

Interpreting in Flemish Hospitals: Interpreters' View and Healthcare Workers' Expectations

*La interpretación en los hospitales flamencos: la perspectiva
de los intérpretes y las expectativas del personal sanitario*

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Abstract: In Flanders (Belgium) social interpreters and intercultural mediators help bridge the communication gap between foreign language speaking patients and healthcare workers. This paper reports on a comparative survey among social interpreters and intercultural mediators with a focus on how they perceive their role and tasks as interpreters in a healthcare setting. We examine if this is related to different codes of conduct and task descriptions. The survey showed that intercultural mediators feel that they can take on various roles, and have a whole range of responsibilities and duties, much more than social interpreters. In practice, social interpreters find it difficult to stick to their code of conduct. Another survey among healthcare workers working inside a hospital revealed that, in general, their expectations of an interpreter correspond more to the profile of an intercultural mediator than to the profile of a social interpreter.

Keywords: Intercultural mediation; public service interpreting; survey; code of conduct; interpreter's role.

Resumen: En Flandes (Bélgica), los intérpretes sociales y mediadores interculturales ayudan a cerrar la brecha de comunicación entre los pacientes que hablan lenguas extranjeras y el personal sanitario. El presente artículo pretende informar sobre una encuesta comparativa entre intérpretes sociales y mediadores interculturales, en la que se pregunta cómo perciben su papel y sus tareas como intérpretes en un entorno de atención sanitaria, y si se relaciona con diferentes códigos de conducta y descripciones de tareas. La encuesta demostró que los mediadores interculturales se sienten capaces de asumir diferentes papeles, y que tienen toda una serie de responsabilidades y deberes, mucho más amplios que los intérpretes sociales. En la práctica, los intérpretes sociales encuentran dificultades para apegarse a su código de conducta. Otra encuesta realizada entre personal sanitario que trabaja en un hospital reveló que, en general, las expectativas que tienen del intérprete corresponden más al perfil de mediador intercultural que al perfil de intérprete social.

Palabras clave: Mediación intercultural; interpretación en los servicios públicos; encuesta; código de conducta; papel del intérprete.

1. INTRODUCTION

In the last decades, there have been some major demographic changes all over the world, one of the most prominent of which is a persistent rise in the number of migrants. Since 2000, the number of international migrants has increased by 41% (United Nations 2015). This is also the case in Flanders, the northern part of Belgium, where the number of international immigrants increased by approximately 50% from 2000 until 2010 (Pelfrene & Van Peer 2014, 18). As a consequence, hospital staff members are increasingly confronted with patients who speak foreign languages and have limited or no skills in the language(s) of the host countries.

Researchers in the Netherlands studied the importance of language in healthcare and concluded that low language proficiency has adverse effects on health, since it impedes doctor-patient communication. They found that knowledge of the local language(s) is essential not only for effective communication in general but that foreign language skills are particularly needed in healthcare settings, where language knowledge can be a matter of life and death, as patients have to be able to explain their symptoms, feelings, and worries. If communication in healthcare settings is ineffective, doctors may be unable to obtain accurate patient assessments and deliver sound diagnoses, and patients may be unable to understand their treatment plans and schedule subsequent visits (de Greef & Segers 2016, 9-12).

When a foreign language speaking patient or a patient with limited Dutch¹ proficiency needs language assistance in a Flemish hospital, several options exist: doctors and

1. Dutch is the official language in Flanders.

patients can try to find a common foreign language (typically English, or French in the case of Flanders); patients can bring a relative or friend that speaks the language; hospital staff members can act as interpreters; and doctors can call on professionals. Previous research has indicated that relatives or friends of the patient should not be called upon to act as interpreters, mainly because the quality of communication cannot be guaranteed and because they are not bound by any code of conduct. Therefore, confidentiality cannot be guaranteed (Green *et al.* 2004; Flores 2005; Pöchhacker & Shlesinger 2007).

This study focuses on the role of professionals to help bridge the communication gap between doctors and foreign language speaking patients. In Flanders, two types of professional interpreters work in the healthcare sector: *social interpreters* and *intercultural mediators*. The main goal of both professions is to facilitate healthcare access for foreign language speaking patients, mainly by interpreting, though the job description for each of these professions differs considerably.

In the first section, a short theoretical overview of both professions is given, including a definition of each type of professional, a description of typical task types, an outline of each one's organizational framework and a discussion of their codes of conduct. The main part of this article, section three, reports on a survey among professional interpreters and intercultural mediators that focuses on how they perceive their role and tasks as interpreters in a healthcare setting. In order to analyze the data, we set the answers side by side and compared them with the task descriptions and codes of conduct of both professions. In the final section, the results of the survey are linked to another survey we conducted one year later in which we asked healthcare providers what they expect of interpreters so as to determine whether their expectations correspond most closely with the profile of intercultural mediators or with the profile of social interpreters.

2. INTERPRETING IN FLEMISH HOSPITALS: SOCIAL INTERPRETERS AND INTERCULTURAL MEDIATORS

2.1. Definition and tasks

In international scientific literature a professional interpreter in a public setting is mostly referred to as «community interpreter» (*cf.* Wadensjö 1998; Valero-Garcés & Martin 2008; Bancroft 2015) or «public service interpreter» (*cf.* Corsellis 2008; Hale 2011). In Flanders, this professional is called a «social interpreter». Social interpreters interpret, by order of a service or authority, for a care provider or public servant with the aim of facilitating access to social services for foreign language speaking users or users with limited Dutch proficiency. Social interpreters work in a variety of settings, like

education, healthcare, social welfare, integration, etc. They have one clearly defined task: interpreting (Junction Migration-Integration 2014).

However, the job description of an intercultural mediator is more complex. Intercultural mediation includes «all activities that aim to reduce the negative consequences of language barriers, socio-cultural differences and tensions between ethnic groups in health care settings.» (Federal Public Service 2016, 5). They are mainly active in a healthcare setting.

Intercultural mediators strive to ensure that the healthcare delivered in Belgium is of equal quality and accessibility for both nationals and foreigners. In order to achieve this, they act as interpreters, but they also facilitate the communication in more complex ways (e.g. clarifying misunderstandings, explaining cultural elements, and supporting doctors and patients in the performance of their duties). They also advocate for changes, although this should be avoided (Federal Public Service 2016, 7-8).

2.2. Organizational framework

Social interpreters and intercultural mediators not only have different task descriptions, but the organizational framework is also significantly different.

Social interpreters	Intercultural mediators
work in a variety of settings (e.g. education, healthcare, integration)	mainly work in health care
funded by the Flemish government	funded by the Federal government
work through social translation services	members of the hospital's staff
interpreting is only task	interpreting is only one of their tasks

Table 1. Organizational framework

There is an important difference between the organizational structure in which social interpreters and intercultural mediators are working: social interpreters work through external social interpreting and translation services, and intercultural mediators are part of the hospital's staff itself. Moreover, social interpreter services are funded by the Flemish government and intercultural mediators in hospitals are funded by the Federal government (Federal Public Service for Health, Food Chain Safety and Environment), i.e. hospitals receive financial aid from the Federal government for deploying intercultural mediators.

Social interpreter candidates who follow a training program and pass the existing interpreting exam (consisting of language proficiency tests in the mother tongue and the foreign language and interpreting tests by means of role plays) are added to a

register of certified social interpreters. When interpreting services are needed by a local, regional or national organism, Belgian law requires that only certified interpreters can be called upon. The register of certified social interpreters contains around 430 professionals².

Intercultural mediators, on the other hand, are staff members of the hospital itself. In 2013, approximately 80 intercultural mediators were active in 52 hospitals in Flanders, Wallonia and Brussels (Verrept 2013, 10; Federal Public Service 2014). Flanders has an undergraduate course called «Intercultural Assistant» which lasts three years and a postgraduate course called «Intercultural Services» which lasts one year. Intercultural mediators who do not have a master's diploma in interpreting or a certificate of social interpreting receive basic training in interpreting strategies (e.g. note-taking and code of conduct). Moreover, they must participate in at least 75% of the training sessions or workshops organized by the Federal Public Service.

2.3. Code of conduct

Both social interpreters and intercultural mediators have their own code of conduct. A code of conduct is a set of rules that not only gives interpreters a professional framework in which they can work but also informs the client about what exactly they can(not) expect from an interpreter (De Bontridder & De Groot 2011, 92). Codes of conduct are indispensable, because they provide clarity on the role of interpreters, which has been frequently discussed in international literature (Wadensjö 1995; Angelelli 2004/2006; Bot 2005). Angelelli (2006, 189) points out that the interpreter's roles are often prescribed without consideration given to the reality in which interpreters work. She claims that interpreting is a «situated practice» and that codes of conduct should vary according to the work setting (e.g. healthcare, court, education...) (Angelelli 2004, 13). In Belgium, there is no separate work profile for social interpreters in healthcare such as those that have been developed by, for example, CCHI (CCHI, Certification Commission for Healthcare Interpreters), CHIA (CHIA, California Healthcare Interpreting Association), IMIA (International Medical Interpreters Association), and NCIHC (National Council on Interpreting in Health Care) in the United States. In Belgium, the intercultural

2. The training and exam center is, since January 1, 2015 part of a new Flemish structure *Agentschap Integratie en Inburgering* (Agency for social and civic integration). Before this date, Junction Migration-Integration (Junction MI - *Kruispunt Migratie-Integratie*) was responsible for everything that involves social interpreting. Junction MI merged into the new structure, together with 19 other organizations, among them 7 are public service interpreting and translation services. For more information on the situation before January 1, 2015 see Van de Geuchte & Van Vaerenbergh 2013.

mediators' code shows more similarities with these profiles than the social interpreters' code.

In Flanders, the Junction MI set up a general code of conduct for *social interpreters* applicable in all settings (e.g. education, social welfare, healthcare, integration) (Junction Migration-Integration 2013). This code contains some deontological principles like discretion, neutrality, comprehensiveness, transparency and professionalism. In this code it is written, among other things, that interpreters shall interpret everything that is said, without additions, omissions or changes (Junction Migration-Integration 2013, 5). Besides the code of conduct of the Junction MI, the Flanders Social and Economic Council (SERV) provides a competence profile for social interpreters (Sociaal-Economische Raad van Vlaanderen 2008). In this profile, the basic skills and tasks of interpreters are determined and the deontological principles that are mentioned correspond to those in the code of conduct of the Junction MI.

On the other hand, the code of conduct for *intercultural mediators* actually comprises part of the «Guide for intercultural mediation in healthcare» which has been written by the Federal Public Health Service (Federal Public Service 2016). The Guide was established in cooperation with, intercultural mediators and specialists in medical right, among others. It contains a description not only of the tasks that intercultural mediators perform, but also of the standards to which they should be carried out. The guide contains a first draft of a code of conduct for intercultural mediators which discusses some of the same aspects as the social interpreters' code: professionalism, transparency, neutrality, and confidentiality, but also includes the following aspects: responsibility, boundaries, and the role of an intercultural mediator in conflict situations. This guide is referred to in this article as the 'code of conduct' of intercultural mediation.

This code of conduct of intercultural mediation is inspired by certain standards of several American medical interpreter organizations, particularly the IMIA (International Medical Interpreters Association), CHIA (California Healthcare Interpreting Association), and NCIHC (National Council on Interpreting in Health Care) (Federal Public Service 2016, 7). Interpreting is defined as «complete and faithful conversion of a spoken or signed message from a source language into an equivalent message in a target language. In principle, nothing is added or omitted» (Federal Public Service 2016, 24). This definition is more nuanced than the one given in the social interpreters' code of conduct in that it explicitly includes sign language interpreting, it stresses the importance of reproducing an «equivalent» message, and it adds «in principle». What is meant by «in principle» becomes clearer in §13 of the standards in which it is stated that in certain cases (which are listed) «the intercultural mediator shall deviate from the principle that nothing shall be added or omitted during an interpreting session» (Federal Public Service 2016, 28-29) [own translation].

3. SURVEY: SOCIAL INTERPRETERS VS. INTERCULTURAL MEDIATORS

Section 2 demonstrated that both social interpreters and intercultural mediators have clearly defined tasks which are described in codes of conduct. We set up a survey that focuses on two research questions: how do social interpreters and intercultural mediators view their role and tasks as an interpreter in a healthcare setting? Does their self-perception correspond to the stipulations in their respective code of conduct?

3.1. Setup and participants

The survey was set up, conducted and analyzed with the research software Qualtrics (version June 2015). Qualtrics is an online survey program that facilitates distribution of online surveys, collection of answers and analysis of the quantitative survey data.

Social interpreters and intercultural mediators received the same survey in order for answers to be comparable³. The survey consists of 39 closed-ended questions⁴ and 7 open-ended questions (see appendix questions 3.7, 3.7.1, 5.2-5.6). We used different types of closed-ended questions: yes-no questions, multiple choice and Likert scale. The questions were divided into five parts: general questions, medical knowledge, language and culture, attitude, and personal information.

The survey was addressed to social interpreters and intercultural mediators in Flanders and was sent on March 24, 2014 to 401 social interpreters listed at that time as certified social interpreters with the former Junction MI. Fifteen e-mail addresses turned out not to be in use anymore, so 386 people received the survey. We received 83 answers, therefore demonstrating a response rate of 21.5% (completion rate: 81.9%).

As well as social interpreters, the survey was sent to the 47 Flemish intercultural mediators listed by the Federal Public Service Health, Food Chain Safety and Environment (only those who have Dutch as one of their languages were selected). We received 33 answers, giving a response rate of 70.2% (completion rate: 81.8%).

3. We only changed the use of words (social interpreter vs. intercultural mediator)
4. 41 closed-ended questions for intercultural mediators, because we not only asked if they had any intercultural mediation training, but also if they received any interpreting training and if so, which one (see appendix 1.6 and 1.6.1)

3.2. Results

Some remarkable differences and similarities in how intercultural mediators and social interpreters perceive their occupation as an interpreter were discovered during the analysis of the data, dissimilarities were also revealed between how they handle specific situations and how their tasks are outlined in codes of conduct. This article highlights the questions and answers from all five of the previously mentioned sections in the survey (general questions, medical knowledge, language and culture, attitude of the social interpreter/intercultural mediator, and personal information). They were selected in consideration of their relevance to the research questions. The focus will thus be on the questions of part IV.

3.2.1. General questions

The survey contains 14 general questions, i.e. questions about the sector in which they work (1.1-1.4), about their education and training (1.5-1.7), and about the medium through which they interpret (1.8).

Intercultural mediators (ICM) mainly work in healthcare settings whereas social interpreters (SI) are active in various settings: healthcare, education, integration, social welfare and other social services (cf. section 2.2.). In the survey, participants are asked if they interpret in settings other than healthcare (figure 1).

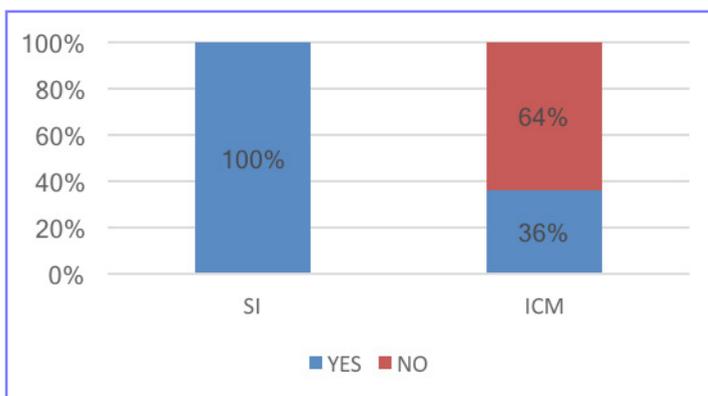


Figure 1. Do you interpret in other public services?

As expected, all social interpreters answered 'yes', whereas only 36% of intercultural mediators answered affirmatively.

In question 1.6 and 1.6.1, participants were asked if they had completed any kind of interpreter training (yes-no) and if so, what kind.

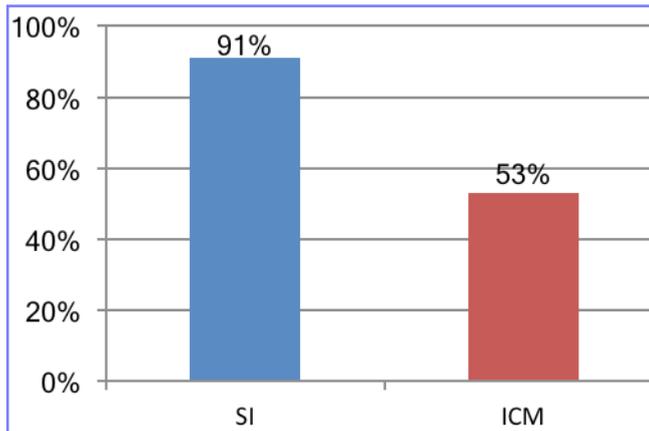


Figure 2. Did you complete an interpreter training?

91% of the participating social interpreters (SI) had some kind of interpreter training: most of them (98%) got their training from the Junction MI. Other answers are for example a masters' degree in translation, a master's degree in interpreting, a master's degree in multilingual communication and formal training in court interpreting.

Although intercultural mediators are expected to follow a basic interpreting course, only 53% of the participating intercultural mediators (ICM) had actually completed some kind of training in interpreting: e.g. training from the Junction MI, training in Flemish Sign Language, interpreting course from the Federal Public Service. Moreover, only 47% of the ICMS answered that they had completed a training course in intercultural mediation specifically (mainly in higher education (47%) and the training courses offered by the Federal Public Service (27%)).

Participants were asked which medium they most frequently used to interpret [via telephone, via internet or face-to-face (on the spot)]. For every question in this section they had to select an answer between 'never', 'now and then', 'often', or 'always'.. The data shows that face-to-face interpreting (where the interpreter or intercultural mediator is physically present inside the consultation room) is still the most popular mode of performing interpreting services (95.46% of SIs ticked 'always' or 'often' and 100% of ICMS ticked 'always' or 'often'). Besides face-to-face interpreting, telephone interpreting is another frequently used method, both for social interpreters (40.91% ticked 'always' or 'often') and intercultural mediators (33.33% ticked 'always' or 'often'). Ba-Bel is the Flemish telephone interpreting service. Certified social interpreters can be asked to interpret over the phone, which can be a good alternative for face-to-face interpreting if linguistic assistance is urgent. Lastly, it is notable that only intercultural mediators interpret relatively often through internet (73.33%) with social interpreters very rarely using this medium (7.58%).

3.2.2. Medical knowledge

In this section, participants were asked if they had had any medical training and if so what kind, and what the advantages of such training were. The answers collected in response to four questions in this section did not reveal any significant differences or similarities between the two groups. The data shows that 9% of the participating social interpreters and 20% of the participating intercultural mediators had followed some kind of medical training (mostly nursing).

3.2.3. Language and culture

In Part III, «language and culture», participants were asked 14 questions. The first series of questions were about their mother tongue and how they acquired the different languages they work with, as well as their knowledge of cultural characteristics (questions 3.1-3.5). It is not a prerequisite to be a native Dutch speaker to become a social interpreter or intercultural mediator in Flanders, though they must know Dutch at least at a B2 level (vantage or upper intermediate) as established by the Common European Framework of Reference for Languages (Council of Europe 2001). Only 27% of the participating social interpreters and 13% of the participating intercultural mediators have Dutch as their mother tongue. The most common mother tongues among participating social interpreters are Russian (19%), Turkish (11.9%), Rumanian (11.9%), and Arabic (11.9%). The most common mother tongues among intercultural mediators are Turkish (36.8%) and Arabic (31.6%). The majority of participants learned their foreign languages (including Dutch) at school or through daily life.

After these more general questions, participants were asked what they would do if cultural elements were not comprehensible to the healthcare provider involved (question 3.6). They were given four possible answers and they had to select 'yes' or 'no' for each of them. Figure 3 gives an overview of the answers that were ticked 'yes'.

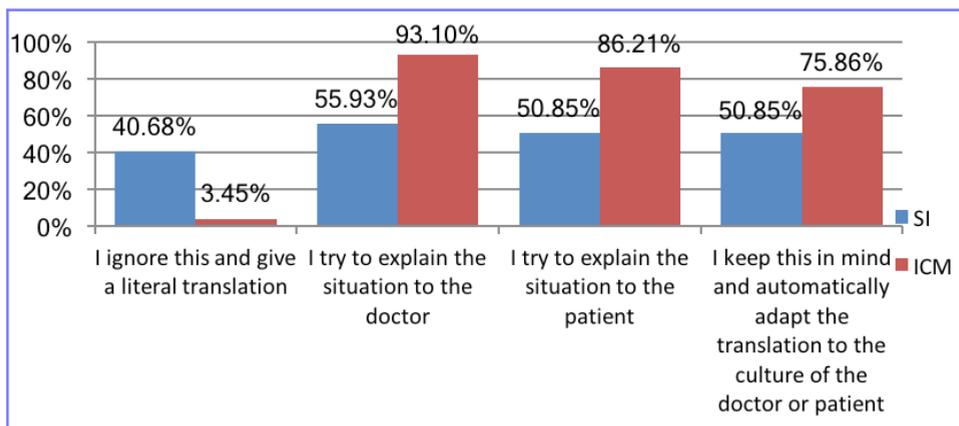


Figure 3. What do you do when cultural elements are not comprehensible for the doctor?

Figure 3 shows that intercultural mediators answered in a more unanimous way than social interpreters. Between 40% and 56% of social interpreters answered ‘yes’ to all options, and thus it follows that another 60% to 44% of them answered ‘no’ to the same question. In most cases, intercultural mediators will try to explain the situation to the doctor (93.1%) and the patient (86.2%), or they will automatically adapt their translation so that all parties are able to understand (75.86%).

The most remarkable difference lies in the first option: 40.68% of social interpreters would ignore the fact that the doctor did not understand cultural differences and would go for a literal translation. On the other hand, only 3.45% of intercultural mediators answered affirmatively to this option.

3.2.4. Attitude of the social interpreter/intercultural mediator

In Part IV on «attitude of the social interpreter and intercultural mediator», ten questions were asked about how participants perceived their role, priorities, responsibilities and duties when interpreting. The first question (4.1), focused on their view of their role as an interpreter. Participants were given nine options: a bridge between people, a cultural informant, a first-contact person for the patient, a care provider, a neutral intermediary, an advocate, a bilingual professional, a translator, and a confidential advisor for the patient (and family). Participants had to choose the three most relevant options and number them in order of importance, with 1 being most important.

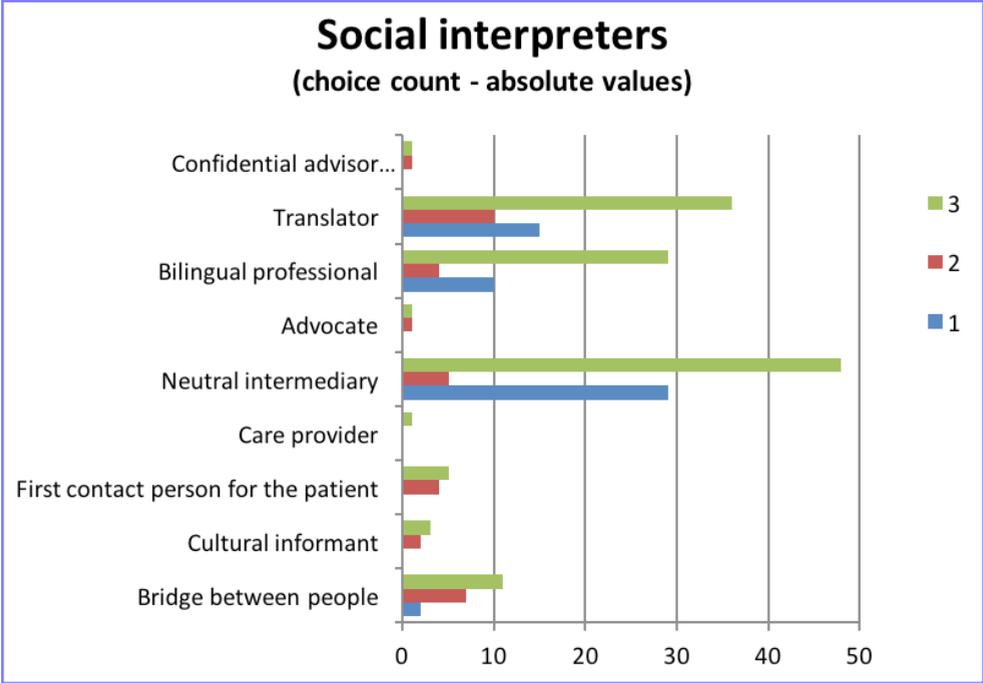


Figure 4. What is your role when interpreting in a medical setting?

Social interpreters agreed on their role. They saw themselves primarily as neutral intermediaries (29 participants put this option in first place, 5 in second place and 48 in third place). In second place they saw themselves translators (15 in first place, 10 in second place, and 36 in third place) and in third place as bilingual professionals (10 in first place, 4 in second place, 29 in third place). The other roles were almost never chosen with the exception of a 'bridge between people' (11 in third place).

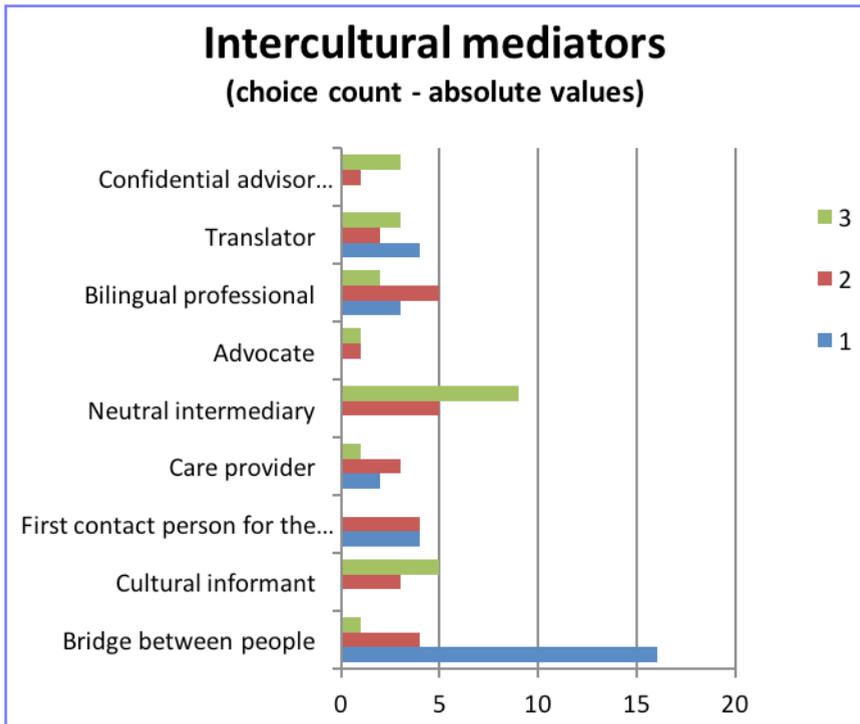


Figure 5. What is your role when interpreting in a medical setting?

Figure 5 shows that intercultural mediators view themselves as having several roles and it is less clear which ones they find most important, with the exception of being a «bridge between people» (16 participants put this in first place, 4 in second place, and 1 in third place). Other roles intercultural mediators indicate as their first choice: a translator (4), a first contact person for the patient (4), a bilingual professional (3), and a healthcare provider (2).

In the next question (4.2), participants were asked what their priority was when interpreting. Five options were given and they had to indicate their number one priority.

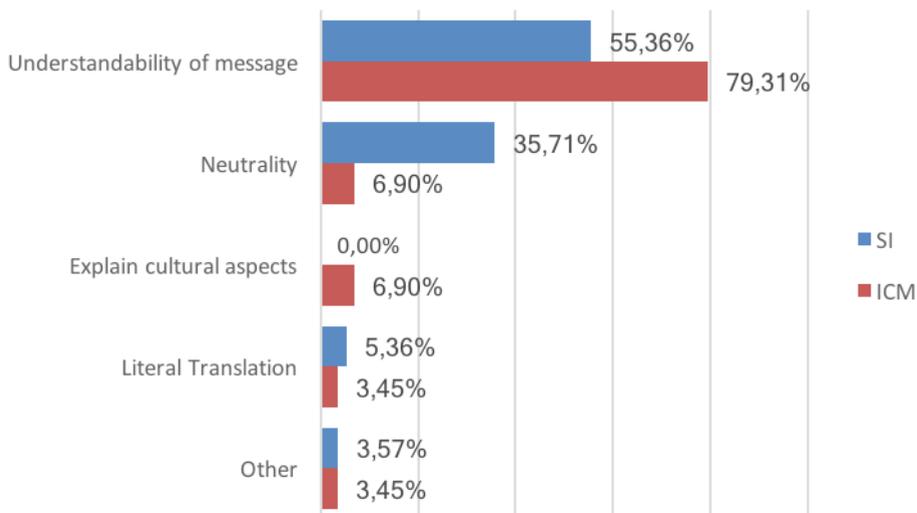


Figure 6. What is your priority when interpreting?

Subjects in both professions agreed that priority should be given to the understandability of the message. Still, there is a relatively noticeable difference between the proportion of social interpreters and intercultural mediators who chose this option (55% and 79% respectively). Additionally, figure 6 shows that social interpreters attached high value to neutrality, a priority that is stressed in the code of conduct of both professions: 'The interpreter adopts a fully neutral (impartial) and objective attitude, before, during, as well as after the interpreting task [own translation]' (Junction Migration-Integration 2013, 3), and: «Intercultural mediators remain impartial and are capable of identifying their own feelings and convictions that could endanger their impartiality. When they cannot remain impartial, they will refuse to mediate for the involved patient» (Federal Public Service 2016, 38). Other priorities that interpreters mention: «interpret everything impartially» (social interpreter) and that «the priority varies according to the situation» (intercultural mediator).

Participants were also asked what they considered their responsibility to be when interpreting in a medical setting (4.4). Eight options were given and they had to tick 'yes' or 'no' for each option. Figure 7 gives an overview of the selected responsibilities (ticked yes).

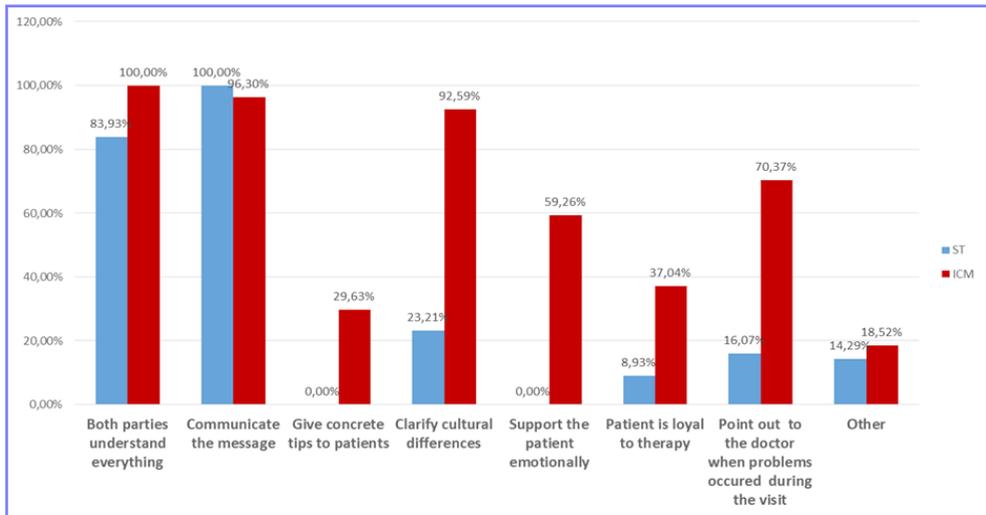


Figure 7. What do you consider your responsibility to be when interpreting?

Figure 7 demonstrates that intercultural mediators see themselves as having more responsibilities than social interpreters. Every responsibility was chosen more than once at least once by the intercultural mediators.

Intercultural mediators and social interpreters agreed that it is their responsibility to make the message understandable for all parties involved and to communicate the message. Other important responsibilities for intercultural mediators (answers that score more than 60%) are: clarifying cultural differences and notifying the doctor of any problems that may have occurred during the visit. Only 16.07% of participating social interpreters would do so. Remarkably, 8.93% of the participating social interpreters felt that it is their responsibility to ensure that the patient is loyal to his or her therapy and 23.21% indicated that they believe they should clarify cultural differences.

None of the social interpreters felt that it was their responsibility to give concrete tips to patients or to support the patient emotionally. Here are two options that scored rather high for the intercultural mediators: 29.63% felt that it was their responsibility to give concrete tips to patients and 59.26% felt that it was their responsibility to emotionally support the patient.

Social interpreters also mentioned the following «other» responsibilities: «prevent the patient from thinking that I (the interpreter) will look after his interests», «be transparent and neutral», «just translate», «no responsibilities», «good relation», and «warm neutrality». The intercultural mediators did not mention any other specific responsibilities.

Participants were asked what they would do if they noticed that a patient did not understand the doctor. Again, they had to tick 'yes' or 'no' to each of the four given

options. Figure 8 gives an overview of the answers that were ticked ‘yes’ and the percentage of interpreters who ticked ‘yes’ to them.

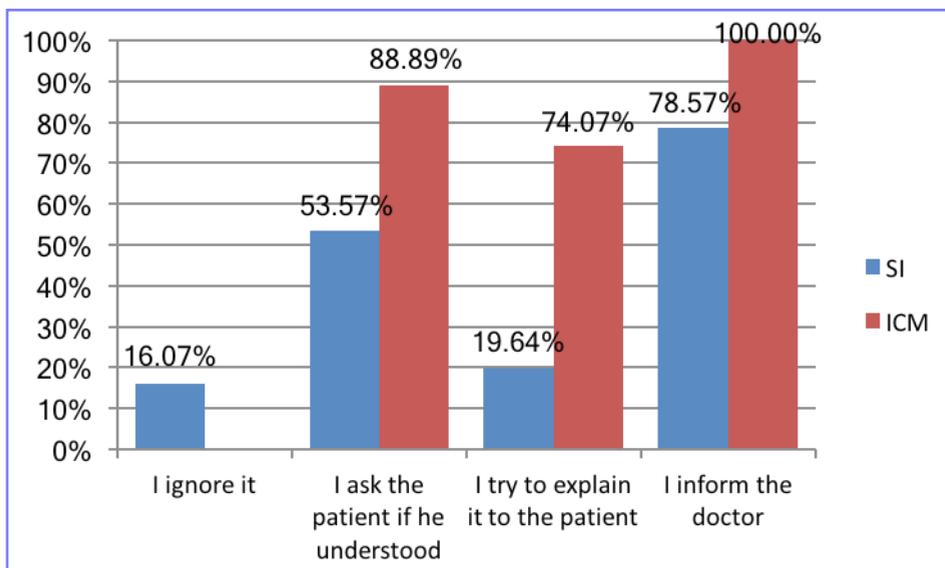


Figure 8. What do you do when you notice that a patient does not understand the doctor?

Figure 8 shows –just like figure 3– that intercultural mediators answer in a more unanimous and convinced way than social interpreters: they would not ignore the problem (0%), but would ask the patient if he/she understood (88.89%), try to explain it to the patient (74.07%) and definitely inform the doctor (100%). 16.07% of social interpreters would ignore the problem, 19.64% would explain it to the patient, 53.57% would ask the patient if he understood and 78.57% would inform the doctor.

The last question in part IV asked participants what they believed was part of their duties when interpreting in a healthcare setting. They had to tick ‘yes’ or ‘no’ to each of the nine options: «literal translation», «provide doctors with further information on cultural background and meaning», «provide patients with more information at doctor’s request», «give advice and tips to patient on one’s own initiative», «explain medical terminology to the patient», «indicate possible misunderstanding to all parties involved», «fill in forms with the patient», «support the patient emotionally», and «other».

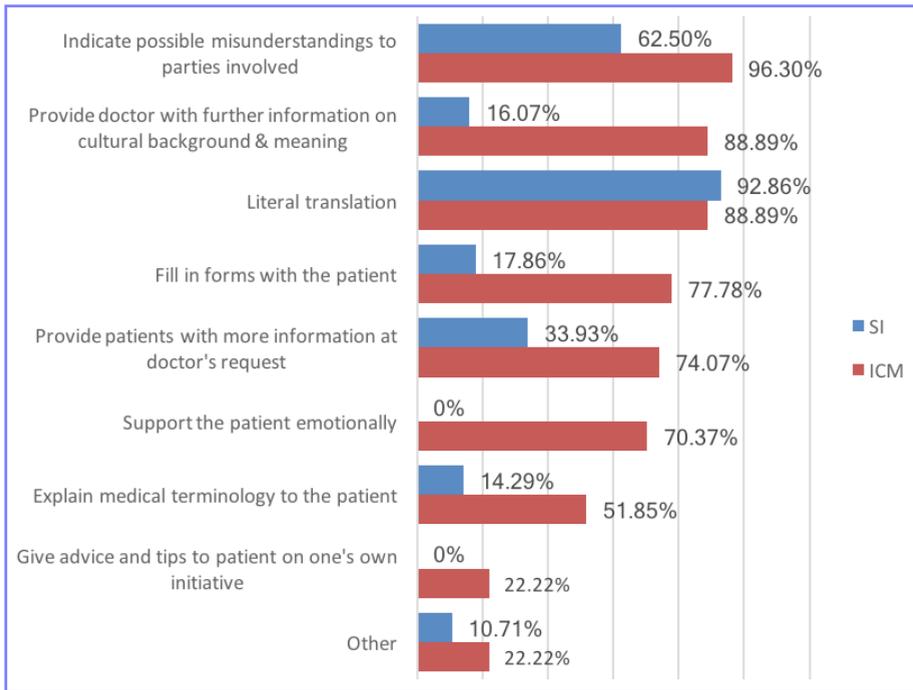


Figure 9. What comprises part of your duties when interpreting in the medical sector?

Similarly to figure 7, figure 9 reveals that intercultural mediators agree on a lot more what their duties are than social interpreters do. 92.86% of the participating social interpreters ticked 'yes' to the option: «literal translation». Rather unusual are the other answers: «provide doctors with further information on cultural background and meaning» (16.07%), «provide patients with more information at doctor's request» (33.93%), «explain medical terminology to the patient» (14.29%), «indicate possible misunderstandings to parties involved» (62.50%), and even «fill in forms with the patient» (17.86%).

3.2.5. Personal information

In part V of the survey, participants were asked some personal information: gender, age, nationality, native country, number of years in Belgium, and main occupation. 75% of participating social interpreters and 93% of participating intercultural mediators were women. This corresponds to reality: mostly women work as social interpreters or intercultural mediators. The age of the participating social interpreters lay between 23

and 62 years old. The age of the participating intercultural mediators lay between 25 and 64 years old.

57.35% of participating social interpreters were Belgian (the other most frequently mentioned nationalities were Dutch and Albanese) and 27.94% were born in Belgium. 62.96% of participating intercultural mediators were Belgian (the other most frequently mentioned nationalities were Turkish, Dutch, and Russian) and 48.15% were born in Belgium.

Social interpreting was the main occupation of only 5% of participants, whereas intercultural mediation was the main occupation of 66.66% of participants. This is due to the fact that intercultural mediators are part of the hospital staff and are stationed inside the hospital itself whereas social interpreters work through interpreting services, more on a freelance basis.

3.3. Discussion

In this section, the most notable differences between social interpreters and intercultural mediators will be discussed and interpreted.

The majority of social interpreters and intercultural mediators work face-to-face, but the survey shows that the telephone is another frequently used medium. The telephone has one important disadvantage: that non-verbal communication disappears. Interpreting by phone is therefore not always recommended, e.g. in a psychiatric setting (Verrept 2013, 5-6). The majority of intercultural mediators interpret often through the internet (73.33%). The success of internet interpreting among intercultural mediators is due to the fact that the Federal Public Service for Healthcare started a successful project in 2009: «intercultural mediation via the internet». Hospital staff can make an appointment for a consultation with an internet interpreter, but there is also a system that allows hospital staff to call on an intercultural mediator at any moment during office hours for the most frequently requested languages (like Arabic, Berber, Russian, Turkish) (Verrept 2013, 12-14). *Agentschap Integratie en Inburgering* is still working on a similar project for social interpreters.

Figure 3 reveals that social interpreters did not give a unanimous answer when asked what they would do when cultural elements are not comprehensible for the doctor. About half of the participating social interpreters answered that they «would try to explain the situation to the doctor», «try to explain the situation to the patient», and «automatically adapt the translation». At the same time, approximately 40% indicated that they would ignore the problem and give a literal translation, whereas a great majority of intercultural mediators would notify the patient, adapt the translation or notify the doctor. To the question of what they would do when they noticed that a patient did not understand the doctor (Figure 8), all intercultural mediators answered that they would

inform the doctor, a great majority would «ask the patient if he understood» (88.89%) or would «try to explain it» (74.07%). Only 78.57% of social interpreters would inform the doctor, only 53.57% would ask the patient and even 16.07% would ignore it. This is closely linked to the results shown in Figure 7, i.e. social interpreters did not find it their responsibility to clarify cultural differences. This is significant because cultural misunderstandings can influence the consultation considerably (e.g. ways of handling or describing pain, eye contact, avoiding 'no' answers).

An explanation might be found in different codes of conduct. Social interpreters have to «translate everything that is said faithfully, without adding, omitting or changing anything» (Junction Migration-Integration 2013, 5) [own translation]. Intercultural mediators have the same task as social interpreters: translate everything, and «in principle» without omitting or adding things, but in their code of conduct it is stated that they shall deviate from this rule if the communication fails for any reason (this can include the intercultural mediator leaving his interpreter role and taking on the role of the facilitator) (Federal Public Service 2016, 28-29)

Thus, social interpreters have only one clearly defined task: interpreting. Intercultural mediators, on the other hand, have more freedom to handle certain situations (Figure 5 and 6). Social interpreters do not choose the more engaging roles such as care provider, confidential advisor, or advocate. They perceive themselves rather as professional, neutral translators, no more and no less. Intercultural mediators can assume several roles. We can assume that the variety of roles that an intercultural mediator can take on may influence their role perception when interpreting. They see themselves more as active participants in the conversation (e.g. a bridge between people, a first contact person, a cultural informant, and a care provider).

This active role becomes even clearer when we ask what they feel their responsibilities (Figure 7) and duties (Figure 8) are. In the study, intercultural mediators indicated that they feel they have much more responsibilities and duties than social interpreters. Intercultural mediators indicated for example that they felt responsible for pointing out to the doctor when problems occurred during the visit (70.37%, whereas only 16.07% of social interpreters selected this answer). The specific work situation of intercultural mediators (being part of the hospital's staff) makes it possible to discuss differences or problems in a briefing or feedback moment. Moreover, §2.1 of the standards in the «Guide for intercultural mediation in health care» states that an intercultural mediator should always attempt to have a briefing with the doctor (Federal Public Service 2016, 24). In addition, if an intercultural mediator takes on the role of the facilitator, §31 of the standards states that (s)he should report difficulties or problems that occurred to the doctor during a feed-back moment (Federal Public Service 2016, 34). In contrast to the standards for intercultural mediation, the code of conduct for social interpreters stipulates that they should avoid «private chat» before, during and after the consultation. If it comes to a briefing with the doctor, it should be limited to

the factual context, interpreter technical arrangements and expected extreme behavior (Junction Migration-Integration 2013, 3-4).

Another difference between the responsibilities of social interpreters and intercultural mediators is that intercultural mediators feel responsible for giving concrete tips to patients and for supporting the patient emotionally. None of the social interpreters in the study selected this answer. In the code of conduct of social interpreters, there is nothing that could indicate that they can give concrete tips or have to support patients emotionally. It is not written explicitly in the code of intercultural mediators, but it is mentioned for example that they can inform the patient about what documents he/she needs or how to make an appointment in a specific service (Federal Public Service 2016, 19). Although this is part of the facilitator role and not the interpreter role, we can assume that the variety of roles can imply that one role influences the other one, e.g. that the facilitator role may manifest itself in the interpreter role.

As social interpreters have only one role, the interpreter, it is rather surprising that many of them still indicate other duties as being part of their role: «provide patients with more information at doctor's request» (33.95%), «provide doctor with further information on cultural background» (16.07%), and even «fill in forms with the patient» (17.86%) (compared to 77.78% of intercultural mediators). The code of conduct clearly states that an interpreter «does not provide any information other than the interpretation of the message, neither on one's own initiative, nor at the patient's request [own translation]» (Junction Migration-Integration 2013, 3). Moreover, an interpreter «sticks to the interpreting task without branching out into other tasks. Therefore, the interpreter does not fill in documents for any of the parties involved [own translation]» (*ibid.*).

The somewhat paradoxical answers given by social interpreters may indicate that on the one hand, they are aware of the deontological principles of their code of conduct, but on the other hand, they are confronted in the context of healthcare with needs and expectations that place them in an ethical dilemma.

4. SURVEY: HEALTHCARE WORKERS' EXPECTATIONS OF INTERPRETERS

After analyzing the answers given by social interpreters and intercultural mediators, we acquired an idea of how they perceive themselves and what they consider their roles, priorities, responsibilities and duties to be. Since we had no idea what healthcare providers expect of interpreters, we decided to set up a second survey in which we addressed healthcare providers. The research question for this survey is how healthcare providers expect interpreters to behave in specific situations. Our aim is to infer from the answers whether the expectations of healthcare providers correspond either to the profile of social interpreters or to the profile of intercultural mediators.

4.1. Setup and participants

Once again the Qualtrics software (version June 2015) was used to draw up, diffuse, and analyze the survey. In total 495 healthcare providers from the same hospital (the Antwerp University Hospital) received via email an invitation to participate in the online survey. A total of 163 respondents participated in the survey, resulting in a response rate of 32.9% (completion rate: 94.5%). The participants worked in 35 different departments, several of which were prominently represented (with 10 or more respondents): paediatrics, oncology, cardiology and otorhinolaryngology.

The survey consisted of 27 closed-ended questions (multiple choice and yes-no questions). Out of these 27 questions, 16 provided the option to give comments. The questions were divided into three parts: personal information, information about experience and training on how to work with interpreters, and expectations. Concerning their expectations, healthcare providers were questioned in two ways. First they were asked what they expect in general through a series of yes-or-no questions. After this they were asked what they would expect in specific cases through multiple choice questions.

This article will not elaborate on all of the questions, but will focus on the questions that are most relevant to the research question, i.e. what the healthcare workers' expectations of social interpreters and intercultural mediators are, as well as the questions that are closely linked to the survey questions presented to social interpreters and intercultural mediators.

4.2. Results

The survey revealed that 79.75% of participants had worked with interpreters before. When we asked who the interpreter was, the following answers were given (multiple answers are possible):

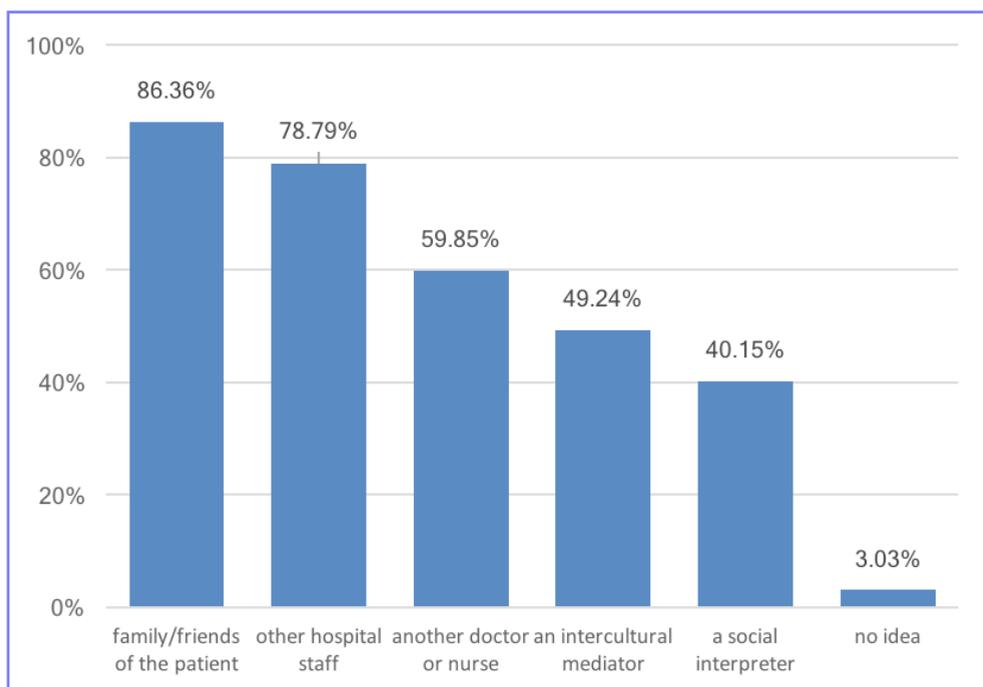


Figure 10. Who was the interpreter?

Figure 10 shows that most of the time interpreters were family members or friends of the patient (86.36%), another doctor or nurse (59.85%) or other hospital staff (78.79%). Only in fourth place can intercultural mediators be observed (49.24%). Social interpreters finish the row with 40.15%. It is no coincidence that intercultural mediators score higher, since they work inside the hospital. Participants mentioned that they first try to bridge the language gap themselves before they call upon a professional interpreter. This could explain the numbers in Figure 10.

We tried to find out the expectations⁵ of healthcare providers by means of a list of 14 questions to be answered with ‘yes’ or ‘no’. In Figure 11 we selected the questions that are counterparts of the questions in our first survey, especially the questions in Figure 7 and Figure 9.

5. In this article, we focus on expectations only. To what extent the fact that 20.25% of participants did not work with interpreters before affects their expectations, will be the subject of a more in depth analysis.

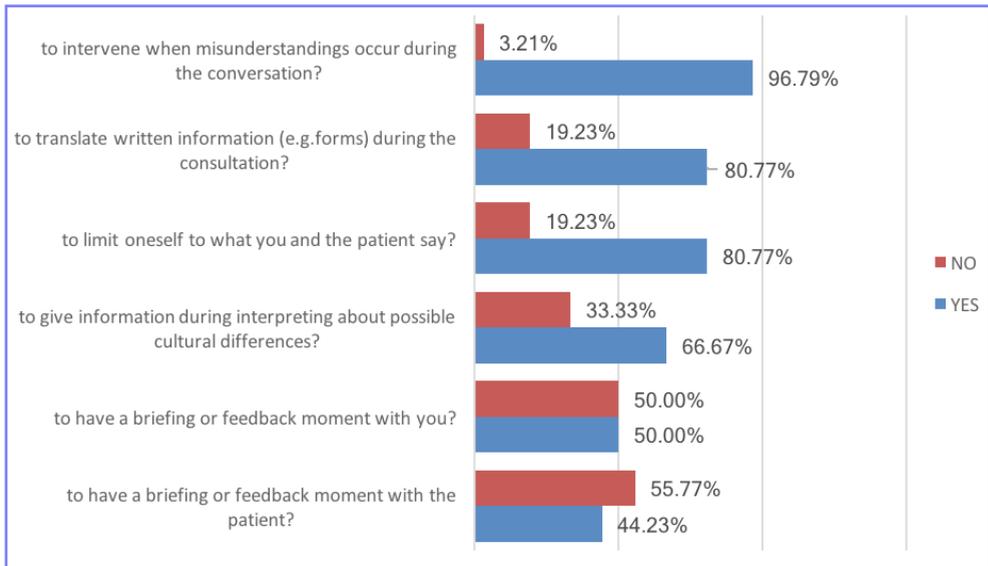


Figure 11. Do you expect the interpreter...

Healthcare providers indicate that they want interpreters to intervene when misunderstandings occur (96.79%), but at the same time they should confine themselves to what the healthcare provider and patient have said (80.77%). Healthcare providers expect interpreters to translate written forms during the consultation (80.77%) and interpreters are expected to give information about possible cultural differences (66.67%). Half of the healthcare workers would like a briefing or feedback moment with the interpreter.

After they had completed the list of general questions, the healthcare providers were asked about specific cases. We will focus on one case: the case in which a patient conceals that he/she is taking antidepressants or sedatives (Figure 12).

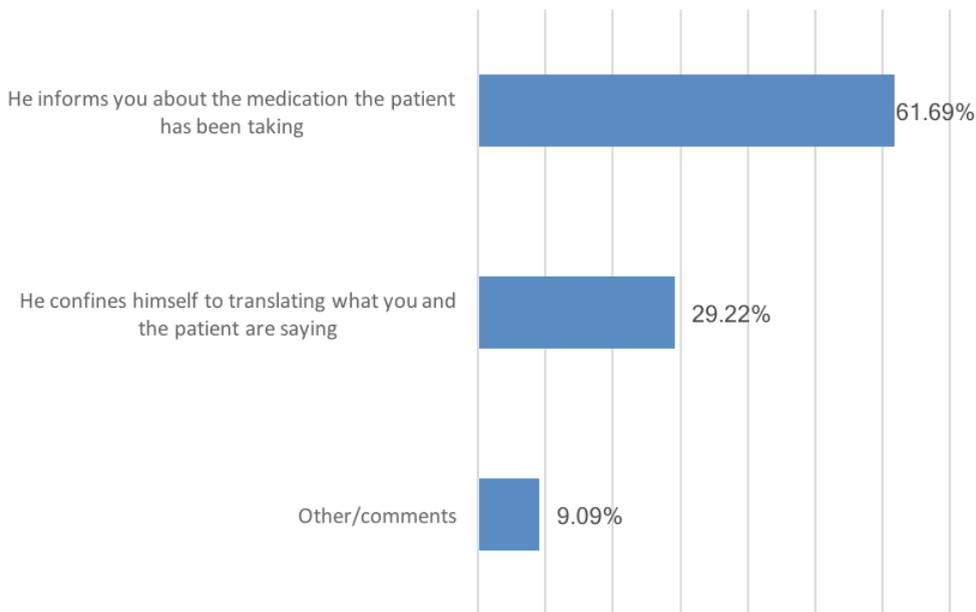


Figure 12. Imagine: the patient says that he does not take any medication, but the interpreter knows that the patient has been taking antidepressants or sedatives for a long time. What do you expect the interpreter to do?

What do healthcare providers expect of an interpreter who knows that the patient is lying? 61.69% of the participants answered that they would expect the interpreter to inform them about the medication and 29.22% said that they would expect the interpreter to confine himself to translating what the patient is saying. All comments on this question indicate that in this case the interpreter has to confer with the patient and should ask the patient’s permission to inform the doctor.

4.3. Discussion

Figure 11 and Figure 12 show that healthcare providers do not agree on what they expect of interpreters. Their answers seem paradoxical. Whereas 80.77% of them expect interpreters to limit themselves to what the healthcare provider and the patient are saying, 60.67% expect that interpreters give information about cultural differences

and 96.79% expect interpreters to intervene when misunderstandings occur. Figure 9 reveals that most intercultural mediators see it as their duty to indicate that there are possible misunderstandings. This was less distinct for social interpreters.

Moreover, healthcare providers expected interpreters to translate written information during the consultation (80.77%). This is no problem for intercultural mediators, but although 17,86% of social interpreters consider it as one of their duties, their code of conduct forbids it: they are only supposed to interpret what is said and therefore they cannot translate forms for the patients (Junction Migration-Integration 2013, 3).

Half of the healthcare providers would like a briefing or feedback moment with the interpreter. As mentioned before, intercultural mediators should attempt to have a briefing and feedback moment with the healthcare provider (Federal Public Service 2016, 24 and 34). On the other hand, social interpreters should avoid «private chat» before, during and after the consultation (Junction Migration-Integration 2013, 3). Although 44.23% of healthcare providers expect that interpreters have a briefing or feedback moment with the patient, this should be avoided by both professions for neutrality reasons.

Next, healthcare providers expect interpreters to explain cultural differences. Figure 3, 7 and 9 show that most intercultural mediators are more likely to expand on cultural differences than social interpreters.

Finally, healthcare providers want interpreters to inform them when the interpreter knows that the patient is taking medication, even though the patient claims otherwise. Figure 7 reveals that a majority of intercultural mediators would point it out to the doctor when problems occurred with the patient. Only a small number of social interpreters ticked this answer.

The answers of the healthcare providers seem to indicate that they have high expectations of interpreters. These expectations correspond with how intercultural mediators perceive their responsibilities and duties; they partly exceed what can be expected of social interpreters.

5. CONCLUSION

The survey we conducted among social interpreters and intercultural mediators revealed that mainly social interpreters have differing opinions on what their tasks, responsibilities and duties are when interpreting in a healthcare setting. Moreover, social interpreters' answers do not always match the provisions in their code of conduct. Since intercultural mediators have more job responsibilities and since their code of conduct gives them more freedom to handle specific situation, they are less often faced with conflicts between their code of conduct and the needs and expectations in actual practice.

Angelelli (2006, 176) stated that most of the codes of conduct were originally written for conference interpreters and were later on adapted for social interpreters. She is of the opinion that interpreting is a situated practice and that there should be a code of conduct for all specific settings, like healthcare. Codes should be based on empirical research (Angelelli 2006, 175-176; Uluköylü 2006, 190-191). The «Guide for intercultural mediation in healthcare» (Federal Public Service 2016) keeps this in mind while writing the standards and uses the American standards for medical interpreters as an example (e.g. IMIA, CHIA, and NCIHC). Currently, social interpreters have the same code of conduct for all social settings: healthcare, education, social welfare, etc.

The survey we conducted among healthcare providers showed that the majority of them expect interpreters to intervene when misunderstandings occur, to give information on cultural differences and to translate written information. These are tasks and roles that can be expected of intercultural mediators but that are not in accordance with the current profile of Flemish Belgian social interpreters. In a later study we will analyze the survey among healthcare providers in more depth in order to examine if there are significant correlations between, for example, expectations and other aspects such as department, age or experience in working with interpreters. Previous interviews as part of this research project revealed for example that healthcare providers working in the field of psychiatry have a tendency to prefer a social interpreter, because they want someone who «just» translates what is said, keeping in mind the importance of language as part of diagnosis and treatment.

In order to gain a clearer insight into these needs, further empirical research is necessary. Not only surveys and interviews are needed but also observations, recordings and analyses of medical conversations, both with and without interpreters, interpreting face-to-face, via telephone or via internet. These analyses aim to compare and improve the quality of medical service provision for foreign language speaking patients. Improvements can imply adaptations to the standards of social interpreting and intercultural mediations.

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