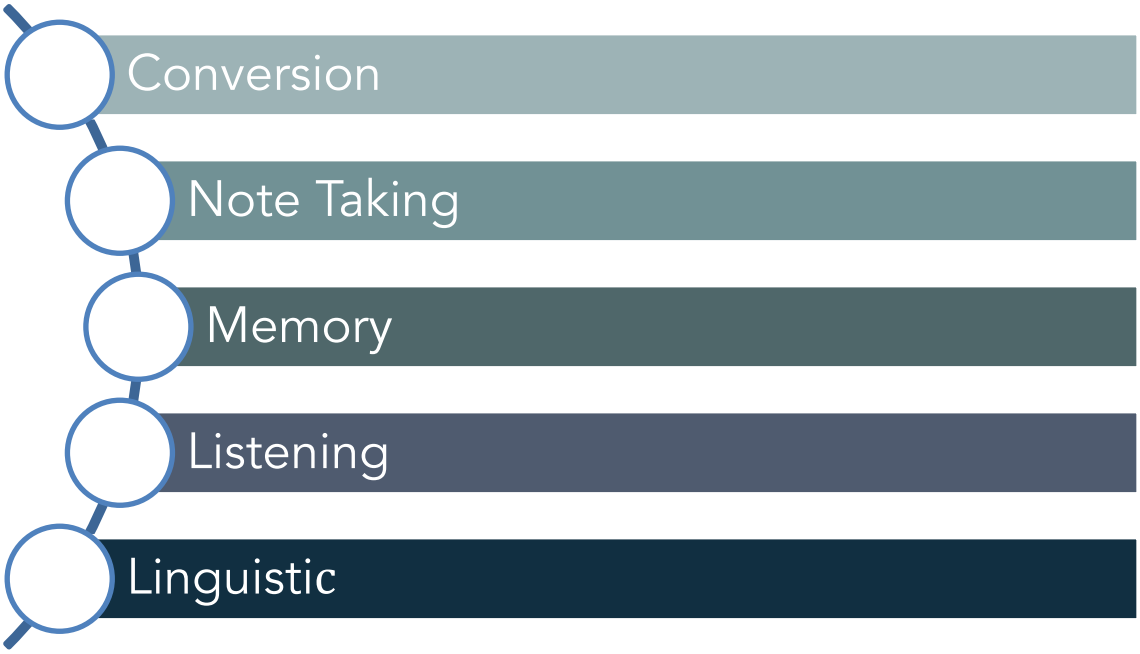
While ethical guidelines provide us with central principles, they are sometimes very nebulous and can mean different things to different people. Especially in a cross-cultural context. Standards of Practice or Codes of Conduct are ways that better define and describe ethical guidelines in that they explicitly state what behaviour is expected.

Standards of Practice

See the **Appendix I** in this manual for a more detailed description of the Standards of Practice

1. Accuracy and Fidelity
2. Confidentiality
3. Impartiality
4. Respect for Persons
5. Maintenance of Role Boundaries
6. Accountability
7. Professionalism
8. Continued Competence

Capability and Performance



To accomplish their work, and to fulfill the role of interpreter, interpreters must have strong skills in these areas:

- Linguistic Skills
- Listening Skills
- Memory Skills
- Note Taking Skills
- Conversion Skills (code-switching)

Linguistic Skills

Interpreters must be fluent in all their working languages. Without fluency or proficiency interpreters will not be able to effectively use other skills, nor be able to work efficiently as an interpreter.

"Language proficiency or linguistic proficiency is the ability of an individual to speak or perform in a language...fluency and language competence are generally recognized as being related, but separate controversial subjects." Wikipedia

Fluency and proficiency can mean different things, but we need not get too theoretical at this stage. What is important for interpreters is to achieve a level of linguistic proficiency that will allow them to be ACCURATE in their rendition of meaning from source to target language. It is estimated speakers should have 20,000 and 40,000 words to be considered proficient, while basic conversational ability may only need as few 3,000 words.[v] The English language has an approximate 170,000 words, and uses about 3000 in an average daily basis, which means you could get by with

just 3000 words – if you are not an interpreter. Interpreters should always be working at a near-native level of language proficiency. That means if you are not at about 10,000 words, you have some work to do.

Another thing that works against us in language acquisition is that we sometimes think we know more than we actually know. So, because you don't know what you don't know, you actually think you do know. Confused? In a 1999 research study, David Dunning and Justin Kruger discovered that people often think they know more than they actually do. This phenomenon has come to be known as "The Dunning-Kruger Effect[vi]" and it happens to everyone including interpreters, especially those that are just starting out in the field. So, be cautioned that linguistic proficiency is something that must be constantly improved upon, not just for specialized language like healthcare or legal, but for all situations in all your working languages.

Interpreters should have a minimum level of listening, comprehension and speaking fluency that are equal to the Canadian Language Benchmark (CLB)8 but preferably higher. [vii]

Listening Skills

- Listening is the ability to accurately receive and interpret messages in the communication process.
- Listening is key to all effective communication, without the ability to listen effectively messages are easily misunderstood

Listening is not the same as hearing. Hearing refers to the sounds that you hear, whereas listening requires more than that: it requires focus. Listening means paying attention not only to the story, but how it is told, the use of language and voice, and how the other person uses his or her body. In other words, it means being aware of both verbal and non-verbal messages. Your ability to listen effectively depends on the degree to which you perceive and understand these messages

Listening is one of the most important skills you can have. How well you listen has a major impact on your job effectiveness, and on the quality of your relationships with others.

For instance:

- We listen to obtain information.
- We listen to understand.
- We listen for enjoyment
- We listen to learn

In fact, most of us are not, and research suggests that we only remember between **25 percent and 50 percent** of what we hear. Turn it around and it reveals that when you are receiving directions or being presented with information, you aren't hearing the whole message either. You hope the important parts are captured in your 25-50 percent, but what if they're not?[viii]

Memory Skills

Memory skills are ESSENTIAL for Community Interpreters because Community Interpreters work in consecutive mode which means that they MUST retain information for some time, and then be able to recall it when needed. This can be very challenging.

Very short-term memory

- allows you to hold an exact string of numbers in your head for 5- 7 seconds
- can only be stretched a bit perhaps a few more seconds

Short-term memory

- helps you recall concepts or ideas
- will allow you to see the most improvement rapidly.

Long-term memory

- your store of knowledge - what you have learned in the past that stays with you over time.
- Improving long-term memory involves studying something over time

You use all 3 forms of memory in your interpreting work! Your brain is on a constant cycle of retrieval and dissemination.

Developing memory capacity is rather like training for long-distance running; it takes repeated exercises, pushing day after day to go farther than the day before.

To help retain what you've heard during an interpreting session:

- Concentrate
- Visualize
- Echo key phrases in your head
- Count the key points

Tips for Building Memory

1. Retelling in the Source Language: Have someone read you a story of about 200 words. Retell it. You can use (NO NOTES):
2. Categorization: Grouping items of the same properties;
3. Generalization: Drawing general conclusions from particular examples or message from the provided text;
4. Comparison: Noticing the differences and similarities between different things, facts and events;
5. Description: Describing a scene, a shape, or size of an object, etc.
6. Shadowing Exercise: This kind of exercise is recommended for training of Simultaneous Interpreting.

Note Taking

The purpose of note-taking is to augment memory efficiency, not to take down everything that is said. What is important to remember about note-taking is that:

1. the interpreter's notes are individual and unique to the interpreter.
2. practicing interpreters develop their own techniques for note-taking.

How do we take notes in community settings? Be prepared:

- Always state that you will be taking notes and for WHAT purpose
- Confirm with/ask clients and attending professionals for permission first (ensuring that you let them know it is important for you to use notes for accuracy)
- Take note circumspectly and diplomatically – be aware of your surroundings
- Develop a system/symbol beforehand – practice and let it come naturally
- Any system that occupies more brain space and energy to remember is working against the whole purpose of note taking
- Dispose of the notes after the session in front of all parties so that they witness their disposal

The most formative work on interpreting in consecutive interpreting is by J.F Rozan in his book Note-taking in Consecutive Interpreting. Rozan identified 7 key principles that can help interpreter use and learn note taking skills. These are:

1. Note the idea rather than the exact words used.
2. Abbreviate long words by noting the first two and the last two letters only.
3. Alternatively, find a short word with the same meaning.
4. Negation (ok to approve, no ok to disapprove)
5. Abbreviations of linking words are important: as, why
6. Underlying idea to stress importance
7. Work down the page, grouping ideas using symbols

Sight Translation

Sight translation refers to the oral rendering on one language of a document written in another. It is called sight translation, instead of sight interpreting because the sources message is written, not spoken. Medical interprets may be asked to sight translate any number of documents, such as:

- Consent forms, registration forms, patient education brochures/flyers
- Pre-procedural instructions, post-procedural instructions, prescriptions

Procedures for Sight Translation

- Read the document all the way through so you understand what is says before you start translating
- Ask for clarification of any words or concepts you do not understand
- Translate at a steady, moderate pace the goal is read as if you were reading in the language of the patient/client. If you read a few lines very quickly and then leave long pause before continuing, it is difficult for the patient to understand and remember what you read.
- Translate exactly what is written: Add nothing, omit nothing, change nothing. Remember that some documents, such as consent forms, are legal documents; it is crucial that they be translated as they stand

Positioning

There are 3 main positions for interpreters in healthcare and each has their advantage and disadvantage.

1. The interpreter beside the HCP
2. The interpreter beside the patient
3. The triangle

Sample Introduction Statement

Introduce yourself using this statement – or construct one that makes sense for you.

Hello my name is _____. I will be your interpreter for the session with ____. Please speak directly to the client and I will ask the client to speak directly to you. Also please allow me to interpret after each response you make. In addition, at the beginning of the session please allow me the opportunity to explain my role to the client. I will state the following to them:

I am here so that you will be better able to understand (the health provider) and that (the health provider) is better able to understand you. It is my responsibility to interpret everything said in the session either by you or the health care provider. Everything said in this room is private and confidential and will not be repeated outside this room.

Additional things to mention (if you wish or need to)

- I am not here to judge or give advice.
- Please listen carefully to me before answering the health care provider – let me finish what I begin.
- If you begin to speak too fast or say too much, I will stop you so that I can accurately interpret what you have said.

PART 2

The Healthcare Setting

The Healthcare Setting

Why is the healthcare setting different?

"Healthcare interpreting is a very demanding intellectual and emotional exercise whose practitioners require training, knowledge of medical terminology and a good understanding of clinical practices and procedures as well as practical knowledge of the healthcare system" (National Standards Guide, 2010, p.20)

In addition to the requirement of competency in medical and healthcare terminology, and familiarity with the healthcare system and specialties, interpreters that work in healthcare must also be very culturally aware, of their own cultural values and foundations as well as those that guide the healthcare system and the clients with which they will come into contact. This awareness is a skill that is an ongoing personal development process and necessary in a healthcare setting because healthcare is a value-laden domain.

Healthcare is:

- Emotionally laden
- Dynamic
- Confusing
- Complex
- Involves a complex lexicon
- Involves a complex infrastructure and political system
- Involves A LOT of people

What is health?

The definition of health has changed over the years and generations. Where once health meant simply the absence of physical illness or disease, it now encompasses a much broader range of factors, and extends out beyond the physical. In 1948, the World Health Organization proposed a definition of health that seemed very different from the general idea at the time, but which has become a much more accepted way of thinking about health and wellness. In fact, the Canadian and BC governments have adopted a similar view of health and wellness.

World Health Organization (WHO) definition:	**BC Ministry of Health:**
"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[ix]	"Health goes beyond lifestyle and health care. It also requires adequate employment, housing, food, education, a health and sustainable physical environment, social justice and equity, and support networks of families, friends and communities."[x]

Social Determinants of Health

Another change that has been implemented in the way we conceptualize health, and the way health policies and programs are developed, has been to view health in a much more wholistic way – to look at other things that influence the health or health status of individuals and populations. This way of thinking about health is called the **Social Determinants of Health**.

What are the Social Determinants of Health?

The Social Determinants of Health are the range of personal, social, economic, and environmental factors that influence health. Determinants of health go beyond the boundaries of traditional health care and public health sectors to encompass sectors such as education, housing, transportation, agriculture, and environment, areas that can be important allies in improving population health.

The determinants of health include:

- The social and economic environment,
- The physical environment, and
- The person's individual characteristics and behaviours

Different Approaches to Health

Biomedical Model of healthcare

- Predominant model used by physicians in diagnosing diseases
- Health constitutes the freedom from disease, pain, or defect, thus making the normal human condition "healthy".
- The model's focus on the physical processes, such as the pathology, the biochemistry and the physiology of a disease
- Does not take into account the role of social factors or individual subjectivity.
- Overlooks the fact that the diagnosis is a result of negotiation between doctor and patient
- The biomedical model of health focuses on purely biological factors, and excludes psychological, environmental, and social influences. It is considered to be the leading modern way for health care professionals to diagnose and treat a condition in most Western countries

Social Model of Healthcare

- A population health approach reflects a shift in our thinking about how health is defined.
- The notion of health as a positive concept, signifying more than the absence of disease, led initially to identifying it as a state of complete physical, mental and social well-being.
- A population health approach recognizes that any analysis of the health of the population must extend beyond an assessment of traditional health status indicators like death, disease and disability. A population health approach establishes indicators related to mental and social wellbeing, quality of life, life satisfaction, income, employment and working conditions, education and other factors known to influence health.

Traditional Models of Healthcare

- Traditional medicine (also known as indigenous or folk medicine) comprises knowledge systems that developed over generations within various societies before the era of modern medicine

The World Health Organization:

- "Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness."
- When adopted outside of its traditional culture, traditional medicine is often called complementary and alternative medicine.
- Traditional medicine may include formalized aspects of folk medicine, i.e. longstanding remedies passed on and practiced by lay people. Practices known as traditional medicines include Ayurveda, Siddha medicine, Unani, ancient Iranian medicine, Irani, Islamic medicine, traditional Vietnamese medicine, traditional Chinese medicine, traditional Korean medicine, acupuncture, Muti, Ifá, traditional African medicine, and many other forms of healing practices.

The Canadian Healthcare System

Canada's Health Care System at a Glance

Canada has a predominantly publicly financed health care system. Our national health insurance program is achieved through thirteen interlocking provincial and territorial health insurance plans, linked through adherence to national principles set at the federal level.

The Canada Health Act establishes criteria and conditions related to insured health care services and extended health care services that the provinces and territories must meet in order to receive the full federal cash contribution under the Canada Health and Social Transfer (CHST). The aim of the Canada Health Act is to ensure that all eligible residents of Canada have reasonable access to medically necessary insured services on a prepaid basis, without direct charges at the point of service.

The federal government's role in health care includes the following:

- Setting and administering national principles or standards for insured health
- Care services through the Canada health act;
- Providing funding assistance to provincial/territorial health care services
- Through fiscal transfers;
- Delivering direct health services to specific groups of Canadians including
- Veterans, first nations peoples living on-reserve, military personnel, the RCMP
- And inmates of federal prisons;
- Fulfilling other health-related functions such as health protection, health
- Promotion and disease prevention.

The administration and delivery of health care services is the responsibility of each individual province or territory. Provinces and territories plan, finance (assisted by federal funding), and evaluate the provision of hospital care, physician services, public health and some aspects of prescription care.

Principles of the Canada Health Act

1. Public Administration: The administration and operation of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority, responsible to the provincial/territorial government and subject to audits of their accounts and financial transactions

2. Comprehensiveness: The health insurance plans of the provinces and territories must insure all medically necessary health services (insured services hospital, physician, surgical-dental) and, where permitted, services rendered by other health care practitioners

3. Universality: All insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions. Provinces and territories usually require that residents register with the plans to establish entitlement

4. Portability: Residents moving from one province or territory to another must continue to be covered for insured health services by the "home" province during a minimum waiting period, not to exceed three months, imposed by the new

province/territory of residence. Residents temporarily absent from their home provinces or territories, or from the country, must also continue to be covered for insured health care services

5. Accessibility: Reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers, such as discrimination on the basis of age, health status or financial circumstances. Reasonable access in terms of physical availability of medically necessary services has been interpreted under the Canada Health Act as access to insured health care services at the setting "where" the services are provided and "as" the services are available in that setting

How the System Works

Canada's health care system relies extensively on primary care physicians (e.g. general practitioners) who account for about 51% of all practicing physicians in Canada. They are usually the initial contact with the formal health care system and arrange for access to most specialists, hospital admissions, diagnostic testing and prescription drug therapy.

Most doctors are private practitioners who work in independent or group practices. Some doctors work in community health centres, hospital-based group practices or work in affiliation with hospital out-patient departments. Private practitioners are generally paid on a fee-for-service basis and submit their service claims directly to the provincial/territorial health insurance plan for payment. Physicians in other practice settings may also be paid on a fee-for-service basis but are more likely to be salaried or remunerated through an alternative payment scheme.

While nurses are generally employed in the hospital sector, they also provide community health care including home care and public health services. Dentists work independently of the health care system, except where in-hospital dental surgery is required.

A somewhat recent addition to the category of healthcare practitioners that can practice autonomously (2005 in BC) is that of Nurse Practitioner, or NP. In British Columbia, NPs are Advanced Practice Nurses (APN) that are licensed by the College of Registered Nurses (CRNBC) in the classification -Nurse Practitioner. Nurse Practitioners provide comprehensive clinical care including the diagnosis and management of disease/illness, prescribing medications, ordering/interpreting laboratory/diagnostic tests, and initiating referrals to specialists.

NP practice does not require physician supervision and can provide care in both primary and acute care settings including rural, remote and urban centers. NPs take a holistic view on health when working with patients, taking care of the physical, emotional, emotional, and social aspects of a person's health needs.[xi]

In accordance to federal, provincial, and territorial legislation and policy, NPs can:

- Provide comprehensive health assessments and perform check-ups.
- Diagnose health conditions.
- Treat and manage acute and chronic illness.
- Treat and manage simple and complex health issues.
- Order and interpret screening and diagnostic tests.
- Order procedures.
- Prescribe treatment and medications.
- Refer clients to other healthcare professionals and specialists.
- Treat, transfer, and may discharge in-patients, and community out-patients from hospitals.
- Provide counselling and education.

For more information on Nurse Practitioners and on Nursing in general, visit the BCNPA and The Coalition of BC Nursing Associations website at https://bcnpa.org/about-bcnpa/bcnpa-the-coalition-of-bc-nursing-associations-2/

Accessing the Health Care System

When Canadians need medical care, in most instances they go to their family practitioner or local clinic and present the health insurance card issued to all eligible residents of their province/territory. Canadians do not pay directly for insured services, nor are they required to fill out forms for these services. There are no deductibles, or payments or dollar limits on coverage for insured services.

In addition to insured hospital and physician services, provinces and territories also provide public coverage for other health services that remain outside the national health insurance framework. These supplementary health benefits often include prescription drugs, vision care, medical equipment and appliances such as wheelchairs for certain groups such as seniors, the disabled and welfare recipients. In general, though, supplementary services such as cosmetic surgery are largely privately financed, and Canadians must pay privately for these non-insured benefits. Under most provincial laws, private insurers are restricted from offering coverage that duplicates that of the governmental programs, but they can compete in the supplementary benefits market.

The Family Physician – the General Practitioner

Family doctors are often a patient's first point of contact for dealing with their health needs. They provide comprehensive care for acute and chronic conditions, as well as preventative health services and treat mental and physical needs. When needed, family physicians may also refer patients to other specialists and help advocate for them and coordinate their care with these providers.

Family medicine became a specialty in Canada in the 1990s, when a mandatory two-year residency program was introduced. Family doctors who completed their medical training prior to the family medicine residency program being introduced, or who were trained in another country, may call themselves general practitioners (GPs). Following the completion of a general medical doctor degree (MD) at an accredited university, family physicians complete a residency program which provides experience in all aspects of primary care (i.e. maternity care, internal medicine, emergency, mental health, care of the elderly, rural family medicine, palliative care, etc.).

Family physician (or General Practitioner – GP) is the primary relationship for most people

- Family physicians work with the individual, get to know their lives, families, and general context
- Act as the advocates and translators for the system
- Act liaisons with other services that the client might need

BC Healthcare System

In 2001 the BC government created six health authorities to manage and coordinate health services. Five of the new health authorities were geographically based, and the sixth, the Provincial Health Services Authority was made responsible for specialized health services and programs province wide. In 2013 the First Nations Health Authority was created and now oversees the planning, management, service delivery and funding of health programs, in partnership with First Nations communities in BC. Under agreement with the BC Ministry of Health, each Health Authority is responsible for ensuring the quality of health programs within their service area.

The 5 regionally based health authorities and the geographic or specialized area of service

BC's HEALTH AUTHORITIES

1. Northern Health Authority
2. Interior Health Authority
3. Vancouver Island Health Authority
4. Vancouver Coastal Health Authority
5. Fraser Health Authority
6. Provincial Health Services Authority

The regional health authorities are responsible for:

- identifying population health needs
- planning appropriate programs and services
- ensuring programs and services are properly funded and managed
- meeting performance objectives

Different Types of Services

Institutional Services • Acute care/Hospital programs • Emergency Health Services • Extended Care • Continuing Care	**Speech and Hearing** • BC Family Hearing Resource Society • Children's Hearing & Speech Centre of BC • Deaf Children's Society of BC
Preventative Services • Public Health • Health Promotion • Dental Health • Occupational Health	**Community Care Services** • Mental Health • Alcohol and Drug • Forensic Psychiatry

The Levels of Healthcare Provision

Healthcare can be classified according to three levels of care that are graded levels of access or contact.

Primary Care

- Primary care refers to the work of health care professionals who act as a first point of consultation for all patients within the health care system,
- Primary care providers can be a general practitioner or family physician, or a non-physician primary care provider, such as a physician assistant or nurse practitioner.
- Primary care providers might also include other health care professionals such as a pharmacist, a nurse, or a traditional medicine professional
- Depending on the nature of the health condition, patients may then be referred for secondary or tertiary care.

Secondary Care

- Secondary care is the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists and dermatologists.
- It includes acute care: necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services.
- The "secondary care" is sometimes used synonymously with "hospital care". However, many secondary care providers do not necessarily work in hospitals, such as psychiatrists, clinical psychologists, occupational therapists or physiotherapists, and some primary care services are delivered within hospitals.
- In Canada, patient self-referral to a medical specialist for secondary care is rare. Prior referral from another physician (either a primary care physician or another specialist) is considered necessary regardless of whether the funding is from private insurance schemes or national health insurance.
- Allied health professionals, such as physical therapists, respiratory therapists, occupational therapists, speech therapists, and dietitians, also generally work in secondary care, accessed through either patient self-referral or through physician referral.

Tertiary Care

- Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral hospital.
- Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions

Home and community care (Public Health)

- Many types of health care interventions are delivered outside of health facilities. They include many interventions of public health interest, such as food safety surveillance, distribution of condoms and needle-exchange programs for the prevention of transmittable diseases.
- They also include the services of professionals in residential and community settings in support of self care, home care, long-term care, assisted living, treatment for substance use disorders and other types of health and social care services

Culture and Diversity

- Culture is an important and significant part of our lives, personally and professionally and a crucial element on communication and health care.
- Cultural frameworks will differ on the basis of ethnicity, national origin, race, religion, class, sexual orientation, gender and age.
- Culture influences how we communicate in many ways. One of which is how much information we convey when communicating

Cultural (and the diversity of cultures) includes	Culture is "learned" from many different sources:
• Language • Ethnicity • Country or region or origin • Dress • Values • Religion and spirituality • Social and community responsibilities • Sexuality • Disability • Family status • Family responsibilities • Political views	• Parents • Family members • Neighbourhood and community members • Educational institutions • Social institutions • Religious situations • Media • Observation of others • Oral histories • Historic legends and stories