



Investigación

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THE IMPACT OF THE COVID-19 PANDEMIC ON MEDICAL INTERPRETERS / CULTURAL MEDIATORS IN ITALY



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ABSTRACT: This contribution, prepared within the Erasmus+ ReACTMe (Research & Action and Training in Medical Interpreting) project, aims at evaluating the impact of COVID-19 on access to medical interpreting and cultural mediation services in Italy. Medical interpreters and cultural mediators, who play in Italy different although often overlapping roles, are particularly significant in removing language barriers to healthcare and social inclusion, despite the notable variation in the provision of these services in each European member state. Italy has been one of the first countries in Europe to be substantially affected by the COVID-19 pandemic in February 2020, going into lockdown as early as the beginning of March, and cancelling all non-urgent medical consultations in an effort to prevent the collapse of ICUs. A similar pattern was observed during the subsequent waves of the pandemic when healthcare services were provided to non-COVID patients although with limitations. To what extent were medical interpreting/cultural mediation services affected and how has this impacted non-Italian-speaking patients? This contribution presents the results obtained through an online survey submitted to medical interpreters/cultural mediators from all over Italy between November 2020 and January 2021. The results reveal that the pandemic has negatively affected the provision of medical interpreting/cultural mediation services with remote communication only partially making up for the lack of on-site language support and creating new challenges for both interpreters/cultural mediators and healthcare professionals.

KEY WORDS: medical interpreting; COVID-19, right to healthcare, Italy

RESUMEN: El objetivo de esta contribución, elaborada en el marco del proyecto Erasmus+ ReACTMe (Research & Action and Training in Medical Interpreting), es evaluar el impacto de la COVID-19 en el acceso a los servicios de interpretación y mediación cultural sanitaria en Italia. Si bien existe una gran diferencia en la prestación de estos servicios en cada uno de los Estados miembro, el papel de los intérpretes y los mediadores culturales sanitarios es particularmente significativo a la hora de eliminar las barreras lingüísticas para promover la inclusión social y a la asistencia sanitaria. Italia fue uno de los primeros países de Europa en verse considerablemente afectado por la pandemia de la COVID-19 en febrero de 2020. Tan solo un mes más tarde, Italia entró en cuarentena, lo que causó que se cancelaran todas las consultas médicas no urgentes en un esfuerzo por evitar el colapso de las UCI. Se observó una situación similar durante las siguientes oleadas de la pandemia, cuando se prestaron servicios sanitarios limitados a los pacientes no afectados por el virus. ¿En qué medida se vieron afectados los servicios de interpretación y mediación cultural en el ámbito sanitario, y cómo ha repercutido esto en los pacientes que no hablan italiano? Esta contribución presenta los resultados obtenidos a través de una encuesta en línea enviada a intérpretes y mediadores culturales sanitarios de toda Italia entre noviembre de 2020 y enero de 2021. Los resultados revelan que la pandemia ha afectado negativamente la prestación de servicios de interpretación y mediación cultural sanitaria, ya que la comunicación a distancia solo compensa parcialmente la falta de apoyo lingüístico *in situ* y crea nuevos retos, tanto para los intérpretes y mediadores culturales como para los profesionales sanitarios.

PALABRAS CLAVE: interpretación médica; COVID-19, derecho a la asistencia sanitaria, Italia.

Eleonora Bernardi and Francesca Gnani were both responsible for the study conception, design and delivery. Eleonora Bernardi undertook introduction, background, literature review and methods, while Francesca Gnani oversaw data analysis and processing, as well as conclusions. Both Eleonora Bernardi and Francesca Gnani drafted and revised the paper.

This research was carried out by two members of the research teams of the Erasmus+ ReACTMe (Research & Action and Training in Medical Interpreting) independently, as this survey was not one of the outputs of the project.

1. Introduction

This contribution was prepared by members of the Italian research teams of the Erasmus+ ReACTMe (Research & Action and Training in Medical Interpreting) project. Given the importance of medical interpreters/cultural mediators (hereinafter medical interpreters/mediators) to guarantee equal access to healthcare for patients with limited language proficiency, researchers have wondered how the provision of healthcare language services has been affected by the COVID-19 pandemic. Even though data on the reduced access to healthcare for all Italian citizens during the pandemic are available, no specific research has been carried out for non-Italian speakers, so far. To fill this void, researchers created an online questionnaire, that was completed by 308 medical interpreters/mediators from all over Italy between November 2020 and January 2021. In the questionnaire, respondents were asked to evaluate the reduction in their work assignments, to describe alternative interpreting/mediation modalities adopted and to give their feedback on such alternative interpreting/mediation modalities. Results show that the pandemic has had an impact on the provision of medical interpreting/cultural mediation services and on the right to equal access

to healthcare, with remote solutions only partially making up for the lack of face-to-face interaction. More specifically, remote interpreting/mediation solutions offer new possibilities for the post-pandemic scenario, but they also pose new challenges that require specific training for both language and healthcare professionals.

2. Background

This contribution was developed within the Erasmus+ ReACTMe (Research and Action and Training in Medical Interpreting) project that aims to take stock of medical interpreting in Italy, Romania and Spain, and to create a dedicated curriculum for training medical interpreters.¹ The right of the individual to healthcare is enshrined in some national legislations and in international law, including in the Universal Declaration of Human Rights and in the EU Charter of Fundamental Human Rights (article 35), while the WHO specifies that “non-discrimination and equality are fundamental human rights principles and critical components of the right to health” (UNHCR & WHO, n.d., 7). Despite the importance of medical interpreting to guarantee access to healthcare without discrimination (Tomassini et al., 2020), medical interpreting is only indirectly mentioned in European legislation (Directive 2010/64/EU and 2011/24/EU) and there are notable differences among EU countries - and sometimes even within the same member state - in the training, certification, organisation and provision of medical interpreting services. In Italy, Romania and Spain, the profession is still lacking regulation and far too often ad-hoc interpreters (or no interpreters at all) are called in to bridge the language gap (Tomassini et al., 2020).

In Italy, since healthcare is free and nationalised, healthcare services are provided by regional governments, thus resulting in significant regional differences in both the services offered and overall healthcare quality (Cicchetti & Gasbarrini, 2016; OECD, 2015), which also applies to medical interpreting/mediation (Tomassini et al., 2020). There is also no national legislation on medical interpreters/mediators although their role and importance have been frequently highlighted in the different regional laws on migration and inclusion since the 1990s (Falbo, 2013). Healthcare providers therefore resort to improvised or ad ad-hoc language brokers, like children, family members and/or volunteers (Garwood & Amato, 2011, 1-2). The Italian medical interpreting/mediation situation is also unique since interpreters and cultural mediators co-exist and function in similar settings (Falbo, 2013; Baraldi & Gavioli, 2012; Dallari et al., 2012), unlike other countries, where mediators and interpreters play different roles in healthcare settings. In Italy, the *mediatore linguistico culturale*² emerged as a response to the migration flows of the 1980s and progressively became a reference point for communication in schools, hospitals,

¹ <http://reactme.net/home>

² Referred to as *mediatore linguistico-culturale*, *mediatore interculturale*, *mediatore socio-culturale*, *mediatore madre-lingua*, *interprete di comunità* or *interprete per i servizi sociali* (Mauriello, 2000, 121), following in the tradition of community or public service interpreting in Anglophone or Northern European countries (Hale, 2007; Carr, 1997).

courts and asylum procedures (Italian Decree laws 40/98, 286/98 and by the Italian Presidential Decree 394/99). Mediators usually belong to migrant communities, being first or second-generation citizens, they may not have Translation/Interpreting degrees (Falbo, 2013, 256), but they have native knowledge of the language and are identified as the true “cultural experts” (Luatti, 2011; Baraldi & Gavioli, 2012, 10–11). According to the extensive research conducted within the ReACTMe project, which is yet to be published, mediators seem to be receiving today professional training by Regional Authorities in the form of workshops and or short mediation courses, which also include mediation/interpreting techniques. Medical interpreters, on the contrary, are usually native speakers of Italian with specific training in the languages traditionally taught in Universities (English, French, Spanish, Russian) (Falbo, 2013, 256) who work in healthcare institutions either for foreign tourists and for migrant citizens when English and French are used as *lingua franca*. They master interpreting techniques and have sometimes completed a module or part of it in medical interpreting, but they may lack the on-the-job experience and the understanding of the migrants’ cultural and experiential background (Niemants & Bernardi, 2022). As for the actual provision of services, only a few healthcare institutions and/or hospitals in Italy have staff medical interpreters³ (examples are the Hospitals of Rimini and Riccione), while most have agreements with agencies or cooperatives that provide such services. Medical interpreters/mediators are therefore usually freelancers or employed by cooperatives (Barbieri & Raciti, 2021), called in for emergencies or scheduled consultations, according to the healthcare institution’s needs. Some hospitals and units also use on-demand telephone-interpreting services, thanks to agreements signed with cooperatives.

3. Literature review

Italy was one of the first countries in Europe to be substantially hit by the COVID-19 pandemic in February 2020 and, within a matter of weeks, the country went into total lockdown (hereinafter lockdown 1) in an effort to prevent the collapse of ICUs, while all non-emergency procedures, and consultations were cancelled. The lockdown ended on 4 May 2020, but in October 2020 partial lockdown measures (hereinafter lockdown 2) were introduced to counter the subsequent waves. In this second period, although healthcare institutions tried to guarantee basic services and catch up with the backlog, they were, at times, forced to limit access to non-COVID services when the number of infections increased. All around the world several reports have confirmed that the pandemic has impacted the provision of healthcare services, whether due to an overload of the healthcare systems or to restrictions to contain and mitigate contagion (OECD, 2021): in Australia, all non-urgent surgical services were cancelled until April 2020 (Australian Government Department of Health, 2020) and similar policies were introduced in the United States, Portugal and Chile (OECD, 2021), while in France outpatient surgical visits dropped by 80% between 15 March and 11 May 2020 (FHF, 2020). A systematic review (Moynihan et al., 2020) analysing data from 20 countries showed that health services were reduced by 37% on

³ All these staff interpreters are required to have a degree in Interpreting (Delli Ponti & Forlivesi, 2012).

average, including 42% fewer visits, 31% fewer diagnostics, 30% fewer treatments and 28% fewer hospitalisations. In Italy, a report by GIMBE (GIMBE, 2021) highlights how, in 2020, Italian healthcare institutions registered a reduction of 17% in hospitalisations and 20% in hospital consultations (including inpatient and outpatient visits, diagnostics, rehabilitation, treatment), with important differences between regions (-60% in Basilicata vs. -3% in the Autonomous Province of Trento). Another Italian survey suggests a decrease by 10 to 33% in emergency hospital services, more than 50% in oncological screenings and around 44% in medical consultations for chronic patients (Galimberti et al., 2021).

Consequently, COVID-19 has also reduced access to other healthcare services, like medical interpreting/mediation, thus potentially worsening inequalities in access to healthcare and susceptibility to COVID-19 (Civico, 2021, 5), although in depth scientific research is still needed. Between 2020 and 2021 news articles and a few academic publications reported that the pandemic has especially affected minority communities and that the lack of provision of language services due to COVID-19 resulted in poor management of patients, sometimes with fatal consequences (Kucirek et al., 2021; Diamond et al., 2020). In the U.S., the National Health Law Program has filed a complaint with the U.S. Department of Health claiming that federal, state, and local agencies are failing to provide LEP individuals meaningful access to COVID-19 services (National Health Blog Program, 2021). The American Translators Association claims that medical interpreting dropped by about 28% during the pandemic (ATA as quoted in Nimdzi, 2020). Even when remote interpreting is available, it is highly impacted by the healthcare providers' lack of time, the emergency situation and poor internet connections (Runcieman, 2020). In Italy, private organisations or NGOs, like Emergency (Emergency, 2020) and Intersos (Parisotto, 2021), have included mediators and interpreters in their COVID-19 support teams, but there is no mention to nor research on how Italian healthcare institutions managed language issues and the pandemic's impact on the right of individuals to receive care in a language they understand.

4. Methods

4.1. Participants

To obtain information on how COVID-19 has changed medical interpreting/mediation in Italy, researchers developed an online survey, "*Interpretazione e mediazione linguistica in ambito sanitario e COVID-19*" [in English: "Medical interpreting and mediation and COVID-19"]. To reach out to the largest possible number of professionals, convenience and snowball sampling techniques were used: the survey was sent to interpreters, between November 2020 and January 2021, through national interpreters and translators' associations, networks of colleagues, and companies that provide language mediation services, to reach out to all those mediators that are usually not registered with interpreters' and translators' associations. This approach to sampling was necessary given the lack of a formal Italian accreditation or centralized registry of interpreters/mediators. The survey call was

nevertheless distributed specifying that only those with present or past working experience in the medical settings were asked to participate. Out of the 308 professionals who filled in the survey, 301 did it in all (or most) of its parts, while 7 replied to less than 4 questions (demographics only) and were thus excluded from the total. As per participants' demographics, 68.6% of our sample have been working in the healthcare sector as interpreters/mediators for 2 to 10 years (31.4% less than 2 years, 46.4% 2-10 years, 22.2% for more than 10 years); 78.7% have some sort of qualification: 18% completed a BA or MA degree in interpreting/translation/mediation, 14.1% have followed unspecified training courses,⁴ while 46.6% have other degrees, ranging from the humanities to law and economics. As per the languages covered, 55 respondents were native speakers of Italian, 40 bilinguals (with Italian being one of the two mother tongues only in 8 cases), and 182 were native speakers of 50 different languages. Approximately 30 languages were represented: European and Eastern-European languages (such as French, Spanish, Polish, Albanian and Bulgarian), Middle Eastern and Asian languages (such as Chinese, Urdu, Bangla and Farsi) and African languages (Edo, Wolof and Bissa, among others), with Arabic and Albanian the most widely spoken languages. Most respondents work in hospitals (ER, wards, outpatient consultations, etc.), in the offices of the local health units (migrant services, etc.) and for health services provision centres (family planning centres, mental care centres, etc.), with the majority of them working in more than one of the above-mentioned settings.

4.2. *Procedures*

The survey was created on an online platform (www.sondaggio-online.com) and Italian was chosen as the survey language, as interpreters/mediators working in Italy should all share Italian as a working language. The survey was aimed to spoken language interpreters/mediators and not to sign language interpreters, although it would be interesting to conduct a similar survey with SLIs in the future. The time-frame to evaluate how COVID-19 had changed their workflow, was what is commonly known in Italy as lockdown 1 (March-April 2020) and lockdown 2 - (September 2020-January 2021) when non-covid healthcare services were partly guaranteed) - thus a limitation of this research is that the survey does not distinguish between the two types of lockdowns. The final draft of the questionnaire was administered to four colleagues for piloting, either academics and/or medical interpreters, whose feedback was collected, and changes were made relating to issues of readability, wording and use of jargon. The questionnaire was anonymous and confidential, and no incentive was provided to complete the survey.

4.3. *Measures*

The survey consisted of 28 questions and was divided into 4 parts. Part one (questions 1 to 6) defined the sample's demographics (*e.g.*, age, years of experience, native and working language(s), healthcare sectors in which interpreters/mediators most frequently work). Age bands identified reflect the three phases of professional life and the levels of experience

⁴ Probably regional courses mentioned in point 2.

one can achieve (18-30: no or almost no experience; 31-55 experience; over 56 extensive experience) and most importantly allowed us to single out the over-55 group, considered more at risk of COVID-19 at the time, to see if it correlated with work choices. On the downside, the second band covering almost double the years of the first and the third one led to misrepresentation in the data analysis phase, where it accounts for 65.3% of the sample, while less “linear” career paths are not considered. Part two (questions 7 to 13) assessed changes in interpreting frequency and mode before and during COVID-19, job rejection for fear of contagion and possible alternatives. To evaluate the decrease in the workflow four bands were used (1-2, 2-5, 6-10, more than 10 and no assignment per month) to analyse as carefully as possible the before/after COVID-19 workload changes, including those cases with few assignments even before the pandemic, despite the risk of granularity. Part three (questions 13 to 22) focused on alternative interpreting/mediation options and gathered interpreters’ feedback on their pros and cons through a mixture of multiple-choice, rating, matrix scale and open questions. In question 18 and 20, we proposed a list of advantages defined in the literature such as a) reduced emotional involvement - identified by Kelly (2008), and by interpreters/mediators interviewed in Focus Groups within the ReACTMe project as one of the biggest challenges of the job, as confirmed also by the relevant literature on vicarious traumatization and job-related stress (Bontempo and Malcolm 2012); - b) privacy (Kelly, 2008) c) time-savings (Kelly, 2008), and d) personal safety from COVID-19. Disadvantages identified were a) difficulty in doctor-patient interaction, due to more problematic turn-taking and overlapping (Oviatt & Cohen, 1992; Ozolin, 2011; Braun, 2015), b) increased job-related stress for the interpreter, which emerged from the above-mentioned Focus Groups; c) lack of visual clues (Andres & Falk, 2009; Braun, 2015), and d) technical issues (Causo, 2011; Amato et al., 2018). The identified categories do not cover the full scale of advantages and disadvantages identified in literature, but were only offered as an input, while in question 19 and 21, respondents had the chance to comment on them in open questions. Since the literature has underlined that trust is a prerequisite for interpreters in medical settings (Angelelli, 2004; Amato et al., 2018; Wadensjö, 2020), and that remote interpreting “may impede the interpreter’s efforts to [...] gain and maintain the patient’s trust” (Klammer & Pöchlacker, 2021) we inserted two questions (16 and 17) about trust. Part four (questions 23 to 27) inquired about the training received, or required, for both interpreters/mediators and healthcare professionals, while question 28 was an open-ended question for interpreters/mediators to freely express their views.

Quantitative data were organised in a spreadsheet and analysed statistically, while qualitative data from open-ended answers were manually coded with content analysis by the authors with a deductive approach, identifying the macro-categories that emerged more frequently from answers, which were later checked by other members of the research teams.

4.4. Analysis

Our analysis started with part 2, assessing changes in medical interpreting/mediation during the pandemic: in question 7, respondents stated that, before the pandemic, 51.3% had 1-5 monthly healthcare assignments, 37.4% 6-10+, while 11.3% stated not to have had any monthly assignments, probably meaning that they did not have a regular and consistent number of assignments per month. During the pandemic, the percentage of monthly assignments decreased (49% had 1-5 monthly assignments, 23.4% 6-10+) and the percentage of professionals with no regular monthly assignments increased from 11.3% to 27.7%. Figures show that respondents with 1-5 monthly assignments registered a job decrease by 2.3%, those with 6-10+ monthly assignments by 14%, with an overall decrease of job assignments being registered by 16.7% of respondents, whereas the percentage of professionals with no regular monthly assignments increased significantly by 16.4%. This shows that there was a general decrease by 17% in the workload, in line with the 20% decrease identified by GIMBE (GIMBE, 2021) and Galimberti (Galimberti et al., 2021). It must be noted that the survey was conceived to obtain data on a national scale and did not allow for assumptions on a regional basis and that respondents were asked to evaluate the change in their workload considering both lockdown 1 and 2: the decrease in workload during lockdown 1 was probably much higher than during lockdown 2, because all non-urgent consultations were cancelled, but the survey does not allow to consider them separately.

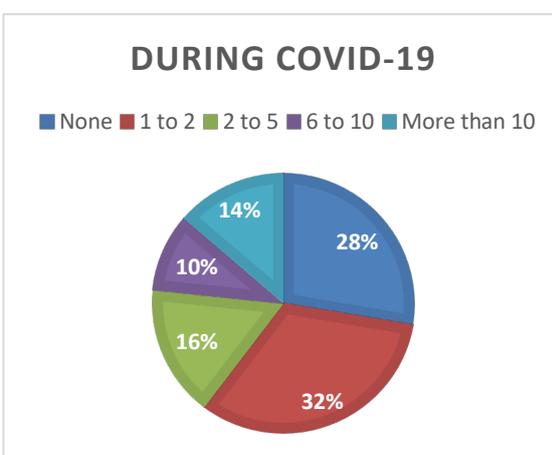
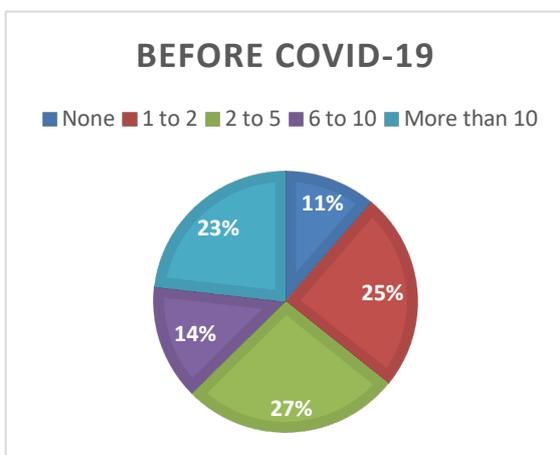


Fig 1 - Monthly assignments before the pandemic

Fig. 2 - Monthly assignments during the pandemic

Respondents declared that before the pandemic medical interpreting/mediation was performed only or mostly face-to-face (72.6%), only or mostly remotely (14.1%) both remotely and face-to-face (13.4%) whereas during the pandemic only or mostly face-to-face accounted for 41.5%, only or mostly remotely for 36.8% and both remotely and face-to-face for 21.6%. Despite the limitations of the sample, the figures show a shift towards remote interpreting: face-to-face interpreting/mediation dropped by 31.1% while remote interpreting rose by 22.7%, thus indicating that almost 22% of the face-to-face interpreting/mediation assignments cancelled were switched to remote and the percentage of professionals working both face-to-face and remotely rose by 8.2%.

In question 11, 30.7% of respondents indicated that they refused face-to-face assignments in healthcare due to concerns related to COVID-19 for themselves or their family members. Such an understandable concern was likely to be particularly relevant to medical interpreters/mediators who usually worked on-site and in contact with patients. Furthermore, they are generally freelancers and, as such, not entitled to the paid sick leave granted to employees. Also, 16.9% of the sample are 56 or more, a category that was identified as particularly at risk of COVID-19. When asked, in question 12, whether, in such cases, they were offered the possibility of working remotely, 34% state they were given the chance to work remotely, whereas 66% were not given any alternative.⁵

61.1% of respondents claim to have used audio-only solutions (phone calls), 13% audio-video solutions (remote-interpreting platforms) and 25.9% both. This might be due to the problems for public health institutions to swiftly adapt to the huge changes that COVID-19 has introduced in communication (also confirmed by question 12), both in terms of skills and appropriate tools, but also of the fact that telephone interpreting was already a well-established practice even before the pandemic (Barbieri & Raciti, 2021, 58).

The third set of questions (questions 14 to 22) collected interpreters' feedback on the advantages and disadvantages of these alternative medical interpreting/mediation modalities, namely telephone and platform interpreting and asked to assess them, considering a) the interpreter's experience, b) the trust relationship created with both the patient and c) the healthcare professional(s). 19.8% of interpreters/mediators judged their own remote experience positively (9.9% stated it was much better than face-to-face interpreting and 9.9% a bit better), 54.6% negatively (16.3% stated it was much worse than face-to-face interpreting and 38.4% a bit worse), while 25.6% expressed a neutral judgment.

⁵ Time.com reported that the 9 staff interpreters at Louisville Main Hospital decided to take unpaid leave when Covid-19 hit rather than work face-to-face due to concern for their safety and that of their families (Aguilera, 2020), although no scientific work has analyzed the issue so far neither for healthcare workers nor interpreters.

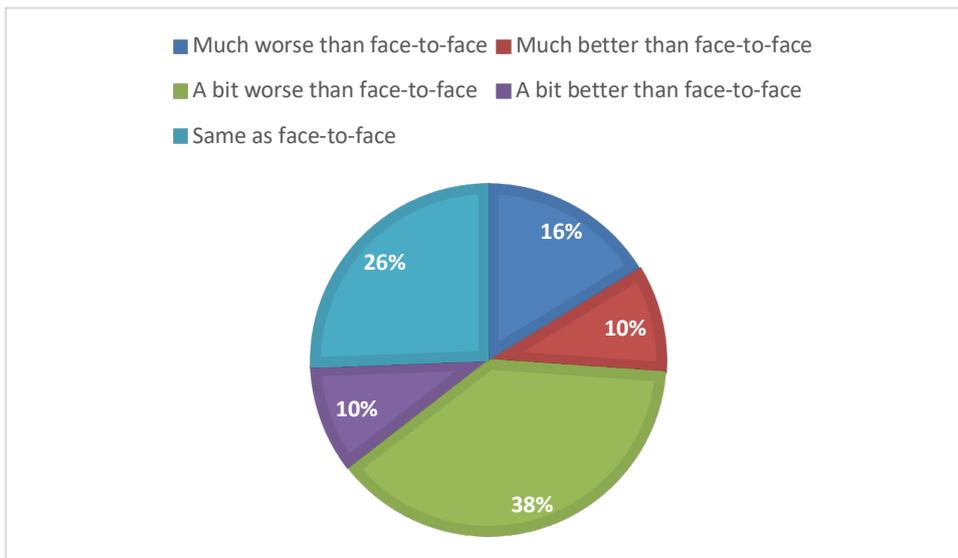


Fig. 3 – Perception of remote interpreting/mediation

When asked about the trust relationship established with patients while working remotely, 45.3% of respondents stated that it was more difficult, 17.2% easier and 37.5% found no real difference. The results were slightly different when they were asked to assess the trust relationship established with healthcare professionals: it did not make any significant difference for 45.8% of them, it was easier for 25% and it was more difficult for 29.1%. Therefore, interpreters/mediators apparently find it harder to establish trust with patients than with healthcare professionals in remote assignments.

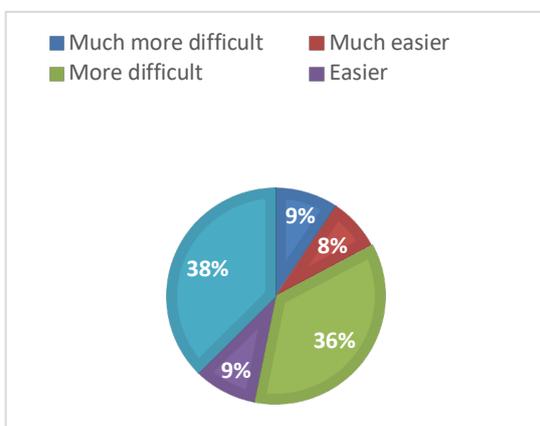


Fig. 4 – Creating trust with patients

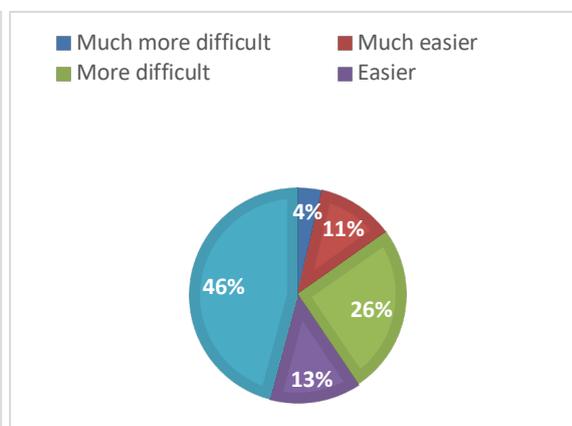


Fig. 5 – Creating trust with healthcare professionals

In matrix question 18, respondents were asked to evaluate potential advantages for audio-only and audio-video remote solutions separately. Results show that both modes have the same advantages, listed as, in order of importance, time savings, more privacy, interpreter’s safety and less emotional involvement. The only difference between the two sets of data is that for audio-only solutions personal safety and emotional involvement are judged to be equally important in remote interpreting/mediation, ranking 2nd and 3rd before privacy, while for audio-video solutions, privacy and emotional involvement rank 3rd and

4th with the same number of votes after personal safety. The number of respondents who commented on audio-video solutions is lower: while 89 respondents identified advantages of audio-only solutions, 40 commented on medical interpreting/mediation using remote platforms, which might be linked to the fact that these haven't been so frequently used in healthcare settings yet. Such a perception of remote interpreting solutions in the healthcare setting is also confirmed in the 66 comments to the open question, where answers varied, but revolved mainly around three main advantages: more flexibility and less time and money spent on travelling (41 comments) – especially since the average pay per interpreter assignment is often not high in Italy – safety (12 comments) and the possibility to accept more assignments also in other areas (7 comments). On this last point, remote medical interpreting is considered an advantage for healthcare institutions as well, as it can solve, for example, the problem of finding the right interpreter/mediator for specific languages, especially in rural areas, as one interpreter/mediator points out:

“I live in a small town near Trento, most of the time I turn down assignments because the pay is low, and the main hospitals are quite far from here. Remote medical interpreting offers you the chance of providing the service throughout Italy. Call it a huge call centre if you want. But it was most needed” [our translation].

Six respondents explicitly mention that remote solutions improve access to high-quality healthcare for foreign and immigrant patients: “Before COVID, sometimes, healthcare professionals would simply give up whenever they could not find a mediator and now the patient is offered the chance of having the same interpreter for a set of consultations” [our translation]. Remote interpreting can therefore become a tool to access interpreters in other regions, which is especially important for rare or less-spoken languages, or to have the same interpreter/mediator for a set of consultations, guaranteeing more continuity.

Interestingly, in both the matrix (where the option “no advantage” was ticked, for both modes, by 15% of respondents) and open question on advantages, interpreters and mediators anticipated their dislike for remote interpreting, with 11 of them stating that it is too impersonal and ineffective in serious cases. In question 20, among the disadvantages proposed, a clear distinction is made between audio-only and audio-video solutions. Namely, the main disadvantages for audio-only solutions were ranked as follows: lack of visual cues, difficulties in the doctor-patient relationship, technical issues and more stress for the interpreter. The main disadvantages for audio-video solutions (platforms) were ranked as follows: technical issues, more stress for the interpreter, difficulties in the doctor-patient relationship and lack of visual contact, thus confirming the issues underlined in the literature (Andres & Falk, 2009; Braun, 2015; Oviatt & Cohen, 1992; Ozolin, 2011). Technical issues are identified as specifically problematic in both modes but rank first in audio-video mode and last in the audio-only mode where “sound quality, poor internet connection, disturbed signal transmission or use of microphones, headsets and loudspeakers [may be] distorting the original audio” (Amato et al., 2018, 21). This confirms

that the skills required to use remote platforms, and probably the quality of remote interpreting solutions, are still unsatisfactory, an issue that emerges later in the questions, specifically on training. Although the literature has not come to a straightforward conclusion, our interviewees seem to prefer video to telephone interpreting, at least in terms of visual cues, interaction and stress for the interpreter, a slight preference also underlined in recent studies on the topic (Joseph et al., 2018; Locatis et al., 2010). In the open question, interpreters confirmed that, next to technical issues due to poor infrastructure and the lack of IT skills on the part of some healthcare workers, the main disadvantages are: difficulty in establishing a relationship of trust with patients through visual contact and onsite presence and the impossibility of interacting before and during the consultation, which is detrimental to the service offered to patients, especially those with mental health problems, as already confirmed by Price et al. (Price et al., 2012). They also mention a lack of empathy, which they deem necessary for the job, as also underlined in the literature (Merlini, 2019; Krystallidou et al., 2020) and the difficulty of picking up on and conveying non-verbal communication:

“Interpreting [...] should be like teaching, a multisensory experience. Body language helps a lot in creating empathy with the listener. Active listening is much more satisfying and productive. The remote limits it. But, in the end, you put yourself to the test and must try to “produce” the “pathos” that you don’t have in the remote interpreting” [our translation].

In question 22, 61.5% of respondents confirm that they would prefer to work face-to-face when the COVID-19 pandemic is over for the above-mentioned reasons. Unfortunately, though, the survey’s structure did not allow us to assess whether this might also be linked to the respondents’ age – 82.2 % of respondents are over 31, while younger generations (18-30) only accounted for 17.9% of the sample – which would be interesting to consider, maybe in a couple of years, if remote solutions continue to be used.

Part four (questions 23 to 27) focused on the training received or required, for both interpreters and healthcare professionals. 66.7% of respondents stated that they did not receive any training for working remotely, while 33.3% claim to have received training, though a limitation of the study is that it was not possible to specify what kind of training: it would have been useful to know whether they referred to platform training made available for free by platform providers or to specific training programs by their healthcare institution or cooperatives. According to 72.5% of the respondents, healthcare professionals did not receive any training on working remotely with interpreters/mediators and such training is considered helpful for both interpreters/mediators (77.6% of respondents) and healthcare professionals (82.2% of respondents). In open question 27, respondents were asked to identify issues to be approached in potential remote medical interpreting/mediation training and they claim that the most important aspects to be covered are technical issues and remote communication (how to improve the relationship with the patient, ensure empathy, perform sight translation, establish eye contact, make up for non-verbal cues, obtain more information on the case and explain healthcare and

administrative procedures). They state that such training would be beneficial for both language and healthcare professionals, but that the latter should be trained to make a better use of IT tools, adapt the way they speak to the remote mode (length of speech, use of deictics and turn-taking) and establish briefing/debriefing sessions in which interpreters/mediators have the chance to provide cultural explanations and feedback.

In the last question (28), respondents were allowed to freely express their views on how the COVID-19 pandemic has impacted medical interpreting/mediation: their comments generally focus on the reduction of monthly assignments. Interpreters/mediators describe their job in negative terms (20 out of 60) and as more difficult, even in presence, as consultations have become shorter and more superficial because of healthcare professionals' time-pressure which results in a lack of understanding, empathy and trust. They also claim that they sometimes refused assignments because they lacked transportation options during lockdowns. Other reflections include disadvantages of remote interpreting/mediation such as: lack of visual cues, technical issues, overlapping of several professionals in the same "physical" room who the interpreter/mediator is often not able to see, lack of empathy and trust, a general sense of discomfort.

5. Conclusions and recommendations

Before moving on to the conclusions of this contribution, we should point out that the study has a series of limitations. First, given the response rate and sampling technique, this study cannot be considered a census of the entire Italian medical interpreter/mediator community; rather, the study seeks to provide a general view to the extent possible of the perceptions and challenges of interpreters working during this time frame and in these settings. Secondly, the survey questions and items were not pilot tested given the time-sensitive nature of conducting this survey as the pandemic unfolded. As a result, additional research is needed to confirm the findings presented here, particularly to examine the differences that might emerge between the different lockdowns and across regions. Nevertheless, our research showed that from March 2020 to January 2021 medical interpreting/mediation fell by 17%, in line with the average 20% decrease in access to healthcare services for all Italian citizens. We believe, nevertheless, that the attempt to prevent contagion resulted in increased difficulties for vulnerable groups that may have experienced greater discomfort in obtaining and understanding COVID-19 information especially in communication with COVID-19 helplines and in isolation, when they could not have a 'friendly' voice in their own language, or even traditional family language support (e.g., children, spouses, etc.).

The pandemic has also led to an increased use of remote interpreting/mediation, mainly telephone interpreting, which had already been in use, and video interpreting although remote platforms appear to be still underused. These solutions came with a set of advantages and disadvantages, the latter identified by respondents mainly as lack of visual

clues, difficulty in establishing trust and technical issues. Respondents also stated that specific training should be provided to language and healthcare professionals on both technical issues and on how to adapt mediated communication to the new context. Although on-site interpreting/mediation is the preferred option, the pandemic has increased the use of remote interpreting/mediation and it is imperative that both language and healthcare professionals learn how to better adjust their work in this new setting and best use these tools. Remote interpreting/mediation, if properly used, could become, in healthcare settings, a tool for greater equality and wider social inclusion, especially for rare languages or for healthcare institutions in remote areas.

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Appendix 1. Survey list of questions

- 1) How old are you?
 - 18–30
 - 31–55
 - 56 or more
 - 57

- 2) How long have you been working as a medical interpreter/mediator?
 - Less than 2 years
 - 2–10 years
 - More than 10 years

- 3) What degree or qualification do you have in the mediation/interpreting field?
 - None
 - Training course (Specify)
 - Degree (Specify)
 - Other

- 4) What is your mother tongue? (Open question)

- 5) What are your working languages? (Specify) (Open question)

- 6) For which healthcare service and/or institution do you work? (Multiple answers possible)
 - Hospitals (ER, wards, outpatients' consultations, etc.)
 - Local health units' offices (migrants' services, etc.)
 - Health services provisions (family planning centres, mental care centres, etc.)

- 7) How many interpreting/mediation assignments did you have before COVID-19 pandemic monthly?
 - 1–2
 - 2–5
 - 6–10
 - More than 10
 - None

- 8) Before COVID-19 pandemic such interpreting/mediation assignments were performed
 - Exclusively (or almost exclusively) face-to-face
 - Mostly face-to-face
 - Both remotely and face-to-face

- Mostly remotely
Exclusively (or almost exclusively) remotely
- 9) How many interpreting/mediation assignments did you have since COVID-19 pandemic monthly?
- 1-2
 - 2-5
 - 6-10
 - More than 10
 - None
- 10) Since the COVID-19 pandemic such interpreting/mediation assignments were performed
- Exclusively (or almost exclusively) face-to-face
 - Mostly face-to-face
 - Both remotely and face-to-face
 - Mostly remotely
 - Exclusively (or almost exclusively) remotely
- 11) Since the COVID-19 pandemic, have you refused a healthcare interpreting assignment due to health concerns for yourself or your family?
- Yes
 - No
- 12) If you answered yes to the previous question, were you offered the possibility to work remotely?
- Yes
 - No
- 13) If you have had assignments in remote modes, how were they performed?
- Audio-only
 - Audio-video
 - Both
- 14) How often have you used the following remote interpreting solutions?
- | | Never | Rarely | Sometimes | Often | Always |
|-------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Audio-only | <input type="radio"/> |
| Audio-video | <input type="radio"/> |
- 15) From the interpreter/mediator's perspective, do you think that working remotely was
- Much better than face-to-face
 - A bit better than face-to-face
 - Same as face-to-face

- A bit worse than face-to-face
- Much worse than face-to-face

16) How would you describe the bond of trust with the patient when working remotely?

- Much more difficult to create
- More difficult to create
- There is no difference
- Easier to create
- Much easier to create

17) How would you describe the bond of trust with the healthcare professional when working remotely?

- Much more difficult to create
- More difficult to create
- There is no difference
- Easier to create
- Much easier to create

18) Which of the following advantages have you identified, if any?

	Audio-only	Audio-video
More privacy	<input type="radio"/>	<input type="radio"/>
Less emotional involvement	<input type="radio"/>	<input type="radio"/>
Time savings	<input type="radio"/>	<input type="radio"/>
Personal safety	<input type="radio"/>	<input type="radio"/>
No advantage	<input type="radio"/>	<input type="radio"/>

19) Which other advantages does the remote working mode offer? (Open question)

20) Which of the following disadvantages have you identified, if any?

	Audio-only	Audio-video
Difficult doctor/patient interaction	<input type="radio"/>	<input type="radio"/>
More stress for the interpreter	<input type="radio"/>	<input type="radio"/>
Lack of visual cues	<input type="radio"/>	<input type="radio"/>
Technical issues	<input type="radio"/>	<input type="radio"/>
No disadvantage	<input type="radio"/>	<input type="radio"/>

21) Which other disadvantages does the remote working mode have? (Open question)

22) In normal circumstances (with no ongoing pandemics like the COVID-19 one) which would be your preferred working mode?

- Face-to-face
- Remotely
- No preference

23) Were you offered training to work remotely in the healthcare sector?

Yes

No

24) If you answered no, do you think it would have been useful to receive training on working remotely in the healthcare sector?

Yes

No

25) Did the healthcare professionals receive training to work remotely with healthcare interpreters/mediators?

Yes

No

26) If you answered no, do you think it would have been useful for healthcare professionals to receive training on working remotely with healthcare interpreters/mediators?

Yes

No

27) If you think that interpreters/mediators and healthcare professionals should be trained to work together remotely, on which aspects should the training focus? (Open question)

28) Here you can freely express your view on how the COVID-19 pandemic has impacted healthcare interpreting/mediation services (Open question)

Thank you for taking part in the survey!