REVUE INTERNATIONALE D'ÉTUDES EN LANGUES MODERNES APPLIQUÉES

INTERNATIONAL REVIEW OF STUDIES IN APPLIED MODERN LANGUAGES

Supplément au numéro 14 / 2021

Actes de la 19ème Conférence internationale
Traduction, interprétation, temporalité

Cluj-Napoca, le 16 octobre 2020

RIELMA, Supplément au numéro 14

Publicaţie LMA sub egida CIL

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ISSN 1844-5586
ISSN-L 1844-5586

Tiparul executat la:
S.C. ROPRINT S.R.L.
400188 Cluj-Napoca • Str. Cernavodă nr. 5-9
Tel./Fax: 0264-590651 • roprint@roprint.ro

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Medical Interpreting – A Race against Time

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Abstract. There are several factors that make medical interpreting particularly difficult, ranging from the emotional burden interpreters have to bear to terminological problems, from ethical issues to role confusion and relational complications. Interpreting tasks are made even more complicated by time constraints. In emergency situations time may even be a matter of life and death, so finding ways to avoid the wasting time is essential.
This paper looks at ways new technologies are currently used to improve medical interpreters' reaction times in the most advanced countries in this field (US, UK, Australia and Canada) and in the three countries participating in the ReACTMe project: Spain, Romania and Italy. The situation is examined from the point of view of the advantages and risks of using remote interpreting in medical settings, of the availability and efficiency of existing tools, and, last but not least, of the possible improvements in the countries of our project.
The aim is to identify and disseminate methods and practices that can aid healthcare institutions and provide the basis for new training programmes that make full use of the different modes of remote interpreting.
Keywords: medical interpreting, over-the-phone interpreting (OPI), video remote interpreting (VRI), remote consecutive, remote-simultaneous

INTRODUCTION

Interpreting is a profession in which time is a central element because communication needs to be fast and efficient. In a healthcare setting, time can become an even more important element for several reasons. In a medical emergency, immediately *finding an interpreter* with the right language combination can sometimes be difficult, and even when the interpreter is found, s/he will have had *no time to prepare* for the specific assignment. There is also a considerable *risk that the situation may rapidly change*, with all the terminological and ethical implications this entails.

Modern technology can be highly beneficial, however, making it quite easy, at least in theory, to solve several problems. And interpreting, as it has done in the past, has taken advantage of the technological advances, "motivated by a desire for

enhancement of productivity and a widening of service capability, with or without commensurate improvements in job satisfaction" (Hlavac, 2013: 35). The methods currently used are "remote-simultaneous" and "remote-consecutive" interpreting. According to Ruiz Mezcua (2018: 10) "[r]emote interpretation happens when the interpreter is not in the same room with the rest of the participants. This means that the interpreter needs a piece of equipment or tool to be connected to the speakers", which can be either telephones or video technology. The first method, called over-the-phone-interpreting (OPI) or telephone-based interpreting, following Braun's terminology, "emerges as a cover term for remote interpreting via telephone and working in interpreter-mediated telephone calls" (Braun, 2015: 353). While the second method, called video remote interpreting (VRI), "refers to the use of video links to gain access to an interpreter in another room, building, town, city or country. In other words, the video link is used to connect the interpreter to the primary participants, who are together at one site"[1].

Remote interpreting makes it possible to significantly reduce response times, even in emergency situations, by increasing interpreter availability, including those of rare languages (GDISC, 2017, as cited in Braun, 2015: 359). It also eliminates, or at least significantly reduces, the risk of ad hoc interpreters being used (usually patients' relatives or friends), with no training in interpreting (not to mention medical interpreting) or familiarity with even the basic principles of a professional code of ethics, first and foremost, impartiality and confidentiality, which are of paramount importance in a medical setting.

This paper looks at how new technologies are currently being used to improve medical interpreter reaction times from three different perspectives:

- advantages and risks of using remote interpreting in medical settings;
- availability and efficiency of existing tools in different countries;
- possible improvements in Italy, Spain and Romania.

These are the three countries taking part in the ReACTMe Project on medical interpreting, involving six European universities[2]. While the three main goals of the project are research, training and the development of pedagogical materials, it is also concerned with raising awareness about the interpreting profession among both healthcare staff and patients. By examining the state-of-the-art of remote interpreting in healthcare settings in the most advanced countries in this area (Australia, Canada UK, US) considering the fact that they were the first to implement remote interpreting (Braun, 2015; Lázaro Gutiérrez, 2021), the aim is to identify and disseminate methods and practices that can aid healthcare institutions and provide the basis for new training programmes using remote interpreting modes in the three countries.

[1] http://wp.videoconference-interpreting.net/?page_id=8

[2] For more information concerning this Erasmus+ project (2019-1-ES01-KA203-064439), please visit http://reactme.net/home

REMOTE INTERPRETING

Remote interpreting (RI) is where the interpreter is not physically present with the primary parties in an interaction mediated by an interpreter. The enormous improvements made in ICT, resulting in access to quality equipment and fast, reliable connections at affordable prices, has meant that RI has become increasingly common in many fields of interpreting, including medical interpreting. The two forms of RI most frequently used in medical settings are OPI and VRI, as previously mentioned. The medical interpreting industry was already heading towards a greater use of RI even before COVID-19, but the pandemic has dramatically accelerated this transformation[3].

Telephone interpreting was first used systematically in Australia, where the OPI Service was introduced in 1973, initially offering eight languages (Ozolins, 1998), but, by 2010, was providing almost one million OPI assignments a year (Ozolins, 2011: 33). The use of OPI spread to other countries, increasing considerably during the 1990s with the telephony revolution and steep fall in costs (*ibidem*: 34), and is now widely used in healthcare settings in many countries. The enormous improvements in broadband Internet connections and the hardware needed (PCs, headsets etc.) has also resulted in an ever greater use of VRI in recent years. However, as Barbara Moser-Mercer highlighted in her study on remote simultaneous interpreting, until now it is interpreters who have always had to adapt to changes in the way they work, including the use of RI: "While many jobs can be considered as having been designed at some point in time, interpreting falls more into the category of jobs that have evolved over time, with each major innovation […] requiring a major adjustment on part of those carrying out the job" (2005: 143). This is also true of both OPI and VRI in healthcare settings, as specific training is manifestly lacking[4].

For Language Service Providers (LSPs) and healthcare administrators, the main advantages of using OPI and VRI in healthcare settings are blatantly evident: above all, lower costs (there are no travel expenses) and the potential almost immediate availability of experienced interpreters in virtually any language or dialect, including minority languages[5], given that interpreters can be located even in

[3] In the US, for example, a recent survey carried out by CSA Research revealed that there was a 40% decline in revenue from on-site interpretation in healthcare settings, while OPI more than doubled and VRI more than tripled. It was stressed, however, that the pre-pandemic baseline for remote interpreting was very low (Heilweil, 2020).

[4] The *SHIFT in Orality* Erasmus+ project is one recent initiative that attempts to address this problem.

[5] As the UK LSP Asian Absolute underlines on its website, however, serious LSPs require some advance notice so they can locate a specialist interpreter rather than a generic one, (https://asianabsolute.co.uk/blog/2020/09/23/8-keybusiness-benefits-of-video-remote-interpreting/

another country. During the pandemic another major advantage of RI has been that it has enabled continued access to healthcare services in a COVID-safe way[6].

When comparing VRI with OPI in healthcare settings, an obvious advantage of VRI is that it provides a visual connection, enabling interpreters to read body language and observe hand and facial gestures, making it more similar to face-to-face healthcare interpreting encounters.

However, the fact that interpreters who work over the phone are missing visual signs does not necessarily imply a reduced quality of interpreting performance as interpreters are "able to process many non-verbal cues, such as hesitations, inflection, tone of voice, and vocal volume" (Kelly, 2007: 83)[7]. Managing turn-taking in the absence of non-verbal elements is clearly more complicated, but, with training and experience, can still be managed effectively (Kelly, 2007: 44-47; Spinolo et al., 2018: 18-19).

The lack of visual clues may sometimes even offer advantages, not only in terms of privacy, especially in delicate situations where the presence of interpreters can embarrass patients, but also as regards factors such as discrimination due to skin colour and ethnicity (Kelly, 2007: 85-86). OPI should, however, be avoided, wherever possible, when involving "children, the elderly, the hard of hearing, and the mentally ill" (*ibidem*: 87) or in the delivery of sensitive news or when critical procedures are performed[8]. Another specific difficulty of OPI is compliance with the impartiality requirement, as interpreters may find themselves on the line with just one of the parties, who may ask for approval or support in delicate situations. Although this problem is not specific to OPI, it does raise specific issues as regards the norms for telephone discourse since "refusing to partake in a conversation may carry more weight on a telephone that in a face-toface situation" (Ozolins, 2011: 45).

The main disadvantages of RI for interpreters appear to be, above all, an increased psychological strain and sense of alienation (Moser Mercer, 2005:145; Mouzourakis, 2006), increased fatigue, the expectation that they are available 'at the push of a button', lower remuneration, loss of status (Braun et al., 2018: 42; Wang, 2018) and difficulties in creating a rapport (Spinolo et al., 2018: 13).

As for user satisfaction, reviews of various studies reveal that there does not appear to be a preference for one particular mode of interpreting. However, many of the studies carried out refer to the US and a Spanish-speaking cohort (Corey et al., 2017), where interpreters tend to be well-qualified and with considerable experience.

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[6] See, for example, https://theconversation.com/remote-interpreting-services-are-essential-for-people-with-limitedenglish-during-covid-19-and-beyond-143531 (Mullan, 2020)

[7] To support this, Kelly mentions the work of blind interpreter: "To date, no evidence has been provided to support the idea that a blind interpreter's lack of ability to process visual cues affects his or her ability to render a high-quality interpretation" (Kelly, 2007: 84).

[8] This was a recommendation made by the Minnesota Department of Health concerning VRI, but it clearly refers equally to OPI. Cf Report to the Minnesota Legislature 2015: 95.

Interestingly, in some studies patient satisfaction of telephone or video interpreter services compared with in-person services was even higher (Crossman et al., 2010).

It is clear that the use of RI in medical encounters is going to increase in the future. The general consensus is that there is a need for further research in this field and that specific training is required not only for interpreters working in this mode of interpreting, but also for those using these interpreting services (Braun, 2015: 10; Kelly, 2007: 84; Braun et al, 2018: 43; ITI position paper) to manage and overcome the specific difficulties of this mode of interpreting (Amato et al., 2018: 8).

The situation in countries considered to be leading countries in the provision of interpreting services and RI is examined in the following section.

REMOTE INTERPRETING IN LEADING COUNTRIES

What are generally considered to be the leading countries in this area – Australia, Canada, the US and the UK – have been using RI for some time and now have well-organised services, in particular for sign-language interpreting, providing 24/7 access, even in rare languages. Key features of the RI services offered in these countries are, therefore, examined. The main common denominator in these countries is the existence of bodies at a national level for the certification and/or accreditation of interpreters, also specifically in the field of healthcare, and a generally recognised professional code of ethics[9], guaranteeing the quality of the interpreting services provided. Together with the relatively long experience of these countries in RI, above all OPI, this results in a clear distribution of roles and clear procedures to be followed when an interpreter is needed.

Legislation and codes of ethics

While legislation ensures the right of patients to be assisted by an interpreter in a medical encounter, whatever their economic situation, a code of ethics in medical encounters not only helps guarantee the quality of the interpreting service provided, but also creates consistency and lessens arbitrariness in the choices made by medical interpreters when confronted with difficult dilemmas (Dueñas Gonzáles et al., 1991).

In Australia, health practitioners are responsible for assessing a patient's need for an interpreter and hiring the interpreter (members of the public cannot book healthcare interpreters). LSPs providing interpreters for healthcare encounters usually state that they use 'certified interpreters'.

[9] The National Council on Interpreting in Healthcare defines a code of ethics as "a set of principles or values that govern the conduct of members of a profession while they are engaged in the enactment of that profession. It provides guidelines for making judgments about what is acceptable and desirable behavior in a given context or in a particular relationship" (NCIHC, 2002).

The national certification body for interpreters in Australia is the National Accreditation Authority for Translators and Interpreters (NAATI), with their certified interpreters considered at the necessary level to interpret in healthcare settings. There is also a higher, more specialist level, Certified Specialist Health Interpreters (CSHI)[10], where the interpreters must also undertake continuous professional development. All certified interpreters must follow the code of ethics of the Australian Institute for Interpreters and Translators (AUSIT) (Dragoje, Ellam, 2020), which is endorsed by NAATI and many other organisations. The New South Wales Ministry of Health (NSW Health) provides very clear guidelines for staff working with healthcare interpreters. It is the responsibility of the interpreters to ensure that they are in a private space where no one else is present while they perform OPI or VRI. When interpreting is provided via a video link, it is essential to ensure that patients and their carers or family members have easy access to video equipment, such as a tablet or smartphone at the patient's bedside or in a private consultation room, whilst still ensuring privacy and confidentiality. Healthcare interpreters should be briefed before and debriefed after each RI session. At the start of the session, healthcare practitioners should explain the context and introduce the participants to one another. Healthcare practitioners are also responsible for establishing the rules of communication and ensuring that everyone can hear and understand one another. Moreover, the patient's medical record should include the interpreting medium used during the encounter (i.e. telephone or video). When an OPI interpreter is hired, the OPI job reference number should be also recorded in the medical record (NSW, 2017).

While the interpreting profession is well regulated in Canada, with clear specifications regarding ethics and confidentiality in the codes of ethics of professional associations and companies providing interpreting services, there is no Canadian regulatory body for medical interpreting and no specific rules of ethics regarding remote medical interpreting. The Canada Health Act, passed in 1984, states that "The primary objective of Canadian healthcare policy is to protect, promote and restore the physical and mental well-being of residents of Canada, and to facilitate reasonable access to health services without financial or other barriers", implying the obligation to provide interpreting services where necessary, but "There is no specific legislation mandating provision of language services in other than the two official languages, except for criminal proceedings" (Bowen, 2011: 29). Given the lack of general rules, various bodies give their own indications, such as the recommendation of William Osler Health System's Health Equity and Inclusion Office that OPI only be used for appointments under 40 minutes. Other than that, it is presumably considered that the general interpreting rules of ethics apply.

[10] https://www.naati.com.au/become-certified/certification/certified-specialist-health-interpreter/

In the UK, the Department of Health and Social Care is responsible for government policy on healthcare, with certain differences between England, Wales, Scotland and Northern Ireland, but the actual delivery of healthcare is provided by National Health Service (NHS) trusts. However, there is no national legislation specifically requiring these trusts to provide interpreting services for people who are unable to communicate in English, with the obligation to provide interpreting services deriving most recently from the Equality Act 2010 (González Núñez, 2016). Nevertheless, there are numerous documents published by NHS trusts that specifically refer to the obligation of confidentiality on the part of interpreters. For example,

> It is the policy of Wrightington, Wigan and Leigh NHS Foundation Trust to only use professional interpreters and translators who are bilingually competent, neutral, independent and professionally trained. In the interests of accuracy, confidentiality and accountability, the use of staff, friends or family members and on-line translation websites in clinical situations is not acceptable, unless there are exceptional circumstances[11].

The Mid Essex Hospital Services NHS Trust is even more explicit in its interpreter guidelines: "The Trust only uses authorised and appropriately trained interpreters […]. All the trusts follow a code of practice which includes the requirement that information is kept confidential". Moreover, a government website states specifically that NHS 111 "can provide a confidential interpreter covering a wide range of languages for those using the service"[12].

In the US there are different laws dealing with language access. The first and most important is Title VI of the 1964 Civil Rights Act, Executive Order 13166 that requires Federal Agencies to develop systems to improve access to their programmes and services for persons with Limited English Proficiency (LEP) (Jacobs et al., 2018). In addition to various federal laws dealing with language access and, therefore, the right to be assisted by an interpreter, such as Medicare Regulations for Medicare Advantage Program and the Medicaid Managed Care Requirements, there are also numerous laws on language access, not only at State level, but also at a local level, such as New York City. The US is one of the most advanced countries in terms of codes of ethics for medical interpreters. The first was drafted by the International Medical Interpreters Association (IMIA) and was translated into 11 languages. IMIA members have to abide by the code of ethics[13]. In 2004, the National Council on Interpreting in Health Care (NCHIC) drafted a national code of ethics after doing a systematic review of existing code of ethics[14].

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[11] https://healthdocbox.com/83165962-Deafness/Interpreting-and-translation-policy-policy-name-version-number-3-date-this-version-approved-april-2017-ratifying-committee.html

[12] https://www.gov.uk/guidance/language-interpretation-migrant-health-guide

[13] IMIA Guide on Medical Interpreter Ethical Conduct (available at: https://www.imiaweb.org/uploads/pages/376_2.pdf)

[14] NCHIC – National Code of Ethics for Interpreters in Health Care (available at: http://www.ncihc.org).

Availability of interpreting services

In terms of the availability of interpreting services, there are certain differences between the different countries, but all provide RI to some extent.

Australia's VRI service NABS[15] allows medical practitioners to book a remote interpreter for video consultations to supplement the generally available OPI, which provides 24/7, year-round services "for the cost of a local call" for anyone in Australia. There is also the 2M lingo platform[16] which combines VRI, on-site scheduling and all the necessary services in a one-stop platform, which improves response times and reduces costs.

In Canada, there is a variety of providers: single centrally-coordinated interpretation services, as in British Columbia and Alberta (Sultana et al., 2018)[17], individual hospitals[18], healthcare organisations, health authorities (ibid), programmes such as Toronto Central LHIN[19], and a community health centre called Access Alliance, which developed the Remote Interpretation Ontario Network (R.I.O. Network). This network, shared with other Canadian non-profit community interpreting agencies, is a collaborative call centre. It integrates local resources and provides a high quality and affordable alternative for on-demand immediate OPI services. The call centre is resourced by each collaborating agency with their own interpreters for the languages most in demand in each region. R.I.O. is backed by LanguageLine Solutions (LLS), the world's largest OPI provider[20]. CanTalk is another major player in the field of over-the-phone interpreting[21]. Remote sign-language interpreting also seems to be particularly well-developed in Canada[22]. Access Alliance offers language interpretation in over 150 languages, 24/7[23]. These services can be accessed via a phone number, email address and, since 2013, Staffpoint software[24]. Language Services Toronto and CanTalk provide interpretation in over 200 languages and can be contacted any time over the phone[25]. There are also smaller-scale services, such as the Interpreter Services Department at

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[15] https://www.nabs.org.au/video-remote-interpreting--vri-.html

[16] https://www.2m.com.au/2mlingo/video-remote-interpreting/

[17] https://www.wellesleyinstitute.com/wp-content/uploads/2018/04/Language-Interpretation-Services-in-theGTA.pdf

[18] One example is the Hospital for Sick Children (SickKids), affiliated with the University of Toronto https://www.sickkids.ca/en/patients-visitors/language-interpretation-services/

[19] http://www.torontocentrallhin.on.ca/

[20] https://accessalliance.ca/access-alliance-language-services/our-language-services-solutions-without borders/remote-interpretation-ontario-network-r-i-o-network/

[21] https://cantalk.com/language-services/immediate-over-the-phone-interpretation/

[22] See, for example, https://www.chs.ca/service/chs-interpreting-services, http://www.aslia.ca/video_remote_interpreting.html

[23] https://accessalliance.ca/access-alliance-language-services/remote-interpretation/

[24] https://www.slideshare.net/AACommunications/staffpoint-simulation-workshop-presentation-dec-2013-final

[25] https://www.interpreterservicestoronto.ca/services/interpretation/, https://cantalk.com/ languageservices /immediate-over-the-phone-interpretation/

SickKids, where interpretation is provided by ten staff interpreters in ten languages, including ASL. Interpreters can also be found in the Directory of Accredited Community Interpreters of the Ontario Council on Community Interpreting, which contains contact details and sometimes their specialisation[26].

In the US, many hospitals have their own language departments with staff interpreters for certain languages. However, the use of RI has increased as a result of the pandemic. Yale New Haven Hospital, for example, reported an increase in the number of cases dealt with using telehealth, involving the use of telephones and a device called the iPole (portable carts with screens as heads used to display video interpreting services) (Tahui Gómez, 2020). They use VRI carts and iPads to communicate with patients, where patients and healthcare professionals are in the same place, while the interpreters interpret remotely from a different location. One of the main providers of RI is LanguageLine Solutions, offering both OPI and VRI. Another important LSP in medical settings is Lionbridge, but there are many others that could be mentioned[27].

It should also be mentioned that in both the US and Canada, there are large companies that collaborate within very well-organised networks[28].

In the UK, the NHS trusts provide a variety of documents, in addition to their annual reports, including guidelines concerning the use of interpreters. In a document describing the interpreting and translation policy of the Mid Essex Hospital Services NHS Trust, for example, it states very clearly that, "[t]elephone interpreters should be used in all cases excluding where exceptions require face to face". Trust reports also mention the use of VRI, but no quantitative data is provided as regards the provision of this service. In all the cases examined, the interpreting services are delivered by a limited number of external providers, such as LanguageLine, which provides numerous NHS trusts with interpreting services, above all OPI, in more than 200 languages 24/7[29] and The Big Word agency, which also recently launched a VRI service[30].

As can be seen from the information contained in this section, there are different providers of RI services. Most companies provide 24/7 access to services for patient and healthcare professionals. Information about the services is easily available for patients and medical staff (Sultana et al., 2018).

In the following section, the situation in the three ReACTMe project countries is described to see what lessons can be learnt from the countries with a long experience in the provision of RI services.

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[26] https://www.occi.ca/occi-accredited-interpreters

[27] https://www.languageline.com/

[28] One example is the Healthcare Interpretation Network (http://hcin.org/), a "non-profit organization led by former hospital executives and technologists dedicated to creating an efficient and high-quality service for video health care interpretation", http://www.hcin.org/index.php/aboutus-whoweare/

[29] https://www.languageline.com/uk/industries/medical-translation/

[30] https://en-gb.thebigword.com/news/thebigword-lands-a-range-of-new-nhs-contracts/

REMOTE INTERPRETING IN ITALY, SPAIN AND ROMANIA

In Italy, healthcare is delivered by *aziende sanitarie locali* (AUSL – local health authorities), which are directly responsible for the services provided and their quality. These AUSL and individual hospitals or groups of hospitals (depending on their size) sign agreements with private companies for the provision of remote interpreting/language mediation services. The most widely used systems in Italy are HELPVOICE® (telephone interpreting/mediation) and HELPFACE® (video-link interpreting, which has proved to be particularly useful during the COVID-19 pandemic), provided by Eurostreet. This cooperative provides its services to over 100 AUSL and hospitals in almost every Italian region and is the main platform in Italy for remote healthcare interpreting services. These service providers sign 2/3/4-year agreements with AUSL and/or hospitals following public bidding procedures and/or direct purchasing of services. Additionally, in Italy, the single European emergency number (112) exists to meet all emergency needs, including health emergencies. Interpreting/language mediation services exist for these emergencies and regional authorities or AUSL sign agreements with private companies, such as Eurostreet. These companies also offer face-to-face interpreting/language mediation services, but during the COVID-19 pandemic, OPI and VRI services almost completely replaced face-to-face interpreting[31].

As for Spain, since the management of the healthcare system is decentralised, each autonomous community is responsible for finding its own solutions to overcoming the linguistic barriers encountered in healthcare services when dealing with allophone patients. The use of OPI is widely used in several autonomous communities. The service is hired by regional or local authorities through a competitive bidding process, in which the most relevant criteria when selecting a company are usually its technical and technological infrastructure, with companies asked to provide a description of their technological equipment, call management, call centre, system for managing issues, security measures, etc. Then there is the number of languages it can offer, an easy to remember phone number, and interpreters with professional qualifications and/or experience in Public Service Interpreting and/or OPI. Even though there are other private companies that have signed agreements with regional and local authorities, the two main companies offering OPI services (alone or combined with on-site interpreting and translation) to public hospitals and outpatient clinics in Spain (as well as other public services) are Interpret Solutions and Dualia Teletraducciones (Del Pozo Triviño and Campillo Rey, 2016). Interpret Solutions is currently testing a new videoconferencing device in order to be able to start providing VRI services in the near future[32].

[31] Information provided during some interviews carried out by the researchers in this Project.
[32] Information provided by Interpret Solutions.

Unfortunately, from the literature review and the interviews conducted so far, no RI seems to be provided in Romania. Telehealth interpreting services do exist, however, and have become more visible during the pandemic. Healthcare providers contacted[33] said they have not even used interpreters because they tend to use doctors who speak the patient's language or a lingua franca. Moreover, one of them stressed that patients can go to virtual clinics in their own country, so the demand for medical services in languages other than Romanian is rather rare.

Guidelines

If we look at the legislation or guidelines, there is no generally accepted professional code of ethics for interpreters at a national level in Italy. However, both Eurostreet and CIES Onlus have their own professional code of ethics, which their interpreters/language mediators must comply with. Eurostreet guarantees confidentiality, professionalism and punctuality and its website clearly states that in the case of OPI and VRI a confidentiality agreement is made and accepted by users before the phone or video call starts[34]. These calls are recorded and stored safely, and can only be accessed by the data controller (upon request). CIES Onlus was one of the first bodies in Italy (in the mid-1990s) to include a professional code of ethics as a key part of the employment contract with its interpreters/language mediators to ensure that the code was complied with during the provision of their services[35]. CIES Onlus states that it is essential for mediators to comply with the code of ethics as it makes them aware of the boundaries regarding the service they provide and helps them respect the neutrality principle in communications between patients and healthcare workers[36].

In Spain, both Interpret Solutions and Dualia Teletraducciones offer initial and continued training for their telephone interpreters, covering not only technical procedures and protocols, but also the main ethical principles they must adhere to (professionalism, impartiality and accuracy). Each company has its own professional code of conduct and trains interpreters on how to react in 'delicate' situations. As regards confidentiality, interpreted conversations are normally recorded, mainly for reasons of quality assessment, and users are informed about this beforehand[37]. That is why the introduction provided by interpreters at the beginning of the conversation is so essential. This enables them to explain some of the procedures that they follow,

[33] Peditel and Femyo.

[34] Of course, all EU Member States must comply with GDPR provisions, so it is safe to assume this is a minimal standard applied in all medical interpreting services.

[35] In particular, a representative of this NGO interviewed stated that there is a professional code of ethics for cultural mediators that is fairly well-recognised, based on principles such as neutrality, impartiality and confidentiality.

[36] https://www.cies.it/chi-siamo/trasparenza/

[37] Contrarily, interpreted conversations with victims of gender-based violence are not recorded for obvious reasons.

such as how turn-taking will be managed or the fact that they will reproduce users' interventions in the first person, interpret everything that is said and guarantee the confidentiality of the encounter.

Languages provided

In Italy, Eurostreet started providing RI services in 2008 (their first customer was Ospedale San Carlo in Milan), while in Spain, RI services were first provided by Dualia Teletraducciones in 2004.

The number of languages offered differs depending on the different LSPs. The Italian provider Eurostreet offers over 150 languages and minor dialects. Response times range from 30 seconds to 2 minutes from receiving the call, and the service is available 24/7, 365 days a year. Eurostreet also provides 32 languages for the Emergency Service 112.CIES Onlus, based in Rome, has a databank of around 600 cultural mediators from 50 different countries.

In Spain, the two companies offering telephone interpreting services for healthcare settings are available 24-hours a day, 365 days a year, with Interpret Solutions offering approximately 70 languages and Dualia Teletraducciones 50. It is the healthcare professional who has to request the interpreting service, using a telephone number provided by the company and selecting the patient's foreign language, without the need for any intermediate figure, such as a telephone operator, to connect the users and the interpreter and inform the interpreter about the origin of and the reason for the call (Fernández and Toledano, 2018: 234).

POSSIBLE IMPROVEMENTS IN THE THREE PROJECT COUNTRIES

As regards possible improvements that can be introduced in the three ReACTMe Project countries, it is difficult not to agree with Braun (2015: 11):

> [g]iven the variation in the use of remote and teleconference interpreting in terms of setting, communication purpose, number and distribution of participants, mode of interpreting and other variables, it is difficult to make general recommendations for practice.

Braun (2015) also states that institutions planning the implementation and use of remote interpreting facilities should carefully consider these variables to determine the requirements and scale of investment. Moreover, it is essential to involve interpreters during the planning stages. Additionally, Braun (2015) and other relevant authors in the field, such as Kelly (2008) and Rosenberg (2007), highlight the importance of using new technology for RI purposes and the inappropriateness of using ordinary telephones and speakerphones rather than dual headset telephones to avoid having to pass the handset back and forth between the speakers. Using VRI may be even more effective for language interpreting services than OPI, as stated by Napier, Skinner, Braun (2018: 12), since

> it is widely accepted that spoken-language interaction includes important non-verbal elements of communication (e.g., eye gaze, gestures, etc.), and the evolution of technology means it has become much easier to interact via video.

With regard to the ReACTMe Project countries, the situation varies considerably. While in Italy and Spain there is a framework that needs improving and updating, in Romania, an entire mechanism still needs to be put in place. Solutions must, therefore, be implemented differently and to different extents in each country. There are some general principles, however, that should be applied throughout.

Firstly, all three countries can learn from the best practices that exist in other countries, such as the efficient organisation of RI services to enable rapid communication between interpreters and clients. Networks of interpreting companies are efficient here and online platforms can also be used. It is also essential to make it clear who is responsible for finding and paying the interpreters. Furthermore, it is crucial to educate the users (both healthcare professionals and patients) as regards RI and its advantages, as well as the interpreter's role. Finally, it is also important to design and implement quality training programmes for remote interpreting.

Conclusions

After examining the situation existing in the most advanced countries and the countries participating in the ReACTMe Project, it seems clear that there are several ways the situation can be improved. First of all, it is evident that there should be some kind of legislation to protect the right of a patient who does not speak the official language(s) of a country to be assisted by an interpreter, as in the case of the most advanced countries. Moreover, specific training programmes and accreditation procedures are needed. However, this, on its own, does not guarantee the provision of quality services. Qualifications and training should be required and provided by either the institutions or the different companies providing the services. There is also another factor that makes a difference in the provision of healthcare services: availability and the number of languages. In the leading countries examined, services are provided 24/7 in a wide range of languages. In order to have professional services, companies have to make sure they hire qualified interpreters or provide their interpreters with the necessary training.

Several good practices have been identified in the most advanced countries as well as in the participating countries. In Italy cooperatives such as Eurostreet or NGOs such as CIES have been providing both face-to-face and remote interpreting/language mediation services in a very high number of languages. They have their own code of ethics, which the interpreters/language mediators who work

for them must adhere to. Unfortunately, there is no national approach and while some regional authorities have made such a choice, in other regions healthcare professionals have no interpreting services available and try to solve linguistic barriers with foreign patients on their own or by resorting to the use of ad hoc interpreters. In Spain, the use of OPI is increasing but very slowly and it is not present in all the regions. In Romania, RI is not provided yet (with the exception of some cases of sign-language interpreting), but face-to face interpreting is still rarely used.

As a result, there is a need for further research on RI, especially its psychological effects, and for specific training to be provided for both interpreters and healthcare professionals. The aim of the ReACTMe Project is to help create new, specific medical interpreting training programmes to meet these training needs, also with regard to the use of RI, following the good practices that have so far been identified, to ensure that they are shared by the three participating countries first and then possibly by other European countries.

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