New Trends in Translation Studies

Vol. 38

Medical Interpreting

Training the Professionals

Almudena Nevado Llopis and
Ana Isabel Foulquié Rubio (eds)

Peter Lang

NEW TRENDS IN TRANSLATION STUDIES

'This comprehensive, insightful and well-researched work is an essential and timely contribution to sustaining the training of healthcare interpreters. It provides an important foundation for trainers, researchers and practitioners, based on a thorough and up-to-date reflection on the challenges and needs of healthcare interpreting today, and on the development of training materials for interpreter trainers carried out by the European project ReACTMe. It is a rich, powerful, compelling and much needed book in the field of healthcare interpreting studies.'

– Dora Sales, Senior Lecturer, Department of Translation and Communication, Jaume I University, Spain

'This volume breaks new ground by examining health inequities through a pedagogical and justice-oriented lens in the context of healthcare interpreting in Spain, Italy and Romania. By foregrounding specialized training that targets both emerging interpreters as well as trainers, the authors offer a fresh look at teaching and learning for healthcare interpreters by offering authentic, creative resources that can be adapted for any national context.'

– Melissa Wallace, Associate Professor of Translation and Interpreting Studies and Director of the Graduate Certificate in Translation & Interpreting Studies, University of Texas at San Antonio, USA

Medical Interpreting: Training the Professionals presents the results of the project Research & Action and Training in Medical Interpreting (ReACTMe) funded by the European Commission, which analysed the interpreting services offered in healthcare settings in Spain, Italy and Romania. This edited collection provides the reader not only with an update on the current situation regarding medical interpreting from different perspectives (decision makers, trainers, professional interpreters, healthcare providers and patients) but also with training resources and a proposal for an academic programme to teach medical interpreters. It is therefore ideal reading for medical interpreting trainers, researchers and practitioners. The book is also of interest to healthcare professionals as it includes a decalogue on how to work with interpreters in five languages.

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Medical Interpreting

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Contents

List of Figures vii

List of Tables ix

RAQUEL LÁZARO GUTIÉRREZ
Foreword xi

ALMUDENA NEVADO LLOPIS AND ANA ISABEL FOULQUIÉ RUBIO
Introducing the ReACTMe Project: Past, Present and Future 1

ANA ISABEL FOULQUIÉ RUBIO, NATACHA NIEMANTS AND ALINA ANDREICA
1 Medical Interpreting in Spain, Italy and Romania: Healthcare Providers' and Users' Viewpoints 9

ALMUDENA NEVADO LLOPIS, FRANCESCA GNANI AND ALINA PELEA
2 Medical Interpreter Training in Spain, Italy and Romania: State of Affairs and Expectations for the Future 57

ANA ISABEL FOULQUIÉ RUBIO, DONATELLA CIFOLA AND VERONICA MANOLE
3 Suggestions for the Professionalization of Medical Interpreting in Spain, Italy and Romania 103

ELEONORA BERNARDI AND LINDSEY BRUTON
4 Training Resources and Methodologies for Medical Interpreters 127

CHRISTOPHER GARWOOD
5 Key Elements to Be Considered When Designing a Course for Medical Interpreters 153

ELENA TOMASSINI
6 A Model Joint Blended-Learning Module for Medical Interpreters 165

BEVERLY COSTA
7 Reflective Practice Support for Interpreters: Why, What and How? 185

CYNTHIA E. ROAT
8 Reweaving the Tapestry: How Healthcare Interpreters Will Save the World 201

ANA ISABEL FOULQUIÉ RUBIO
Annex. Guidelines for Working with Medical Interpreters 219

Notes on Contributors 229

Index 235

ANA ISABEL FOULQUIÉ RUBIO, NATACHA NIEMANTS AND ALINA ANDREICA

1 Medical Interpreting in Spain, Italy and Romania: Healthcare Providers' and Users' Viewpoints

1. Introduction

Medical interpreting mainly occurs in triadic exchanges in which patients and health professionals exchange information with the help of an interpreter. The role of the interpreter, however, is not always clear and can be shaped by the expectations of the other interlocutors in this exchange (Hsieh 2006; Sleptsova et al. 2015). For this reason, when trying to understand the phenomenon of medical interpreting, it is important to gather the opinions not only of interpreters but also of the professionals and patients who use interpreting services.

In this chapter, only the opinions and views of the primary participants in the exchange are analysed, leaving the third actor, the interpreter, for a separate chapter (see Chapter 2 in this volume) where the views of interpreters working in medical settings are analysed and presented.

According to Leanza (2005: 167), 'interpreting is more beneficial to the healthcare providers than to the patient'. For this reason, in this chapter we concentrate mainly on the opinions of healthcare providers, while also looking briefly at the experiences of healthcare users who, at the time of accessing the service, did not speak the official language of the country. The data collected in this study informs us about the expectations of the interpreter held by both parties, and about their experiences when no professional interpreting was provided.

2. Methodology

As explained in the introductory chapter of this volume, the ReACTMe project lasted three years (2019–2022) and addressed a variety of topics related to medical interpreting based on data collected from three participating countries: Italy, Romania and Spain. The information presented in this chapter corresponds to the research carried out during years 1 (2019–2020) and 3 (2021–2022) of the project. Different data-collection methods were used, and different target populations were addressed depending on the information being collected and the aim of each year.

The aim of year 1 was to assess the situation of medical interpreting provision and legislation, which was achieved by analysing the existing legislation in each country combining different methods such as a literature review and document analysis as well as information provided in personal interviews with the different stakeholders. During year 1, data was collected from policy decision makers, heads of department in hospitals and hospital managers on the one hand, as well as medical and patients' associations and NGOs working with migrant populations on the other.

The aim of year 3 was to evaluate the quality of medical interpreting services provided in the different countries according to the stakeholders. This was done by conducting interviews with people on the frontline of healthcare: healthcare providers communicating with allophone patients (HCPs) and allophone patients using healthcare services (HCUs).

The interviewees were selected using the above-mentioned target criteria in the three participating countries, and the data-collection method used was in-depth, semi-structured interviews. To ensure comparability of the collected data, the project team agreed on the questions and the interviews were first prepared in English, the working language throughout the project. The questions were then translated into the languages spoken by the interviewees in each country (i.e. Italian, Romanian and Spanish). The interview questions were presented to the ethics committee for each university (according to the requirements of each institution) and approval was granted. Interviewees were provided with a consent form to sign and an information sheet explaining the project.

Table 1.1. Questions for year 1 and year 3

Year 1	
Policy decision makers	Associations and NGOs
1. Is there any legislation ruling medical interpreting/mediation in Spain/Italy/Romania (or the specific region/city/hospital)? If so, please indicate the relevant pieces of legislation. 2. From the information you have, how are linguistic and cultural barriers between Spanish/Italian/Romanian healthcare providers and foreign-language-speaking patients overcome? 3. What would you expect from a medical interpreter/mediator? What are her/his role and her/his duties? 4. In your opinion, what are the main differences between non-professional (family members, friends, other patients, healthcare professionals) and professional medical interpreters/mediators? 5. (Only to hospital directors or heads of medical departments) As far as you know, have there been any problems at your workplace when using a non-professional/a professional medical interpreter/mediator? Could you describe that specific situation (who was involved, what the problem was, what consequences were derived, etc.)? (Closing: Would you like to add anything regarding this topic?)	1. (Only to medical/patient associations and NGOs representatives) Do healthcare professionals have difficulties when communicating with foreign-language-speaking patients? 2. (Only to medical/ patient associations and NGOs representatives) How are these difficulties overcome? 3. Is there any legislation or regulation ruling medical interpreting in Spain/Italy/Romania (or the specific region/city/hospital)? If so, please indicate the relevant pieces of legislation. 4. (Only to interpreters' associations representatives) Is there any medical interpreters'/mediators' association in Spain/Italy/Romania? 5. (Only to interpreters' associations representatives) In case there aren't, do you think there should be at least one? Why? 6. (Only to interpreters' associations representatives) Is there any official code of ethics for medical interpreters/mediators in Spain/Italy/Romania? 7. What competences (knowledge, skills, attitudes) do you think a medical interpreter should have?

(*continued*)

Table 1.1. Continued

Year 1	
Policy decision makers	Associations and NGOs
	8. What would you expect from a medical interpreter? What are her/his role and her/his duties? 9. In your opinion, what are the main differences between non-professional interpreters (family members, friends, other patients, healthcare professionals) and professional medical interpreters/mediators? (Closing: Would you like to add anything regarding this topic?)
Year 3	
Healthcare providers (doctors, nurses, helpdesk assistants, etc.)	Healthcare users
1. Do foreign-language-speaking patients use healthcare services at your workplace? 2. Do healthcare professionals at your workplace have difficulties when communicating with these patients? How are these difficulties overcome? 3. If there are professional interpreting services at your workplace, do the language combinations available answer the linguistic and cultural needs? 4. Are Spanish/Italian/Romanian healthcare providers and students informed about the interpreting services available (in case there are professional interpreting services)?	1. How are linguistic and cultural barriers between Spanish/Italian/Romanian healthcare providers and foreign-language-speaking patients overcome? 2. Do the language combinations available answer the linguistic and cultural needs in Spanish/Italian/Romanian healthcare services? 3. Are you, as a foreign-language-speaking patient, satisfied with the communication outcomes when using Spanish/Italian/Romanian healthcare services? 4. Have you had any problem when using an ad hoc medical interpreter (family members, friends, 'bilingual' medical staff, etc.)? Could you describe that specific situation (who was involved, what the problem was, what consequences were derived, etc.)?

Table 1.1. Continued

Year 1	
Policy decision makers	Associations and NGOs
5. Do you think that foreign-language-speaking patients are satisfied with the communication outcomes when they use Spanish/Italian/Romanian healthcare services? 6. As far as you know, have there been any problem at your workplace when using ad hoc medical interpreters (family members, friends, 'bilingual' medical staff, etc.)? Could you describe that specific situation (who was involved, what the problem was, what consequences were derived, etc.)? 7. Have you had any experiences with professional interpreters in healthcare settings? Could you briefly describe them stressing both the advantages and disadvantages of this collaboration? 8. Do you have suggestions for improving the quality of these services (from the point of view of logistics, skills, ethics, etc.)? (Closing: Would you like to add anything regarding this topic?)	5. Have you had any experiences with professional interpreters in healthcare settings? Could you briefly describe them stressing both the advantages and disadvantages of this collaboration? 6. Do you have suggestions for improving your communication as a foreign-language-speaking patient with the Spanish/Italian/Romanian healthcare professionals? (Closing: Would you like to add anything regarding this topic?)

Source: ReACTMe researchers

The interviews were carried out by the project team members in each country. Due to the COVID-19 pandemic, most of the interviews were carried out online using the available platforms. While this was an advantage in the sense that it allowed some interviewees to attend the interviews from greater distances, it may have caused people to feel less comfortable than they would have felt in face-to-face interviews. Despite this disadvantage, we were able to collect the necessary data.

Table 1.2. Interviews carried out in each country classified by year and target population

Country	Year 1		Year 3	
	Decision makers	Interpreters' associations & NGOs	Healthcare professionals	Patients
Spain	14	7	26	13
Italy	6	2	5	5
Romania	7	5	4	7

As for the number of participants, the aim at the initial stage of the ReACTMe project was to conduct at least three interviews per partner for year 1, and interviews with two healthcare professionals and two patients per partner for year 3. Even though the same number of interviews was not carried out in all participating countries, all three countries managed to conduct more interviews than the number required to fulfil the project aims, as shown in the table below:

The interviews reveal interesting results that allow us to achieve the goal of presenting a comparative analysis of the situation in the three countries (see Section 4).

All interviews were either audio or video recorded to allow the data to be analysed. The recordings were then transcribed and anonymized, and qualitative analysis was carried out. Nevertheless, it is important to consider that although the interviews were semi-structured, interviewers sometimes changed the order of the questions and interviewees were able to add additional information they considered important to the topic.

Each university analysed its own data, after which the analysed data were shared with the rest of the team of the project to compare the results, grouping the information by topic. Some of the results from year 1 have already been published in different publications (Tomassini et al. 2022; Garwood et al. 2023). This chapter, however, also includes the results from year 3 of the project and offers a comparative analysis of the results, depicting the situation not for each country in isolation but in comparison with the other countries participating in the project.

The data were analysed and compared according to the relevant stage of the project but also according to the different target groups. The information presented in Section 4 of this chapter is, therefore, divided according to the target groups.

3. The Spanish, Italian and Romanian healthcare systems

Health is a fundamental human right enshrined in international treaties and European conventions, and every member state that has ratified these conventions shall guarantee its enjoyment through national legislation and organizational choices. In all three participating countries – Spain, Italy and Romania – the right to access to healthcare services is guaranteed by their respective constitutions. To give specific information for each country, the right to access to healthcare services is guaranteed by the Spanish Constitution as well as by Law 16/2003 of 28 May. This law was modified by the Royal Decree-Law 7/2018 on Universal Access to the *Sistema Nacional de Salud* (National Health System 2018), which is granted to every Spanish citizen and those residing in Spain, including foreign regular/authorized and irregular/unauthorized populations. The Spanish healthcare system is also based on the Law on General Health, passed on 25 April 1986 (Law 14/1986 on General Health). In Italy, Article 32 of the Italian Constitution of 1948 states that health is a fundamental human right and ensures free access to healthcare to those who could otherwise not afford it, stressing the importance of respect for every individual in all circumstances. Articles 7 and 9 of the Charter of Values of Citizenship and Integration, adopted in 2007, complemented Article 32 of the Italian Constitution, underlining that this fundamental right to access to healthcare also applies to immigrants, who equally deserve medical treatment that fully respects their wishes, dignity and sensitivity (Gerolimich 2015). As is the case of Italy and Spain, the Constitution of Romania also mentions the right to healthcare. Article 34 guarantees the right to access to the Romanian healthcare services and Article 148 includes the obligation to respect the provisions and requirements of EU

treaties in the domain of healthcare. Article 20 of the Constitution of Romania also includes the duty to respect human rights as part of the country's obligation to comply with the Universal Declaration of Human Rights, as well as with the international treaties and agreements to which the country is signatory (Constitution of Romania, Art. 20, 34, 148).

According to Ozolins (2000) and Giarelli (2008), the fact that healthcare is protected by a Constitution is not insignificant, because this influences the responses given by public and private institutions to the need of communication with allophone patients.

Unfortunately, however, 'the letter of the law cannot, by itself, guarantee the enjoyment of human rights in practice' (Vecchiato 2015: 11), especially when foreign patients do not speak the language of the host country sufficiently well for the purposes of communication in healthcare. According to Tomassini et al. (2022: 289), in their review of European legislation related to interpreting in healthcare settings, 'although detailed information is provided about how to obtain medical treatment in each Member State, the websites containing this information and leaflets for cross-border patients make no reference to concrete ways in which language barriers can be overcome.' In accounting for the different contexts of healthcare systems across the EU, Angelelli (2019: 35) similarly underlines,

> Although it is obvious that access to information is crucial for anyone to pursue healthcare assistance in a member state, none of the four documents constituting the EU framework explicitly refers to language provision for EU citizens or legal residents in that condition. In the absence of a clear EU legislative guidance, each member state has its own legislation and those vary considerably from one member state to another.

In countries like Spain and Italy, where healthcare competences and responsibilities are shared between the State and the Regions or Autonomous Communities, for many years there have been considerable organizational dissimilarities across the national territories. As such, it will be useful to offer a brief introduction to the healthcare systems in these countries and in Romania, before moving on to the comparative analysis of the interviews conducted in the three countries.

3.1. Spain

In Spain, while the Ministry of Health is responsible for proposing and executing the general government guidelines on health policies, the Autonomous Communities have their own healthcare services. Each Autonomous Community divides its healthcare services into two basic health areas: (1) primary care, which is provided in health centres, and (2) specialized care, which is mainly provided in hospitals covering different specialities. Apart from the public health system, people in Spain can choose to have additional private health insurance, allowing them to receive healthcare in private hospitals. In such cases, patients can choose where to receive healthcare. As Tomassini et al. (2022: 291) explain,

> although there is no specific legislation on the right to translation and interpreting in healthcare services, this right can be inferred from the Spanish Law 41/2002 on patients' autonomy, as it states that information and consent should be comprehensible and appropriate to the needs of the patients.

To give an example of how this translates into regional legislation, Regional Law 3/2009 for the Region of Murcia states that patients should be able to understand the information provided to them; in the case of foreign patients, therefore, this might imply the need for translation/interpreting. The organization of communication with patients who have limited proficiency in Spanish is assigned to the Autonomous Communities, which are responsible for including the strategies and solutions in their Strategic Plans related to social services and healthcare. More precisely, many Autonomous Communities sign agreements with external companies that provide interpreting services. That is, for instance, the case of Interpret Solutions, a company that offers telephone interpreting services for the social and healthcare services of several autonomous communities, adapting their services to regional needs.

As we will see in Section 4, some Spanish hospitals also have in-house interpreters or mediators; however, they are not directly hired by the hospital or health institution, but by the company that wins the

tender, just like in many Italian regions, where the service is offered by local cooperatives. In both countries, though, the problem is that when language services are available, they are offered only in some facilities and at specific times of the day. Therefore, HCPs and HCUs cannot always benefit from such services, and at certain times and in some places fair access to healthcare by allophone patients is impossible in practice.

3.2. Italy

In Italy, as Bernardi and Gnani (2022: 56) argue, 'healthcare services are provided by regional governments', and therefore, significant differences are visible both in the services offered and in their overall quality. The European Observatory of Health Systems and Policies (<https://eurohealthobservatory.who.int/countries/italy>) confirms that,

> despite a strong commitment to equity in health care provision across regions, regional differences exist in population health status, access and quality of services. Northern and central regions generally have higher capacity and more advanced technology with care being perceived to be better quality, leading patients to travel to northern and central regions for services.

The current Italian National Health Service (*Sistema Sanitario Nazionale* or simply SSN) was created in December 1978 by Law no. 833. Inspired by the principles of universality, equality and equity, this law defines the facilities, services and activities needed to ensure the physical, mental and social well-being of the whole population, irrespective of individual and social conditions. A welfare system funded by national and regional taxes was created and organized in Local Health Authorities (*Aziende USL*), which since the 1990s have their own organizational, administrative, managerial and technical autonomy. A national system of quality and quantity control was also put in place and over recent decades, this monitoring system has been based on the assessment of Essential Levels of Care (*Livelli Essenziali di Assistenza* or LEAs), that is the 'national benefits package guaranteed to all citizens and registered foreign

residents'.[1] LEAs are defined by the national Ministry of Health,[2] but it is the primary function of the Local Health Authorities to ensure that those levels are respected. More precisely, the regions independently plan and manage healthcare in the area under their jurisdiction, making use of both Local Health Authorities and university hospitals (*Aziende ospedaliero-universitarie*) where they are present. Since each Italian region has its own specificities – making it impossible to cover them all here – we will complete this short overview by providing one representative example of how public healthcare is deployed in regional, provincial and local bodies. For this we have chosen Emilia-Romagna because it is the Italian region with the highest level of foreign residents within the total population (Barbieri 2021: 28), implying that, by necessity, it has had to organize its healthcare services in such a way as to address the needs of foreign patients. In Emilia-Romagna, there are eight *Aziende USL*, which roughly correspond to its provincial territories, as well as four *Aziende ospedaliero-universitarie*, in the towns of Bologna, Ferrara, Modena and Parma. Each *Azienda USL* of the Emilia-Romagna region is then divided into Districts, and each District ensures the provision of services included in the LEAs to its target population. For example, the *Azienda USL della Romagna*, which is situated in the South-East of the region and covers the provinces of Forlì-Cesena and Rimini, has eight Districts and the Rimini District alone covers the needs of thirteen municipalities.[3]

1 See <https://eurohealthobservatory.who.int/countries/italy> where it is also specified that 'LEAs include hospital care, pharmaceuticals, outpatient health services, and rehabilitation and community health services. Over-the-counter pharmaceutical products are not covered and dental care coverage is very limited.'

2 The latest update on LEAs dates back to 2017, and a subsystem of 'core' indicators was also introduced in 2019.

3 For an overview of the organization of these services in the region, see <https://salute.regione.emilia-romagna.it/ssr/organizzazione/aziende-sanitarie-irccs/i-distretti-delle-aziende-usl>.

3.3. Romania

Similarly, the Romanian healthcare system also aims to ensure equitable and non-discriminatory access to a package of basic services for those covered by national health insurance. The country's National Health Insurance House (*Casa de Asigurări de Sănătate*, or CNAS) is an autonomous public institution, whose main object of activity is to ensure the uniform and coordinated functioning of the social health insurance system in Romania. According to the European Observatory on Health Systems and Policies (<https://eurohealthobservatory.who.int/countries/romania>),

> the Romanian social health insurance system (SHI) aims to provide universal health insurance coverage. In practice, SHI covered 89 per cent of the population in 2017. The state has a large presence in Romania's health system. The Ministry of Health is responsible for overall governance, while the National Health Insurance House (NHIH) administers and regulates the system.

At the local level, there are forty-two District Health Insurance Houses (*Casa Județeană de Asigurări de Sănătate*, or CJAS). Primary care is provided by family medicine physicians, under contract with the CJASs. As in Spain and Italy, in Romania there are university hospitals along with public or private hospitals, but the main difference, which will be illustrated more clearly in the comparative analysis below, is that there is no specific legislation ruling interpreting services, and thereby the access to healthcare services by foreign patients and refugees. Healthcare service providers who work with such users thus have to follow the provisions of various pieces of European and Romanian legislation (e.g. Law no. 272/2004 on Child Protection, Law no. 122/2006 on Asylum, and Law no. 292/2011 on Social Assistance), where the objectives of communication and non-discrimination are stated, but the means to reach them are not overtly explained.

4. Comparative analysis of results in Spain, Italy and Romania

This section presents a comparative analysis of the results obtained in the three countries and is organized into two main subsections: Healthcare providers' viewpoint (Section 4.1) and Healthcare users' viewpoint (Section 4.2).

4.1. Healthcare providers' viewpoint

The label *healthcare provider* (HCP) includes here a wide range of professionals who contribute, in some way or another, to providing healthcare services to native and foreign users in the three countries under scrutiny. Such professionals range from the heads of hospitals, health departments and clinics we interviewed in year 1 of the project, to the doctors, nurses, physiotherapists and care workers we interviewed in year 3. This provides us with a wide spectrum of viewpoints across the organizational structure of local healthcare facilities. Section 4.1 is further divided into five subsections, according to the topics discussed in the interviews, namely the legislative framework, the expectations concerning medical interpreting, the availability of language services, the pros and cons of ad hoc solutions and the providers' suggestions for improvement.

4.1.1. Legislative framework: From the letter of the law to local healthcare facilities

Given the specificities of the legislative and organizational scenarios in which the healthcare facilities of a specific country operate (see Section 3 and Angelelli 2019: 34–37), one could expect that the Spanish, Italian and Romanian HCPs would depict very different frameworks in the interviews. However, the comparative analysis of their answers showed similar issues being raised. To begin with, as Tomassini et al. (2022: 291) have already underlined in a chapter comparing legislation and opinions

of top managers and associations in the three countries part of the study, 'there is no specific national legislation regulating medical interpreting, nor specific references to medical interpreters, in either national or regional legislation in any of the three countries involved in this study'.

SPAIN

On the issue of legislation, the Spanish interviewees talked about specific agreements made between local health authorities and external collaborators, such as associations of volunteer interpreters or interpreting companies. Only two of these interviewees referred to the legislation on the rights of patients. The provision of language services to foreign HCUs is, however, sometimes problematic 'as regards both the availability of interpreters and the failure of some companies to check on the training and qualifications of the interpreters they hire' (ibid.: 291–292). Consequently, although the letter of the Spanish law stipulates the right to healthcare, HCPs working in individual healthcare facilities are not always aware of the existing legislation. Their answers additionally show that such national and regional legislation does not always translate into adequate services at the local level.

ITALY

In the case of Italy,

> although there is no specific legislation regulating medical interpreting, the interviewees did, however, mention several documents, working groups and draft laws aimed at recognizing the profession of the cultural mediator, considered by interviewees to be far better than interpreters, who merely perform a 'linguistic translation', clearly revealing their lack of knowledge as regards the role of interpreters. (ibid.: 292)

Two important elements shall be retained from this quote, namely the proliferation of references to so-called intercultural mediators (*mediatori interculturali*) in Italian legislation and the confusion surrounding the professional figures of mediators and interpreters. We will briefly expand on the former, providing a short overview of recently introduced laws

and standards in Italy, of which the interviewees could not be fully aware, while the issue of interpreters will be addressed in Section 4.1.2. As emerged from the interviews, in Italy there is still no national legislation on medical interpreters but there exist laws on intercultural mediators. This role was first mentioned in a law dating back to 1998 and then in a legislative decree of 2013 that aimed at creating a national system for the certification of competences. As interviewees stated, that decree remained stuck in Parliament for years, until a national framework of qualifications (*Quadro Nazionale delle Qualificazioni*) was finally established in 2018. As a consequence of the national legislative void, the Italian regions continued to act autonomously to establish the professional boundaries and curricular training of intercultural mediators. For the Emilia-Romagna region, Regional Council Resolution no. 936 (17 May 2004) establishes a system of qualifications, including that of intercultural mediator. This role is further described in Regional Council Resolution no. 1576 (30 July 2004), roughly establishing at 350–400 the number of intercultural mediators who should work not only for hospitals but also for social services, schools and courts in the region. Regional Council Resolution no. 2212 (10 November 2004) defines more precisely the intercultural mediator as a person who helps migrants to communicate with the relevant local authorities, removes language and cultural barriers, knows and promotes the migrants' culture of origin and helps them access private and public services. This Resolution thus places intercultural mediators in the professional area of social care, including them in a register of professional qualifications (*Repertorio delle professioni ISFOL*). Regional Council Resolution no. 141 (16 February 2009), introduced a few years later, describes the main competences of intercultural mediators and recommends specific training ranging from 300 to 500 hours in duration and including both formal education and practical experience. In parallel to the development of regional resolutions, Italian universities have created courses (see Chapter 2) on intercultural mediation, NGOs provide volunteer services, and a private not-for-profit association called UNI has developed a norm on professionals working in the field of translation and interpreting (UNI 11591:2015). In a significant achievement, this norm has recently been revised (UNI 11591:2022) and now clearly refers to the

national framework of qualifications and to the UNI ISO 21998 standard on interpreting services in healthcare. However, HCPs and HCUs are generally not aware of this norm and continue to ask for intercultural mediators rather than interpreters, so the profession is not defined univocally across the country, and the two professions continue to work in parallel, alongside the ad hoc solutions that we will mention below.

ROMANIA

All Romanian interviewees admitted that there is no specific primary legislation governing medical interpreting in the country and stated that HCPs turn to several pieces of legislation that mention the right to non-discrimination, fair treatment and good communication. These three rights are also stated in the physicians' and nurses' national codes of ethics, where good communication means using terms that can be understood by the patient (Art. 10, Nurses' National Code of Ethics 2009), making sure the patient understands what is being communicated by the health professional and properly informing the patient before asking for informed consent (Art. 2, 11, 14, 27 the Code of Medical Ethics of Romanian College of Physicians 2016). These provisions are reinforced by Law no. 43/2003 on Patients' Rights (2003), in particular Article 8, which makes specific reference to language and states that information must be presented in clear and respectful language, and that, if healthcare users do not understand the official language, the information must be conveyed in a language they understand, either their native language or another.

In other words, the problem of interlinguistic communication is acknowledged in Romania, but, for the time being, no solutions are provided (unlike in the case of legal translators and interpreters, for which legislation does exist, although it is still not detailed enough). Along the same lines, we should mention that Article 25 of the Code of Medical Ethics of Romanian College of Physicians also refers to the importance of an 'unmediated relationship' between physicians and their patients.

It is also worth underlining that in Romanian law, interpreting is not distinguished from translation. As we will see in the next sub-section, the absence of such a vital distinction may explain a certain degree of confusion

and misunderstanding that Romania shares with the other two European countries analysed here.

4.1.2. Varying levels of expectations concerning interpreting and mediation services

Starting from Tomassini et al.'s (2022: 297) conclusion that 'there is considerable ignorance as to the role of medical interpreters/cultural mediators' in the three countries under investigation, we will compare here the different expectations that were nonetheless expressed by the interviewees. Such expectations were discussed both in year 1, when the question was explicitly addressed to NGO representatives and to professionals at the top of the organizational structure, as well as in year 3, when some expectations emerged from the interviews with healthcare professionals interacting with foreign patients.

SPAIN

HCPs appeared to hold little awareness of the roles and duties of medical interpreters. Interviewees mentioned the key principles of confidentiality and data protection and generally stated that the main function of interpreters is that of *translating*, thereby showing a similar misunderstanding to that found in Romania over the terms *to translate* and *to interpret* as they understand *interpreting* as something else than '*just translate*', going further than when translating. Just like their Romanian counterparts, some Spanish interviewees consider that the interpreter should translate but not interpret. This opinion is visibly in contrast to what Seleskovitch and Lederer (2001) state in their pioneering work *Interpréter pour traduire*, whose title implies that one cannot translate without interpreting, in its first meaning of making sense of what participants are saying before rendering it into another language. Interestingly, however, greater awareness came from one Spanish NGO representative, who highlighted the importance of the interpreter's cultural competence, as problems in the communication might arise that are more related to culture than to language.

ITALY

In this country, interviewees had much clearer expectations of the people ensuring communication with allophone patients, although their answers revealed a similar lack of understanding of what *interpreting* implies. When talking about their expectations in this area, most of the interviewees referred to intercultural mediators, and according to the representative of one NGO, the ability to mediate conflicts should be one of the two competences of mediators, alongside a socio-pedagogical competence that would be visible when they actively listen to patients and welcome them. Similar to what emerged in Spain, the two Italian NGO representatives underlined in their interviews that language and culture are both crucial in helping patients and their families to access healthcare services, and privacy and neutrality were also considered key indicators of service quality. Italian heads of hospitals and health departments were even more precise in stating their expectations. In their view, intercultural mediators must be trained and experienced, in other words, they need to hold exact and in-depth knowledge of what participants may discuss in a specific health context. They also stated that intercultural mediators must be willing to engage in dialogue between HCPs and HCUs in both oral and written forms, and therefore rapport building and the translation of medical forms are also expected of them. Finally, Italian interviewees see language as part of a wider framework of expectations, which one of them clearly linked to five different levels of intervention in the provision of intercultural mediation services:

1. the 'psychological and relational' level, which aims at assessing the needs and resources of immigrant service users;
2. the 'educational and informational' level, which relates to the orientation of relations between immigrant service users and service providers and includes training on access to services, the organization of services, and related procedures and regulations, so that intercultural mediators can then provide foreign patients with such information;

3. the 'cultural' level, which helps ensure the understanding of the cultural codes of all parties involved in communication between HCPs and foreign HCUs, and aims at improving the knowledge of specific groups of patients in managing illness and health;
4. the 'linguistic and communicative' level, which refers to the provision of oral and written translation with the aim of helping providers better understand what immigrant service users need;
5. the 'organizational' level, which aims at orienting the services by designing guidelines, actions and new services in line with immigrant or ethnic minority service users' needs.

In short, according to Italian interviewees, interpreters would cover only part of these goals and expectations, while intercultural mediators would cater for a wider range of needs. In their view, whenever doctor-patient communication occurs, it is always mediation that is required, while in situations where Italian doctors are talking to foreign doctors, interpreting is required, implying that mediation is used in asymmetric interactions, while interpreting is used in symmetric interactions (on asymmetries in the medical setting see Lázaro Gutiérrez 2013). However, such a distinction clearly does not match current understandings of the role of the interpreter: in the UNI revised norm mentioned in Section 3, the knowledge of interactional dynamics and potential asymmetries is in fact one of the distinctive features of medical interpreters, and medical interpreting requires specific skills that are listed in the norm. Interestingly, however, no interviewee mentioned this norm, which uses the term *mediation* not to describe the different levels of intervention of intercultural mediators but rather to cover the whole range of professional activities of translators and interpreters. Even more interestingly, while providers at the top of the organizational structure always used the term *mediator* to talk about the person ensuring communication with foreign patients, providers working directly in the field also used the term *interpreter*. This was especially the case for a nurse and a doctor working in two different facilities of the Emilia-Romagna region, who clearly stated the advantages and disadvantages of different solutions and made

practical suggestions to improve interpreting services, which will be further discussed in Section 4.1.5.

ROMANIA

In line with its legislation, interviewees often made no distinction between *translating* and *interpreting*, but all seemed to hold clear expectations of those who ensure communication with allophone patients. Based on their knowledge of the communication requirements for the talk-based medical profession, as well as on their experience with ad hoc interpreters (see Angelelli 2019: 29 for a definition), they mentioned several required competences. Three of these stand out as most important in their view; namely accuracy (one interviewee, head of a hospital department, said that the patient's words should not be *interpreted*, but rendered with no trace of subjectivity), confidentiality and the knowledge of medical terminology. Romanian interviewees also mentioned communication skills, neutrality, familiarity with the Romanian healthcare system and, in one case, the mastery of both languages, including their various registers and dialects.

4.1.3. From individual solutions to organized language services: The spectrum of responses across the three countries

Our three-year research project confirmed the initial findings by Tomassini et al. (2022: 293) that 'there is no standard approach to resolving language barriers in any of the three countries and that healthcare institutions frequently resort to ad hoc solutions'. Starting from this common premise, we can, however, make some distinctions between the exclusively individual solutions adopted in Romania and the tentatively common services that exist in Spain and in Italy, where the decentralization of services and the different funding allocated by each region partly explain the absence of a fully nationwide solution and the existence of scattered pilot experiences.

SPAIN

The decentralization of services partly explains the lack of a unitary solution in Spain, where hospitals at least try to create their own common resources, thereby providing healthcare professionals with a range of possibilities to overcome linguistic and cultural barriers. The most widely used are relatives, friends and members of the same linguistic community, followed by healthcare professionals working in the facility who know foreign languages, and then by organized volunteers and interpreters – be they professionals working on site or for remote interpreting companies that win a tender for offering their services for a number of years. Local healthcare facilities additionally resort to pictograms adapted to different languages and cultures, as well as to translated documents. However, interviewees said that only a small number of documents are translated – usually documents such as informed consent forms – and then only into the most common languages, such as English, French and Arabic. Some interviewees even told us that they had translated some documents themselves and one provided us with a webpage created by the Spanish Association of Paediatric Emergency Doctors containing documents translated into different languages. Almost all interviewees admitted to using automatic translation services such as Google Translate, not only for written documents but also for oral communication with patients who cannot read. Some interviewees said that they worked with external translation and interpreting companies for some languages and usually for fixed times in the day. However, they underlined that it is impossible to have interpreters at every moment, and when they are not available, providers either resort to ad hoc interpreters provided by the patients themselves or try to speak in a foreign language they know (some studied English or French in school), making use of gestures and drawings when needed. Interestingly, they added that when they use a foreign language, their intention is not to translate 'properly' but to make the patient understand at least some information, and they also acknowledge that this is not always a good solution because their command of the foreign language is not sufficient. Some interviewees also complained that whenever they do not have an interpreter, they have to keep the information to a minimum, that is, they

try to present the most important elements but do not cover all the issues they would raise with Spanish-speaking patients, which has clear implications in terms of fair and equal access to healthcare.

From the interviews conducted in Spain, we can thus conclude that there is not a homogeneous provision of services, since even though all the interviewed healthcare professionals were working in public hospitals across the country, they answered differently depending on the facility. Even within the same region, answers were very different if the interviewee was working in the main hospital or elsewhere. From their answers, we can, however, infer that the language combinations available in the interpreting services do not meet the existing needs, and when patients speak a different language, they are advised to bring their own interpreter. In the event that patients come on their own, people in the waiting room may be used as interpreters; this is recognized as a problematic solution but is sometimes the only option available. Some Spanish healthcare professionals also referred to problems with Ukrainian patients, probably due to the fact that most interviews were conducted after the Russia-Ukraine war began in February 2022. However, it is important to note that there was already a high number of Ukrainians living in Spain before the war. What is more, it is unclear whether the limited number of language combinations used in Spanish healthcare facilities is because other languages are not offered by face-to-face translation/interpreting companies, or simply because providers are not aware of the outsourced interpreting services available. The crucial point here is that even in hospitals where interpreting *is* provided, not all professionals are aware of the existence of this service, and they often learn about it only by chance (a similar situation can be seen in Italy, as will be discussed below). Once HCPs start using interpreting services, some complain that the system is not straightforward and that, for example, in the emergency department, they cannot use the service because they have to book it in advance, which is clearly not possible in emergency cases. It is worth specifying that all the information gathered in Spain was related to hospitals, as we had no interviewees working in public health clinics. None of the HCPs interviewed worked for private hospitals, but according to the data gathered in year 2 of our research (see Chapter 2 in this volume), some private hospitals hire in-house interpreters, usually according to the

language combinations needed. However, English again tends to be used as a *lingua franca* for patients whose languages are not common in the country, so the language coverage is not sufficient to meet the needs of all foreign patients and ensure them fair access to Spanish healthcare.

ITALY

Just like in Spain, in Italy there is no nationwide solution to language and cultural barriers, but attempts made by the Local Health Authorities for their various Districts and facilities can roughly be divided into two categories: so-called 'linguistic and cultural mediation services' deployed in hospitals as well as in routine local services such as family counselling on the one hand, and ad hoc solutions on the other. Mediation services are generally offered by intercultural mediators (and sometimes interpreters) working for the cooperative that wins a tender for a certain number of years and guarantees availability at certain times of the day. These mediators generally live in the area and are familiar with the facilities within that specific Local Health Authority, which according to interviewees is a significant advantage, since it enables them to offer far more than 'mere' linguistic mediation, thereby achieving the expected educational and informational goal stated in Section 4.1.2. Interviewees stated that, when available, such services work well: providers are confident that the messages are rendered correctly (two recurring words in the interviews were 'ease' and 'certainty'), and as far as they can tell, the patients seem happy with the service. In the HCPs' view, remote forms of interpreting can also be useful if it is 'just a matter of' linguistic mediation, with video being preferred rather than telephone interpreting because it is considered more human than just a voice (see Angelelli 2019: 31 on the use of video 'that emulates most closely the in-person experience'). However, HCPs interviewed in year 3 raised two problematic issues which may partly explain the reason why doctors (and patients, as we will see) are not always aware of the existing services (similar to the case of Spain) and why professionals resort to some of the individual solutions we will also find in Romania. Providers firstly mentioned the paucity of interpreters/mediators for large institutions with many foreign patients, and secondly they lamented

the time it takes to activate the service, which is often not provided when needed (again, very similar to the situation in Spain). Italian HCPs consequently argued that many healthcare professionals prefer not to call interpreters/mediators (some additional reasons for this will emerge in Section 4.1.4), and they also stressed the absence of any reference to interpreting/mediation services in university courses, which explains why Italian providers often get to know the service by chance (unsurprisingly, this is very similar to their Spanish counterparts). In light of all these limitations, Italian healthcare units and/or their individual hospitals also resort to non-professional solutions, which were mentioned not only by NGO representatives and heads of hospitals/health departments in year 1, but also by healthcare staff interviewed in year 3. This includes solutions that are also used by Romanian and Spanish providers, such as relatives and friends onsite or over the phone, volunteers, web apps and the use of *linguae francae*, especially English and French, which appear to be widely used in the three European countries within this study. Italian interviewees additionally mentioned child language brokering, Italian language courses for migrants, as well as the use of non-verbal forms of communication such as gestures, which are also resorted to whenever the mediation service is unavailable.

Summing up the Italian situation, when the number of interpreters/mediators is sufficient, the service is timely, and the language combinations offered are adequate to local needs, there appear to be some good examples of services that are both available and well appreciated. That is, for instance, the case of the *Azienda USL della Romagna*, where, in hospitals located in a touristic area along the Adriatic coast, English, French and German are needed and offered. However, providers agreed that this is not the case at all times and in all places, and they also stressed that not all members of the healthcare staff speak English sufficiently well for the special purposes of communication in healthcare, which hinders their direct communication with patients. In the regions of Emilia-Romagna, Lombardy and Piedmont, where most of the interviewees came from, interpretation/mediation services generally cover French, German, Russian and Arabic in addition to English. However, many other languages are not sufficiently covered by the available services. According to our interviewees,

this is the case for Albanian, Chinese and for Slavic languages other than Russian, such as Bosnian/Croatian/Serbian, Czech, Polish and, last but not least, Ukrainian, for which in Italy, just like in Spain, ad hoc solutions are often the only ones possible.

ROMANIA

Medical interpreting is not a distinct profession in the Romanian classification of occupations and, consequently, it is not regulated as such. According to the interviews with HCPs and also those with experts, decision makers and representatives of NGOs and associations, each healthcare facility has a list of options they tend to favour. Individual solutions are found for each situation, depending mainly on the language combination needed. Whenever possible, certified translators/interpreters are used, but being a certified interpreter does not imply that one is indeed trained or specialized in healthcare interpreting. To make things worse, in the case of refugees who speak languages or dialects that are not taught in Romania, certified interpreters are not a viable solution, unless the patients also speak a *lingua franca*, generally English or French. Interpreters are sometimes contacted through consulates or embassies and, in their absence, nurses or auxiliary medical staff may provide interpretation or translation. In the region of Transylvania, it is not uncommon for medical staff to speak Hungarian, so they can assist patients who are better able to express themselves in this language. Social workers or other employees of NGOs or of the healthcare institution may also act as interpreters, thereby fulfilling two roles at a time: interpreter *and* professional in their respective fields, with all the advantages and disadvantages we will review below. Sometimes doctors and patients have one common language and two scenarios can be identified: either both speak English (usually as a foreign language) or both speak a common language (usually their mother tongue) – in Romania this is most often Hungarian, but there are also doctors whose mother tongue is Turkish (from the Turkish community in the Dobrogea region) or Arabic (graduates of Romanian universities who originate from Arabic-speaking countries). Interestingly, as two interviewees pointed out,

doctors may even be selected for employment at the hospital on the basis of the languages they speak. Finally, family members or acquaintances may also act as ad hoc interpreters. In the case of refugees, a common solution is that of relying on another refugee who has been in Romania for a longer period of time and who speaks a little Romanian in addition to the language or dialect of the person who requires interpretation. Additionally, help can be provided by members of the respective ethnic communities. This list of solutions was confirmed by the interviews with doctors, as well as through the workshops conducted with medical professionals in year 3. We can thus confirm the initial results of Tomassini et al. (2022: 294), who stated that 'in Romania there is no single strategy, nor any kind of coordination of efforts between healthcare providers', who are thus left to find individual solutions to the specific communication issues that arise.

4.1.4. Pros and cons of using ad hoc solutions from HCPs' perspectives

HCPs also commented on the pros and cons of ad hoc solutions, especially on the use of family members and healthcare staff. Spanish and Italian providers, on the one hand, had generally tried both language professionals and ad hoc solutions, and were thus in the position to take stock and to mention some differences and implications we will briefly recall below, first accounting for results or year 1 (representatives of healthcare institutions and departments) and then of year 3 (healthcare professionals). HCPs interviewed in Romania, on the other hand, seemed well aware of the risks of ad hoc solutions and interpreters, but had never worked with specialized medical interpreters – given that such a specialization does not exist in their country – so it was understandably hard for them to make proper comparisons and this is why Romania is not covered here.

The Spanish representatives of healthcare institutions mainly mentioned the following points:

- unlike professional interpreters, ad hoc interpreters can be selective in what they interpret and may not have a good enough understanding of Spanish to accurately interpret;

- unlike professional interpreters, ad hoc interpreters do not usually know specialized terminology;
- when using family members and friends as ad hoc interpreters, the privacy of the patient is compromised (problems were reported when the interpreter was the patient's husband).

While acknowledging these differences and being aware that, when using ad hoc interpreters, providers need to analyse the information carefully without relying too much on what has been translated, some interviewees still did not see the need for professional medical interpreters. In their view, language barriers can be overcome with alternative strategies, and some even said that cultural barriers can be far more problematic than linguistic ones. The cultural element was also stressed by Italian interviewees, especially by the heads of departments and healthcare services interviewed in year 1. In their opinion, interpreters are technical experts who can translate information for patients literally, thus ensuring the first two points above, but who lack the necessary cultural background to enable patients to fully understand the situation, its gravity and the implications of certain conditions. Mediators, on the other hand, are perceived as professionals trained to facilitate communication in healthcare settings where language is not the only variable and where people belonging to the same ethnic group are believed to better understand patients' expectations and cultural presuppositions (on the risk of different presuppositions and expectations between HCPs and HCUs, see Baraldi et al. 2012 and Angelelli 2019). In addition to mediators, relatives and friends are also considered extremely important, since they can help create a 'bridge' and a bond between healthcare service users and providers, thereby contributing to socio-emotional communication and the forging of relationships.

In both Spain and Italy, the healthcare professionals interviewed in year 3 showed different degrees of awareness compared to interviewees in year 1. Spanish HCPs were relatively unaware of the pros and cons of using family members as interpreters and some considered that, since these people know the patient better, they are better placed to provide doctors with more information. In their view, family members concentrate not only

on information transmission but also on the transfer of feelings, which only partially compensates their lack of fluency in Spanish and their lack of knowledge of medical terminology. They also stated that children are sometimes used as interpreters, and while they believe that this is not an ideal solution, they also state that it is sometimes the only option available. Spanish healthcare professionals seem happy when their colleagues act as interpreters, since they consider them to have sufficient medical knowledge, which appears to be the most important issue for Spanish HCPs.

Greater awareness of the ad hoc solutions and their (dis)advantages was found among the Italian HCPs interviewed in year 3. When admitting that they resorted to Google Translate and other automatic translation applications, they underlined that they did not trust these apps, because they cannot check the accuracy of the translations. A nurse also said that even when professionals know English – or German in some rarer cases – they use medical jargon. While this is sufficient to communicate with peers, like other doctors in a conference, it is not enough to talk to patients, who generally do not understand medical terminology but speak about their illnesses and symptoms in lay terms, with the 'voice of the lifeworld' (Mishler 1984). Italian healthcare professionals also expanded on the pros and cons of using family members and colleagues to interpret. In the case of family members, they believe that the cons outweigh the pros. Although relatives generally accompany the patient and are thus easily available upon the patient's arrival,[4] they may not be available outside visiting hours or when they work, which is a problem if the patient is admitted to a ward. Italian professionals additionally lamented the possibility of dominant partners speaking for the patient (husbands were mentioned in Italy just like in Spain), or of children lacking an understanding of medical procedures and terminology. Inaccuracy or incompleteness in an interpretation may not only be linked to a lack of understanding, which can happen with children and adults alike, but also to the withholding of information (or 'gatekeeping') when it comes, for example, to the delivery of bad news, or as a result of shame, anxiety and taboos, which may prevent the family

4 This was not the case during the COVID-19 pandemic, when family members had no or very limited access to the facility if the patient was elderly.

member from rendering all that is said by a participant. As for the use of colleagues working in the same healthcare facility, in the view of HCPs, the pros here outweigh the cons, because, although this means that they stop doing their job and thus cause a disservice to their own department while interpreting (see the dual-role mentioned by Romanian interviewees above as well as by Angelelli 2019: 5), they are generally more easily accessible and available for longer periods of time. What is more, colleagues know medical procedures and forms (interviewees reported that they are often called for the signing of informed consent forms), they speak the same medical language as the provider (which confirms the importance of medical knowledge that Spanish professionals also underlined), and they can correctly 'interpret' and render the message for the patient, thereby also facilitating rapport building. A nurse working in the Emilia-Romagna region interestingly told us that professionals always need to *interpret* what the patients are saying, even when there are no linguistic barriers, which reminded us of Angelelli's (2019: 47, our emphasis) words about providers who 'are trained in listening and in *interpreting* what patients are trying to say'. In the nurse's view, doing such interpretation with a patient who speaks another language is – in her words – an interpretation of an interpretation, which can be 'different' and 'deeper' if it is a colleague who is helping to communicate with the foreign patient.

4.1.5. Healthcare providers' suggestions for improvement

HCPs in general, and doctors and nurses in particular, see interpreting and mediation services through their own professional lenses, which appears to have both advantages and drawbacks. On the negative side, the fact that their opinions are based on what happens in their own professional field makes it hard for them to distinguish professional from unprofessional interpreters. This issue clearly emerged from interviews conducted in Spain, where healthcare professionals tend not to be aware of whether the interpreter is really a professional interpreter, or even if they have any training at all. They tend to think that, since this person has been sent by the translation/interpreting company, s/he has the required training to provide interpreting. Unfortunately, however, this is

not always the case, as some companies do not check the background and experience of their interpreters, nor do they provide them with training. It is important to note here that interpreting, and particularly medical interpreting, is not a regulated profession, which means that in Spain, but also in Italy and Romania, 'anyone who knows two languages' can interpret. To perform as a healthcare professional, on the other hand, one has to demonstrate the requisite skills and training to carry out the tasks of the profession. Therefore, healthcare professionals tend to think that the same applies to interpreting, and that if a person has been sent as an interpreter, s/he is a professional.

On the positive side, the fact that HCPs see interpreting services from the point of view of their own profession enables them to provide useful suggestions that language and communication professionals may not envisage. This is an issue that clearly emerged from two interviews conducted with an Italian nurse and an Italian doctor working in two different hospitals of the *Azienda USL Romagna*, in the Emilia-Romagna region. To begin with, both insisted on the need to institutionalize and better structure the available interpreting/mediation services, which in their view can be done in different ways. Their basic suggestion is to make a clear distinction between time-dependent situations/contexts and those requiring longer admission to specific units, in other words, between the demands of the emergency department and those of other hospital wards where patients have a range of changing needs over longer periods of time. On the basis of this crucial distinction – and of one other important distinction between cases where remote interpreting can be effective and those where it is not – one could work to improve services in the two contexts. As for the emergency department, the interviewed doctor underlined the importance of having an interpreter accompany the patient all the way from admission in triage through to the different consultations/exams. Based on this doctor's experience, such an interpreter can act as a crucial link between different healthcare units and professionals, which is what already happens in some emergency services of the Emilia-Romagna region.[5] Not only in

5 For instance, in the hospital where this doctor used to work, qualified interpreters give voice to possible changes in patients' feelings and narrative, from the moment

the emergency department but also in other units where doctors deal with particularly sensitive issues (e.g. reproductive health), the availability of gender-concordant interpreters is seen as an important improvement to be made. One interviewee, a nurse on an emergency surgery ward, thus suggested that the concept of on-call availability generally associated with healthcare professionals be extended to include language professionals, be they interpreters or mediators. To improve other types of healthcare units, where patients may stay even longer, the same nurse also suggested that routine interpreters'/mediators' visits be organized (e.g. ten-minute visits scheduled on a regular basis in each ward that regularly receives foreign patients). By doing so, the ward staff would know when language professionals are coming, and they could optimize their service, that is, by concentrating the linguistic and cultural issues of different patients and/or by anticipating possible communication issues that may arise depending on the evolution of the patient's condition. In her view, this is what already happens with certain healthcare professionals, for example, with physiatrists who are not permanently in the surgery ward but come regularly to assess specific aspects of patients' conditions. Therefore, in the view of this interviewee, there is nothing to prevent this good medical practice from being transferred to language services. According to both the doctor and the nurse, context-specific demands can be anticipated in training, but internships in healthcare facilities are crucial for would-be interpreters to see what their experienced colleagues are saying and doing, which was also suggested by interviewees in year 1. To acquire the needed experience interpreters should – as one interviewee said – 'steal with their eyes' from experienced professionals, in the same way healthcare professionals do through compulsory internships during their university years. Healthcare professionals, on

they first talk with nurses at triage, to the time when they first address the doctor. The entire process could potentially take a number of hours, if the emergency department is crowded and the condition is not life threatening, so the fact that interpreters can see and report those changes is, in the interviewee's view, highly valuable. In the doctor's opinion, this may imply something different from what is generally stated in interpreters' codes of ethics, given that interpreters are not only translating what primary participants are currently saying but also relaying what has been said before, in the triage.

the other hand, should participate in joint interprofessional training with interpreters, so that they become familiar with interpreting/mediation services at university and learn to work with them before the need arises. Finally, for those HCPs who do not speak English sufficiently well for the purposes of communication in healthcare – the vast majority, according to our Italian interviewees – organizing courses in English for Specific Purposes (ESP) is also paramount for improving access to healthcare services by foreign language users.

4.2 Healthcare users' viewpoint

When analysing the quality of interpreting services, studies tend to concentrate on the perspectives and opinions of professionals. It is important to highlight that HCUs' views have to be considered because they are the *recipients* of the healthcare services (Angelelli 2019). However, contrary to what many professionals tend to think (i.e. that it is the users who require the interpreting service), interpreting services are needed equally by both parties: without interpreting, healthcare professionals face greater difficulties in performing their job and allophone patients do not receive nor perceive the same quality of treatment as national patients.

This section, in which the results of the interviews with HCUs carried out in the three countries are presented, is divided into four subsections according to the major topics that emerged in the interviews.

4.2.1. Availability of professional interpreting services in healthcare settings

According to HCUs from the three countries, patients do not have access to interpreting services, a situation which appears to be systemic because even where interpreting or mediation services *are* available, they are not necessarily used and patients are not informed of their existence. This is in line with what we have seen in previous sections: too often healthcare professionals are not sufficiently aware of this service. In HCUs' view, the absence of interpreting services in healthcare facilities is in line with what

happens in other public institutions, where they also have to communicate without any language support. HCUs state that they cannot count on HCPs (doctors, nurses, administrative staff at helpdesks) speaking English, nor on the forms to be read and completed being translated into a language they understand. In the case of the HCUs interviewed in Spain, they had never had the possibility of using a professional interpreter, in general relying on an ad hoc interpreter – usually a relative or friend or simply someone who happened to be at the hospital at the time interpretation was needed but who was not a trained interpreter. These people who had needed an interpreter when arriving to the country acted as ad hoc interpreters themselves after becoming fluent in Spanish, and often after having experienced the lack of such a professional. The most similar experience to having a professional interpreter was reported by one interviewee who was helped by a bilingual HCP who was able to speak English.

Patients indicate that, in their experience, there is usually no information in languages other than the country's official language and that forms are only available in the official language, with a few exceptions (in some hospitals, forms are available in English or French). In this respect, while patients do not expect to have forms and information in their native language, they expect them to at least be available in English or French as a *lingua franca*.

SPAIN

In the case of the interviews conducted in Spain, only the two interviewees who spoke English (either as their native language or as a *lingua franca*) indicated that at times they were able to communicate directly with some HCPs in a language other than Spanish, but that this was not the case every time they needed assistance. According to the interviewees, the availability of someone speaking other languages depends mostly on the people who are working at the healthcare facilities at any given time, and not on the type of healthcare facility (healthcare clinic, hospital, emergency department, etc.). Even English-speaking patients are asked to bring their own interpreter, with some healthcare facilities displaying

handwritten posters asking patients to bring their own interpreter. For other languages, as we will present in the following section, patients need to resort to their own solutions to communicate with healthcare staff.

ITALY

As for the language combinations offered, the interviews carried out in Italy revealed that patients consider that the language combinations available often depend on local needs and communities, without any systematic organization at a national level. HCUs agree with HCPs on the fact that healthcare staff does not speak English sufficiently well for the special purposes of communication in healthcare. The other foreign languages that are generally covered in addition to English are Russian and Croatian, mainly during summer months, while languages such as Arabic, Albanian, Chinese and other Slavic languages such as Bosnian/Croatian/Serbian, Czech, Polish and Ukrainian are not sufficiently covered by the available services, because, as patients report, only Russian is taught at universities in the country. HCUs disagree with HCPs on the issue of Arabic language provision, with HCUs finding that the language is not sufficiently covered, while HCPs believe it is.

ROMANIA

The situation in Romania is similar to that in Spain. According to the interviewees, it is very difficult to communicate in healthcare settings unless the HCU speaks Romanian, English or French. However, speaking French or English does not guarantee successful communication either, as many healthcare professionals do not speak these languages.

4.2.2. Solutions adopted to eliminate linguistic barriers

The results obtained from a qualitative analysis of the interviews conducted in year 3 showed similar results for the three countries participating in the project. All interviewees stated that, before being able to speak the language of the host country, when they needed someone to communicate

with healthcare staff, they usually relied on a friend or relative. Some of the interviewees later became ad hoc interpreters themselves for family members and extended family and would also interpret for friends who had just arrived in the country. Some had in fact already acted as interpreters when they were children. One of the HCUs interviewed in Spain told us that she had acted as an interpreter for her family and that this experience was behind her decision to pursue a Degree in Translation and Interpreting, so that she could help others avoid going through what she went through as a child. Even in the cases where they do not work as interpreters on a regular basis, many of the interviewees who once were allophone patients have worked as ad hoc interpreters for other users. Interviewees stated that when the visit to the healthcare facility was not to an emergency service, they would attend accompanied by someone who can help them to understand the language. The accompanying person then translates the doctor-patient dialogue and mediates any cultural issues (related to food, religion, etc.) that may arise during the communication.

HCUs interviewed in Italy mentioned some of the ad hoc solutions found, namely the use of family members or friends who know both Italian and the foreign language and the use of partners (e.g. one's girlfriend) along with the use of *linguae francae*, mostly in cases where the patient and the professional can speak some English, or French in fewer cases.

Some interviewees consider the use of children as interpreters to be normal practice. However, others state that the use of children is usually restricted to situations with the family doctor, where they felt the issues dealt with were easier than those addressed by other specialized doctors. For these more specialized doctors, patients stated that they try to attend the appointment accompanied by a friend or relative. Children who act as interpreters do so not only for their parents but also for other relatives and friends. Studies on the consequences of using children as interpreters have mainly focused on the United States (Antonini and Torresi 2021), and research findings remain inconclusive; while some children might like to interpret in such situations as it gives them a sense of pride for helping their families, others see interpreting as a huge responsibility that puts them under pressure and causes them to worry about not doing the work sufficiently well (Weisskirch and Alatorre Alva 2002; Bauer 2012).

In the case of Romania, one of the main solutions mentioned by HCUs – mostly for Hungarian patients and probably due to the immigration and historical context – was the use of bilingual staff, that is, Hungarian or Hungarian-speaking nurses, who help to interpret or speak directly in Hungarian to the patient. Other HCUs in Romania again reported that patients usually go to the hospital linguistically prepared, that is, they bring a relative or a friend to help them to communicate. It is also interesting to mention that, according to the interviewees, in the private healthcare system in Romania written documents, such as informed consent forms, are translated into a language other than the official one, mostly English or French.

One solution mentioned in the three countries by HCPs but not by HCUs is the use of machine translation applications to communicate in healthcare settings. This is probably because this solution is not widespread in healthcare services, possibly because most of the time HCUs are accompanied by someone speaking the official language and thus do not need to resort to this means.

From the interviews it seems that patients are generally satisfied with healthcare services despite the communication difficulties they might encounter. One explanation for this is that patients are happy that they are able to receive treatment for their health issues and are not fully aware of the beneficial consequences of having a qualified interpreter to help them with communication. Another reason might be that, since most of the time they bring their own ad hoc interpreter, they do not really feel the need for a professional interpreter, as long as they are able to communicate their problem to the doctor.

4.2.3. Healthcare users' experiences when using ad hoc interpreters

Experiences when using ad hoc interpreters are varied and seem to depend on the results of the consultation. It is interesting to note that most of the interviewees, who had once needed interpreting services, later went on to act as interpreters themselves after learning the official language of the country. Interviewees therefore also spoke about their own experiences as interpreters. As we have mentioned before, and at

least in the case of Spain, most of the interviewees were once recipients of interpreting carried out by a friend (when they first arrived and they did not speak the language), but as soon as they were able to express themselves in the official language, they themselves became ad hoc interpreters for others. One of the interviewees stated that being an interpreter as a child put a great deal of pressure on her, because she and her brother did not know the terminology and were afraid of making a mistake when interpreting for their parents. In the case of Italy, a foreign (female, Ukrainian) patient working as a caregiver reported on her experience of ad hoc interpreting for a Russian lady who was in Italy to visit her daughter; she had been taken to hospital by ambulance but did not understand why, and doctors were unable to communicate with her. The interviewee explained that the lady's daughter had accompanied her mother but could not speak Italian at all, and that she was the only person able to ensure communication with the medical staff. Her report clearly shows that on that occasion, several years ago, no communication was possible between healthcare professionals and this elderly Russian patient in that hospital, which could have led to a real emergency, as the doctors were unable to obtain any information from the patient. Only after running some tests, it turned out that, fortunately, it was simply a case of high blood pressure and that the patient had no significant health problems. However, had the health condition been more serious and had the interviewed HCU not been at the hospital at that time, there would have been an impenetrable linguistic barrier that could have led to significant consequences for the patient.

As far as the use of partners for language mediation is concerned, one of the HCUs interviewed in Italy expanded further on his experience when his girlfriend – who would usually interpret for him – was not available. He provided two useful insights into the advantage of using professional intercultural mediators instead of ad hoc solutions when explaining medical problems to the service providers, be they doctors or staff at help and reception desks. Firstly, since the mediator was able to clearly communicate the problems and obstacles, he felt much more secure because he had passed the communicative responsibility on to the mediator and secondly, he was able to explain everything in his own language without feeling the

need to invent words, find shortcuts or draw on a piece of paper. Having said this, the same Serbian patient admits that he managed to communicate with doctors and staff at helpdesks directly and explained that when the interpreter was not available, he used English as a *lingua franca*.

Some other interviewees also mentioned using English as a *lingua franca* for communication when the HCU and HCP speak a shared language other than the language of the host country, often English, which is then used by the HCP to speak directly to the patient without the need for any third party. One interviewee in Italy stated that some doctors hold a positive bias towards native English speakers and that this enabled her, as a native English speaker, to receive better treatment when communicating directly with them. She also indicated that the times she had to speak in Italian to high-level medical professionals, the fact that she did not know the words in Italian but did know them in English always worked to her benefit, because even though it was clear that she had an accent when speaking in Italian and that she could not speak the language well, they managed to understand her. However, she considered that there was a huge difference in the treatment received by her, as a native speaker of English, and that received by other immigrants speaking other languages.

There are other cases in Spain and Romania when the effort made by HCPs to speak to HCUs in English is mainly seen in a positive way. In Spain, this was the case for a native English-speaking patient and for a Polish patient who could communicate in English and German.

Some interviewees reported bad experiences when using ad hoc interpreters. One Romanian patient interviewed in Spain reported that on one occasion her mother went to the hospital on her own; she did not speak any Spanish and therefore, as none of the HCPs could speak Romanian, the hospital staff called on someone working in the kitchen. This person interpreted incorrectly and changed the meaning (saying that the woman was allergic to medication that was important for her treatment). The problem was not solved until the woman visited the doctor accompanied by her Spanish-speaking daughter, after which she received the correct treatment and her condition improved.

Sometimes, the lack of an interpreter can lead to significant problems, as one of the interviewees in Romania, a HCU from Morocco, reported. In this case, the HCU had contracted COVID-19 during the pandemic and needed to call an ambulance. At that point in time, the HCU spoke Romanian at A2 level and was not proficient enough to fully communicate his situation, while the triage nurses spoke neither English nor French. Although the nurses followed protocol, the HCU had an allergy to a medication he was given, and, as a result of the treatment, had to be admitted to hospital. After this, he called the Honorary Consul of France in Cluj and the Consul himself had to interpret.

4.2.4. Healthcare users' suggestions for improvement

According to most interviewees, there is a need to offer more interpreting services and also to better inform both HCUs and HCPs of their existence. Interviewees also commented that more information about the service should be made available, for example, through posters displayed in the waiting rooms in the most encountered languages. However, it is important to bear in mind that the system works as follows: HCPs are the ones who should contact the interpreters in the first place if they realize that there might be communication problems in the three countries.

In Spain, suggestions for improvement are related to the ability of HCPs to speak a *lingua franca*, such as English or French, at the triage stage, as a means of ensuring at least minimal communication. While this is not an ideal situation either, if the patient speaks that language, it is considered an adequate way to overcome communication issues at the initial admission stage. Similarly, some interviewees consider it important that ambulance drivers speak English so they can communicate when they pick up a patient. Some users also agreed with the use of remote interpreting as a way of improving communication for allophone patients and healthcare professionals. However, they also indicated that they had never used such a service.

In the case of Italy, HCUs considered that interpreters and mediators should be able to speak several languages, at least in main/regional hospitals. Two interviewees considered that interpreting services should be

institutionalized, with one arguing that the only way such a service could really work was if interpreters were part of the institution and the planning process, thus ensuring that the services offered through interpreters are co-created with the interpreters themselves. This same HCU, a native English speaker, also added an interesting point about written materials, which she later formulated as a direct suggestion for the improvement of written documentation used in healthcare facilities. She stated that everything in the hospitals *was* in English but was mostly incomprehensible, that most of the written materials had not been written directly in English but translated from Italian and did not make much sense to her. She believed that if these documents were difficult to understand for a native speaker of English, someone using English as a *lingua franca* would probably not be able to understand them.

A male Serbian HCU interviewed in Italy also suggested the institutionalization of interpreting services, based on two separate experiences he had in the Emilia-Romagna and Trentino regions. In his opinion, there should be a methodical procedure when a foreign patient who does not speak the country's official language arrives at the hospital: an interpreter should be automatically requested and the patient would therefore feel more relaxed, knowing that there would be someone to support him/her in communicating his/her issues.

A third HCU interviewed in Italy presented an amalgamation of the suggestions of the two previous interviewees, suggesting an improvement in the language of forms, the institutionalization of services and the filtering of allophone patients; this interviewee stated that the most basic suggestion would be to complete forms before someone attends the actual medical appointment to determine the patient's linguistic needs.

One of the interviewees from Romania reflected on the idea of confidentiality when using ad hoc interpreters, even if they are healthcare professionals or students and the importance it should have in the course of interpreting. Finally, but of no less importance, this interviewee indicated that having professional interpreters would reduce stress, not only for patients, but also for healthcare professionals.

6. Conclusions

As stated by Angelelli (2019: 22), 'hospitals, clinics and community health centres are organizations embedded in specific societies'. In this chapter, we have tried to account for how Spanish, Italian and Romanian healthcare organizations are embedded in their respective countries on the basis of information gathered from people on the front line, that is, healthcare service providers and users. After introducing our methodology in Section 2, in Section 3 we provided a short overview of the healthcare systems and legislation in Spain, Italy and Romania. Section 4 was then organized into two main subsections, one giving voice to HCPs and the other to HCUs. From the comparative analysis of their viewpoints, which we will briefly recall below, we can conclude that Spain, Italy and Romania are at different stages of their development, which we will summarize borrowing on Schuster's (2013) model of language access to public institutions.

This five-stage sociological model describes and analyses the processes leading from a chaotic public sphere in which no institutionalized and professional solutions are in place to facilitate communication between service providers and members of a linguistic minority, to a public sphere that is linguistically accessible as part of a comprehensive policy of cultural competence. The model proposed by Schuster (2013: 63) includes the forces impacting the process, such as those that facilitate or hinder full language access. The following are the stages of the model:

A. Chaos
B. Emerging awareness
C. Piloting professional interpreting services
D. The decisive phase:
    D1. Disappearance of the service
    D2. Small-scale projects continued
    D3. Expansion, Duplication and Institutionalization
E. Spillover

HCUs interviewed in the three countries were not as precise as HCPs in talking about solutions adopted to eliminate cultural and linguistic barriers, instead they simply state that interpreting services do not exist. In the case of Spain, users seem to take for granted that they need to attend medical appointments with someone who speaks the country's official language, and that it is normal to bring one's own ad hoc interpreter, because they appear to assume that it is their duty to take responsibility for enabling communication with HCPs. Users thus forget that interpreting services are necessary for both sides: the interpreter is needed by HCPs to provide quality healthcare and by HCUs to receive the correct treatment. In any case, HCUs were surprised to learn that interpreting services do exist in some hospitals.

In Italy, users substantially agreed – among each other and with providers – on the need to institutionalize interpreting services to ensure that they are linguistically appropriate, sufficient in availability, and timely. Their suggestions for improvement are based on personal (often negative) experiences and take two main directions: better translations of written documents, which could be used to filter allophone patients from the moment they access the healthcare facility; and linguistic assistance and guidance throughout the path of care, starting from the moment in which patients' linguistic needs have been determined and appropriate interpreters are methodically assigned.

As for Romania, it seems that at least sharing a *lingua franca* with the HCPs would satisfy the HCUs, but the fact remains that the situation is extremely chaotic in the countries under investigation and that if we only considered the beliefs of the users interviewed, the three countries would probably be at stage A of their development according to Schuster's (ibid.) model.

If we consider the HCPs' viewpoints, however, some differences emerge between the three countries. In the case of Romania, while it is true that 'the state does not provide comprehensive and institutional means of linguistic access' (ibid.: 63) and that 'the service provider must resort to ad hoc solutions' (ibid.) – two typical conditions of the chaos A stage – it is also true that interviewees showed an emerging awareness. According to Schuster (2013: 64), awareness is generally the result of different processes and forces,

such as scientific research and the knowledge of solutions adopted in other countries, to which ReACTMe undoubtedly contributed. We may thus conclude that, at least partially thanks to this three-year Erasmus+ project, Romania is currently moving from the stage of chaos (A) to that of emerging awareness (B), although some obstacles still prevent it from piloting professional interpreting services and thus from moving to the third (C) stage of development. In the words of Schuster (2013: 66),

> Stage 3 of the model entails the founding of a designated professional interpreting service, usually for a trial period. This service may be part of an organisation or public service, or may be an independent (profit- or non-profit) organisation that subcontracts interpreting services to public institutions.

This quote recalls the system of subcontracts with companies, associations and cooperatives that we have found both in Spain and Italy, through which, according to HCPs, some interpreting and mediation services are available. However, despite some commendable pilot attempts, most of the services are insufficient in number, language provision and timeliness; there is thus a need for further research and partnerships for these two countries to face the decisive stage of their development. To quote again Schuster (2013: 67), who draws inspiration from the ground-breaking volume *The Critical Link: Interpreters in the Community* (Carr et al. 1997),

> Partnerships with members of academia who deal with interpreting are important in ensuring a professional and reliable service based on proven models and on standards of ethical practice. Researchers can assess needs, perform quality control, and evaluate performance, thereby helping to create strategic plans for the future of language access.

To conclude, we may say that both Spain and Italy are in the fourth decisive (D) stage of their development, where following Schuster (2013: 67) there are three main options for proceeding: (D1) the disappearance of the few services available and the return to a state of chaos; (D2) the continuation of a small-scale operation of the service, which implies that many regions and local health authorities will go on adopting ad hoc solutions, with the advantages and disadvantages listed above; or (D3) the expansion, duplication and institutionalization of the good services that currently exist.

This third direction entails not only the introduction of the successful interpreting services described by our interviewees into additional institutions, but also the introduction of national legislation and regulations ensuring that interpreting is included in the regular budget. Although we can hardly impact on the latter, we do hope that the ReACTMe project has made a contribution to mapping what exists and what is still lacking in Spain, Italy and Romania in terms of medical interpreting, thereby providing commendable examples and useful suggestions for exiting the current 'limbo stage' between chaos and full access (ibid.: 69) and to improve the healthcare and language services nationally and Europe-wide.

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