Teoría vs Realidad: la interpretación médica en los servicios públicos de Inglaterra y España.

Un estudio comparativo desde las perspectivas de profesionales sanitarios del día de hoy y el futuro.

Theory vs Reality: medical interpreting in the English and Spanish public services.

A comparative study from the perspectives of healthcare professionals on the present day and the future.

2016-2017

Máster Universitario en Comunicación Intercultural, Interpretación y Traducción en los Servicios Públicos

Presentado por:
Dª Sarah Gibbons

Dirigido por:
Dª Carmen Pena Díaz

Alcalá de Henares, junio de 2017

ÍNDICE:

RESUMEN

En la época en la que vivimos de migraciones, con la inmigración y la posibilidad de viajar sin precedentes, los países como Inglaterra y España se encuentran afectados y las particularidades de sus servicios lingüísticos son destacadas por estos movimientos migratorios crecientes. En teoría, se considera el Reino Unido como un país pionero en cuanto a la provisión de servicios de interpretación en los servicios públicos, con la cualificación reconocida nacionalmente, el *DPSI,* y la acreditación nacional. No es así en España, donde no se tiene está situación en tan alta estima. No obstante, la situación en papel no se traduce siempre a la realidad, razón por la cual un análisis de los servicios de interpretación actuales empleados y disponibles en el ámbito sanitario público de cada país es indispensable para poder comprender la situación actual.

El objetivo principal de esta investigación es analizar y comparar los servicios de interpretación actuales disponibles en los sistemas sanitarios públicos de Inglaterra y España, cuáles son las soluciones empleadas, y si corresponden con lo que se establece en la legislación. También se discutirá el futuro de estas provisiones en relación con el movimiento político reciente: *Brexit.* Este estudio comparativo tiene la intención de relacionar los resultados obtenidos de entrevistas realizadas a profesionales médicos, que tienen conocimiento sobre los dos sistemas públicos de salud, con el marco teórico que incluirá: legislación actual, cursos de formación, cuerpos acreditados y las provisiones existentes que están implementadas, además de estudios previos que tratan sobre este ámbito.

La hipótesis que se plantea es que habrá diferencias no solamente entre los dos países investigados, sino que también entre la teoría y la realidad de la práctica, donde la mayor disparidad se encontrará en Inglaterra. También se provee que estos profesionales sanitarios favorecerán las provisiones de interpretación de Inglaterra que las de España, y finalmente que estos profesionales proveerán que tendrá un impacto significativo el *Brexit* sobre dichas provisiones.

Por último, los resultados confirman que existen grandes discrepancias entre la teoría y la realidad de los servicios de interpretación médica de los dos países, en los cuales se depende mucho de las soluciones *ad hoc,* que es atribuido a la falta de comprensión sobre el papel del intérprete. Además, la mayoría de los entrevistados no proveen que el *Brexit* tendrá un impacto sobre las provisiones de ninguno de los dos países, aunque la literatura propone lo contrario.

PALABRAS CLAVE:
Interpretación sanitaria, Brexit, ISP, realidad, teoría, profesionales sanitarios

ABSTRACT

In this era of migration, immigration and the increased opportunity to travel, England and Spain are bearing the impact of this elevated number of immigrants and so are their linguistic services. In theory, the UK is considered to be a pioneering country in terms of its provision for interpreting in the public services, with its nationally recognised qualification, the DPSI, and national accreditation. The situation in Spain, on the other hand, is not held in such high esteem. However, these perceptions do not always translate into reality, which is why an analysis of the actual interpreting services employed and available in each country's public health sector is invaluable to truly understand the current situation.

The main objective of this investigation is to analyse and compare the current interpreting services available in the public health systems in England and Spain, which services are utilised, and whether they correspond to what is set out in legislation. The future of these provisions will also be discussed in relation to the recent political movement: Brexit. This comparative study aims to compare the results obtained from interviews with medical professionals who have knowledge of both public healthcare systems, with the theoretical framework which will include: current legislation, training courses, accredited bodies and the existing provisions that are in place, as well as previous studies in the field.

My hypotheses are that there will be differences not only between the two counties themselves but also between the theory of the situations in the two countries and the reality, where England will show the greatest disparity. It is also predicted that these healthcare professionals will favour England's interpreting provisions over those in Spain, and lastly that these professionals will also foresee Brexit having a significant impact on these provisions.

Finally, the results confirm that there are major discrepancies between the theory and reality of the medical interpreting services in both countries, where both rely heavily on *ad hoc* solutions, attributed to a lack of understanding of the role of the interpreter. Moreover, the majority of the interviewees did not foresee that Brexit will impact the provisions of either country, although the literature suggests otherwise.

KEYWORDS:
Medical interpreting, Brexit, PSI, reality, theory, healthcare professionals

1. Introducción

1.1 La inmigración y la política: un contexto

"The migration process is never static" (Corsellis 2008:2)

En la época en la que vivimos de múltiples migraciones, con la inmigración y las posibilidades de viajar sin precedentes, ya sea por motivos de guerra y la necesidad de asilo, la búsqueda de oportunidades para estudiar y trabajar, o, simplemente el deseo de descubrir otras tierras, los países como Inglaterra y España, en los cuales se centrará el presente trabajo, se encuentran afectados y las particularidades de sus servicios lingüísticos son destacadas por estos movimientos migratorios crecientes (Corsellis 2008:1). Desde ahora en adelante, se utilizará el término "inmigrantes" para hacer referencia a todos los tipos de extranjeros que migran a un país por alguno de los motivos mencionados anteriormente.

En España durante el primer semestre de 2016 se registró un crecimiento global de la población por primera vez en siete semestres, porque, aunque murieron más personas de las que nacieron, llegaron más inmigrantes que los emigrantes que volvieron a su país de origen (Lantigua, 2016). La población residente en España se situó en 46.468.102 habitantes a 1 de julio de 2016 y de estas personas 4.396.871 eran extranjeras. Esta cifra sólo cuenta las personas registradas oficialmente (Lantigua, 2016). En términos absolutos, las nacionalidades que más han aumentado en el país son la italiana, la china y la población del Reino Unido y Ucrania, y en cuanto a los españoles que se marchan, la mayoría optaron por irse principalmente a Reino Unido, Francia y Alemania (Lantigua, 2016). Por ello, queda claro que la inmigración es un tema importante en España, ya que hoy en día se ha convertido en un país multicultural por esta importante afluencia de personas, lo cual no se puede ignorar, y, cabe subrayar que existe un movimiento significativo entre los países de la presente investigación, España y Inglaterra.

Asimismo, en abril de 2016 se estimó que había 761.000 británicos residiendo en España, una cantidad que representa casi el 2% de la población (Nicholas, 2016) y cabe destacar que esta cifra solo cuenta los británicos, no incluye otros inmigrantes angloparlantes, ni los que hablan otros idiomas. Es necesario establecer que en la presente investigación se referirá a la situación del uso, o, mejor dicho, las provisiones del inglés en España ya que es el idioma con el cual los profesionales sanitarios que participaron en las entrevistas tienen experiencia, como se explicará más adelante.

En cuanto a Inglaterra, según Baker y Eversley (2000), 30% de los alumnos en Londres hablaban en casa uno de los 300 idiomas europeos, asiáticos, y africanos, una estadística que también se parecía a los perfiles de otras ciudades en el Reino Unido y en Europa en general durante este tiempo, destacando los movimientos migratorios crecientes de esta época hace unos 16 años (de Corsellis 2008:1).

Además, la realidad que presenta esta estadística no parece haber cambiado, entre junio de 2015 y junio de 2016, hubo una migración anual de 650.000, la mayor cantidad jamás registrada con un porcentaje de 43.7% de ellos viniendo de la Unión Europea (UE) para buscar trabajo (Travis, 2016). Este artículo publicado por el periódico *The Guardian* subraya que estos datos récords coinciden con el periodo previo al movimiento político reciente por parte del Reino Unido, el denominado *Brexit*, pero que los datos iniciales después del voto en favor sugieren una disminución en la cantidad de migración (Travis, 2016). Todo ello enfatiza que la inmigración sigue siendo un asunto clave y primordial en el Reino Unido, del cual forma parte Inglaterra, y junto con la preocupación actual de que este movimiento político supondrá

un nuevo sistema de inmigración del país, nos encontramos en una situación sin precedente alguno.

Asimismo, según Gentile (2017:63) durante los últimos años, la crisis económica y el incremento de la migración han causado la implementación de políticas de austeridad en los países de la Unión Europea. Dichas políticas han tenido un impacto a nivel nacional en cuanto al trato de la inmigración y por ello, han causado que los gobiernos subcontraten los servicios lingüísticos de interpretación, o bien la ISP (la interpretación en los servicios públicos), a empresas privadas por un precio reducido, o que recorten completamente la financiación para estos servicios (Gentile, 2017:63). Pero como sabemos todos, una reducción en el precio va en desmedro de la calidad, llegando a incluso, según Gentile, a contratar interpretes no calificados (2017:64).

A menudo se refiere a España como un país ejemplar, cuyas prestaciones en los servicios de traducción e interpretación han sufrido una reducción en la financiación por la crisis económica (Valero-Garcés, 2014). Sin embargo, el Reino Unido es un país considerado como pionero en este ámbito, puesto que se reconoce la profesión del ISP, al menos formalmente gracias a la creación de un registro nacional de lo que se hablará más adelante. Pero estos servicios de un país tan desarrollado se encuentran afectados por los recortes, la privatización y subcontratación, como ya se ha mencionado, todo esto ha generado una considerable diminución en las tarifas, causando así la salida de muchos intérpretes de esta profesión, es decir, provocando una reducción de la calidad de los servicios (Gentile, 2017:64).

Otro reto al que se debe hacer frente en este ámbito es el impacto negativo que ha tenido esta crisis al nivel político y social, y, la actitud que lleva consigo a la población en sí. Según *The Guardian,* un periódico inglés, en 2015 la xenofobia se convirtió en uno de los factores comunes y más prominentes dentro del ámbito político y el enfoque de muchos de los partidos políticos, lo cual llevó a los recortes de los servicios sociales, violando los derechos de las personas más vulnerables y marginadas, es decir, los inmigrantes (Gentile, 2017:65). Además, si nos referimos específicamente al ámbito en cuestión, en 2015, Teresa May quien era el *Home Secretary* [Ministra del Interior] pero quien es la Primera Ministra hoy en día, sostuvo que:

> "*We will plan a step change in the way we help people to learn the English language. There will be new incentives and penalties, a sharp reduction in funding for translation services, and a significant increase in the funding available for English language training.*" (May, 2015; lo subrayé yo)

Esto destaca como aún los políticos y así los gobiernos no reconocen la importancia de la traducción y la interpretación, opinando que la enseñanza de la lengua inglesa es más importante, también se verá más sobre este tema más adelante. Pero es necesario subrayar cómo en esta citación se descarta la importancia y relevancia de los servicios de traducción e interpretación en facilitar la acogida a los inmigrantes, o aún en el ejercicio de sus derechos. Es más, aunque los inmigrantes reconocen y aceptan la necesidad de aprender el idioma del país con el fin de integrarse, muchos de ellos requieren acceso a los servicios públicos, ya sea en el hospital o a los servicios sociales, antes de que consigan aprender dicho idioma, es decir, necesitan ayuda para comunicarse; un derecho humano (Gentile, 2014 & 2017:64).

Por una parte, se puede decir que la xenofobia existe hasta un cierto punto en cualquier país donde se encuentran los inmigrantes. Sin embargo, por otra parte, cuando esta opinión se ve apoyada por el gobierno, o bien, los partidos políticos, el impacto aumenta y las

consecuencias también. Desafortunadamente, esto es lo que se encuentra actualmente en Inglaterra, según *The Independent* (2016) después del referéndum en el cual se votó en favor del *Brexit* se incrementó de forma acelerada el número de delitos de odio hacía los inmigrantes en Inglaterra; un aumento de 41% desde el año pasado.

Sin importar el país de procedencia o cual sea el motivo por su estancia, estas personas extranjeras pueden verse perjudicadas por su nacionalidad, condición de inmigrantes, su desconocimiento del idioma, del país o, aun, por el desconocimiento de sus derechos y el funcionamiento de los servicios públicos a los que piden ayuda y a los que tienen derecho a acceder (Abril Martí, 2015: 80-81). Si imaginamos la carga emocional que sufren estos inmigrantes cuando se encuentran en una situación vulnerable por la que piden ayuda de los servicios públicos, además de las razones dadas anteriormente y ahora con la carga política añadida en el Reino Unido sobre su situación (*Brexit*), y un cambio en el sistema de inmigración, nos presenta un tema único. Esta situación presenta una oportunidad de estudiarla en la presente investigación que trata sobre las provisiones existentes de servicios lingüísticos en el ámbito sanitario disponibles para estos inmigrantes; o bien la realidad de estos servicios, con el fin de también averiguar qué impacto ha tenido este movimiento político hasta la fecha de hoy, y quizás lo que podemos proveer. Es más, esta realidad quizás irá cambiando de la situación teorética, es decir, las provisiones que se han desarrollado hasta la fecha en este ámbito pueden verse modificadas, ya que se está entrando en vigor una nueva realidad económica y política. Como destaca *The Guardian* en las noticias del 18 de abril de 2017 en el cual se ha convocado a unas elecciones generales por la falta de apoyo del Estado sobre el asunto de *Brexit*, se ve cómo con cada día esta situación sigue creciendo y demostrando un entorno político inestable, y a su vez, una sociedad fracturada del país en sí. El problema es que nadie está de acuerdo con la dirección del país, luchando entre ellos y así creando un ambiente poco acogedor para los extranjeros o inmigrantes, lo cual no presenta una situación prometedora para el futuro en cuanto al apoyo para estas personas a integrarse, es decir, la ayuda para comunicarse; la traducción e interpretación. Sin embargo, se estudiará este asunto en más detalle más adelante en la investigación.

1.2 La T/ISP: una definición y una breve historia

A fin de presentar el alcance de esta investigación, cabe definir a lo que se refiere cuando se menciona los servicios lingüísticos disponibles a estos inmigrantes y los profesionales correspondientes, en el ámbito sanitario en el Reino Unido y España, es decir cómo definimos la ISP y la TISP:

> *"La traducción e interpretación en los servicios públicos (TISP) es la Interpretación y/o traducción que tiene lugar en el ámbito de los servicios públicos para facilitar la comunicación entre el personal oficial y los usuarios: en las comisarías, oficinas de inmigración, centros de ayuda social, centros de salud, escuelas, juzgados o servicios similares" (Wadensjö, 1998: 33).*

En el Reino Unido el término original que se utilizo fue "Community Interpreting" [la interpretación comunitaria], igual que en Australia, pero por la confusión de que se asociaba solo con la "Comunidad Europea" y las lenguas oficiales de sus Estados Miembros, y, por la asociación de esta labor con estándares más bajos de formación, se decidió sustituirlo con el término *PSI (Public Service Interpreting)* para así clarificar la terminología (Corsellis, A.

2014). Con la intención de mantener coherencia se referirá al concepto de *PSI* por sus siglas en español "*ISP*".

Hoy en día es bien sabido que la ISP, a diferencia de su 'hermana' la interpretación de conferencias, es una profesión poca conocida (Valero-Garcés, C. 2016), puesto que es una labor bastante 'joven' que está todavía en el proceso de la profesionalización (Gentile, 2017:63). Pero como se verá más adelante en esta investigación, dentro de los ámbitos considerados como los servicios públicos (SSPP), la interpretación en el ámbito sanitario se encuentra en una situación aún más precaria cuando lo comparamos con el ámbito jurídico. En el mundo de la TISP, se puede ver que con cada año surge más información y más investigaciones sobre el estado de esta labor en distintos países a través del mundo, en los cuales los investigadores, profesionales o quizás aún gobiernos se esfuerzan para desarrollar las provisiones de los servicios de ésta (Hale, 2007:200). También, encontramos varios retos a que se le debe hacer frente para conseguir el desarrollo y a su vez el reconocimiento debido que quieren obtener.

1.3 El fundamento de la presente investigación

El presente trabajo plantea las situaciones de dos países notables en esta esfera de investigación, Inglaterra y España, y tiene por objeto analizar la diferencia entre la situación en teoría de la interpretación en el ámbito sanitario, y la situación actual que se encuentra en ambos sistemas, desde la perspectiva de profesionales en el ámbito sanitario con conocimiento de los sistemas de ambos países.

Estos profesionales cuyas opiniones y experiencias forman el centro de la investigación trabajan, en primera instancia, para una compañía internacional de seguros de viaje, en el departamento de asistencia médica, pero también solían trabajar o siguen trabajando para el sistema nacional de salud del Reino Unido (NHS). La meta del departamento de esta compañía, al igual que todas las compañías de seguros de viaje con provisiones en la asistencia médica, es la de garantizar que los pacientes aseguradores tengan el necesario tratamiento, independientemente de donde se encuentran, y que tengan la posibilidad de estar repatriados en situaciones muy graves.

Por ello, cada compañía cuenta con un equipo médico interno y de guardia, formado por ambos médicos y enfermeras especializados en "critical care" es decir, tienen vasta experiencia en situaciones de cuidados intensivos, repatriación internacional y los requisitos correspondientes que exige este tipo situación urgente (Healix International, 2017, AXA Assistance, 2017, Allianz Assistance, 2017). Dichas compañías, de las cuales he citado las más conocidas de Inglaterra, deben depender de la comunicación y las habilidades de personas con destrezas lingüísticas para llevar a cabo su labor, y ayudar a los pacientes al extranjero, sea la comunicación verbal o sea la comunicación escrita:

> "*We carry out more than 7.4 million health and life interventions for you and your customers each year. How do we do this? Thanks to our multi-lingual, travel and medical assistance specialists who work around the clock, around the world.*" (Allianz Assistance, 2017).

Cómo vemos en la citación proporcionada, estas compañías destacan su acceso a los servicios lingüísticos y su personal multilingüe. Esto recalca la importancia de la comunicación multilingüe en esta línea de trabajo en el ámbito sanitario, puesto que para llevar a cabo su labor, el personal médico tiene que obtener información médica, ya sea en inglés o en lengua

extranjera, para poder asegurar el tratamiento, hacer decisiones sobre el mismo y organizar el cuidado continuo o repatriación si se la requiere. Por lo tanto, queda claro que tienen que contar con los servicios lingüísticos de algún modo, ya sea mediante la traducción o la interpretación.

Así, podemos suponer que los profesionales que forman parte de los equipos médicos para estas compañías de seguros tienen un profundo conocimiento sobre el ámbito sanitario internacional, y tienen experiencia trabajando con otros idiomas, sea hablando las lenguas en cuestión o bien contando con servicios lingüísticos. Dichos servicios lingüísticos pueden ser intérpretes internos contratados por la compañía en sí o proporcionados por los gobiernos u hospitales en que se encuentran los pacientes.

Debido a este ámbito específico se decidió centrar el estudio en cuestión como consecuencia de la experiencia laboral adquirida con estos profesionales médicos en el campo de asistencia médica de viaje, se estima que la información que podría aportar esta perspectiva será original. Por lo tanto, es de interés hacer notar este campo distinto y comparar estas experiencias con otros estudios en el ámbito sanitario en general. Además, este papel y esta labor que desempeña el personal mencionado, podría proporcionar una nueva percepción sobre los dos sistemas sanitarios públicos de Inglaterra y España, y los servicios lingüísticos o de interpretación que emplean.

La parte final de la investigación tratará el futuro de este ámbito y planteará la cuestión ya mencionada de *Brexit*, la salida del Reino Unido de la Unión Europea (UE), ya que es un asunto político y de primordial importancia actualmente. La intención es averiguar si estos profesionales proveen un impacto de este movimiento político sobre las provisiones futuras de la ISP en los dos países.

1.4 La estructura

En cuanto a la estructura, el presente trabajo está formado por cinco capítulos: la introducción, la metodología, el marco teórico, la investigación y las conclusiones. La introducción tiene la intención de presentar el tema y las razones por las cuales se ha elegido.

En la parte de metodología se explicará cómo se llevará a cabo la investigación y las razones por las cuales se utilizarán los métodos de recopilación de datos elegidos. En el marco teórico se planteará la situación teórica, es decir, los servicios de ISP existentes en los dos países, las medidas de formación, la legislación actual acerca de dichos servicios, y el *Brexit*. También se presentará otros estudios relevantes en el campo para que se pueda comparar los resultados de las entrevistas con los de los estudios previos.

El cuarto capítulo trata sobre la investigación, la explicación del alcance de las entrevistas que fueron realizadas y el análisis sobre ésta. Y finalmente en la conclusión se discutirá la realidad de los servicios de ISP por los resultados de la investigación comparado con la situación teórica presentada en el marco teórico.

A través del presente trabajo se hará referencia a varios estudios y trabajos realizados por investigadores y expertos en el ámbito de la TISP, para proveer una base de la investigación y presentar la situación respectiva por los distintos temas examinados, pero también para poder comparar sus resultados con los de la presente investigación. Estos expertos incluyen Abril Martí (2006, 2015), Corsellis (2008), De Pedro Ricoy (2010), Gentile (2017), (Gerrish et al, 2004) Hale (2007), Leman et al (1999), y una amplia gama de trabajos por Valero-Garcés (2009, 2014, 2016) entre ellos.

1.5 Hipótesis

Considerando la investigación y lo que incluye, se espera revelar que existen unas diferencias entre cómo parecen los dos sistemas de servicios de ISP en Inglaterra y España, y la realidad de las dos situaciones. En papel, el Reino Unido está considerado como un país pionero en este ámbito con reglas y provisiones oficiales reguladas por el Estado, pero lo que se cree averiguar es que ésta no es la realidad y que siguen con deficiencias.

Además, en cuanto a la comparación entre los países de Inglaterra y España, se prevé ver que los profesionales considerarán que las provisiones en Inglaterra son mejores que las de España en cuanto a la disponibilidad y la calidad.

Finalmente, aunque aún no ha estado implementado y es bastante pronto determinar el futuro del movimiento de *Brexit*, se espera encontrar que los profesionales creen que el *Brexit* tendrá un impacto significativo sobre los sistemas sanitarios de los dos países en cuanto a la prestación de servicios lingüísticos en el sector público, con atención especial a la financiación.

1.6 Los propósitos de la investigación

(i) Presentar la situación actual de los sistemas sanitarios y la prestación de servicios de traducción e interpretación y, si ha cambiado en los últimos años.
(ii) Comparar la relación entre la situación teórica con la situación actual de los servicios de la ISP.
(iii) Proveer el futuro de dicha situación de la interpretación en los dos países, según los profesionales, y el impacto que podría tener el *Brexit* sobre este ámbito y su desarrollo.

2. Metodología

En este apartado, se explicarán los métodos de recopilación de datos y las razones por las cuales se seleccionaron, comparándolos con otras posibilidades que también se ven utilizados en estudios parecidos. Se mencionará los limites encontrados en su caso.

2.1 Estudios anteriores

En la presente investigación se hará referencia a varios estudios previos que tratan sobre el tema en cuestión en el ámbito sanitario para poder compararlos, sus resultados y conclusiones con ésta. Según Hale (2007:226) esta es una frase significativa para poder aprender de los estudios existentes con el fin de definir mejor el propósito de la investigación propuesta y encontrar un hueco en la literatura para ella. Es más, los estudios anteriores dan contexto al tema en cuestión, una estructura ejemplar y una base para estudios en el futuro.

Estos estudios, de Hale (2007), Gerrish *et al* (2004) y Leman *et al* (1999) presentan situaciones de distintos países, que son relevantes a la presente investigación por los estudios llevados a cabo y los resultados obtenidos.

2.2 Entrevistas

Las entrevistas son una forma cualitativa de recopilación de datos que producen y permiten respuestas auténticas y extendidas formadas de información pertinente según el

entrevistado (Codó, 2005: 158). En la presente investigación, en su mayoría se utilizan las preguntas abiertas para garantizar la calidad y autenticidad de las respuestas, así se le da cierto control al entrevistado y la libertad de reflexionar sobre su conocimiento del tema, permitiéndoles compartir exactamente lo que quisieren con respeto a cuánta información proporcionan y cómo la comunican (Turner, 2010). La naturaleza de este tipo de entrevista significa que consumen mucho tiempo, no sólo a la hora de realizarlas, sino que también al transcribirlas y analizarlas, por lo cual se tiene que limitar el número de participantes a menos que se tenga un periodo ilimitado de tiempo. Por esta razón, cabe destacar que la selección de la muestra a investigar está limitada por dicha restricción de tiempo. Otro criterio que se ha utilizado es la accesibilidad a los profesionales disponibles durante este periodo de la investigación. Si no se estuviera limitado a un corto periodo, se podría ampliar la magnitud de la investigación en cuanto a los profesionales entrevistados, empleando también los cuestionarios para obtener los datos cuantitativos al respecto, lo que permitiría un mayor índice de respuestas de los profesionales de ambos países ya que se podría mandar por correo electrónico en forma masiva.

Otro método bien reconocido de recopilación de datos en este tipo de estudio es el uso de los cuestionarios. Los cuestionarios son útiles porque, en general, son más rápidos a realizar y se pueden aplicar a más participantes. La información recopilada, en su mayoría, es cuantitativa, es decir, los participantes tienen que seleccionar la respuesta con la que están de acuerdo, en lugar de escribir su propia contestación a la pregunta. La ventaja de esto, a diferencia del estilo de las entrevistas explicado anteriormente, es el hecho de que consume menos tiempo, y se puede presentar los resultados por medio de un gráfico. Además de ser más visual, los resultados de estos cuestionarios facilitan una evaluación más rápida de los datos.

Sin embargo, se puede utilizar también cuestionarios que incluyen ciertas preguntas abiertas para aportar información cualitativa, igual que las entrevistas que emplean preguntas cerradas, es decir, las que conllevan una respuesta cerrada como “si” o “no”. La ventaja de esto como ya se ha subrayado con respeto a los cuestionarios, es el hecho de que se puede presentar las respuestas cerradas en la forma de un gráfico también.

En cuanto a la estructura de las entrevistas de la presente investigación, se organizarán las preguntas por tema, es decir, se empezará con una introducción para poner al participante en contexto, y luego se separará las preguntas por país, y se acabará con unas preguntas concluyentes que abordan el futuro. La intención es utilizar el mismo protocolo de aplicación con todos los participantes, de esta forma las respuestas pueden ser consideradas y evaluadas de la misma manera. Sin embargo, dado que el estilo de las preguntas es abierto, se debe realizar posibles modificaciones cuando sea necesario, por ejemplo, si un participante proporciona información relevante a dos preguntas en la misma declaración. Asimismo, otro elemento importante de las entrevistas estructuradas, es la posibilidad de adaptar el tipo de cuestionamiento según la línea de pensamiento del entrevistado, por ejemplo, si abordan un tema inesperado, pero de interés, se puede continuar en éste a ver si trae información útil a la investigación (Turner, 2010). La información es auténtica, ya que el participante tiene esta libertad de introducir asuntos distintos o sus propias experiencias que consideran relevantes al tema del cuestionamiento.

Con el fin de asegurar la anonimidad de los participantes de la investigación, se decidió asignarles una letra (de A hasta G) con la que se le referirá desde entonces durante la investigación. Asimismo, antes de empezar las entrevistas se confirmó que los participantes fueran informados del proceso de la investigación y la naturaleza de su participación por

proporcionarles con un folleto informativo junto con el consentimiento informado que firmaron. Se puede encontrar esta información en el Anexo A en el cual se explica la relevancia y el motivo del presente estudio además de garantizar que tanto la identidad del entrevistado como la de su organización no serán reveladas en la investigación.

En cuanto a la muestra y la gama de participantes, aunque la inicial intención sólo incluyó los profesionales de la compañía de seguros, como ya se ha explicado, al final, también se decidió incluir y entrevistar a una enfermera recién cualificada, de octubre de 2016, la participante G, que sólo trabaja para el NHS. La razón por esta decisión se basó en la oportunidad de comparar las experiencias de los profesionales experimentados, con las de una profesional que ha recibido recientemente su formación en el mismo ámbito, para averiguar si la formación en esta área ha cambiado, es decir, formación específica al uso de los servicios lingüísticos empleados por el NHS, dada la situación migratoria creciente ya descrita.

Los otros seis participantes (A – F), como ya se ha mencionado, son profesionales sanitarios, enfermeras, que trabajan primariamente para una de las compañías de seguros de viaje que proporcionan asistencia médica a sus aseguradores cuando están al extranjero. La meta de este departamento es la de garantizar que los pacientes aseguradores reciban el necesario tratamiento, y tengan la oportunidad de estar repatriados, si la situación lo requiere, independientemente de donde se encuentran los pacientes en el mundo. Para poder asegurar el tratamiento adecuado y organizar repatriaciones, estos profesionales médicos tienen que revisar informes clínicos, además de hablar con los médicos responsables para los cuidados de estos pacientes de los hospitales al extranjero. Por ello, el trabajo que realizan estos profesionales, para esta compañía, les da una oportunidad indispensable de conocer los distintos sistemas de salud a través los diversos países del mundo, y también involucra una cierta demanda y dependencia sobre los servicios lingüísticos para poder llevar a cabo esta labor y comunicarse.

Dado que España es el destino de vacaciones más popular según los británicos, los profesionales de la presente investigación tienen un gran conocimiento sobre el sistema sanitario público español (Arnett, 2015).

Asimismo, además de su trabajo para dicha compañía de seguros, estas enfermeras solían o todavía siguen trabajando para el sistema nacional de salud del Reino Unido (NHS), y por esta razón este grupo de profesionales sanitarios tienen la única position de poder comparar los sistemas de ambos países.

Es más, estos profesionales fueron elegidos por la amplia gama de conocimiento que presentan, es decir, cada enfermera cuenta con una experiencia diferente, en cuanto a los años de experiencia y su especialización en distintos ámbitos de la medicina, sea cuidados intensivos, urgencias, cardiología, pediatría o cirugía, por ejemplo. Esta información concreta se presentará en los resultados ya que forman preguntas de la entrevista.

Cabe mencionar otro límite de la información que será obtenida; el conocimiento de estos profesionales sobre los servicios de interpretación en España está limitado a la provisión del inglés, porque la mayoría de los aseguradores son nativos del inglés.

Con respecto al proceso de las entrevistas, después de haber leído y firmado el consentimiento informado, se procederá a avisar al participante que se grabará toda la conversación.

La duración prevista de las entrevistas es de 10 a 15 minutos, sin embargo, no se puede controlar de forma absoluta, ya que se le dará libertad al participante contar sus experiencias y proporcionar la información que crea más importante y relevante para cada pregunta. Tras las

entrevistas, en siguiente paso será de transcribir todas las grabaciones, y presentarlas como un anexo al final de la investigación (ver Anexo B).

En el apartado que trata sobre los resultados, se los presentará en varios cuadros, separándolos por pregunta y participante, para que solo se vea las citaciones más importantes para la investigación.

Ahora, se procederá a presentar el marco teórico para dar un contexto y base de la investigación con respecto a la teoría, es decir, en lo que consiste la ISP, las particularidades de la interpretación sanitaria, la legislación existente, las provisiones respectivas de la interpretación sanitaria en ambos países incluyendo servicios lingüísticos existentes y los cursos de formación. También, se incluirá una sección que presenta la cuestión de *Brexit* y otra que trata sobre algunos estudios previos.

3. Marco teórico: la situación teórica

3.1 Introducción a la traducción e interpretación como disciplina

En este apartado también hace falta definir cuáles son las habilidades del intérprete para trabajar en este ámbito ya que como se analizó en la sección anterior, muchos profesionales en el ámbito no reconocen las particularidades y requerimientos de la profesión. Aunque hay quienes defienden la teoría de que "el intérprete nace, no se hace" o bien, que existen "intérpretes natos" que demuestran una facilidad natural para interpretar sin haber recibido ningún tipo de formación, estos son la minoría (Bosch March, 2012). La inmensa mayoría de los intérpretes no "nacen" sabiendo interpretar, sino que lo consiguen a través de una amplia formación y vasta experiencia (Bosch March, 2012). No obstante, todos los autores parecen estar de acuerdo con las cualidades que necesita el futuro intérprete para permitirle lograr las habilidades requeridas de interpretar: competencia lingüística, capacidad de análisis, memoria, cultura general y gestión del estrés (Bosch March, 2012).

También se presenta el siguiente cuadro comparativo proporcionado en los materiales de clases del primer módulo del máster de la Universidad de Alcalá por Valero-Garcés y Pena Díaz (2016).

El cuadro muestra las diferencias entre las habilidades, o mejor dicho lo que se espera, de los bilingües y los traductores/intérpretes (T/I) profesionales:

Cuadro 3.1.1

Diferencias entre Bilingüe y Traductor / Intérprete Profesional	
BILINGÜE	**TRADUCTOR / INTÉRPRETE**
Puede tener fluidez limitada en una de las lenguas.	Se requiere fluidez en ambas lenguas.

Tiene voz propia para intervenir, expresar opiniones, etc.	Hace posible la comunicación entre otras personas; identifica diferencias entre las lenguas y las culturas y reproduce el mensaje de otros.
No tiene por qué atenerse a un código de conducta o unos principios propios.	Debe observar un código de conducta propio de su profesión.
No tiene por qué estar preparado para hacer de puente y puede transmitir el mensaje de un modo incompleto, olvidar parte de él, quitar lo que no considera importante, etc.	Debe conocer la terminología adecuada y los procedimientos necesarios para reproducir con fidelidad el mensaje.
No ha recibido ningún tipo de formación sobre cómo tratar la información o sobre estrategias para procesar y reproducir esa información	Suele contar con cierta formación o experiencia para procesar y retener los mensajes con fidelidad.
Puede dejarse llevar por ciertos condicionantes externos a la hora de trasvasar la información (compasión, amistad, alegría, familiaridad...) y dejar de ser objetivo, añadiendo comentarios personales, interpretaciones subjetivas, etc.	Provee información fiel, adaptada a la nueva realidad y se mantiene despegado de consideraciones personales.

Cabe destacar la diferencia que vemos en el cuadro entre las habilidades de un bilingüe y las de un T/I profesional, ya que muchas personas clasifican estos términos como sinónimos porque no entienden las destrezas particulares asociadas con la labor de traducción e interpretación.

Si consideremos las destrezas mencionadas anteriormente, por ejemplo, mientras que la competencia lingüística parece una habilidad bastante obvia, la capacidad de análisis de las lenguas y la cultura son menos aparentes y requieren un conocimiento profundo de las lenguas de trabajo. A la hora de traducir o interpretar estas últimas habilidades se presentan un gran reto, ya que la labor del T/I consiste en transmitir los mensajes de la comunicación, no las frases traducidas literalmente, es decir, palabra por palabra, porque si no una frase hecha o idiomática traducida literalmente podría resultar en un malentendido por una de las partes, dificultando la comunicación y causando tensión y frustración (Bosch March, 2012). Esto nos lleva a los siguientes apartados que tratan sobre las particularidades de la ISP y las habilidades específicas de un T/I en el ámbito sanitario.

3.2 La ISP contra la interpretación de conferencias

La interpretación de conferencias es una profesión establecida y la más reconocida de todas las ramas de interpretación (Corsellis, 2008:53). Es por ello que, como se explicará más adelante, la mayoría de los cursos ofrecidos sobre interpretación abordan la interpretación de conferencias, en lugar de la interpretación en los servicios públicos. Una razón por la cual este

tipo de interpretación se ve mucho más desarrollado que la ISP, es por el contexto de que se trata: negocios y relaciones internacionales, el último puede referirse a las conferencias entre gobiernos cuando están discutiendo cuestiones de primordial importancia tales como la guerra o el medio ambiente, por mencionar algunos ejemplos.

Por ello, en este mundo globalizado, en el cual tenemos más oportunidades de viajar y donde los gobiernos y oficiales de los países también se reúnen con mayor frecuencia, resulta de vital importancia brindar servicios de interpretación de calidad. Sin embargo, comprender esta dimensión ha llevado décadas para despertar la consciencia sobre la necesidad de intérpretes cualificados y bien preparados en estos contextos, a veces muy sensibles, y a su vez se han desarrollado cursos de formación para asegurar la calidad de la labor de este importantísimo papel. Por ello, la interpretación de conferencias y los propios intérpretes cuentan con un mayor nivel de reconocimiento y una mejor remuneración, puesto que generalmente trabajan al nivel internacional, como ya se ha mencionado, o su labor forma parte del sector privado, y así cada empresa se encarga de sus necesidades individuales y las financia por su cuenta. Asimismo, esto significa que, hoy en día, la mayoría de los locutores de las conferencias internacionales, sea entre empresas globales o sea gobiernos, están acostumbrados a trabajar con los intérpretes y de manera eficaz, mientras que un médico o juez en una consulta médica o un juicio no tienen el mismo conocimiento, ya que no trabajan de manera tan regular con estos profesionales (Corsellis, 2008:5).

De la misma manera, la interpretación de conferencias se diferencia de la ISP por el contexto de la labor; un intérprete de conferencias (IC) se encuentra normalmente dentro de una cabina y no tiene que interactuar con su público, es decir, los interlocutores o participantes de la conversación como si sucede en el contexto de la ISP. Sea en una consulta médico o en un juzgado ante un juez, normalmente el intérprete está presente, ante los participantes, y tiene la presión añadida de ser una presencia física constante en situaciones y conversaciones que son de vital importancia para los individuos involucrados (De Pedro Ricoy, 2010:110).

Por ello, se podría opinar que la carga emocional es mayor en el contexto de la ISP puesto que uno de los participantes se encuentra en una situación vulnerable y por eso el intérprete tiene gestionar, no solamente el contenido de la conversación, sino que también la presión y las consecuencias de la misma sobre el sospechoso o paciente, por ejemplo. Esto se explicará en el apartado siguiente que trata la ISP en el ámbito sanitario.

Otro elemento destacado de la ISP es el hecho de que el intérprete tenga que manejar las dos lenguas en un alto nivel, sea interpretación directa o sea inversa, ya que el modo más frecuente de interpretación en los SSPP es la bilateral, o bien la consecutiva de frases cortas desde y hacia ambas lenguas, mientras que la interpretación de conferencias casi siempre consiste en la interpretación simultanea hacía su lengua materna (Corsellis, 2008:5). También, en ocasiones se puede encontrar el uso de la interpretación simultánea en contextos de los SSPP, pero en este caso en vez de contar con una cabina como los intérpretes de conferencias, este interprete debe sentarse al lado de la persona e interpretar la información de manera susurrada.

Asimismo, en cuanto al lenguaje utilizado, en la mayoría de los contextos de la interpretación de conferencias, los interpretes trabajan con variados estándares de la lengua con un registro más formal (Corsellis 2005:161). En cambio, los intérpretes de los servicios públicos se encuentran trabajando con una gran gama de acentos, registros, desde el formal hasta el coloquial, y a veces distintos dialectos, y en la mayoría de los casos no se sabrán los antecedentes o particularidades del mismo hasta que lleguen a trabajar.

Aunque ambos tipos de interpretación requieren que el interprete entienda y pueda manejar los distintos tipos o medios de la interpretación, además de manipular la terminología especifica al contexto, los interpretes en contextos de servicios públicos tienen una presión añadida por trabajar en ambas direcciones.

Es por esto que, a pesar de que la teoría presenta la interpretación de conferencias como el tipo más reconocido y quizás aún más importante por el papel indispensable que tiene en la escena internacional, la realidad demuestra cómo la ISP exige aún más de los intérpretes por todo lo que implica, enfrentándose ante situaciones tensas diariamente, y siguen sin el debido reconocimiento.

3.3 Las habilidades del intérprete en el ámbito sanitario

Con la intención de continuar con el tema del apartado anterior, se explicarán las habilidades particulares que exige el campo sanitario basándose también en las destrezas ya señaladas. Como en otros ámbitos de la interpretación, el intérprete tiene que conocer la terminología adecuada, como se explica en la tabla proporcionada, la cual en el campo sanitario es el vocabulario médico especializado.

Al igual que los otros campos de los servicios públicos, cabe destacar la responsabilidad que impone el ámbito sanitario en el intérprete; debe no solamente estar al corriente con la terminología pertinente, sino que también tener un cierto conocimiento sobre el tema para poder comunicarlo correctamente, además de desarrollar la capacidad y confianza de pedir aclaraciones del profesional sanitario cuando sea necesario. La vida del paciente está en las manos del médico y el intérprete, puesto que el intérprete es el que facilita y hace posible la comunicación. Por ello, el intérprete tiene que tener un sólido conocimiento y preparación, saber cómo gestionar la situación y tratar los temas sensibles que implica el ámbito sanitario, tales como las enfermedades graves o la muerte.

Un conocimiento profundo del idioma y de la cultura en cuestión es imprescindible en la traducción e interpretación en general, como ya se ha mencionado. Sin embargo, se diría que aún más en este ámbito debido al contexto delicado en el cual se encuentra; una de las partes se encuentra en una situación vulnerable y depende del intérprete para comunicar la información sobre su salud de la manera más clara posible en su lengua, respetando y comprendiendo su cultura, ya que cada cultura tiene su propia manera de concebir, expresar y organizar el mundo (Garcia, 2009:53).

Es más, el interprete debe entender que los inmigrantes a veces se ven perjudicados en el ejercicio de sus derechos por no hablar el idioma del país o por no tener las mismas costumbres, y así se sienten aún más vulnerables y tienen menos confianza en el intérprete (Campos Lopez, 2004:2). Por eso, es imprescindible mantener la neutralidad para asegurar la profesionalidad de la situación y poder obtener la confianza de ambas partes, lo cual es fundamental en situaciones del ámbito sanitario para facilitar la comunicación y así el trabajo del personal médico.

También con respeto a la gestión del estrés, en el ámbito sanitario además del estrés normal de interpretar, por ejemplo, la sensación de exposición continua, el miedo a no entender, las posibles distracciones y la presión de dirigirse a un público más o menos numeroso, el intérprete también tiene que confrontar la presión y la carga emocional de una situación sensible (Bosch March, 2012:6). Todo ello puede afectar al intérprete en cuanto a sus propias emociones ya que amén de reconocer, aceptar y gestionar las emociones de las partes

involucradas, el interprete debe también ser capaz de desarrollar empatía sin perder la imparcialidad (Pena Díaz et al, 2014). La labor de un intérprete en el ámbito sanitario es muy compleja, requiere una persona dedicada, bien preparada, empática, fuerte, imparcial y alguien que también es confidencial, algo que se explicará en el apartado que discute los códigos deontológicos.

Como ya se ha destacado, esta labor no es un cargo que se pueda realizar o comprometer fácilmente, y por eso imprescindible entender y hacer entendido que no es una labor que puede hacer cualquier persona, especialmente los niños. La responsabilidad y la carga emocional son algunos ejemplos de lo que implica el trabajo que no pueden ser subestimadas, con respeto a la salud de una persona y las posibles complicaciones y graves consecuencias que puede tener un error en la interpretación, tales como un diagnóstico erróneo.

Sin embargo, todavía es habitual encontrar casos en los cuales los profesionales de la salud recurren a los interpretes *ad hoc,* que suelen ser personas sin formación en interpretación, tales como los profesionales sanitarios bilingües, otros trabajadores bilingües del hospital, voluntarios que a veces colaboren con ONGs, o amigos y familiares del paciente, que incluso pueden ser niños (Corsellis 2008:24, Garcia 2009:6, Abril Martí 2006: 203,345). La razón por la cual se siguen encontrando soluciones poco adecuadas es debido a la falta de reconocimiento sobre la necesidad de interpretación profesional en el ámbito sanitario, es decir, el uso de intérpretes cualificados. Los gobiernos, las instituciones ni tampoco los propios profesionales sanitarios, no comprenden lo que implica dicha labor y por ello siguen utilizando las personas sin formación, lo cual corre el riesgo de causar las consecuencias graves para el paciente, el interprete no formado, y a su vez la institución o hospital en sí.

Por este motivo, se puede encontrar iniciativas basadas en la evolución de abajo arriba (*bottom-up)* que originan en las bases de la sociedad, entre los lingüistas, las instituciones o los profesionales del campo en cuestión, que reconocen este peligro de no contar con interpretes profesionales y llegan a captar el compromiso de las autoridades de contratar a dichos intérpretes formados (Abril Martí 2006:571). Las iniciativas arriba hacia abajo (*top-down),* en cambio, son desarrolladas y creadas por las autoridades y puestas en marcha como así.

En los siguientes apartados que presentan las situaciones de los dos países de esta investigación, y la legislación pertinente en marcha, se verá unos ejemplos de los dos tipos de iniciativas.

3.4 Legislación internacional

Al nivel internacional, o bien al nivel europeo, cabe hacer referencia a la Directiva 2010/64, la cual, aunque se circunscribe al contexto jurídico, representa sin duda el paso más prometedor para la interpretación en los servicios públicos en Europa. Esta Directiva 2010/64 exige que los Estados Miembros tengan medios para garantizar la provisión de servicios de traducción e interpretación de calidad que asiste a toda persona implicada en un proceso penal (Abril Martí 2015:85). Es más, se insta a los Estados Miembros a velar por la calidad de la traducción e interpretación y que establezcan uno o varios registros de traductores e intérpretes independientes debidamente cualificados (Abril Martí 2015: 85-86).

Mientras que, en cuanto al ámbito sanitario todavía al nivel internacional, en relación con el alcance de Europa, no existe una legislación en marcha que la regule. La existencia de la Directiva 2010/64 representa una iniciativa alentadora, la cual cabe esperar que tenga un efecto multiplicador o que se refleje en el resto de los servicios públicos (Abril Martí 2015:85).

Asimismo, la UE está tomando medidas, es decir, apoyando unos proyectos, que tienen la intención de informar mejor sobre la situación de la interpretación en el contexto sanitario, lo cual podría llevar a una Directiva parecida a la 2010/64.

Por ejemplo, MedInt, un proyecto financiado por la Comisión Europea, tenía la intención de desarrollar un programa normalizado de formación para la interpretación específicamente en el ámbito sanitario, con el fin de mejorar la calidad de la formación existente, además de la calidad de la interpretación en los entornos sanitarios en general (Ertl y Pöllabauer, 2010). Después de investigar el tema de la interpretación en el ámbito sanitario, encontraron los creadores del proyecto que esta fue realizada a menudo por legos, es decir, personas o familiares sin formación (Pokorn, 2008:6) Por ello, el proyecto involucró profesionales con antecedentes diferentes: expertos de la prestación de servicios sanitarios, depositarios y las personas encargadas con las decisiones tomadas en este campo, no solamente para incluir sus perspectivas distintas sobre el tema sino también para despertar la consciencia a la necesidad de una prestación adecuada de intérpretes bien formados (Pokorn, 2008:3). Otra meta que tenía MedInt era de crear materiales para la enseñanza de la misma, los cuales podrían ser adaptados para cumplir los requisitos nacionales de los países deseando implementarlos e incluirlos en su legislación nacional, un proyecto parecido a lo del ámbito jurídico se llama "*Building Mutual Trust*" (Pokorn, 2008:6, Ortega Herráez 2015:133). MedInt fue llevado a cabo en los países de Alemania, Austria, Finlandia y Eslovenia durante el periodo de diciembre de 2007 hasta julio de 2009, un primer paso con la esperanza de convertirse en proyectos de una escala más grande, que quizás podrían influenciar las políticas de la UE como la Directiva 64/2010 (Ertl y Pöllabauer, 2010, Pokorn 2008:22).

No se puede negar que la implementación de la Directiva 2010/64/UE del Parlamento Europeo y del Consejo fue uno de los pasos más prometedores en los últimos años, Abril Martí en su artículo de 2015, afirma que en el contexto español todavía no se adelanta esta provisión debido la falta de reconocimiento sobre la Interpretación en los Servicios Públicos en general (ISP) (pp.84). Explica que en España se sigue contando con soluciones improvisadas más que en la prestación de intérpretes de calidad, y que el creciente recurso a la subcontratación de los servicios lingüísticos, con escasos y deficientes mecanismos de control, ha resultado en una merma de la calidad de la interpretación que supone un verdadero retroceso en cualquier progreso que se hubiese alcanzado en los últimos años (Abril Martí 2015:84). Esto demuestra como una ley, la cual representa un desarrollo tan notable en teoría, puede verse desalentada, si no está regulada suficientemente después de haberse implementada y así la realidad de la situación no cumple los requisitos establecidos.

Se nos deriva al siguiente apartado la legislación nacional, en el cual se verá las leyes o normas establecidas en los dos países.

3.5 La situación actual en teoría de la interpretación sanitaria en ambos países y la legislación nacional

3.5.1 El Reino Unido: Inglaterra

El proceso de desarrollo formal de la ISP en el Reino Unido empezó en 1983, cuando la fundación *Nuffield,* una institución benéfica, financió un proyecto y varias iniciativas para abordar la cuestión de la ISP y la prestación de servicios oficiales y adecuados (Abril Martí 2006:180). Antes de la década de 1980, había intérpretes y lingüistas trabajando en los SSPP proporcionando servicios de la ISP en sus localidades por su cuenta, destacando la

característica particular del Reino Unido de la evolución de la ISP de abajo hacia arriba, ya que fue su labor y trabajo continuo que hizo hincapié a la necesidad de investigar el tema de manera oficial (Abril Martí 2006:180).

Sin embargo, todavía no existe legislación explicita que trate sobre el uso de la interpretación en el ámbito sanitario, pero la necesidad de la comunicación está destacada, y así el contar con interpretes en este campo no ha sido ignorada, ya que la gravedad de las consecuencias de no emplearlos se ve reconocida por varias instituciones.

En la última década, el *NHS* y sus distintas fundaciones hospitalarias han tomado medidas por iniciativa propia para abordar el tema de la multiculturalidad creciente y las barreras de comunicación que lleva. Pero antes de presentar dichas medidas, cabe explicar cómo funciona el NHS, es decir, cómo está estructurado. El *NHS* es un cuerpo independiente del gobierno, formado por numerosas fundaciones hospitalarias [Trusts] que se encargan de los cuidados hospitalarios en Inglaterra (NHS Choices 2017). *NHS England* se ocupa de los cuidados primarios, mientras que las *NHS Foundation Trusts* se hacen cargo de los cuidados secundarios, los hospitales, y son entidades legales independientes, libres del control del gobierno central y así tienen gobernanza sobre sus principios y futuro (NHS Choices, 2017).

Según Alexander et al (2004:65), pese a que Inglaterra lleva décadas considerado como un país y sociedad multicultural, como se explicará también más adelante, todavía se va percibiendo una tendencia creciente hacia políticas centradas cada vez más en fomentar el aprendizaje del inglés que en la prestación de los servicios adecuados de interpretación.

Sin embargo, las iniciativas de abajo hacia arriba han continuado ser implementadas por los distintos cuerpos del *NHS* a través del Reino Unido, ya que se van reconociendo la necesidad de los servicios de interpretación y cómo una barrera de comunicación puede afectar, impedir o demorar a la capacidad del médico a entender los síntomas de un paciente, diagnosticar el problema, y recomendar tratamiento (NHS 2014:3). Es más, si el paciente no pueda entender en lo que consiste el tratamiento y las recomendaciones del médico, no es capaz de dar su consentimiento informado al mismo (NHS 2014:3).

El *NHS Tayside,* en el norte de Inglaterra, publicó en 2010 su política sobre la traducción e interpretación. Esta política propone que todo el personal debe saber cómo acceder a los servicios de interpretación, sea telefónica o sea presencial. En caso de que no esté disponible las opciones preferidas serían usar personal bilingüe o un familiar en circunstancias especiales, teniendo en cuenta la preferencia del paciente. No hace referencia especial al uso de niños, ni los riesgos de no utilizar un intérprete formado. (NHS Tayside 2010:1-27)

La fundación hospitalaria del *Heart of England [Foundation Trust]* también publicó una política sobre los servicios de traducción e interpretación en 2011. Esta política hace referencia a varias leyes incluyendo la *Equality Act 2010,* la constitución del *NHS* de 2009 y la *Human Rights Act 1998*, como precedente en el empleo de servicios de interpretación. Este documento en particular proporciona información muy detallada sobre el papel del intérprete, la necesidad de ello y el protocolo para trabajar bien con ellos, antes, durante y después de la consulta. Es más, *Heart of England Foundation Trust* proporciona a su personal los datos de contacto y cómo acceder a los interpretes en plantilla, además de las empresas de la interpretación telefónica y presencial. Cabe indicar que también incluye un descargo de responsabilidad por si un paciente desea utilizar un familiar o amigo para comunicarse con los profesionales médicos, puesto que describe que el uso de familiares, amigos o personas no formadas en la interpretación es extremamente inapropiado, destacando que la interpretación es una destreza profesional. (Heart of England NHS Foundation Trust, 2011:1-20)

Durante este tiempo también, se han llevado a cabo investigaciones tratando este campo, por parte de varias instituciones, las cuales han ayudado a reconocer la necesidad de la interpretación aún si no se lo demanda el usuario. En 2014, el *NSPCC [Sociedad nacional para la prevención de crueldad contra los niños del Reino Unido]* publicó una serie de estudios de caso en la cual salió varios ejemplos de crueldad y maltrato contra los niños, que podrían haber sido reconocidos y abordados de forma oportuna, si hubieran reconocido la necesidad de emplear los servicios de un intérprete (*NSPCC,* 2017). Consideremos el siguiente caso en el cual murió un bebe de 2 meses en septiembre de 2013 como resultado de heridas graves de la cabeza (NSPCC 2017). El caso concluyó que la comunicación entre la pareja lituana y los profesionales médicos tenía mucha relación con lo que sucedió, por la barrera lingüística y la falta de poder llevar a cabo el cuestionamiento típico en las consultas médicas, se recomendó que se debe tener en cuenta que a veces es necesario tener presente un intérprete aun si no se lo solicita la familia (NSPCC 2017). Además, se hace notar que la presencia del hombre en algunas culturas durante las consultas médicas puede impedir la comunicación entre las mujeres y los profesionales médicos en casos de violencia, por ejemplo (NSPCC, 2017).

Por ello, y por muchos otros ejemplos de casos cuyos resultados podrían haber sido diferentes si se hubiera empleado un intérprete, el *NHS England,* en 2014, lanzó un proyecto para evaluar la necesidad y el uso de los servicios de la traducción e interpretación en los servicios de cuidados primarios primero, es decir, el médico de familia. El proyecto tenía la intención de deducir cómo se puede reconocer una interpretación de calidad, llegar a un acuerdo para establecer reglamentos relativos al ésta en cuanto a la financiación y organización (NHS, 2014:3).

El proyecto llevado a cabo por el *NHS England,* igual que la política de la *Heart of England NHS Foundation Trust,* dispone las leyes relevantes que se tiene que cumplir el *NHS*, proporcionando más detalle sobre lo que exponen:

> El artículo 13G de la *NHS Act 2006*, lo cual fue modificado por la *Health and Social Care Act 2012,* afirma que el *NHS England*, en el ejercicio de todas sus funciones, debe reconocer la necesidad de reducir las desigualdades entre los pacientes con respeto a su capacidad de acceder los servicios de salud, y los resultados logrados para los pacientes por la prestación de los servicios de salud. Esto apoya y fortaleza las obligaciones previas para reducir las desigualdades sanitarias expuestas en la *Equality Act 2010.*
>
> Es deber del *NHS England* eliminar o minimizar la desventaja sufrida por las personas que comparten las características protegidas pertinentes y tomar medidas de cumplir sus necesidades. También, el documento explica como todas las fundaciones hospitalarias del *NHS* tienen que atacar el *public sector Equality Duty,* el cual exige que los cuerpos públicos hagan lo necesario para eliminar la discriminación, promover la igualdad de la oportunidad y fomentar buenas relaciones entre distintas personas cuando llevan a cabo sus actividades (Gov.uk 2017).
>
> Artículo 29 de la *Equality Act* demanda que todas las organizaciones que proporcionan/prestan un servicio al público deben cumplir los reglamentos anti-discriminatorios, es decir, tratan todas las personas igual y que ninguna persona es víctima de una acción por una característica particular que le causa un impacto adverso.
>
> Artículo 13G de la *NHS Act 2006* exige que los comisionados involucren los usuarios de manera que se cumple sus necesidades comunicativas. Es más, los deberes que

> involucran los pacientes y aseguran la calidad pueden verse impedidos si no existen servicios adecuados de traducción e interpretación.
>
> La constitución del *NHS* declara que todos los cuerpos comisionados deben evaluar los requisitos para sus poblaciones y tener en cuenta las desigualdades al acceso a los servicios de salud y los resultados de ello para comisionar los servicios considerados necesarios para cumplir estas necesidades.
>
> *(NHS 2015:3)*

También, se destaca que el recortar el financiamiento de los servicios de interpretación y traducción, arriesgaría violar los deberes del *NHS* según artículo 13G de la *NHS Act* y el *public sector equality duty* además de la ley de los derechos humanos de 1998 (NHS 2014:3). Por lo tanto, el *NHS* tiene una obligación de exigir que los servicios de interpretación estén disponibles a los pacientes que los necesitan.

Este proyecto se tradujo a la implementación de unos principios del *NHS England,* en 2015*,* proponiendo las razones por las cuales es necesario emplear los intérpretes, y el protocolo que se debería seguir en cuanto a los riesgos de no seguir dichos principios, cómo contratarles, la importancia de la calidad y las debidas cualificaciones del intérprete, lo que consiste su papel y cómo facilitar la comunicación de la mejor manera posible con el paciente e interprete (NHS England, 2015).

Al igual que los ejemplos que ya se ha presentado, este documento identifica las leyes pertinentes que se debe cumplir en *NHS* en cuanto al facilitar la comunicación, pero incluyen también los siguientes:

- European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)
- United Nations Convention on the Rights of the Child (1989)
- UN Convention on the Rights of Persons with Disabilities 2005
- La *Social Value Act* de 2013
- *NHS England Accessible Information Standard* (ISB 1605)

Estos principios declaran que el empleo de un intérprete no formado, o no emplear un intérprete, pone en riesgo no solamente el paciente, también al proveedor también, dado que ninguna de las partes puede asegurar de la calidad de la comunicación. Asimismo, los errores que pueda cometer un intérprete no formado, familiar o amigo, pueden ser de mayor riesgo que no utilizar a nadie para asistir. (NHS England, 2015:1)

De todos los principios, cabe señalar los siguientes ya que están muy claros [traducciones propias] (NHS England, 2015:3-11):

> 1.4 Cuando se requiere un intérprete, hará falta reservar más tiempo para la consulta (normalmente dos veces más que una consulta normal).
>
> 1.5 *Se debería constar en el historial médico las preferencias lingüísticas y necesidades comunicativas del paciente*, para compartirlas con otros servicios a los que se puede derivarle (por ejemplo, los cuidados segundarios). [acentuación mía]
>
> 2.3 Los interpretes deben ser inscritos con un regulador apropiado (*NRPSI).*
>
> 2.4 Se debería proporcionar a todo el personal la información relativa a como contratar los intérpretes.

> 2.5 *Se debería ofrecer a todo el personal de los cuidados primarios formación* en cómo trabajar con intérpretes, en qué consiste su trabajo, el impacto del mismo para los pacientes y por qué es de vital importancia asegurar la calidad. [acentuación mía]
>
> 4.4 Los comisionados debería tener en cuenta la necesidad de un intérprete en cada paso del proceso (organizando una revisión, surtiendo una prescripción etc).
>
> 4.5 Se debería ofrecer al paciente un intérprete registrado. Se desalienta fuertemente el uso de un familiar, amigo o intérprete no cualificado en las normas nacionales e internacionales.
>
> 4.6 En el caso de que quiera el paciente emplear un familiar o amigo como intérprete, se debe obtener el consentimiento informado en su propio idioma, independientemente de dicho familiar o amigo.
>
> 4.7 *No es aceptable en ningún caso usar una persona menor de 16 años para interpretar, salvo si se requiere tratamiento urgente e inmediato*. [acentuación mía]
>
> 4.8 Los profesionales y el personal de los cuidados primarios pueden usar sus propias competencias lingüísticas para ayudar a los pacientes organizar una consulta o para identificar las necesidades comunicativas, pero *no deben encargarse del papel del intérprete si no están cualificados, a menos que se requiera tratamiento urgente e inmediato*. [acentuación mía]
>
> 5.10 Está presente el intérprete solo para facilitar la comunicación durante la consulta. No se debería pedir al interprete que realice otras tareas.

Como se puede ver en los ejemplos anteriores, estos principios implementados en los cuidados primarios establecen claramente el papel y la labor del intérprete, y promueven el uso de intérpretes cualificados e inscritos con el *NRPSI [registro nacional de intérpretes en los servicios públicos]*.

Asimismo, los proyectos e investigaciones continuas, como los ya subrayados, alientan la revisión de servicios distintos y la aplicación de normas actualizadas por otras fundaciones hospitalarias de los cuidados segundarios.

Consideremos los siguientes extractos de las normas de interpretación de la fundación hospitalaria de *South London and Maudsley* (2015:4-18):

> "*El personal debería utilizar los interpretes cualificados del proveedor de servicios de interpretación cuando se requiere un intérprete*" [Traducción propia]
>
> "*El personal no debería usar jamás los niños como intérpretes*" [Traducción propia]

También declara que "puede ser que el utilizar un familiar no sea por el bien del paciente" y presenta las razones por las cuales no se lo alienta: la posibilidad de abuso familiar, la falta de imparcialidad y confidencialidad, falta de formación.

Mientras que no se puede negar el alcance del reconocimiento de los servicios de interpretación y su importancia en el ámbito sanitario, es necesario comentar sobre el uso y la selección de las palabras de las 'recomendaciones' desde una perspectiva lingüística. La mayoría de los principios y recomendaciones utilizan la palabra "should" [debería] que comunica una 'sugerencia' o una posible medida. Pero, si se la compara con "must" [debe], se ve que esta palabra comunica el sentido de *obligación* en lugar de una opción. Estos detalles,

aunque pueden parecer intrascendente/pueriles, sí que reflejan una actitud u opinión sobre los mismos principios de tiene la institución o cuerpo que está proponiéndolos.

Sin embargo, como se puede ver los principios y políticas sobre la interpretación en el ámbito sanitario en Inglaterra han mejorado bastante, ya que en los ejemplos más recientes del *Heart of England NHS Foundation Trust* (2011) y *South London and Maudsley* (2015) disponen explícitamente las normas con respeto al uso de niños, de familiares y los interpretes no formados, explicando las razones y los riesgos.

Pero como destaca Gentile (2017:63) la subcontratación de los servicios en los últimos años ha causado una disminución en la calidad ya que las empresas han empezado contratar intérpretes no cualificado, y así se corre el riesgo de deshacer todo lo que se ha conseguido, como se ha expuesto en este apartado.

3.5.1.1 Servicios de interpretación profesionales existentes

Entre las otras modalidades de acceso a servicios lingüísticos en el Reino Unido, tales como las soluciones *ad hoc* como ya se ha mencionado, cabe destacar que el país cuenta con servicios de interpretación telefónica profesionales y muy desarrollados.

Language Line fue el primer servicio telefónico empleado en el Reino Unido en 1990 como proyecto piloto para cubrir las necesidades de interpretación del *Royal London Hospital* de Londres (Abril Martí, 2006: 204). *Language Line* lleva más de 20 años apoyando el *NHS,* la policía y los organismos gubernamentales ambas centrales y locales, por todo el Reino Unido, en cuanto a la interpretación telefónica, que está disponible 24 horas al día, 365 días al año en más de 240 idiomas, y la interpretación presencial (Language Line, 2017).

InTran, otro servicio lingüístico empleado por el *NHS,* es una sociedad colectiva no lucrativa que contrata y gestiona los servicios de traducción e interpretación por parte de las organizaciones públicas por el este de Inglaterra (InTran, 2017). Fue fundado en 2000 y ahora es el conjunto de múltiples asociaciones de servicios lingüísticos en el Reino Unido, contando más de 60 miembros a través del este de Inglaterra, incluyendo organizaciones del *NHS,* asociaciones de vivienda agencias de justicia penal e instituciones educativas (InTran, 2017).

InTran se encarga de organizar la interpretación telefónica además de la interpretación presencial, atendiendo las necesidades de dichas organizaciones y asociaciones en más de 180 idiomas que se habla en esta región del país.

Estos dos servicios hacen referencia a su afiliación varias asociaciones profesionales tales como el *Chartered Institute of Linguists* y el *Institue of Translation and Interpreting (ITI).*

Sin embargo, mientras que *Language Line* (2017) destaca la alta calidad de la interpretación que proporcionas, además de la formación continua que sus intérpretes deben cumplir, *InTran* (2017) menciona explícitamente en su página web que las cualificaciones requeridas para formar parte de su equipo de intérpretes. Estas cualificaciones incluyen el *DPSI*, el *Diploma in Translation,* y un máster en interpretación y traducción, junto con experiencia trabajando como intérprete o traductor en el contexto de los servicios públicos.

De todos modos, cabe recalcar que, tanto al nivel nacional como al nivel internacional, se debe subrayar que en cuanto a los SSPP, el ámbito que ha conseguido más en cuanto al uso de los servicios de interpretación hasta la fecha es el jurídico. De este modo, el *DPSI* cuenta con el reconocimiento efectivo de la Administración pública en el ámbito legal (policía y judicial) a través del *National Agreement for England and Wales* de 1997 (Abríl Marti, 2006:183). Según este acuerdo, las autoridades judiciales se comprometieron a contratar

exclusivamente a intérpretes de *National Register* o *NRPSI* para todos los procedimientos penales que requieran interpretación en Inglaterra y Gales desde finales del año 2001 (Abríl Marti, 2006:183). Y en caso de no existir intérpretes de una lengua determinada en el *National Register,* este acuerdo estipula la contratación de intérpretes con un nivel de cualificación equivalente al *DPSI* o pertenezcan a alguna asociación de intérpretes reconocida (Abríl Marti, 2006:183).

Asimismo, la implementación de este acuerdo en 1997 demuestra que el Reino Unido ya había reconocido la necesidad de proporcionar intérpretes cualificados en los procesos penales antes de que se lo exigiera la UE con la Directiva 64/2010.

Por lo que se ha conseguido hasta la fecha, teniendo en cuenta los distintos cuerpos independientes del *NHS* y los principios y las políticas que se han implementados, parece que el ámbito sanitario sigue el ejemplo del judicial. Pero esto es la teoría, como parece en el papel, lo que sería interesante, considerando la situación política cambiante del país hoy en día, es como es la realidad de la situación, una cuestión que abordarán las entrevistas más adelante.

3.5.2 España

Todos los extranjeros en España tienen derecho a la atención sanitaria, según artículo 43 de la Constitución española de 1978, la normativa de la UE en materia sanitaria, y la Ley de Extranjería (Abril Martí, 2006:130). Sin embargo, aunque la Ley de Extranjería (artículo 12.1) garantizaba el derecho de los extranjeros a la asistencia sanitaria "en las mismas condiciones que los españoles", ninguna de estas leyes u otras expresan o hacen referencia al derecho a intérprete en el uso de las prestaciones de la sanidad pública (Abril Martí, 2006:130-131).

La Ley General de Sanidad de 1986 establece en su artículo 10 los derechos del usuario de la sanidad pública, entre los se incluye el siguiente:

> 5. [El derecho] A que se le dé *en términos comprensibles*, a él y a sus familiares o allegados, información completa u continuada, verbal y escrita, sobre su proceso, incluyendo diagnóstico, pronóstico y alternativas de tratamiento. (Ley 14/1986, de 25 de abril, General de Sanidad en Abril Martí 2006:131).

Este artículo claramente implica una interacción comunicativa entre el proveedor sanitario y el usuario, una interacción que difícilmente se puede llevar a cabo en los términos previstos si el usuario no habla o entiende el idioma del país.

No obstante, en 2012 se entró en vigor el Real Decreto 16/2012 del Ministerio de Sanidad, el cual modificó el régimen del derecho a la salud en España, impidiendo a los inmigrantes en situación administrativa irregular a recibir cobertura sanitaria, excepto en casos de emergencia, a mujeres embarazadas y a menores de edad (Lema Tomé, 2014, El Mundo, 2012). La implementación de esta normativa recibió duras críticas desde la sociedad civil y organizaciones tales como Amnistía Internacional y Red Acoge, opinando que la normativa supone una violación de los derechos humanos y "una acción de xenofobia y racismo institucional", por limitar el derecho a la salud de algunos de los colectivos más vulnerables de la sociedad y por ser una medida regresiva y discriminatoria (Lema Tomé, 2014, El Mundo, 2012).

Según Abril Martí (2006:132) la falta de implementación de servicios de interpretación a nivel superior o nacional por parte de la Administración pública es debido a su perspectiva,

o bien su filosofía, de que es la responsabilidad de superar la barrera lingüística corresponde exclusivamente al usuario.

Del mismo modo, puede ser por esta creencia que España todavía no cuenta con un sistema de acreditación para los traductores o interpretes en el ámbito sanitario específicamente. Sin embargo, esto no significa que no existan personas formadas en España ni soluciones *ad hoc* para realizar la debida labor.

De hecho, lo que se encuentra en España en cuanto a la interpretación en el ámbito sanitario es una gran disparidad en los 'servicios' empleados, es decir, las soluciones *ad hoc* contra los servicios oficiales, los cuales se presentará en el siguiente apartado; servicios de interpretación profesionales existentes.

Abril Martí (2006:133) plantea las soluciones *ad hoc* más frecuentes empleadas en España:

- Comunicación a través de gestos y dibujos
- Implicación de familiares o amigos del paciente
- Recurso a profesionales o personal bilingüe
- Uso de voluntarios sea alguna ONG, conocidos del personal sanitario que "hablan idiomas", personal de embajadas, consulados e incluso hoteles, o estudiantes de escuelas de idiomas y Facultades de Filología y Traducción e Interpretación

Sin embargo, cabe subrayar que no se exige ningún tipo de cualificación para realizar esta labor de interpretación médica.

Esto demuestra cómo la teoría de la prestación de servicios parece poco prometedora si la Administración pública no reconoce la necesidad de dichos servicios, y de hecho está limitando el derecho a la salud de los inmigrantes en situación irregular, como ya se ha mencionado. Cabe recalcar que, como se ha presentado en la introducción, y como se verá más adelante, al igual que la situación política del Reino Unido, los gobiernos parecen estar concentrando sus recursos en combatir la inmigración, causando un entorno poco acogedor, en lugar de proveer un entorno que respetan los derechos de estas poblaciones, y que intenta apoyarles a ejercer estos derechos humanos básicos.

Es más, en realidad, como se verá más adelante en el apartado siguiente, aunque existen servicios oficiales e iniciativas de forma abajo hacia arriba para promover los servicios disponibles e intentar mejor la prestación de los mismos, se sigue recurriendo a soluciones improvisadas más que en la provisión de una interpretación de calidad y con control de la profesionalidad (Abril Martí, 2015:84).

La interpretación está más estructurada y regulada en la Administración de Justicia, con distintos tipos de soluciones y cabe recalcar que puede ser debido a la Directiva 2010/64/UE, ya que la legislación española introdujo la Ley Orgánica 5/2015 de 27 de abril que transpone dicha Directiva, relativa al derecho a interpretación y a traducción en los procesos penales (Ortega Herráez, 2015: 149-149). Esto representa que las únicas referencias explícitas a la ISP en España tratan exclusivamente al ámbito judicial, pero como destaca Abril Martí (2015:84), como ya se ha planteado, la subcontrata creciente de los servicios lingüísticos ha derivado en una merma de la calidad de la interpretación que implica una involución en cualquier progreso que se hubiera logrado en los últimos años. Por ello, no se ha alcanzado el cumplimento de esta directiva todavía debido a la falta continua por parte del país de reconocer la ISP en general.

3.5.2.1 Servicios de interpretación profesionales existentes

En España, también se ha visto un aumento en la prestación de servicios lingüísticos tanto en la interpretación telefónica como en la presencial.

Interpret Solutions (2017) es una empresa y proveedora de servicios de "mediación lingüística" en más de 30 idiomas facilitando la comunicación, no solo en el ámbito sanitario, sino que también en los bancos, colegios y otros entornos empresariales, por ejemplo. Fue fundada la empresa en 2007 y se creó la página web en 2014 lo cual demuestra que es una empresa bastante joven en comparación con otros servicios parecidos del Reino Unido (del Pozo Triviño y Campillo Rey, 2016:76).

Sus intérpretes deben "superar un estricto proceso de selección diseñado para garantizar su capacidad para la prestación de un servicio profesional de alta calidad, así como un curso de formación en los ámbitos más comunes de la interpretación" (Interpret Solutions, 2017).

Cabe mencionar también que *Interpret Solutions* hace referencia especial a su deseo que ayudar a conseguir el reconocimiento de la ISP por mantener acuerdos de prácticas con universidades españolas que ofrecen formación específica en este ámbito (2017).

Dualia (2017) es otro ejemplo de una empresa proveedora de servicios de teletraducción e interpretación telefónica disponible en más de 50 idiomas. Fue fundada la empresa en 2003 y se creó la página web en 2009 y, actualmente, sus servicios se ven empleadas en los servicios públicos sanitarios del País Vasco y Extremadura (Auzmendi, 2016, Baigorri y Travieso, 2016, Dualia, 2017, del Pozo Triviño y Campillo Rey, 2016:76).

Queda claro que los servicios oficiales existentes en España no tienen el mismo alcance que los de Inglaterra, ya que en Inglaterra están los principios impuestas en las fundaciones hospitalarias y hay más entendimiento sobre la importancia del tema. No obstante, cabe subrayar que algunos de los servicios de interpretación en España en los hospitales se han visto anulados por recortes en la financiación, debido a la crisis (Ortega Herráez y Blasco Mayor 2017).

Aunque la labor de la ISP no cuenta con el mismo nivel de reconocimiento en España como en el Reino Unido, como se puede ver de los servicios prestados y disponibles, la formación exigida entre los dos países, y la falta existencia de asociaciones profesionales de la ISP en España, está claro que se están haciendo esfuerzos por parte de dichas empresas españolas en conseguir algún reconocimiento y proporcionar el debido servicio.

Se podría plantear también que ya que Inglaterra, o bien el Reino Unido, siempre ha llevado la delantera con respeto al tema, por ejemplo, con del *National Agreement for England and Wales* que trata sobre el ámbito judicial, puede que España también llegue a esta altura con el tiempo.

En el siguiente apartado se presentará la formación disponible en los dos países en cuanto a la interpretación en el ámbito sanitario y los sistemas de acreditación establecidos.

3.6 Formación y los sistemas de acreditación

La formación presenta un asunto de estudio de creciente interés entre la comunidad académica y un tema recurrente en investigaciones desarrolladas por intérpretes, lingüistas y profesionales sanitarios, que quieren hacer alusión a las competencias necesarias exigidas por la actividad y la importancia de regular la calidad de la misma (Álvaro Aranda, 2016:154).

Como ya se ha presentado, la interpretación en el ámbito sanitario implica varias destrezas y habilidades específicas que requieren una persona formada para poder desempeñar

la labor de manera profesional, segura y adecuada. También, para reducir el riesgo de graves consecuencias que pueden surgir por una mala interpretación, tales como un diagnóstico erróneo, una buena formación es imprescindible.

Por ello, se presentará en este apartado cómo se lleva a cabo la formación en los dos países nombrados, Inglaterra y España, para comparar las opciones disponibles en cuanto al formarse en la interpretación del ámbito sanitario. Es más, se intentará llegar a conclusiones sobre el vínculo entre la formación disponible, la calidad de ella y la provisión actual de los servicios lingüísticos encontrados.

3.6.1 Inglaterra

En el caso de Inglaterra, la creación y la demanda de formación de calidad por parte de los profesionales lingüistas y los centros académicos en cuanto a la ISP provocó la sistematización de servicios de interpretación (Corsellis, 1997:81, Abril Martí 2006:276).

Actualmente Inglaterra plantea un panorama especialmente interesante por su progresiva evolución desde la provisión de servicios *ad hoc* hasta un sistema generalizado de ISP, y esto está relacionado con las avanzas que se ha conseguido en la formación y sistema de acreditacion (Abril Marti, 2006: 179).

Sin embargo, en cuanto a la formación de la ISP, en Inglaterra a provisión es bastante esporádica. Actualmente la única cualificación nacional y formal es el *Diploma in Public Service Interpreting o DPSI* ofrecida por el *Chartered Insitute of Linguists (CIOL),* está clasificada como equivalente a una cualificación universitaria en cuanto a las competencias lingüísticas requeridas (CIOL, 2017). Esta cualificación está disponible en cinco áreas de especialización: Derecho inglés, Derecho escocés, Derecho norirlandés, Servicios de la Administración local y Servicios de salud (CIOL, 2017).

La intención del *DPSI* es proveer un estándar nacional y consistente de profesionalismo en la ISP (CIOL, 2017). Asimismo, con respeto al reconocimiento de esta titulación, cuenta con acreditación gubernamental a través de su inclusión en el sistema nacional de titulaciones de formación profesional *[National Vocational Qualifications]* y también dentro del marco nacional de titulaciones *[National Qualifications Framework]* (Abril Martí, 2006:181). También, existe una cualificación parecida que trata sobre el ámbito policial solamente. El *DPSI* está disponible en 52 lenguas (CIOL, 2017).

La obtención de la titulación del *DPSI* da acceso a inscribirse con el *Chartered Insitute of Linguists* amén de incluirse en el *National Register,* lo cual se explicará más adelante.

El *Chartered Insitute of Linguists* también proporciona, a través de su página web, una lista de centros que imparten cursos del *DPSI* o celebran los exámenes. Existen 15 centros de Inglaterra en la lista incluyendo empresas que proveen la formación a distancia, es decir, en línea (CIOL, 2017).

En cuanto a la educación universitaria como una alternativa a los centros de formación sugeridos por el CIOL, pocas universidades en Inglaterra ofrecen la ISP como parte de su curricular. De hecho, según UCAS y la página web "Find a Masters" la provisión de ISP se centra más en los cursos de postgrado, aunque no existe ningún curso presencial especifico a la ISP (2017). En general, los cursos universitarios de postgrado, los másteres, incluyen la ISP como módulo solamente, ya sea la interpretación jurídica o bien sea la sanitaria.

Por un lado, la Universidad de Westminster en Londres, por ejemplo, ofrece un máster en traducción e interpretación que incluye un módulo obligatorio y introductorio sobre la ISP de un semestre, en el cual se aborda todos los ámbitos que encuadra (Westminster University,

2017). Pero, por otro lado, la *London Metropolitan University* (2017) ofrece un máster dedicado solamente a la interpretación, el en cual existe un módulo obligatorio de la ISP que vale 20 créditos y consiste en 74 horas de clases presenciales además de 116 horas de estudio personal. No obstante, este módulo solo trata sobre la interpretación jurídica, y, es más cabe destacar que este curso implica dos módulos obligatorios de interpretación de conferencia (London Metropolitan University, 2017). Este hecho, además de la amplia cantidad de másteres centrados en ella recalca otra vez la mayor importancia que se pone sobre la interpretación de conferencias. Cabe subrayar que ninguno de los másteres disponibles relacionados a la ISP provee la oportunidad de realizar prácticas en este ámbito.

También existen licenciaturas de grado que incluyen módulos de ISP que duran un semestre, pero cabe mencionar que muchos de estos cursos se ven promocionados como cursos introductorios donde, al igual que los másteres, la prestación de enseñanza está limitada con respecto al número de horas presenciales con el profesor, y así se tiene que suplir con una cantidad mayor de horas dedicadas al estudio personal (De Pedro Ricoy, 2010:104). Por ejemplo, la Universidad de Southampton en Inglaterra ofrece uno de estos módulos opcionales de ISP en el último año de la carrera, que consiste en 24 horas de enseñanza presencial amén de 126 horas de estudio personal, vale 7.5 créditos al nivel 6, el mismo nivel que el *DPSI* (The University of Southampton, 2017). La Universidad de Middlesex en Londres también ofrece un curso parecido a éste, pero los módulos relevantes están separados por ámbito, es decir, hay un módulo especifico a la interpretación jurídica, y otro a la interpretación sanitaria (Middlesex University London, 2017).

Cabe mencionar que estos módulos ofrecidos por las universidades en la ISP se ven limitados a las lenguas mayoritarias en las cuales se centran los másteres y estudios universitarios.

Amén de los cursos impartidos por las instituciones universitarias, se encuentran cursos formativos, ambos a distancia y presenciales tales como los cursos ofrecidos por el *Hammersmith and Fulham Adult learning and skills service* [*HFALS*] y dpsionline.co.uk (2017). Estos dos cursos están incluidos en la lista de centros recomendadas por el *CIOL*. El curso del *HFALS,* ofrece impartir clases de 3 horas a la semana durante 10 meses, desde octubre hasta junio, para un precio de £1600 que incluye el examen, el cual cuesta £680 en sí (2017). Sin embargo, este curso, a igual de muchos otros, solo trata sobre el ámbito jurídico.

Por otra parte, el curso del *dpsionline.co.uk* ofrece no solamente el *DPSI Derecho,* sino que las opciones de sanidad y policía, y el curso de sanidad, el ámbito en el cual se centra esta investigación, está disponible las siguientes lenguas: francés, italiano, mandarín, polaco, portugués, romano y español (DPSIOnline, 2017). El curso dura 30 semanas, cuesta £725 y el curricular está separado en varios módulos desde el primer módulo que trata sobre la estructura del *NHS* hasta los otros seis que se ocupan de las distintas partes del cuerpo humano en más detalle (DPSIOnline, 2017). Sin embargo, al igual que los otros cursos presentados en este apartado, no se incluye la posibilidad de realizar prácticas en el ámbito.

Por último, cabe destacar que Ann Corsellis (2008:20), la vicepresidenta del *Chartered Insititute of Linguists,* propone que se están discutiendo la posibilidad de formalizar el desarrollo profesional continuo para los interpretes con más experiencia. Se está planteando la introducción de exámenes en áreas más especializadas dentro de los campos de la ISP, un ejemplo sería la oncología (Corsellis, 2008:20).

3.6.2 España

Al contrario que en otros países, como Inglaterra, en los cuales la actividad de la ISP se encuentra más definida, en España no se exige ningún tipo de acreditación oficial mediante examen o curso formativo para interpretar (Álvaro Aranda, 2016:155). Por ello, no existen normas establecidas con respeto a los requisitos obligatorios al nivel curricular.

Sin embargo, existe un número considerable de universidades españolas que incluyen en sus programas de grado y de postgrado asignaturas de interpretación. Pero cuando examinamos estas asignaturas, encontramos que las asignaturas que tratan sobre la ISP son optativas en la mayoría de los casos, y, se ocupan de las varias ramas de los servicios públicos en general, es decir, el ámbito jurídico, administrativo y educativo, por ejemplo (Álvaro Aranda, 2016:157). En cuanto a la interpretación en el ámbito sanitario, la prestación de formación se encuentra reducida aún.

Es innegable que la Universidad de Alcalá ofrece el curso de postgrado más desarrollado sobre la ISP. Su máster en comunicación intercultural, traducción e interpretación en los servicios públicos, el cual incluye un módulo obligatorio dedicado a la ISP, y la oportunidad para los alumnos conseguir prácticas en el campo también, sea presencial en uno de los centros de salud de Madrid con el cual se tiene un acuerdo, o sea con *Interpret Solutions* que provee servicios de interpretación telefónica (UAH, 2017). Este módulo vale 5 créditos. Cabe mencionar también que al incluir también un módulo de traducción especializada en el ámbito sanitario implica que los estudiantes adquieren conocimiento sobre el campo y el vocabulario necesario a lo largo de los dos módulos.

La Universidad Pablo de Olavide de Sevilla también ofrece un máster en comunicación intercultural, traducción e interpretación, en el cual incluye un módulo obligatorio de la interpretación social, del cual la interpretación sanitaria forma parte, valiendo 3 créditos (UPO, 2017). También, este curso ofrece una estancia de prácticas en el ámbito elegido del estudiante (UPO, 2017).

Con respecto a la formación universitaria de grado, la Universidad de Granada, por ejemplo, ofrece un módulo optativo de interpretación en los servicios públicos, a los estudiantes del cuarto curso que han superado los módulos previos de interpretación (UGR, 2017). Este módulo que dura un semestre y vale 6 créditos, cubre cuatro temas, unos de los cuales trata el ámbito sanitario (UGR, 2017). La Universidad de Murcia, al igual que la Universidad de Granada, ofrece un módulo optativo en el cuarto año de la carrera sobre la interpretación en los servicios públicos (UM, 2017).

Además, cabe mencionar que se ve desarrollando cursos en línea de formación en este campo en España. Recientemente, los grupos de FITISPos y FITISPos e-learning de la Universidad de Alcalá han desarrollado un curso piloto (MOOC) que se puede realizar a distancia (MOOC, 2017). Este curso consiste en 10-12 horas semanales a ritmo del usuario para formarse en los distintos ámbitos de la ISP a través de videos teóricos, actividades individuales de reflexión y autoevaluación y varios otros ejercicios (MOOC, 2017).

Un elemento fundamental que cabe destacar es el hecho de que, entre todos los cursos ofrecidos, pocos incluyen la posibilidad de realizar prácticas en el campo en cuestión, pero las oportunidades se presentan más en España que en Inglaterra. Según Álvaro Aranda (2016:157) sobre la realidad española por su propia investigación, este problema se base en la falta de convenios entre las universidades y los centros de salud.

Sin embargo, Valero Garcés (2009), la directora del máster de TISP de la Universidad de Alcalá, recalca que el uso de *roleplays* o situaciones de prueba solo pueden aproximar las

situaciones reales a los cuales estudiantes tendrían que hacer frente en la vida real, y desempeño profesional de la labor en cuestión. Es por ello que Valero Garcés sostiene la necesidad de que los estudiantes de dicho máster de UAH tengan la oportunidad de enfrentarse a las situaciones reales, y los retos que conllevan, al realizar prácticas en entornos profesionales, aplicando las técnicas y habilidades adquiridas bajo la supervisión y dirección de un perito (Valero Garcés, 2009).

Es más, se puede opinar que la realización de prácticas puede ayudar a hacer un puente entre la teoría y la práctica de la ISP, y también entre los estudiantes de interpretación y los profesionales del ámbito, por ejemplo, los médicos, para que se aprenda del uno al otro sobre sus papeles y profesionales respectivos (Valero Garcés, 2009). De Pedro Ricoy (2010:109) está de acuerdo, sosteniendo que las universidades e instituciones de formación superior deberían reconocer que la obtención de calificaciones no cuenta como una substitución a la experiencia práctica.

En conclusión, el beneficio de los cursos universitarios, ambos de grado y de postgrado en los dos países, en comparación con los cursos del *DPSI,* por ejemplo, es la enseñanza añadida para desarrollar las destrezas de interpretación, además del vocabulario especifico al ámbito; los cursos se centran más en la teoría. Sin embargo, cabe destacar que estos cursos universitarios quizás no incluyen tanta información detallada sobre el vocabulario y los sistemas sanitarios en cuestión, ya que estos cursos tratan sobre varios ámbitos, no solamente lo del sanitario, y por eso tienen que cubrir más aspectos temáticos. Asimismo, el precio de los cursos es un elemento importante cuando se considera las situaciones existentes de la ISP en ambos países, ya que los cursos del *DPSI* cuestan mucho menos que los másteres españoles o ingleses. La accesibilidad a la formación, en cuanto al precio inferior o la cantidad de cursos ofrecidos, contribuye al número de personas formadas que se encuentra. Por ello, se podría plantear que la situación actual en Inglaterra, la realidad de que la ISP cuenta con más reconocimiento que España, está relacionada directamente a esta accesibilidad a la formación. No obstante, la inclusión de prácticas en algunos de los cursos españoles, proporciona una experiencia indispensable para los estudiantes y futuros profesionales. No se puede negar que la experiencia de trabajar bajo supervisión en un entorno médico, por ejemplo, presentará una oportunidad imprescindible para los estudiantes al familiarizarse con el entorno, las situaciones en las que se podrían encontrar, y los retos que conlleva. Por esta razón, se podría plantear que estos cursos españoles, que incluyen una estancia obligatoria de prácticas, en realidad preparan los estudiantes de una manera más real en la labor de la ISP.

3.6.3 Registro Nacional de Intérpretes en los Servicios Públicos del Reino Unido

Otro elemento que hace que el Reino Unido sea un país pionero en el ámbito de la ISP es el *National Register of Public Service Interpreters (NRPSI)[el Registro Nacional de Intérpretes en los Servicios Públicos*] que se creó en 1994, tras ganar un concurso público, el *Institute of Linguists* (Abril Martí, 2006: 181). El *NRPSI* es un cuerpo independiente y voluntario que regula la profesión de la interpretación en el Reino Unido en cuanto a la calidad, sólo incluyendo los intérpretes debidamente cualificados en su base de datos, por el bien de los intérpretes y el público (NRPSI, 2017). A fin de poder inscribirse, un intérprete deberá poseer el *DPSI* ya mencionado, o bien demostrar un nivel de cualificación equivalente. Este directorio también tiene su propio código deontológico específico y un procedimiento disciplinario por el cual los intérpretes inscritos están regulados (Abril Marti, 2006: 181).

Este registro y cuerpo regulador de la profesión y calidad de la ISP en el Reino Unido representa uno de los elementos más destacados y notables en cuanto a la situación del país como pionero en este ámbito. Es más, hoy en día el *NRPSI* cuenta con 1.900 intérpretes en una gran variedad de idiomas, aproximadamente 100, extendiéndose por el Reino Unido y su base de datos está actualizada de manera constante con los datos de nuevos inscritos (NRPSI, 2017).

Aunque no se puede negar que el Reino Unido ha conseguido un desarrollo notable en la provisión y calidad de la interpretación en este ámbito durante las últimas décadas, cabe mencionar que el *NRPSI*, en su página web (2017), destaca que todavía existe una falta de comprensión sobre la importancia y la necesidad de utilizar los intérpretes cualificados en los SSPP. Hace referencia a un caso muy grave que ocurrió en 2013 en relación con Daniel Pelka, un niño de 5 años que murió por maltrato familiar. Explica como la situación podría haber resultado de manera diferente si el niño hubiera tenido la oportunidad de comunicarse con los SSPP a través de un intérprete, ya que su competencia lingüística y bajo nivel de confianza impidió comunicar su situación a las autoridades en inglés:

> *'Without proactive or consistent action by any professional to engage with him via an interpreter, then his lack of language and low confidence would likely have made it almost impossible for him to reveal the abuse he was suffering at home.' (NRPSI, 2017)*

La teoría que se predica es diferente a la realidad que se encuentra aún hoy en día.

3.6.4 Códigos deontológicos

Además del *NRPSI,* como ya se ha mencionado, el *Chartered Institute of Linguists (CIOL)* también cuenta con su propio código deontológico, el cual deben seguir todos sus miembros. Un código deontológico es un conjunto de principios dirigidos a un colectivo de profesionales para orientar el ejercicio de su profesión desde una perspectiva ética.

Según Corsellis (2008:84) un código deontológico es uno de los elementos claves para definir una profesión:

> "*A profession is a group of people who share a common expertise and who profess to a code of conduct and values that is designed to protect their clients, their body of expertise and their colleagues in their own and associated disciplines*."

El código ético que impone el *CIOL* (2015) se centra en los siguientes principios: juicio profesional *[sobre su competencia de poder realizar la tarea específica]*, competencia lingüística, competencia temática, competencia profesional, desarrollo profesional continuo, responsabilidades a los empleadores *[asegurar la calidad, imparcialidad, confidencialidad, profesionalidad],* responsabilidades a los compañeros profesionales lingüísticos y a la *CIOL [integridad y profesionalidad],* responsabilidades a otras agencias, organismos públicos y la sociedad *[atacar las leyes pertinentes, cumplir las reglas impuestas, no cometer delitos mientras realicen dicho trabajo]*.

Esto, junto con el procedimiento disciplinario asegura que los intérpretes inscritos en el *CIOL* cumplan los requisitos establecidos para llevar a cabo la debida labor. Por tanto, si los gobiernos e instituciones siempre exigieran y siguieran los principios de emplear sólo a los intérpretes cualificados y reconocidos por el *CIOL,* mejoraría la calidad de la interpretación utilizada y reduciría los errores. Pero como ya se ha explicado, la crisis económica ha tenido

un impacto notable sobre esta situación y así no se puede garantizar la calidad en todos los casos.

Aún en España, como ya se ha explicado, no se cuenta con un sistema de acreditación para estos traductores o intérpretes en el ámbito sanitario ni existe un código ético establecido para estos intérpretes en este ámbito. Sin embargo, existen unos códigos deontológicos de otras asociaciones españolas de intérpretes que tratan otros campos, tales como ASETRAD (La Asociación Española de Traductores, Correctores e Intérpretes), APTIJ (Traductores e Intérpretes Judiciales y Jurados) y CEATL (Consejo Europeo de Asociaciones de Traductores Literarios). De esta manera, los intérpretes médicos en España suelen seguir uno de estos ya establecidos que se centran en la imparcialidad, neutralidad, exactitud, confidencialidad e integridad (Valero-Garcés y Pena Díaz 2016: Materiales de clase).

En conclusión, como se ha visto con la teoría, no se puede negar que Inglaterra cuenta con un sistema de prestación de servicios de ISP más desarrollado y regulado que España. La existencia de un cuerpo regulador de la profesión que incluye un código deontológico y la cualificación del *DPSI* reconocida a nivel nacional ayudan a que se reconozca la profesión por sí misma, y han conseguido la implementación de políticas o principios oficiales en las fundaciones hospitalarias de ambos cuidados, primarios y secundarios. Un avance formativo que todavía no tiene un equivalente en España. Es más, Inglaterra siempre ha estado a la delantera con respecto a la implementación de políticas relacionadas con la interpretación, si se considera el ejemplo de la interpretación en los procesos penales ya descrito en el apartado sobre la legislación internacional. En España, como se ha comentado, todavía se lucha por conseguir la implementación completa y adecuada de dicha Directiva de la UE que trata la interpretación en el ámbito judicial.

Según Sales (2005:10) la falta de formación y un sistema de acreditación supone un freno para que este campo se profesionalice y sea reconocido, es decir, es un pez que se muerde la cola y anteriormente se lo decía sobre la situación española. Sin embargo, cabe destacar que actualmente existen cursos de formación en España, algunos másteres que reconocen mejor la realidad de la ISP en cuanto a la necesidad de buena formación, por lo cual se exige a los estudiantes que realicen prácticas. Por ello, se podría suponer que la ISP en España se va desarrollando de abajo hacia arriba, de la misma manera que Inglaterra subió a su altura, y así puede que la ISP en España también llegue a un estado más estable y reconocido.

Esa es la teoría.

Cuando se toma en cuenta los retos a los que hacen frente los dos países en el entorno cambiante en cuanto a la inmigración, la situación política con especial atención a Inglaterra y, por tanto, las actitudes de la sociedad, sería interesante averiguar la verdadera realidad de la situación.

3.7 Brexit y la situación política del Reino Unido

En este apartado, se presentará el movimiento político recién votado por el Reino Unido, el *Brexit*. *Brexit* es el término empleado para referirse a la salida [exit] del Reino Unido [Britain] de la Unión Europea, votado por los ciudadanos de los distintos países del Reino Unido, de los cuales Inglaterra votó en favor, con una mayoría de 53.4% (BBC, 2017). Este referéndum, como demuestran los resultados, fue un asunto muy complicado; dividió y sigue dividiendo el país. El primer ministro del momento, David Cameron, renunció porque estaba en contra de esta salida y Theresa May, quien también estaba en contra, tomó su lugar para llevar a cabo la labor necesaria en el tan álgido movimiento político. May invocó el *Artículo*

50 del Tratado de Lisboa*,* que empezó un proceso de 2 años el 29 de marzo de 2017. May también ha destacado que uno de los focos principales de las negociaciones del *Brexit* será la inmigración y su intención es de reducir el número de inmigrantes a un nivel "sostenible" (BBC, 2017). Por ello, May ha descartado la posibilidad de que el Reino Unido permanezca como parte del mercado único de la UE, el cual permite la libre circulación de las mercancías, servicios, dinero y personas dentro de la UE como si fuera un único país (BBC, 2017).

Asimismo, como ya se ha mencionado en la introducción, la entrada en vigor de *Brexit* también pone en duda el sistema actual de inmigración del Reino Unido en sí, y el estatus de los ciudadanos extranjeros que están estudiando y trabajando en el Reino Unido, pero también el de los británicos que están al extranjero. Hasta la fecha, el gobierno británico ha denegado proporcionar una respuesta sobre la condición de los nacionales de la UE que residen en el Reino Unido, aunque los ciudadanos con derecho a residencia permanente no deberían ver sus derechos afectados después de haber vivido 5 años en el Reino Unido (BBC, 2017).

En cuanto a los nacionales comunitarios que trabajan o quieren trabajar en el Reino Unido, el futuro es un poco turbio, todo depende de si el gobierno decide implementar un sistema parecido a los permisos de trabajo, iguales a los que necesitan los extranjeros no comunitarios, el cual limita el permiso laboral a aquellos trabajadores que se dedican a una profesión especifica necesitada por el Reino Unido en caso de deficiencia en un área en cuestión (BBC, 2017). Mientras que los británicos que trabajan, viajan o residen fuera del Reino Unido en uno de los Estados Miembros también podrían encontrar limitaciones impuestas sobre sus movimientos en el futuro después del *Brexit,* es poco probable, ya que estos países no querrían desalentar a los turistas (BBC, 2017).

Una investigación realizada por *Channel 4,* un canal de televisión del Reino Unido, mediante una encuesta llevada a cabo con 270 de las fundaciones hospitalarias del NHS, tuvo la intención de determinar el impacto que tendrá el *Brexit* sobre el personal extranjero del NHS (2017). La investigación presenta cómo el NHS, que cuenta con un personal cada vez más internacional, del cual 140.000 trabajadores del 1,2 millón en total son extranjeros, y 60.000 son europeos, ahora se está enfrentando a una escasez de personal mayor que nunca debido al *Brexit* (Channel 4, 2017). De las 1000 personas encuestadas, el 70% comentó que, debido a dicho referéndum, el Reino Unido es menos atrayente para trabajar, el 66% se preocupó por su carrera profesional en el país, y el 44% afirmó que estaba considerando dejar el Reino Unido a lo largo los próximo cinco años (Channel 4, 2017). Asimismo, ha habido una reducción de un 90% en el número de solicitudes al NHS de la UE y 5.500 europeos ya han dejado su empleo con el *NHS England*, una cuestión muy preocupante, ya que según *The Department of Health* [el Departamento de la Salud], los trabajadores extranjeros, especialmente las enfermeras, forman una parte fundamental del personal del NHS y es más la mayoría de ellos se reclutaban de Italia, Portugal y España (Channel 4, 2017).

Además de la incertidumbre sobre su futuro en el país y sus derechos a trabajar, unos trabajadores encuestados mencionaron su falta de deseo de quedarse en el país después del *Brexit* por no sentirse bienvenidos*:*

"Hungarian worker – I don't feel welcome in the country anymore" (Channel 4, 2017)

Esto demuestra y apoya que la xenofobia ha aumentado en el país, y que está teniendo un impacto directo sobre los empleados extranjeros y, por tanto, en el personal del NHS. Por un lado, la reducción del personal multilingüe, o bien extranjero, podría significar que el *Department of Health* o el NHS tendrá que reevaluar y mejorar los servicios lingüísticos, es

decir, los servicios de traducción e interpretación, dado que no podrán contar con tantos trabajadores bilingües para facilitar la comunicación con los pacientes extranjeros. Esto, aunque no debería pasar por falta de formación en la interpretación en algunos casos, por ejemplo, sí que se da hoy en día.

Por otro lado, cabe mencionar que, según el mismo artículo de *Channel 4* (2017), ante esta crisis de escasez de personal, el NHS está buscando personal y reclutándolo de países más lejanos como India y Filipinas, lo que presenta complicaciones en cuanto a la inmigración, los visados requeridos y el hecho de que esta opción cuesta el doble que un empleado europeo. Por ello, se podría proponer que, si el gobierno o el NHS tuvieran que gastar más dinero en reclutar empleados de países más lejanos, ya que no hay suficiente personal nacional, habría menos dinero para invertir en la prestación de servicios de interpretación y traducción y podrían darse quizás, aún más recortes en esta área.

En cuanto a las reducciones económicas, como se ha planteado en la introducción, en los últimos años el sector público se ha visto afectado por los recortes debido a las políticas de austeridad y esto también ha tenido un impacto sobre el NHS y los servicios de traducción e interpretación. En 2012, la Dra. Samantha Gan publicó un informe sobre cuánto dinero gastaba el NHS en la TISP, el cual se llama "Lost in Translation". El informe presenta que el dinero gastado en dichos servicios está aumentado, particularmente en la interpretación, el total de gastos del NHS durante los años 2008-2011 fue de £64,4 millones de libras. Gan cuestiona si realmente se puede justificar. No obstante, cabe mencionar que esta cantidad es mucho menor que la del Ministerio de Justicia durante ese tiempo, lo cual puede ser porque los servicios de traducción e interpretación tienen más reconocimiento dentro del ámbito jurídico y está normalizado por la ley nacional y la Directiva de la UE, como ya se ha explicado.

Gan no niega que la comunicación es primordial dentro del ámbito sanitario, no solo para asegurar los cuidados del paciente, sino también para hacerles entender la información proporcionada por los profesionales sobre su condición y tratamiento (2012:2). No obstante, Gan subraya las opiniones de aquellos como el Señor Rahman, un abogado de Londres especializado en derechos humanos, que pone en duda la necesidad de los servicios de traducción e interpretación, en favor de prestar más atención a la enseñanza del inglés (2012:3). Según Rahman, la prestación de traducción e interpretación está perjudicando a su comunidad, ya que refuerza la barrera idiomática, separándola de los ciudadanos nativos, impidiéndoles integrarse y desalentándoles a aprender el inglés (2012:3). Theresa May claramente apoyó esta opinión en un discurso de 2015, como se ha presentado en la introducción, en el cual May propuso una reducción marcada en la prestación de servicios de traducción e interpretación para invertir más en la enseñanza de la lengua inglesa.

Por otra parte, el informe plantea que quizás debería haber una ley que requiriese que todos los recién llegados aprendiesen el inglés, con el fin de combatir los factores culturales que impiden a ciertos miembros de la población extranjera conseguirlo, por ejemplo, en algunas sociedades donde las mujeres se encuentran sometidas a los varones de la familia (2012:3). Gan también afirma que el aprendizaje del inglés dará a los inmigrantes acceso a más información sanitaria que aún no ha sido traducido, además de a servicios sociales tales como servicios de apoyo en casos de ser víctima de violencia doméstica o de un delito en general; para reducir la desigualdad sanitaria (2012:3). No se trata solamente de recortar los gastos en servicios de traducción e interpretación, sino de centrarse también en la meta final de la integración, para que los inmigrantes puedan aprovechar de todo lo que el Reino Unido tiene que ofrecer.

Gan concluye que, en un país de acogida como el Reino Unido, siempre habrá demanda de servicios de traducción e interpretación para asegurar que se cumpla las necesidades de estos inmigrantes. Sin embargo, destaca que el proporcionar estos servicios a los recién llegados en una emergencia es diferente al caso de un ciudadano británico que lleva muchos años ahí y todavía no domina la lengua inglesa (2012:10).

Por un lado, lo que Gan y May plantean tiene sentido, se beneficia a ambas partes, los proveedores y los inmigrantes, si los últimos pueden defenderse en la lengua inglesa, pero, por otro lado, solo hasta un cierto punto. Si consideramos lo que se ha mencionado previamente, los inmigrantes necesitan un conocimiento sobre los sistemas de los distintos servicios públicos a los que piden ayuda para poder entender y hacerse entender en el contexto donde se encuentran.

Según Ann Corsellis (2008: 2) la capacidad de comunicar con precisión y fiabilidad en estos contextos también requiere una competencia y una fluidez igual a la de un nativo, lo cual es equivalente a un nivel de posgrado en términos académicos. Mientras que lo ideal sería que toda la población del país tuviera ese nivel de inglés, muchas personas subestiman el hecho de que, para llegar a este nivel lingüístico, se requieren muchos años de estudio continuo. Es más, existen numerosos elementos que afectan al aprendizaje de un segundo idioma, tales como la hipótesis del período crítico postulada por E. Lenneberg (1967), que plantea que la capacidad de adquirir una lengua merma al alcanzar la pubertad, alrededor de los catorce años.

Asimismo, como ya se ha explicado, el lenguaje empleado en las distintas ramas de los servicios públicos, ya sea la jurídica o la sanitaria, es muy especializado y requiere aún más conocimiento del idioma en cuestión (Corsellis, 2008: 2). Por todo lo que implica conseguir el nivel adecuado en la lengua nativa del país, mientras que no se puede garantizar que una persona lo pueda lograr, no se debe subestimar la importancia de la interpretación en estos ámbitos. Es más, cuando se considera la carga emocional que siente un paciente a la hora de acudir al médico a pedir ayuda, este estrés también puede afectar a las habilidades lingüísticas del mismo. Lamentablemente, se comete el error de requerir, de manera ilusoria, que todos los inmigrantes puedan aprender el inglés suficiente como para manejar una situación de este tipo, y, por ello, no se puede recortar la prestación de servicios de interpretación en favor de la enseñanza del idioma.

El *Brexit,* aunque presenta una situación inestable para los inmigrantes y parece alentar a un entorno xenofóbico, no se conseguirá revertir la sociedad multilingüe y multicultural con la que cuenta el Reino Unido hoy en día. Por ello, la única opción es aceptar y promover la integración de los inmigrantes existentes sino futuros también.

Pascal Rillof (2014) destaca que la integración es un proceso doble, es decir, mientras que los usuarios o inmigrantes que vienen a un país deberían intentar integrarse y aprender el idioma, por ejemplo, los proveedores e instituciones también deben organizarse para asegurar que dichas personas recién llegadas tengan acceso a los servicios necesarios para ejercer sus derechos humanos y participar en la integración como sea necesario. Rillof (2014) también plantea que la ISP es fundamental para la democracia, y la democracia es un proceso continuo donde los gobiernos aseguran el acceso a los derechos fundamentales de los usuarios: gestionar y financiar la prestación de servicios públicos y sociales. A este respeto, la educación, las agencias de empleo, los servicios sociales, los servicios sanitarios y el acceso al sistema jurídico, entre otros, representan los derechos humanos a los que toda una sociedad democrática tiene derecho (Rillof, 2014). Por lo tanto, en este mundo globalizado que es cada vez más diverso y multilingüe, estos servicios deben estar disponibles a todos, a los ciudadanos y a los

recién llegados, en una sociedad democrática así, y, para garantizar una prestación apta de servicios, el primer paso es que los proveedores aseguren que puedan comunicarse con todos los usuarios (Rillof, 2014). Por ello, no se puede negar que la traducción y la interpretación facilitan la comunicación, y la comunicación o la capacidad de comunicarse, es decir, de entender y hacerse entender, es un derecho humano, así que no se puede recortar la financiación o negar la prestación de servicios de traducción e interpretación sin violar dichos derechos de los usuarios extranjeros.

Además, si consideremos lo que plantea Corsellis (2008) sobre las habilidades requeridas para comunicar suficientemente en este ámbito, el usuario necesitaría una fluidez nativa para entender el vocabulario especifico que utilizan los profesionales en los campos distintos, amén de los sistemas en cuestión, algo que no está garantizado a todos los estudiantes de un segundo idioma. El no proveer servicios lingüísticos adecuados a estos usuarios supondría una violación de sus derechos.

Cabe recalcar que el *Brexit* no afectará al poder de la corte europea de los derechos humanos que tiene sobre el Reino Unido, ya que no es una institución de la UE (BBC, 2017). Sin embargo, la *Human Rights Act* de 1998 seguirá en marcha y, por lo tanto, el Reino Unido no podrá reducir la calidad de la interpretación hasta un nivel que amenace esta ley y los derechos humanos de los usuarios.

Otra cuestión importante que se ha planeado sobre el asunto de *Brexit* es si se darán modificaciones en lo relativo al funcionamiento de la tarjeta sanitaria europea. Según el artículo del BBC (2017), por el momento las tarjetas, que conceden a todos los viajeros titulares la asistencia sanitaria pública para cualquiera condición o herida que requiera tratamiento urgente, dentro de los países del Espacio Económico Europeo, también conocido como 'mercado único', siguen en vigor y no están vinculados a la UE directamente. Sin embargo, el futuro de dicha iniciativa depende de si el Reino Unido decide cortar lazos con el Espacio Económico Europeo también, y, en este caso, los derechos de los británicos sí podrían verse afectados; los turistas, los estudiantes y algunos trabajadores en España y Europa en general, obligándoles adquirir un seguro sanitario privado.

Ahora, por el momento los extranjeros en el Reino Unido y los britanos al extranjero, se encuentran en un limbo hasta que los Estados Miembros de la UE y el Reino Unido discutan los términos de *Brexit* y lleguen a un acuerdo (BBC, 2017).

Las razones principales por las cuales se votó a favor del *Brexit* se basaron en la inmigración, pero también en la economía, como se ha planteado, y cabe recalcar que la UE cobró mil millones de libras al año del Reino Unido por su pertenencia, lo cual después podría verse invertido en otras partes (BBC, 2017).

Además, el Reino Unido tendrá que obedecer las leyes de la UE hasta que deje de ser miembro el 29 de marzo de 2019 (BBC, 2017). Esto significa que, después de esta fecha prevista, el Reino Unido no estará obligado a obedecer ninguna de las leyes de la UE vigentes o nuevas si no lo desea, tendrá poder sobre sí mismo. Por una parte, en cuanto a las Directivas de la UE, y considerando que la UE está desarrollando unas Directivas relevantes con respecto a la ISP, como el MedInt, que trata el ámbito sanitario como ya se ha mencionado, que, si no se implementase antes de que finalice el proceso de *Brexit,* el Reino Unido no estará obligado a hacerlo. Así que se podría plantear que las provisiones de la ISP en el Reino Unido puedan verse desatendidas por la falta de regulación superior de la UE que monitoriza todos los Estados Miembros. Sin embargo, por otra parte, si consideramos el ejemplo de la Directiva 64/2010/UE, que trata sobre el ámbito jurídico, el Reino Unido había puesto en marcha una ley

a nivel nacional antes de que la UE la ordenara (Abríl Marti, 2006:183). Por lo tanto, se podría sugerir que el Reino Unido ha tomado siempre las medidas necesarias por su cuenta y sigue siendo un país pionero en el campo de la ISP y, seguirá así sin la necesidad de las órdenes de la UE. Pero todavía es demasiado pronto para poder saber o prever la realidad que traerá el *Brexit* con respecto a los servicios de ISP, pero ya se ha presentado la situación teórica basada en la historia y los avances que se ha tenido hasta la fecha de hoy.

Para concluir, como se ha mencionado en la introducción, las políticas de austeridad surgidas de la crisis se han visto implementadas en numerosos países de la UE, incluso Inglaterra. Por ello, se podría plantear que quizás el salir de ella significaría un cambio en este aspecto y, junto con los mil millones de libras que no tendría que pagar a la UE cada año, se podría suponer que habría más fondos para invertir en el NHS y en la provisión de servicios de ISP. Por otro lado, quizás se verá una reducción general en la financiación de estos servicios por un posible cambio en las políticas de inmigración, lo que no ayudaría ni a la integración de los inmigrantes, ni al estatus de la profesión de la ISP. Es demasiado pronto para afirmar nada, pero, como ya se ha visto, en 2015 Theresa May apoyó la idea de recortar la financiación en los servicios de traducción e interpretación para invertir más en la enseñanza de la lengua inglesa, así que sería muy sorprendente si se decidiera cambiar de opinión e invertir más en la primera, dada la situación actual del *Brexit.* En el caso de más recortes, es muy probable que haya más subcontratación a empresas privadas para los servicios de la ISP, lo cual, como ya se ha explicado, puede significar una disminución en la calidad del servicio donde la reducción de costes parece tener más importancia.

Sea como fuere, queda claro que la situación del Reino Unido es inestable y no ofrece ninguna esperanza de cambio en el futuro inmediato, ni para los inmigrantes, ni para los propios ciudadanos nativos. No obstante, no se puede negar que el no proveer los servicios lingüísticos adecuados a los usuarios extranjeros de los servicios públicos en general, por comprometer la calidad de los mismos por un precio más bajo, es una violación de sus derechos, y, por tanto, habría haber consecuencias para el gobierno.

3.8 Previous studies: a base for the present investigation

In this section, several case studies will be presented in order to gauge the situation of medical interpreting in recent years, with the intention of comparing and discussing the findings of these studies with the reality found in England and Spain today. These studies will not only be based on the countries discussed in this investigation, but also include a study carried out by Hale (2007) in Australia, since the findings are of particular relevance to this thesis.

<u>UK: England</u>

In 1998, Dr P. Leman, a specialist registrar, decided to carry out an investigation into the use of interpreting services in the accident and emergency (A&E) departments of the UK. The objective of the study was to determine the support for the national telephone service from A&E departments across the UK, and the factors that may influence said support, as well as to determine the nature of interpreter needs for these departments. The study involved sending out questionnaires to 255 A&E departments across the UK out of which a total of 197 replies were received. The results showed that 66.7% of A&E departments supported the concept of a telephone interpreting service in situations arising out of hours where face-to-face interpreters

could not be organised, both in large multicultural cities and rural areas. What is more interesting, however, is that in each department various resources were used to deal with interpreter needs: 87.6% of the departments used bilingual medical and nursing staff, and *86% used patients' relatives and friends*. Furthermore, *58.1% of departments used non-medical bilingual staff* and 56.5% used translation cards or books. With respect to professional interpreters, 46.2% departments used face-to-face interpreters and 17.7% used a local telephone interpreter service. Of those departments using face-to-face interpreters, 89.5% had difficulty in obtaining an interpreter in the required language, 89.5% difficulty in less than two hours, and 88.4% difficulty in obtaining an interpreter out of hours.

Whilst Leman acknowledges the reasons for which family and friends are often used as interpreters, primarily being their easy availability, the pitfalls and risks are also recognised. These risks include children interpreting in embarrassing situations which creates an uncomfortable atmosphere for all parties involved, and may also cause the patient to withhold some information. There is also the danger of using the partner as an interpreter in domestic abuse situations, as this impedes the work of the medical professional and their ability to assist and help the patient and victim out of their situation. These are two examples of many situations that require a professional interpreter.

The study concluded that bilingual professionals are considered the best option, and whilst very few participants made use of telephone interpreting services, they recognised this would be beneficial if there were a service made available 24 hours a day. This is a solution which Dr Leman believes would reduce the spending on *ad hoc* services currently employed by NHS trusts.

(Leman, P. and Williams, D. J. 1999:271-275)

Gerrish *et al* (2004) undertook a study in a city in the north of England, UK, to address the use of interpreting services by a range of primary care nurses. The study carried out focus groups with both nurses, interpreters and minority ethnic communities. However, for the purpose of the present investigation, only the results from the focus groups carried out with the medical professionals will be provided and discussed. These professionals included: district nurses, health visitors, practice nurses, community midwives and specialist nurses.

The findings from this study confirmed those of existing UK studies which examined the interpreting provision in primary care at this time, in such that the services were inadequate and heavy reliance was placed on family members to interpret. Whilst several of the participants did express concern about how using family members, especially children, could compromise confidentiality and privacy, leading to an adverse impact on family relationships, and the risk that these *ad hoc* solutions may compromise the message and quality of communication, the majority seemed resigned to compromise care in this way. However, some nurses claimed that they would only use children in exceptional circumstances, and that some sensitive topics such as contraception or incontinence would be inappropriate to discuss via a family interpreter.

There was also a clear lack of understanding on the nurses' part of what the role of the interpreter involved, and what skills and preparation they required to carry out their work. Many nurses were also unaware of how to access different types of interpreting services, meaning they were unable to advise their patients respectively.

However, according to the practice managers who participated in the study, training on using interpreters *had* been available to a wide range of primary care professionals, but it seemed that only health visitors and specialist nurses had taken up this opportunity.

Another concern expressed, as seen in the previous study by Leman (1999), was the limited availability of interpreters, who usually had to be booked two days in advance. This was not always possible, since some visits were urgent and could not be postponed until an interpreter was available.

The study also showed that the decision to forgo a professional interpreter was exacerbated by financial constraints. Several nurses mentioned that their choice of interpreter was influenced by the pressure put on them by their managers to reduce costs in using interpreting services. For this reason, a number of nurses agreed that they would use a professional in the initial visit with a patient, due to the complexity of the interaction, but in future visits, which are less formal, hey would accept interpretation by a family member.

Some nurses also commented that they had concerns about the level of training that some free-lance interpreters had received, based on negative experiences they had encountered, such as an interpreter acting inappropriately and conveying their own opinion about the personal circumstances of the patient.

Concluding the study, Gerrish *et al* express their view that, if those with direct responsibility for providing care do not recognise the disadvantaged position of the communities they serve, since they are willing to simply 'make do' with inadequate linguistic services, then it is unlikely that managers and healthcare commissioners will make these services a priority for improvement.

Gerrish *et al* also suggested that in order to improve the quality of interpreting and the interaction with patients, as well as to raise awareness of the importance of interpreters and of the primary care and interpreting services available to patients, both healthcare professionals and interpreters need specific training in this field.

(Gerrish, K. *et al*, 2004:407-413)

<u>Australia</u>

Hale (2007), using the results of a small study carried out in Sydney, Australia, discusses the issues involved in interpreting in healthcare settings, by presenting the different perceptions and expectations that healthcare professionals have of interpreters. The study was carried out by means of a questionnaire that was sent to 100 doctors, of which only 20 responses were received. Hale suggests that this small response could be due to a general lack of interest for interpreting on the part of these professionals.

Since Australia is considered one of the pioneering countries in terms of *ISP,* due to the recognition and accreditation it has achieved, as well as the well-developed and regulated training programs in place, the study on the role of the interpreter from the perspective of Australian doctors is very relevant (Ertl and Pöllabauer, 2010).

The results showed that, firstly, 100% of the doctors employed the services of the government or private companies in order to contract an interpreter for a specific job. Interestingly, 46% of the doctors said they did not expect interpreters to have a specific qualification to interpret, and 23% believed that simply speaking both languages was enough. Only 23% of doctors mentioned that they would expect the interpreter to be NAATI accredited (National Accreditation Authority for Translators and Interpreters, Australia), and only 30% considered a university education as a prerequisite. This only reinforces the misconception that

medical interpreting isn't a 'profession' that requires specific training, although 80% of the doctors stated that they believed interpreters to be 'professionals'.

Whilst 45% of doctors declared that they were able to recognise the difference between trained interpreters and untrained interpreters, some mentioned that they were unaware of what qualifications were held by the interpreters they had used. This may be due to the fact that the doctors are not hiring the interpreters directly, but instead going through an agency, without knowing the requirements and skills needed. Furthermore, this isn't surprising when only 15% of the doctors questioned had read about or received any kind of training or information about what the role of the interpreter implied and the skills required.

90% of the doctors questioned stated that they trust interpreters to be professional, maintaining that the most important factors were confidentiality, accuracy, integrity and impartiality. Moreover, in terms of accuracy, 75% of doctors stated that it was essential for the interpreter to have understood the meaning of the entire discourse in order to be able to communicate the message accurately to the patient, i.e. to understand medical discourse.

However, when asked about the role of the interpreter, 40% of the doctors questioned said that the interpreter should "ensure that the patient has understood what the doctor is trying to say by simplifying their words and expressions". This answer contradicts the previous point in such that the interpreter cannot be accurate if they are simplifying the message.

This study, although on a very small scale, does present some interesting points which reflect an ongoing misconception of the role of the interpreter, even in a country whose *ISP* services are as developed as Australia. The healthcare sector still sees a lack of recognition for the profession of the medical interpreter due to a lack of appreciation for what the role involves and what training is required.

(Hale, 2007:143-168)

4. The investigation

4.1 Results of the interviews carried out for the present investigation

In this section, the results from the interviews carried out with the aforementioned healthcare professionals will be presented. As described in the methodology, the interviews were structured, but allowed the interviewee some freedom to guide parts of the conversation, as this way the information is more authentic. Whilst the interviews provide qualitative data for the most part, as the responses accorded to the individual's experience, there are also occasions in which responses were "yes/no" or where the answers may be grouped together allowing for these to be presented as percentages in the analysis.

The intended duration of the interviews was between 10-15 minutes, however this of course cannot be absolutely controlled if the participant wanted to expand upon their answer. By nature, open questions allow for more perspective as the content and amount of information given lies with the participant, and therefore the information collected is qualitative. For example, the interview with participant B was 25 minutes long.

The results will be presented by means of several tables which are split to give the participants' answers to each question they were asked. Quotes will be used to present the most relevant and vital points from the participants' answers, as the full answers are often extensive and this is the best way to present qualitative data. Since the interviews were all recorded and subsequently transcribed, the full transcriptions are provided in Annex B.

Note: as this is an anonymous study, the name of the insurance company used in this investigation will not be provided and will instead be referred to as 'X'.

It is also worth mentioning that during the interviews the use of "translating" and "interpreting" are used interchangeably by the medical professionals, and are seen as synonyms rather than separate skills altogether.

Furthermore, the responses given by the professionals with respect to the provision of interpreting services in Spain are mainly limited to the provision of English since their work involves English-speaking patients.

4.1.1 Table showing interview questions and answers

4.2.1.1 Profession (where do you work, what position/speciality, years of experience):

A	Registered general nurse, the head of medical services. For the NHS I worked within Acute Hospital Trusts in the South East of England – the departments varied from A&E through to acute surgical, acute medicine and outpatients' department.
B	I work at X insurance, been working here for one year and I've been a qualified nurse since 2001.
C	Staff nurse. I have been working for a very long time. Currently I'm in paediatric intensive care, still working at the Brompton Hospital in Chelsea – that's cardiac mainly – and I've been in medical assistance for (…) about 11 years.
D	I am a nurse, a registered general nurse. I work a X Assistance Insurance in the international emergency medical assistance as an assistant. My speciality is travel medicine and aviation medicine with a background in intensive care and I have been a nurse for 38 years.
E	Registered nurse in the UK, I have done an Aeromedical diploma, I've done a counselling and hypnotherapy diplomas (…) I have been a nurse over the last 50 years and I have had experience in all sorts of different fields including Accident and Emergency, Surgery and Cardiac and Orthopaedics (…)
F	Critical care nurse for 10 years, I work in private medical assistance, I've worked for the government, I still work for the NHS.
G	Children's nurse at Ashford's and St. Peter's Trust and qualified since October 2016.

4.2.1.2 Do you currently or have you worked for the NHS (where, what position/speciality)?

A	Used to - worked for the NHS for 20 years [see above].
B	Not really. I can work the odd shift whenever I choose to.
C	Yes, still do [see above]
D	Yes, previously but not for about 9 or 10 years.
E	Yes previously.
F	Yes [see above]
G	Yes [see above]

4.2.1.3 What languages do you speak and to what level?

A	English native speaker
B	English, full English.
C	[English native speaker] A few words of French.
D	[English native speaker] None really, I did French, German and Spanish at school…bits and pieces – I can order a cup of tea in about 4 or 5 languages, I used to speak Japanese but I can't remember any of it.
E	[English native speaker] I speak French at very basic level and I can read the Latin languages basically, Spanish, Italian.
F	Native English speaker with some French and Spanish to a very rudimentary level.
G	English

4.2.1.4 Can you give me a brief explanation of your role working internationally for insurance?

A	Oversee all medical cases in the UK for X travel insurance.
B	I work as a repatriation nurse and what the role involves is that you work on a medical desk managing cases (…) for patients that are abroad and they become ill. My role is also to actually travel and collect the patients – repatriate them back to the UK.
C	Liaising with medical teams worldwide, assessing medical information and translating that into repatriation.
D	To review medical reports and offer medical opinions as to appropriate treatment, centres of medical excellence and care available and arrange evacuations and repatriations.
E	My role is to act as an intermediary really between the patient overseas and the insurance agents in the UK (…) to seek medical information, interpret medical information from the point of view of what we are going to do with that information and use it to assist people who have got medical problems abroad – so that I am trying to give them the best and safest assistance we can medically but also one of my roles there is to contain insurance company's costs.
F	We manage cases of people with private medical insurance who are either ill or injured abroad, arranging their care locally, monitoring their care locally, including speaking with hospitals internationally, reviewing medical reports which are sent to us in written format and liaising about the safe repatriation or discharge of the patients.
G	N/A [does not work for insurance].

4.2.1.5 What experience and type of communication have you had or do you have with Spanish public hospitals?

A	Regularly speak to…to get verbal medical reports from public hospitals (…) and private hospitals in Spain.
B	I've had Spanish notes, made calls to Spanish hospitals, been to collect patients from Spanish hospitals and spoken to Spanish doctors or nurses on the phone.
C	(...) Any medical case that we have in a public hospital in Spain is **very difficult**. Generally, the only way I can ever **get any medical information is via a patient themselves or the relative,** and say "is there anybody there that speaks English? Can

	I speak to them?" – it's one of the only ways unless I beg Barcelona [another office] to help.
D	Thankfully **very limited**, due to language issues (…) most of the experience is actually turning up and doing repats [repatriations] and actually speaking to the nursing staff and medical staff when you go to get a patient – **have tried but fail on most occasions to call and actually speak to staff in public hospitals due to language issues** – so we **tend to ask native Spanish speakers or good Spanish speakers.**
E	**As little as I possibly can** because I don't speak Spanish and in Spanish public hospitals **very very often they either wont or don't speak English adequately**. If it is a Spanish State hospital I will do everything I can to get somebody else to speak to them because even if I can speak to a treating doctor for example in a Spanish hospital whose English might be very good **the difficulty for me to get through to that doctor, past the reception and telephonists etc can be very time consuming and quite difficult so I rely on the people who speak Spanish around me**, that might be a doctor in our case or it might be the operations team to get through to a doctor who speaks English.
F	**Dealing with Spanish public hospitals is very difficult** (…) they are quite resistant to speak to us and even if they speak English they would be quite resistant to it – they would much prefer to speak to a Spanish native (…) and that is apparent.
G	N/A

4.2.2 Questions relating specifically to the UK:

4.2.2.1 What current translation or interpreting provisions are you aware of being used by the NHS in the UK?

A	Language Line is the only one or is the only authorised one that we should use in the UK.
B	In the NHS (…) we've got an interpreter line so we always have access to **the majority of languages**, not just Spanish, so if there's a language that you cannot speak and you've got a patient, you're able to call **Language Line** and you'll be able to have a conversation through an interpreter**, a trained interpreter with Language Line.** (…) there are a few flaws sometimes – because I have worked in different systems and one of the flaws (…) sometimes you can't listen to what the patient is saying – you've only got one line so you only speak – **you haven't got the 'three-way'**. I have worked in the NHS establishment but in a prison where we do have **three lines** so when you have the three lines at least **you can listen to the interpreter, you can listen to the patient and the conversation is much more fluent with three of you on a three-way call** but previously in the NHS, I don't know if they have improved in hospitals now but they used to be just two of you speaking – just the option for both of you to speak – so therefore you would speak to the interpreter, the interpreter would speak to the patient and then you go back **so the communication is not as accurate when it isn't a conference call**. [Two-way communication] Can change the communication because I might ask the interpreter to ask the patient if they're short of breath and if they have any chest pain, I might ask three questions – I don't speak the language but what happens (…) is by

	the time you pass it back to the interpreter and the interpreter says – A. **I don't know what the interpreter is saying to the patient** and then sometimes **she doesn't answer all the questions fully** – when I'm on the line I can – I've got my 3 questions there and I can ask – have you answered those three questions that I've just asked? – but **when you keep passing it backwards and forwards things get lost on a long conversation** (…) when you are all on the call it's much easier, you are less likely to lose [information]
C	I know in my own hospital where I still work there is **a number of interpretive services which include every language** (…) well many languages: all the Indian languages, all the Pakistani languages, pretty much worldwide really, all the Arabic's, all the Erdus, everything (…) polish (…) eastern European (…) they send requests out on the emails all day (…) whatever is required. Agencies? (…) **I actually don't know to be quite honest** – unless we've got a database of people on our…I think they might have a database of people on their list and they can call them or they can send out an email to them…I am not 100% sure how it works – it's actually a good question – I could find out…
D	Well I haven't worked for the NHS for about 9 or 10 years but the last hospital that I worked in – we had a list of foreign language speakers – we also had a facility to telephone interpreters, I think it was **Language Line**, these were the official services.
E	I am not aware of any. The last NHS work I have done was many years ago so I am not familiar with how the NHS works in terms of interpreters, I am only familiar with occasionally we might get a foreign patient in a UK hospital and I know that in some hospitals particularly the bigger hospitals, the teaching hospitals they will get somebody within that hospital to speak in that language for that patient but how that works and how widely available that is and to what level of expertise I've got no idea.
F	**Most translation that's utilised within the NHS is not professionally done** (…) the **people that work for the NHS are so multicultural that you generally use other people working there** in whatever format so not necessarily medical to do **basic translations** for you and there's an international workforce so you can often in a large trust, get any language you want.
G	There is the "Intran" service which is the 'over-the-phone' one which I have seen used a couple of times but I have also seen staff members being used.

4.2.2.2 Are these official services? And are they always used?

A	If Language Line cannot produce anything, we have to wait for Language Line to provide a service, we are not allowed to go outside Language Line.
B	That is the only one that they use – **Language Line**, but I do know, working with the NHS that (…) you can get actually interpreters that come in – not just through Lanaguage Line, if you need an interpreter to come in in person, you can get it and you can order an interpreter in person to come in **(…) sometimes communication may be really difficult over the phone and a person will need (…) an interpreter there.** (…) if I can recall rightly when I worked for the NHS, it gives you an option so you can phone and if you decided that you wanted an interpreter to come in person, say for example if someone had **mental health issues**, and they couldn't communicate over the phone and it was just difficult and you wanted the person to come in (…)
C	Yeah, I just asked my ward clerk to find me an interpreter, not sure how they do it – just try and find one – **sometimes the staff help like lots of our staff speak different**

	languages – sometimes the staff like, **we've got Arabic doctors, we've got German doctors, we've got nurses** (…) half our nurses are (…) Spanish or Portuguese…
D	From what I can remember there were Spanish speaking staff in the hospitals, but it depended on who you were trying to talk to and what information you were trying to gain so if it was relatives they would use the staff.
E	N/A [hasn't worked for NHS for many years – see above]
F	The only formal professional use I have experience of is **Language Line** which is a telephone translation service. [Language line is] **not very instant** (…) there is generally a delay on that and you will sort of book an interview in.
G	Intrans is the official service. [not always used [see below]

4.2.2.3 What about family members, hospital staff etc?

A	Had been up until about 5 years ago, then has been discouraged because of the clarity of the translation.
B	**Definitely**, when I worked for the NHS, **there was a case in A&E a patient that couldn't speak, they were deaf, and there was a trained nurse that could do sign language** and she was an interpreter for the patient **instead of getting a correct interpreter in they used a nurse**, and the patient decided to self-discharge and go home – and the **patient actually died** and there was a **big issue about the interpretations that we used** and **if the person wasn't trained she was open to scrutiny** (…) and from then **we learned that we should never use an interpreter if it wasn't a trained interpreter by the trust**. (…) there was a lot of work that went into it and so even if it was **domestic staff** they often spoke different languages – they were called – with **no confidentiality**. (…) there was a lot of work done in that area because of that incident that happened – so personally for me**, I have learned in my training that if you are not recognised to be the interpreter – then I don't want you to interpret anything for me** – because when it comes to a court of law, I have got no leg to stand on.
C	[Hospital staff – see above] They are natives of other languages. [Family] Yeah, sometimes…**you can use family members**…yeah… they often, like **children**, you know children speak…**the younger members of the family will speak better English than the parents and they'll translate** (…) sometimes an aunt or an uncle, someone like that, some relative will translate and we do use them, **even though they are not medically 'au fait'** with it all they can generally…and we do use them. [**Cleaners/housekeeping] Occasionally yep, occasionally we do**.
D	[see above]
E	N/A
F	[For hospital staff – yes used – see answer above for provisions/services available] **Family members – yes**. Where there are family or friends – anybody socially who may speak, have a better standard of English – you'd use those.

G	Sometimes in **emergency situations they will use family members** but a lot of the time also with the children, **the children tend to translate for their parents** – the children are at school and can speak better English. It depends on the situation, because you never know that they are going to be translating it the right way or they're just **sugar coating** it or **saying something completely different.** Then you have the issues around **domestic violence** and if they can **completely lie and say something completely different to what the patient is actually wanting to tell you.** [Hospital staff] Can be anyone really, I have seen **cleaners** being used because we needed something to be done then and there. For official things like **consent** and things like that for **surgery** – It needs to be…**they wouldn't let it be a staff member, it has to be through an interpreter or through Intrans**, whereas if it is just relaying messages – less formal things…

4.2.2.4 Has this changed in recent years or since you started working for the NHS?

A	[see above]
B	**These changes happened for this particular trust** that I worked for – there was a lot of work that went into it (…) I think because of the nature of places where we work, especially for the NHS, it's so busy, if you work somewhere so busy, although the rule stands as a rule it sometimes as a shortcut – sometimes you know **if you're too busy, sometimes people might take a shortcut – that still happens**. Case roughly about 8 years ago – changes since then.
C	Used **Language Line** at other job. I haven't used them since my other job, but it was good you could ring them up (…)
D	N/A
E	N/A
F	Not really, not beyond the general changes and **provision is very tight** and resources are few and far between – increasingly so – and **you're encouraged where possible not to use a fee-paying translation service** but you have to use whatever is required at the time. I work in critical care, it is often not acute in that **the team responsible for a patients care will do whatever is in that patient's best interests** and they may not, whether they are native English speakers or not be capable of giving consent or information except for just **due to the nature of their condition**.
G	N/A

4.2.2.5 How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

A	-
B	It is always going to impact because **Language Line is time consuming** so **even if it doesn't impact on that particular patient, it impacts on other patients because you're always going to take longer to deal with that patient**.
C	Yes, **it is an issue** but at the moment I work with children so it's not quite the barrier it could be if it were adults.
D	N/A
E	N/A

F	It is **difficult** but **possibly slightly less so in that where you have a patient with no English they are generally living and working in a country where they don't speak the language at all** and so it is not always beyond their day-to-day life though obviously it is such a **key and important issue – it causes more anxiety** – I am sure they are used to experiencing the language barrier.
G	N/A

4.2.3 Questions relating specifically to Spain:

4.2.3.1 What translation and interpreting provisions, if any, do you find in Spanish public hospitals? Does it differ greatly from the UK?

A	It's very **sporadic** to be honest, depending on which area and which hospitals (…) generally there is **some form of translation service or international department** in the hospitals that I've encountered (…) but again the level of translation is difficult sometimes and **availability is very difficult**. Some public hospitals not all. Generally, in the more **tourist areas** they are more available.
B	No, the provisions don't differ, from what I have seen they have got similar provisions what we have in the NHS. They've got **"a translator"** so most things are done through the translator so if you come to the ward – some of them speak very limited English and they can't help you and **they call the translator who speaks fluent English**, **but they're not medical the translator is not medical so the translator doesn't understand everything** that goes on so sometimes **can get missed and so they'll translate what you need and the information that you ask for** (…) You may miss our tiny bits of information because it goes through the translator rather than the nursing staff (…) [Quality the same in Spain as UK?] I think it's different and I say that because I am doing the full assessment myself when I am here on occasion and I am asking for someone to interpret it and its more time… when you get to the hospitals in Spain and you're relying on the translator I think that the nursing staff are really busy… they haven't got the time so your translation will never been the same because you're relying on their assessment and **you're getting your information from someone who is non-medical.**
C	In public hospitals in Spain…I am sure some hospitals do have them, it's actually **trying to get through to them** to help us. Because **once again you almost need Spanish help to get through to the Spanish helpers** (…) some hospitals must have a system similar to a private… it's just more difficult to access, and maybe we don't know about it. [Comparison to UK] (…) it is probably similar, **say if the boot were on the other foot and you were Spanish calling England you'd have the same trouble**.
D	**A lot of the hospitals have international departments** because we tend to access or have patients in **high tourist areas** so they will have international departments or interpreters – **a lot of the staff will try to speak English for you** – a lot of the doctors will – not a lot some of the doctors have had experience in the UK and will speak English as well but it is quite limited – it is **very hit and miss**.

	I am not aware that if they don't have an international department what other facilities or dealing with any type of they have…[the service on site] that **tends to be office hours and around the afternoon siestas so it's the morning** – if you phone **in the afternoon: no chance**. Sometimes you're lucky if you can then phone back in the evening – and **at the weekends almost certainly not. Only mornings.**
E	**Limited** (…) I think in some of the state hospitals where we've got patients going regularly in Spain because there isn't a private facility close by for example, and we've got **tourists going there regularly** (…) sometimes (…) we'll actually speak to somebody who is, **by job allocation**, has got a **designated role to help and to assist and interpret** and that we do come across sometimes, and that is **really helpful and really good.** My problem is (…) **I am not really aware of what that person's capabilities are** and we've got the same old problem all over again and **the same does exist with private hospitals in Spain that is all very well being able to speak Spanish and English fluently but whether you have got the knowledge to understand the medical side of things added to that, that's always a great big problem even when there are dedicated and designated interpreters**. It's not a question of just translating Spanish to English or English to Spanish [lack of medical knowledge] **it's always the problem** so sometimes I might here – **get a Spanish speaker to speak to a Spanish doctor with me sitting next door to them** so that **I can actually give them English questions which can be translated – I will then hear back** from our linguist **the answer so I can then put in the appropriate next question so then the translator is acting more safely as an intermediary rather than trying to interpret actual medical information which can get very difficult**.
F	**None.** The only options we have are utilising **Spanish speakers based here in England that we work with.**
G	N/A

4.2.3.2 If nil, who helps with communication with these hospitals? Family members, hospital staff, staff in UK insurance office?

A	-
B	-
C	Always **easier to communicate when you are there** because when you are on the ground (…) you can generally work out more…even if you can speak the language, you can generally, together you can work out something – or find somebody who can speak a little bit of English (…) definitely easier when you are there – **although that could be too late.** In the office that's difficult too (…) **we just try and find someone who can speak Spanish really**, there is one or two that can – members of staff in the office – if not…try and ask Barcelona to see if they can help us.
D	We would use the language speakers in the office or in Barcelona – the DZ [abbreviation/jargon given to offices located worldwide]
E	[Family members] **yes occasionally** that happens but I would say that it doesn't happen very often but then the difficult (…) is that is a **subjectivity** involved of the

	family member and so **you are never quite sure that you can totally rely on what is being said or what the treating doctor is being urged to recommend**.
F	We try to use them [family members] but it **can be quite difficult having a medical conversation with somebody completely untrained and also who is emotionally involved in the situation** – that's not always helpful – **sometimes close relatives or people who care about the patient can be the worse people to converse with in any language.** There is a **very strong bias**, there is a lot of anxiety, there is a lot of upset so any conversation **is very emotionally driven, that's true even without any language considerations across the board in healthcare**, it can be very difficult conversing with loved ones.
G	N/A

4.2.3.3 How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

A	-
B	I think that the care in Spanish is different to the care here in the NHS and I think that **patients have complained about the language barrier** so for example **they might be in pain for longer than needed** to because **they can't communicate it in the normal way or they are not confident enough to communicate** it. It is not that they wouldn't treat their pain in Spain but (…) it makes it harder to communicate what I want because I don't speak the language – so **if you're a patient you're a little more vulnerable as well** (…) and you are in a lot of pain maybe it is even harder for you to communicate so (…) you've got two things – **you've got your condition and you've got the barrier** which doesn't help, which in an English hospital or English speaking hospital it would be a lot easier.
C	-
D	**Yes, it affects our work**. Because they are obviously very busy because they are high tourist areas and (…) you may phone the international department and you get a Spanish speaker but they don't speak English – it may be the Spanish speaker that speaks Portuguese and German or Italian so you are **not always guaranteed in the international department that English will be the language that you get**. Getting through and getting answered because they are out and about on the wards – some do carry bleeps – some carry contact phone numbers – but sometimes you just can't get through – and again you know they're on the phone and they're engaged and **you can't get through so again it is a bit hit and miss**. **It delays making necessary judgements or calls on the work**. In public hospitals in Spain you are not normally concerned at the level of care but it may delay getting the information as to what the diagnosis is, what the treatment is and when are they going to be discharged, when they can be repatriated…so it causes delays (…) I don't think it would cause an impact on the actual patient care. **Patients always mention the language barrier**, because it is again hit and miss and particularly English people they are not normally…encouraged to try to speak a different language. **It is a very arrogant thing that they think everybody should speak English when in fact they are in Spain** and there is no 'legal' requirement to speak English, it's not their native language but the English expect Spanish people to speak English.
E	I think the problem is that there are often delays because it is difficult for us to get hold of the treating doctor and because it is a state hospital and their attitude is very

	much "**why should we give you information**" "**you're not paying for it – it's not a private facility**" (…) it could be then there are delays in helping the patient in getting home and those delays can have effects on their treatment and their recovery sometimes.
F	**Yes, definitely**, there is often a conversation that patients particularly want to have about **having treatment abroad vs coming back for treatment** – we would have strong recommendations in many ways which is based solely on the safety of the patient so certain things should be treated locally prior to transfer because the condition could be destabilised by the transfer if not (…) they and loved ones are **often very keen to come home because they don't really understand what is happening to them** even though that might not be in their best interests. There is also **a lot of fear of the unknown** and many people, though they travel to countries abroad, have quite **biased views of healthcare abroad** and so managing patients and ensuring that they receive the best care has to be based solely on conversation and that can be very difficult in those circumstances. [Regarding repatriations] It's much better when I am in the hospital, more commonly in countries like Spain (…) they would be in private clinics and predominantly because that is where they are taken, **ambulance services have a bias for taking British people to private hospitals** where there is need for acute care (…) you can converse freely with those private clinics and obtain all the medical information you need, language skills there are good. That said, even in public hospitals, when you are there, you can have access to medical reports etc.
G	N/A

4.2.3.4 How would you compare the two public healthcare systems in Spain and England with respect to these linguistic services?

A	-
B	-
C	-
D	**Big difference.** It is **better in Spain** because they are **more geared to tourists and foreign nationals – particularly in high tourist areas** – they expect to have a certain amount of non-Spanish speaking patients. The **UK don't have any facility, make very limited facility because they expect 99.9% of all patients to speak English.**
E	N/A
F	**Formal interpretation services in the UK aren't great**, I haven't really seen any in public facilities in Spain, and **that may just be that there is far greater access to private healthcare in Spain** (…) it is preferred locally for foreign patients to be utilising private healthcare rather than public healthcare.
G	N/A

4.2.3.5 What do you think about using non-registered or untrained translators and interpreters? Can you notice a difference between trained and untrained interpreters?

A	Cannot tell the difference. I think it is **very difficult if you are a non-language speaker to identify the pitfalls** in someone's translation (…) I have been witness to a translator, a Spanish translator (…) I had a Spanish nurse standing next to me and she did actually lean over and say **that that's not what you asked them to say.**

B	**No. I don't understand the language** so it would make no difference to me. They all have a number, when you phone language line, **a trained interpreter is supposed to give you their number** so you can put their number in the notes and so their number is on the files and that is what I call a trained interpreter.
C	**Yes, definitely**, and the reason I would say that – like medically trained? Or…? [trained as an interpreter with specialism in healthcare - DPSI] – I get the impression that many would not have it [DPSI], **people who speak both languages, live there and start working in the hospital helping and act as a go-between**…**some of the translators with just basically help the patients rather than do a whole lot of medical stuff** because if you call them up (…) I can say "how is Mr XXX" "what's the update" – and they reply "oh I am not medical, I can't tell you. All I can tell you is that I saw him this morning and he is fine etc" (…) **Very seldom that I've got like a conference call** – you see I haven't had a conference call since I have been here really because A – our lines don't allow it really and yeah that would be helpful so **if you could do a conference call and you had a proper interpreter in the middle and I could ask the questions and the questions were relayed – backwards and forwards** – doesn't really happen as you can't find someone to do it but **would work quite well**.
D	**Yes, because of the nature of what we are asking for** – so it is okay to have conversational Spanish but **we're asking for very intricate medical information** – **they don't understand, even if you asked them in Spanish – they may not understand what you're asking for** so when you ask in English they find it difficult, they have difficulties then knowing what the Spanish equivalent is or the relevance of it. We don't expect them to interpret the results but **they don't understand what is it that you are asking for even if you asked them in Spanish.** [In the office] yes can tell the difference between trained and non-trained interpreters. Only again because you can have native Spanish speakers and very good English speakers **only conversational** but ask them a medical question and rarely do they know without having worked here or in another assistance company – **favourable to have someone specifically trained in healthcare.**
E	**Yes, a significant difference** – **much more confidence and the preparedness to question the treating doctor more: "I don't quite understand what you have said – can you explain that to me?"** – whereas somebody who isn't familiar with this side of things is **too sometimes intimidated by a treating doctor** who is in a hurry and realises he is not speaking to a medically qualified person.
F	**Yes, you definitely can** (…) **medical care should and gold-standard care would be based on a conversation (…)** for each piece of information given (...) that would just produce more questions so we need to be able to converse rather than just review a medical report or just be handed information.
G	Not sure - the **non-trained people aren't necessarily going to know the words that they are translating**, if it something **medical** they are not really going to know or understand that they are saying so if the person has any questions, then it might be harder.

4.2.3.6 How important do you believe training in this field to be? Why? (Would you consider an Ethics code to be important in this field?)

A	Yes – ethics. Definitely it's a big responsibility to translate any document or a service, anything medical has to be a priority because **if you get something wrong or you change the exact question that you needed answering, it actually affects the response and then obviously, the treatment and diagnosis of someone's care**.
B	**Yes, I think anyone looking after patient should have an ethics code** – when you are caring for somebody, especially **people that are vulnerable** as well.
C	**It would definitely definitely help** – it would be really helpful. [Ethics] Yes exactly, **I think that is important** – I think that it's missed because all **we want to do is try and find the first person we can who can help us** in any way they can. **Finding someone causes a delay**….so you just find a relative, you find a cleaner you find somebody who can help.
D	**Yes, it is important.** [ethics code] Yes because you're also not only…**data protection and confidentiality**. We are governed in the UK by things like Caldicott and Clinical governance (…)
E	It would be **hugely useful to have specialised training but it is quite difficult** – I think it **would be quite difficult to work out to what level the interpreter was expected to understand medical problems**, I mean it is difficult enough for us on the medical desk and our experience is very broad and our medical knowledge is very good to do this job, even so we sometimes see treatments that are different, we find it difficult to understand what is being told to us because **the name given to something is different in Spain than it is here** so our knowledge has to be as encyclopaedic as it can possibly be – **to what extent should an interpreter understand in order to be useful…I would think that would be difficult**. Ethics…that's a difficult one really…it is all to do with **honestly recording and passing on the information that you are competent to pass on**. It would be very **easy for an interpreter to assume what they have understood and then there are ethical issues** with that…
F	I think **absolutely it can only benefit patient care to have somebody that is trained, knowledgeable and experienced in healthcare** working in medical translation. [Ethics] Yes. Because (…) so many things are contextual and it is very difficult **if somebody perhaps who has language skills but no medical knowledge will then maybe make assumptions that aren't correct based on a direct translation.**
G	You need to be able to understand (…) what you're saying, because **if it is said slightly differently, it could mean a completely different thing**. Ethics code – because then you've got a similar…like all the rules we have to follow with (…) **confidentiality**.

4.2.3.7 What experience do you have working with interpreters and have you received training regarding working with them?

A	No.
B	No. No-one.
C	No. Never.
D	No.
E	No.
F	No.
G	No.

4.2.3.8 With respect to the England and Spain, do you see any changes taking place in these areas in the future? Why? Also since Brexit is on the horizon, do you think this will have any impact?

A	No. I don't think actually it will affect the way we translate too much, **I think we'll still have a movement of people within the UK**, to the continent and vice versa – I think the translation service at the moment is almost adequate for Language Line – the availability is the issue we have.
B	Just to go a little bit back, one thing I didn't mention is that sometimes we've got translating like **"Google Translate"** and sometimes if you get a report its going to translate it by using the translation app and that gives you the information but you still can't rely on it as well. In terms of what I see in the near future – is the answer for English people to learn Spanish or Spanish people to learn English? Is that going to be an answer? **We've been going for years and years and years and we haven't cracked it** so I don't think that is going to happen any time soon and what's a way around it…there probably needs to be, just like in the hospitals employed a translator and the translator translates and helps to cut down that barrier by translating things (…) for example the hospitals in Spain (…) admin staff needs to be could be **medical admin** – because they are given a lot of medical notes (…) mix the teams up like in an insurance company (…) like I worked in a prison before and you've got healthcare and you've got security and you've got two services in one and the only way to get a better outcome is **to mix the two** so if you have for example and operational language person sitting on the desk with the medical team and maybe even the other way around (…) you have a fair mix so it's getting better communication – **the only way to get better communication is to cut down barriers.**
C	No, I don't think it would affect it much (…) wonder whether it will affect us the other way around – us calling Spain (…) **I would like to think it wouldn't** – that what we've got wouldn't diminish.
D	I haven't noticed, well not from the interpreters' service. (…) there are a lot (…) **more English speakers, native English speakers, who have gone to Spain to improve their Spanish who are working as interpreters**. (…) I know in Son Espaces (…) they went to improve their Spanish but again they didn't have a medical background, so **they have gone to improve their conversational Spanish but in fact they are working in an environment that has its own language**.

E	I am not sure that it is going to make that great a change (…) my views about Brexit are that at the end of the day we are not going to notice in this particular area any great change at all. **I very much doubt that Spanish hospitals are going to invest in a whole medico-legally acceptable interpreter training because of money**, it is all down to money and you know **more and more people are travelling every year, more and more people are pushing on to state hospitals** that should really be used for the local population and **the state hospitals want to get British people out so I can't see them investing in this particular thing**, why should they?
F	**Yes.** (…) we are starting to see the signs that **resources are very tight both in the UK and abroad** (…) I think that **Spain in particular would prefer foreign nationals to use private healthcare** and utilise their interpreters rather than accessing public healthcare although currently they still have a right to and **treatment that can be delayed will be and people will be encouraged to return home for healthcare.** (…) **the patient experience will be made far more difficult** as a result and necessary care may not be there – I am not suggesting acute care won't be offered but where it is safer and better for people to receive immediate care there – **they will be encouraged to go back home to seek care. Less likely to improve public sector as more likely to send them elsewhere.** [In England] I think the same thing (…) it's very **political** that people may be accessing free care here that they are not fully entitled to (…) they are looking much harder at **what care should be available for people and finance is becoming far more key and could perhaps overtake good patient care**.
G	Not heard anything at the minute but **I don't think it will affect it that massively to begin with** because I think **a lot of the people who already work there shouldn't be affected as much, so you are still going to have the people in the trust who can speak all the different languages**.

4.2.3.9 Do you have any suggestions on how these provisions and services in each country could be improved?

A	I think over the next couple of years (…) because we have such a big movement of people in and out of the country, from different countries, from different languages, I think we need to move towards a more robust translation service within the trusts.
B	**The translator should be medically trained** (…) you'll know the importance when you get a case and you read a case and this person is to be repatriated back to the UK or you're dealing with a country that doesn't speak English – you'd know everything medical about that case so you'll make sure you cross the T and dot the I because you are medically trained – if the interpreter is an admin staff and she is not medically trained she is going to have experience like the operational people that work here – they have a lot of experience because they are dealing with medical notes all the time but when you actually work as a nurse you see things a little bit different to how they see things and so that – it adds to that missing puzzle – so to me **you have got to close down those barriers** so a medical person changes to admin and they're medial admin (…) **you are less likely to get mistakes and here when you're working together** (…) **interdisciplinary training** so mix them rather than keeping them separated and segregated.

C	**On-site interpreters or better telephone interpreters** I suppose.
D	From our point of view, if we had requests for medical reports, ITU templates, if we could send **already translated documents** that we had written – so we have the English version and it is translated into Spanish so that people can see what it is we want **without having the language barrier and necessarily having to speak over the telephone** and you know and make an on the spot judgement. (…) we've got several things that we send that are **all in English** and as I say it is **very arrogant** to do that.
E	That every state hospital, certainly in a tourist area, has **somebody who is designated** to speak to people like us in order **to give better care and better planning for the patients** that they've got but you know **it is a question of money**, it's always a question of money.
F	I think that it could have been useful, but **we may have missed the boat a bit** if it became **an EU wide policy** because the **same resource could be utilised by all countries so if there were an interpreting service** and people were either bi or multilingual that could be utilised for foreign nationals in the UK or UK nationals in foreign hospitals and it could have been a **European wide initiative**, whether that is still possible I don't know, but that would have **certainly helped with patient care** and made cost savings for all countries involved.
G	I think the thing that stopped people using the interpreters is if **we don't know that we are going to need an interpreter** (…) **if you've got a planned appointment and you know they don't speak very good English or their English is not their first language then its planning for that in advance**. I think they find Intran hard sometimes because **you need two phones, or you need it on speaker phone which you obviously can't do in the middle of the room when there is loads of other people because it is not confidential then.** **There aren't many delays with Intran** but with the interpreters **you to have plan when they are going to come in and make sure the family is there at the same time** – it's the logistics there but sometimes we've had them on the unit so we have **quickly borrowed them for someone else** whilst they were there.

4.3 Analysis of results

Firstly, if we consider the scope of the professionals interviewed (7 participants), whilst all those interviewed are Registered General Nurses, we can see that there is a wide range of experience, both in years and speciality. The years of experience range from six months (participant G) to fifty years (participant E), in various specialities including critical care, burns, paediatrics, A&E, internal medicine, cardiology and acute surgical which gives the investigation a broad range of experience. It must also be noted that six of the seven participants all have experience in the aeromedical field since their role for the insurance company involves not only making decisions on treatment overseas but also on repatriation requirements. Participant G does not work for the insurance company, as previously mentioned, but is a recently qualified nurse working for the NHS and so their contribution may provide a different perspective since they received their training considerably more recently than the other interviewees.

It must also be highlighted that with only seven participants, the results are limited. It is a qualitative study and so the results obtained are still valuable and insightful into the reality

of the situation today and in recent years. However, it cannot be denied that a larger number of participants would bring more validity and scope to the conclusions.

In terms of the knowledge that the participants have in relation to the two countries in question, all seven have experience with the NHS, although only three stated that they still work regularly for the NHS, meaning that arguably these three can give the most up to date information about NHS interpreting provisions. As for Spain, six of the seven nurses interviewed work in the insurance sector, and so regularly travel to and work with Spanish public hospitals.

With regards to the languages spoken by the participants, 100% are native English speakers with only four out of the seven (57%) even mentioning any knowledge of other languages, and these were predominantly French and Spanish, to a basic level.

When asked about the contact that these professionals had with Spanish public hospitals as part of their work with insurance "*What experience and type of communication have you had or do you have with Spanish public hospitals?*" (see 4.2.1.5) four out of the six interviewed [since participant G does not work with insurance] responded negatively: "thankfully very limited"[D], "as little as I possibly can"[E], "very difficult"[C,E,F]. The type of communication is both verbal, to obtain verbal medical reports and updates on patient condition either over the phone or face-to-face, as well as written, through the reception of medical reports in Spanish. The consensus of the answers given to this question focussed on the language barriers encountered with Spanish public hospitals, whereby native in-house Spanish speakers, relatives or patients themselves are utilised in order to help obtain medical information. Participant F even mentioned resistance on the part of the Spanish public hospitals to speak to them, even if they indeed spoke English.

When asked about the current interpreting provisions being used by the NHS, three out of the seven nurses mentioned *Language Line* specifically, one mentioned *Intran* as being the official service for their trust, and two mentioned that services were available but had no name or further information for these services (see 4.2.2.1). Participant F commented that:

> "*most translation that's utilised within the NHS is not professionally done […] the people that work for the NHS are so multicultural that you generally use other people working there…not necessarily medical to do basic translations […] there's an international workforce so you can often, in a large trust, get any language you want."*

This is making a direct reference to the use of untrained interpreters, both medical and non-medical staff, to facilitate communication between patient and provider, in order to 'make the most of' the multilingual and multicultural staff on hand, even if they are not trained to interpret.

This leads on the next question posed to the healthcare professionals as to whether the 'official services' are always used or whether staff and family members are also involved in facilitating communication with the patient (see 4.2.2.2 and 4.2.2.3). Whilst participants A and B maintained the correct practice of requesting assistance from *Language Line* and waiting for interpreter availability, the other participants (4 out of 7) admitted to using either staff (medical and non-medical) or family members to assist, except for participant E who had not worked for the NHS for a considerable time. Participants A and B, stated they would not trust the services of an untrained interpreter, due to previous experience and the disastrous consequences they have observed. Yet participant B admitted to the use of the Google Translate application as

another solution to language barriers (4.2.3.8), although they did state that isn't the most reliable tool.

Participants C and G both referenced the use of children in interpreting scenarios, where the children have a better level of English and so interpret for their parents. Participant F recognised the use of *Language Line* but commented on the delay in service.

It must be highlighted however, that participants A, B, E, F and G, five out of seven, all mentioned the risks involved with using family members as interpreters, although some would still continue to rely on them. Particular comments were made regarding the clarity, confidentiality, subjectivity and impartiality of these individuals:

> *"yes occasionally [use family members] […] then the difficult […] is that is a subjectivity involved of the family member and so you are never quite sure that you can totally rely on what is being said or what the treating doctor is being urged to recommend*" (Participant E)

> "*We try to use them [family members] but it can be quite difficult having a medical conversation with somebody completely untrained and also who is emotionally involved in the situation – that's not always helpful – sometimes close relatives or people who care about the patient can be the worse people to converse with in any language. There is a very strong bias, there is a lot of anxiety, there is a lot of upset so any conversation is very emotionally driven, that's true even without any language considerations across the board in healthcare, it can be very difficult conversing with loved ones*." (Participant F)

Participant G's answer is particularly noteworthy:

> "*Sometimes in emergency situations they will use family members […] it depends on the situation […] you never know that they are going to be translating it the right way or they're just* ***sugar coating*** *it […] then you have the issues around* ***domestic violence*** *[…] they can completely lie and say something completely different to what the patient is actually wanting to tell you […]* ***for official things like consent*** *and […] surgery […]* ***it has to be through an interpreter or through Intrans****, whereas if it is just relaying messages, less formal things [family members would be acceptable]"* (participant G)

It is important to recognise that risks such as accuracy and impartiality are identified by some of these professionals, and interesting to note that Participant G, the most recently qualified nurse, mentions the risk of domestic violence situations.

With respect to whether these services had seen any changes in recent years (see 4.2.2.4), only four participants responded, of which two claimed that provision had become stricter in terms of quality within the last eight years, after cases emerged where the lack of a qualified interpreter had endangered life (see participant B's answer). However, participant F commented on the encouragement and pressure to "*not use a fee-paying translation service",* but said they use the service that is required at the time.

In terms of the process of using these interpreting services impacting their work and the patient (see 4.2.2.5), the interviewees, although only three gave answers to this question,

admitted that using these interpreters was an issue due to it being time consuming, causing more anxiety for the patient, and impacting other patient care.

When asked about the interpreting services in Spanish public hospitals and how these differ from UK provisions (see 4.2.3.1) the responses described the services as "sporadic", "limited", "hit and miss" and even "none" [non-existent]. Four out of the six interviewed made reference to the "translators" or "international departments" found in *some* Spanish public hospitals, although these services are usually limited to tourist areas and only available during the mornings (participant D).

Furthermore, the description of these "translators" in Spanish public hospitals, as provided by these professionals, leans more towards an administrative role or patient-liaison with language skills, rather than a professional interpreter or translator as defined earlier in the theoretical framework. For the most part, the professionals seemed to agree that these on-site and dedicated "translators", or rather English-speaking patient-liaison staff members, were helpful, but that does not mean that there are not pitfalls and problems involved.

Participant C described these "translators" as:

> *"people who speak both languages, live there and start working in the hospital helping and act as a go-between…some of the translators will just basically help the patients rather than do a whole lot of medical stuff*"

This description reflects what has been documented in the literature, as these individuals are not trained in interpreting, let alone in a specialised branch of medical interpreting, but are in fact bilinguals or individuals who merely "speak both languages".

> *"(...) tiene que haber un reconocimiento general de este oficio como realidad profesional, no sólo por parte de la Administración sino por parte de otros muchos sectores del país. En España todavía demasiada gente no distingue entre el conocimiento de idiomas y la capacidad para traducir o interpretar".* (Martin, 2000:220)

Some sixteen years after this comment by Martin (2000), the present investigation demonstrates that there is still a lack of comprehension about the role the interpreter plays in the communication process and what is required of them. The "translators" used in public hospitals that have been visited by these professionals are recruited for their language skills, i.e. their "bilingual" status, not their interpreting nor translating skills, since they are not required to possess them.

Moreover, this is supported by the comments made by the participants B, D and E on the quality, skills and pitfalls of these "translators":

> "*the translator who speaks fluent English, but they're not medical the translator is not medical so the translator doesn't understand everything" (Participant B)*

> "*We don't expect them to interpret the results but they don't understand what is it that you are asking for even if you asked them in Spanish […] so when you ask in English they find it difficult, they have difficulties then knowing what the Spanish equivalent is or the relevance of it.*" (Participant D)

> "*is all very well being able to speak Spanish and English fluently but whether you have got the knowledge to understand the medical side of things added to that, that's always a great big problem even when there are dedicated and designated interpreters"* Participant E)

The issue with these "translators", as presented in both the interviews and the literature, is their lack of knowledge of the medical context, which then causes delays in communication and casts doubt over the reliability and accuracy of the interaction.

In addition, whilst it was identified by a number of participants that conversational Spanish or English wasn't sufficient in order to discuss medical issues (4.2.3.5 and 4.2.3.8), the willingness to use family members and untrained individuals contradicts this belief, and therefore continues to compromise patient care.

These "translators" found in Spain's public hospitals are not fulfilling the role of an interpreter since they are not being used as a tool to facilitate communication between two parties. Instead of a three-way conversation, these "translators" are relaying the information given to them earlier by the Spanish medical staff, or from a written medical report, to the healthcare professionals in the UK. Therefore, they cannot answer questions about the patient's treatment and care since they are not medically trained.

Furthermore, as previously mentioned, another issue is the fact that these international departments have very limited availability, so unless you call at a certain time, you may not be able to speak to the "translator" and therefore cannot receive an update on the patient in question. No other services are available and even connecting to these departments at times can be a challenge if you do not have a Spanish speaker to help communicate with the switchboard (4.2.3.1):

> "*you almost need Spanish help to get through to the Spanish helpers*" (Participant C)

It is clear that whilst there may be on-site staff whose role is dedicated to assisting foreign patients and their communication, this role does not require the same level of quality, in terms of accreditation and certification that, in theory, is compulsory in the UK. This lack of quality, as well as the 'translators' failing to fill the role of an 'interpreter', highlights how there is a severe lack of understanding of what an interpreter is and what skills should be expected in this service.

In terms of how these professionals communicate with Spanish hospitals, aside from the in-house language staff (bilinguals), who are not specifically qualified in interpreting, they also resort to asking the Spanish branch of the company to help (4.2.3.2).

With respect to the linguistic provisions available in Spain and the impact it has on the patients (4.3.3.3), four out of seven commented that there was a negative impact since care and treatment can be delayed if the patient is unable to communicate their pain or, for example, if they need a drink. This also increases stress and anxiety according to participant B. However, participant D mentions that they do not agree that it should be expected of these hospitals to speak English, and this is English arrogance.

With regards to whether the participants felt that they could notice a difference between using trained and non-trained interpreters four out of the seven affirmed that they could indeed tell the difference (4.2.3.5):

> "*Yes, because of the nature of what we are asking for […] we're asking for very intricate medical information"* (Participant D)

> "*Yes, a significant difference – much more confidence and the preparedness to question the treating doctor more: "I don't quite understand what you have said – can you explain that to me?"* (Participant E)

Participants A and B did not feel able to tell the difference due to their lack of knowledge of the other language in question.

The situations in both countries, as presented in this investigation as well as the literature, highlight the ongoing challenge and recurring issue faced by medical interpreters: the general lack of understanding on the part of the doctors and other health professionals, on what the role of the medical interpreter involves and the specific skills and training that are required.

The fact that these professionals are willing to use family members and untrained and unqualified solutions, as previously mentioned, demonstrates the real lack of awareness of the responsibility that the interpreter assumes in the healthcare sector. Yet, it is interesting to highlight that three of the professionals interviewed, participants B,C and E, did recognise the correct practice of an interpreter, as part of a three-way conversation or conference call, where the interpreter is used to relay messages between the two parties. These professionals identified the benefits of this practice where they are actively engaged in the conversation, unlike in the Spanish context using the assigned "translators" (Participant B, 4.2.2.1, Participant C, 4.2.3.5, Participant E, 4.2.3.1).

It is necessary to highlight that, although the present investigation has been carried out with medical professionals who work on a daily basis with international patients, where translation and interpreting services are required in order to carry out their jobs and ensure patient care and treatment, the interviews show that this unique position working between both healthcare systems does not necessarily mean that their knowledge, understanding and recognition of the interpreter's role is any greater than those presented in the literature. The fact that these professionals were trained in the UK, and three still regularly work for the NHS, shows how the reality does not live up to the theory that England presents in this field, as the profession is still not entirely appreciated or recognised. However, it is worth mentioning that participant E, who has the most years of experience both as a nurse and in this sector of insurance, is more knowledgeable in terms of the risks involved in using untrained and *ad hoc* solutions, what should be required and expected of a professional interpreter, and the correct practice when working with one.

A solution to combat the lack of recognition that medical interpreters face, would be to educate medical professionals on not only what the interpreting in this sector entails, but how to best facilitate practice. Although there are recommendations set out in some NHS policies and principles, as seen in the NHS England Principles (2015), for healthcare professionals to receive training on how to work with interpreters, 100% of the professionals interviewed in this investigation had neither heard of this possibility nor received any such information or training (see 4.2.3.7). Furthermore, whilst there is still the misguided belief among these professionals and institutions that bilinguals and interpreters are one and the same, true recognition of the profession will not be obtainable. As presented in this study, the NHS is taking steps to ensure the use of qualified interpreters, however medical staff are still resorting

to *ad hoc* and inappropriate solutions due to the lack of knowledge they have on the risks involved. Only once such training is implemented would we perhaps see a development and increased level of appreciation and recognition for this profession, which could then lead to the much-needed improvement of services and training available.

In terms of training, as can be seen from both the study carried out by Hale (2007) and the present investigation some 10 years later, there is still a question over training of healthcare interpreters, in accordance with what is expected and what is needed according to medical professionals. This is unsurprising considering the general lack of understanding of what the role actually involves. It is particularly significant that these two studies were carried out with medical professionals in two of the countries considered to be most developed and advanced with respect to *ISP*.

From the interviews, it is apparent that out of those interviewed, six out of the seven nurses would agree that specific training is important when interpreting in the medical field, due to the nature of the conversation, the responsibility it carries, the risks involved in an incorrect translation, and the specific vocabulary utilised in the context. However, as participant E pointed out, there is no common understanding of what this entails, or to what extent you could define the limitations or knowledge needed to be able to interpret adequately in this field.

Similarly, of the professionals who took part in Hale's investigation (2007), as previously reported, 46% did not feel a specific qualification was necessary and only 30% believed that a university education was a prerequisite. The DPSI which is the most recognised and the only accredited qualification in the UK, was not mentioned nor did it appear to be known to the professionals interviewed in the present study. Moreover, the DPSI, whilst it is technically a diploma, a qualification which does not usually receive as much recognition as higher education qualifications, it is considered to be equal to an undergraduate university degree.

The results from the present investigation showed that one of the participants, participant B, believed it necessary for inter-disciplinary training to take place, where interpreters should also be 'medical', i.e. medically trained. These are referred to in the literature as 'bilingual professionals' where usually already qualified doctors and nurses receive extra training to qualify as interpreters. The study carried out by Leman *et al* (1999) also concluded this to be the preferred solution. It must be underlined that a bilingual professional should not be in a position to interpret for patients if they have not received specific training. This training would consist of imparting the knowledge on the specific skills required of interpreting in the medical setting, as mentioned previously, such as cultural issues they may be unaware of, the need for impartiality and also the interpreting techniques such as note taking and simultaneous interpreting, skills that are not typical to a bilingual. The advantage of bilingual interpreters, however, is that they are already bound by an ethics code.

On the other hand, it could be argued that the downside of this suggestion raised by participant B is that this could lead to issues further down the line. If a nurse were to also carry out the role of an interpreter, does that mean they would only be assigned patients of their given languages? Or would their language skills be an addition to their role? Could this then impact their workload and cause an imbalance in the work assigned to given nurses compared with other 'non-interpreter' nurses? These points need to be considered when such suggestions are proposed.

This participant (B) also suggests having interdisciplinary training where staff with different roles, such as interpreters, nurses, doctors and administrative staff all train together to understand each other's work and purpose. This is a point that has been raised on numerous occasions by both interpreters and researchers in the public service field, since there is indeed a lack of real understanding on how to work with the other professionals in terms of what is involved and what can be expected (Abril Marti, 2015). This suggestion would allow not only the medical professionals to learn about interpreters, but also for the interpreters to better understand the environment of the healthcare setting, a mutually beneficial solution.

It cannot be denied that specific training is a prerequisite to work in this field in order to be able to perform the required tasks adequately and safely. With respect to the provision and accreditation in England and Spain, it is clear that England is far more developed with the National Register, the DPSI, and a fully regulating body complete with deontological code. Official services are promoted, if not always followed, and accreditation is required by said services. In Spain, however, accreditation has not yet been obtained nor has the recognition of the medical interpreters' profession, and therefore there is no governing body regulating medical interpreters nor is there an ethics code. Nonetheless, those interpreters who have been trained in the medical field in Spain are following the guidelines established by other interpreting organisations, which demonstrates the existence of trained professionals who are respecting and promoting best practice, even in a country that as yet fails to recognise them. This presents a promising outlook, and along with the continued research in the field by professionals and university institutions, it could suggest a bottom-up approach to recognition as seen in the UK.

Aside from the nationally recognised DPSI courses, the training available is similar in the two countries, where optional and compulsory modules in *ISP* are offered, covering all areas of the public services at both undergraduate and postgraduate level. Online courses are also available in both countries. However, the DPSI available throughout England and online, offers a specialised focus on the chosen area of SSPP, be that health or legal, for example. University courses focus more on the theory of interpreting than the in-depth knowledge required of a particular sector. Furthermore, the cost of the DPSI is significantly lower than a university course, meaning that access to these courses is more widely accessible in England. Be that as it may, the University of Alcalá, Spain, provides a unique course: "Masters in Intercultural Communication, Interpreting and Translation in the Public Services", which not only provides training in the health, legal and administrative fields, but also requires that students carry out work experience in one of these respective fields. The University of Seville (Pablo de Olavide) also offers students the chance to carry out work experience in the public services. This is not an option available as part of the courses offered in England, and so it could be argued that Spain is starting to recognise the value of the profession and, as such, taking measures to give their students the best possible exposure and real-life experience in the field.

With respect to the ethics involved in medical interpreting, it is interesting to note that 100% of the professionals interviewed for this investigation stated that they believed ethics to be as important for an interpreter as it is for a medical professional, since they are working in the same field and need to be bound to principles such as accuracy, confidentiality and integrity (see 4.2.3.6). Yet, not all of these interviewees recognised the unethical decision to employ the use of untrained and biased individuals to carry out these communicative tasks.

In terms of the current political climate, it could be argued that Brexit will not impact the provision of interpreting services, a belief supported by five of the seven interviewees. However, it could also be argued that whilst it may not present a direct link, the trending behaviour of the xenophobia in society will not lead to increased support and funding for those "non-natives" living in the UK. In 2015, before becoming Prime Minister, Theresa May said that her answer to the immigration 'crisis' and the resulting increased demand for the public services by immigrants, was to cut funding for the translation and interpreting services and instead increase funding into promoting the acquisition of English. This is a belief which is unlikely to change if May remains Prime Minister throughout the Brexit negotiations.

This is not the first time that it has been suggested to reduce funding of translation and interpreting services in the NHS, as seen in the study by Gan (2012), in which comments are made suggesting that the overprovision of interpreting services hinders the immigrant population in their attempts to integrate into society, by discouraging their learning of English.

However, as stated by Corsellis (2008:2) many immigrants require the use of the public services, be it health, legal or social support before they have managed to acquire the local language, and moreover the ability to manage the technical language and specifics of these fields requires native-like competence, which as any linguist would agree is a feat in itself, requiring many years of study, and may not even be possible once passed the critical period (Lenneberg, 1967). Therefore, reducing funding for the translation and interpreting services for these people is not a solution.

Similarly, it could be supposed that, although the UK may see an increase in funds available after having left the EU, forgoing the requirement to pay for their membership and following the austerity policies as mentioned by Gentile (2017), the likelihood for May to increase funding in an area she has previously undervalued is minimal. However, it must be highlighted that any further cuts in this area, which would lead to the privatisation and outsourcing of interpreting services at a lower cost, as seen in the legal sector, risk the quality of the interpretation and also risk violating the human right of these immigrant patients to communicate.

An interesting point relating to this issue was made in this investigation:

> "*English people they are not normally encouraged to try to speak a different language, it is a very arrogant thing that they think everybody should speak English when in fact they are in Spain and there is no 'legal' requirement to speak English, it's not their native language but the English expect Spanish people to speak English"* (Participant D)

Whilst this particular response is related to English people abroad, it can be presented as a generalised belief and trait of British citizens, whose native language is one of, if not, the most important and globalised language in the world. Therefore, the lack of understanding of the difficulties involved in language acquisition for this context, by May and others who have suggested reducing the funding of translation and interpreting services, in favour of providing more languages courses, may be seen more as an example of their ignorance on the subject, and not necessarily arrogance.

On another note, it has also been reported that leaving the EU could mean that the current UK immigration system will be revised, which only supports and encourages the sense of xenophobia being experienced across the UK since the referendum.

On the whole, the majority of the interviewees of this investigation did not foresee Brexit having any impact on the linguistic services provided in either country, since they did not believe it would have an impact on migration in general. On the other hand, participant F disagreed, supporting the opinion, as presented in the literature, that xenophobia and discrimination will only flourish in both countries if politics continues to focus on separation and exclusion, and that this will be seen in the way in which patients are treated (4.2.3.8). Participant F also argued that changes have already taken place due to Brexit, in terms of cuts in financing and resources both in the UK and abroad.

Furthermore, participant G mentioned the existing multilingual staff employed by the NHS in reference to their ability to help facilitate communication, commenting that they shouldn't see themselves threatened by the current political climate (4.2.3.8). Although, as already established, unless they are qualified in interpreting, their services should not be employed to carry out these communicative tasks. These comments differ from what has been found in the literature and in the study carried out by Channel 4, Dispatches. This study concluded that many NHS trusts are already seeing the impact of Brexit, in that many of these international multilingual staff are resigning, feeling "unwelcome" in the UK due to this political change. This has meant that the NHS is struggling to find and contract enough staff to compensate for these losses, and are recruiting from further afield, such as from Asia, producing a much higher cost for the NHS. However, should the immigration system be amended in a way that directly impacts these international recruits, the NHS will still suffer staffing shortages risking the welfare of all patients.

Whilst it could be surmised that the lack of multilingual staff would increase the need of effective interpreting services, the full extent of the Brexit impact cannot be predicted nor comprehended, although the research to date does not look promising with regards to this field.

The comparison between the two countries at this stage, with respect to the provision of services available and recognition of the medical interpreter profession, shows England as holding a more promising and positive stance. However, whilst one of the initial hypotheses of the investigation predicted that the professionals interviewed would agree with this theory, the reality wasn't conclusive:

> "*It is better in Spain because they are more geared to tourists and foreign nationals – particularly in high tourist areas – they expect to have a certain amount of non-Spanish speaking patients. The UK don't have any facility – make very limited facility because they expect 99.9% of all patients to speak English*" (Participant D)

This perception may have some merit in the fact that it recognises the benefits of a dedicated member of staff to translate and interpret, irrespective of the quality of work or training that these members of staff have received. However, as presented in the section dedicated to UK national legislation and NHS principles, the Heart of England NHS Foundation Trust does, in fact, have in-house interpreters employed for the most common languages found in the area, due to the high immigrant population. This is an example of one Trust who have taken the decision to provide these services based on their own patient demographic.

Moreover, when the interviewees were asked if they had any recommendations for the improvement of services in either or both countries (4.2.3.9), two supported the abovementioned statement, suggesting that provision for more in-house interpreters in the UK

should be developed, to mirror the on-site interpreters found in Spain, in order to rely less on telephone interpreting services. Participant G also commented on need to address the issues encountered when the need for an interpreter, which should be noted on the patients' record, is not communicated to secondary care services, preventing them from booking the required linguistic services in advance of an appointment.

Furthermore, participant B mentioned that the need for a quality service is particularly necessary in mental health cases, where provision for face-to-face interpreters needs to be increased and improved since telephone interpreting is not appropriate in these situations, and reiterated the need for more bilingual professionals (4.2.2.2). Participant F, however, believes that the implementation of an EU wide policy, that would regulate healthcare interpreting across all Member States, would be a step in the right direction in terms of improving national and international provisions. This suggestion reflects what has already been proposed in the MedInt project, however this would now no longer apply to the UK due to Brexit.

5. Conclusions

In recent years both England and Spain have seen an increase in migration and the number of immigrants living within their borders. As a consequence of this rise in population, there is an increased demand on healthcare and other public services, and whilst one may assume this would cause the respective governments to support this demand and enable immigrants to exercise their rights, we are actually seeing the opposite. In theory, it would be logical to assume that countries regulated by international legislation on human rights and equality would ensure these laws are respected and adhered to, however, in reality this may be too much of an idealistic view.

By looking at the respective national laws in place in these two countries, it can be seen that there is not a regulated framework in place, at least not in the healthcare sector. Both nationally, and internationally, by means of the EU Directive 64/2010 implemented into every Member State, interpreting in criminal proceedings is at least recognised, and steps have been taken to ensure the correct execution of this measure. However, as mentioned by Gentile (2017), cuts in funding in the public sector and subsequent privatization of services in the UK have caused even these internationally recognised requirements to suffer, and so the companies responsible for providing these legal interpreting services are contracting undertrained staff, at a lower cost, impacting the quality and in turn the professionalisation of the profession.

Although medical interpreting also remains unrecognised on the international level, steps are being taken by the EU to tackle this situation, in the form of projects such as MedInt, which looks to assess the current medical interpreting services and training in existence in Member States. The intention is to then devise a curriculum which would be implemented into all Member States, following the example of the legal sector, by way of an EU Directive. However, it is important to note that the UK recognised the need for the professionalisation of legal interpreters before it became internationally recognised in official terms. This is one example of how the UK in theory could be seen as pioneering due the fact that it sets the example, ahead of even EU requirements. In contrast, in Spain, the measures taken to apply this EU Directive are still being described as ineffective and in need of much improvement, due to the lack of recognition that *ISP* receives, nationally and institutionally which impacts the resources available for contracting qualified interpreters and adequate training in the field.

On the national level, neither country has legislation that directly and explicitly refers to interpreting in the healthcare sector. However, England has managed to implement interpreting services into the various NHS trusts, in line with a number of laws relating to equality and human rights, as well as the NHS constitution itself. These laws and policies all recognise the need of effective communication between patient and healthcare provider. As previously explained, NHS trusts are independently managed and regulated, and therefore they contract their own interpreting services that adhere to their own policies or principles. The service most recognised in the interviews was *Language Line.* These respective policies and principles, in theory, provide medical professionals with recommendations or rules for the correct practice of working with non-native English patients, and those who speak no English at all. However, the reality of the situation is a somewhat different story.

As one can see from the literature, the studies by Leman *et al* (1999) and Gerrish *et al* (2004) showed that family members were utilised frequently in order to overcome the language barriers between the patient and healthcare professionals. Whilst both studies recognised the pitfalls and risks of these linguistic solutions, the majority of the professionals were willing to compromise the integrity of the communication and, in turn, the care in this way.

Since then, many NHS trusts have seen policies and principles regarding the use of interpreters implemented, as presented earlier. These policies and principles recommend that trusts contract professional interpreters, usually from the providers endorsed by the Trust, and that it is not advisable to use family members. However, when the participants in the present study were asked about the use of such individuals and other hospital staff who are not necessarily medically trained nor trained in interpreting, the majority, some five out of seven nurses, agreed that this does still happen and they would continue to use these individuals to facilitate communication today.

This is particularly worrying considering the skills and abilities required to work as an interpreter in this field. These skills, as seen earlier, include: having knowledge of medical vocabulary, impartiality, accuracy in terms of not changing the message, adding or omitting information, stress management since medical situations are usually sensitive and tense due to the nature of the environment and vulnerability of the patient, and finally confidentiality. The fact that professionals are still employing the services of untrained and, with respect to family members, biased, people as solutions to language barriers, shows that they are essentially putting the patients' health and the provider's reputation and trustworthiness at risk.

A number of these participants who admitted to utilising these *ad hoc* and untrained individuals did also recognise the risks, particularly with using family members, in relation to the clarity, confidentiality, subjectivity and impartiality of these individuals. Although it is worth mentioning that two professionals stated that they would not trust the services of an untrained interpreter, due to previous experience and disastrous consequences they have been witness to. One interviewee also mentioned the issue of domestic violence being a primary reason why family members should not be used, unless in extremely urgent circumstances.

Another important point, is that two of the participants admitted to the use of children as interpreters, and although they did identify the lack of medical knowledge as an issue, the justification was that younger members of the family will usually speak better English than their parents. This is particularly alarming, considering the aforementioned pressures that interpreting in a medical context entails, and the position this in turn puts the patient in; for example, they may feel uncomfortable and embarrassed speaking about certain medical issues in front of their children or even minimise the reality of their pain or condition. However,

without knowing the specific contexts in which children are used to interpret, it is difficult to identify the limitations on how complex an issue the professionals would expect them to interpret.

Nevertheless, this is particularly worrying considering the UK is acknowledged as a pioneering country in the world of translation and interpreting in the public services, and using children is known as one of the greatest taboos in this field. This shows that there are flaws in the implementation of the aforementioned NHS policies and principles, since there was a consensus in the literature that the use of children is completely inappropriate:

> "*It is professionally and ethically not acceptable to use children (under 16) as Interpreters*" (Heart of England, 2011:6)
>
> "*Staff should never use children as interpreters*" (South London and Maudsley, 2015: 4).

This need for further recognition of qualified medical interpreters is reiterated by the *NSPCC* whose case reviews from 2014, some 3 years ago, established the existence of severe oversights in this area. In one particular case, medical professionals failed to recognise the need for an interpreter in consultations with a Lithuanian couple, resulting in the death of their two-month old baby due to domestic abuse. In this situation, the perpetrator, the father, was acting as an interpreter for his wife. This case reaffirms how fundamental it is to recognise the need for an interpreter, as their role, as seen in the table 3.1.1 (page 13), is also to recognise tensions and cultural elements of behaviour that could suggest an underlying issue that would be relevant to the medical professional. It is interesting to note that it was the most recently qualified nurse that mentioned the risk of domestic violence situations when assessing the use of family members vs professional interpreters, which could suggest that awareness of the issue in this field is improving.

Another important point with respect to *ad hoc* solutions is the use of the Google Translate application, as mentioned by one of the participants in this investigation, and although it was identified as an unreliable solution, its existence and use in this context must be noted.

From this we can see that the ideals on paper are not quite reflected in reality. If these were executed as planned, with respect to using professional and qualified interpreters, in the same way as in the judicial field, it would provide an unparalleled improvement in this area. This would not only improve the quality of the interpreting but it would also likely increase the services available; if the profession and work is recognised by those who require it to carry out their work successfully i.e. to communicate with their patients, then it's more likely that the providers and authorities themselves may also take note, heed this advice and promote a regulated service.

In addition, the interpreting services available in England offer both face-to-face and telephone interpreting, where in theory the interpreters must either hold the necessary and recognised DPSI qualification or appear on the National Register. With respect to these services, the case studies carried out by Leman *et al* (1999) and Gerrish *et al* (2004) concluded that one of the main pitfalls stated by medical professionals was the delay in service, and having to organise an interpreter well in advance. At least in the former study telephone interpreting did not seem to have much recognition in the medical field.

Today however, according to the interviews carried out and the NHS principles, it is clear that telephone interpreting services are relied upon to a great extent, such as the services

from Language Line and Intran. These companies also offer face-to-face interpreting although there are not as many languages readily available as there are over the telephone. The results from the interviews concluded that delays in availability and service are still an issue. Furthermore, it was commented that the need for an interpreter or any communicative requirement should be noted on the patient's record, as also mentioned in NHS England's Primary Care principles (2015), but the reality is that this is often not the case and patients arrive for appointments without having a qualified interpreter present. These delays in availability and poor organisation with respect to recording the communication requirements on file after being initially established, could be part of the reason that these professionals resort to using *ad hoc* and inappropriate solutions.

With respect to the situation in Spain, in terms of national legislation, it is clear that the recent reform of the health service, the *Real Decreto 16/2012,* which denies healthcare to illegal immigrants unless in cases of emergency, pregnancy or to those under 16, received a lot of criticism. In the face of increased immigration and also the economic crisis, Spain imposed limits on the access to healthcare for those who are not registered residents of Spain, a move which was described as not only a step backwards, but also a xenophobic, racist and discriminatory action that threatens to violate basic human rights. This in turn, in the same way as Brexit poses a threat to the current immigration system in the UK, incites xenophobia and increases hostility towards foreigners, rather than encouraging and promoting integration and asylum where necessary.

In terms of the linguistic services available in the public healthcare sector in Spain, whilst telephone interpreting companies such as Dualia and Interpret Solutions do exist and have been available since 2003 and 2007 respectively, the reality, as presented in this work according to the interviewees, shows the employment of other solutions. In accordance with the situation presented by Abril Martí (2006) the primary and most often employed solution in Spanish public hospitals, is the use of *ad hoc* solutions, namely "language speakers", being medical or nonmedical staff, who hold no qualification relating to either translating or interpreting. It is worth noting that the Spanish economic crisis impacted the development of official interpreting services significantly, with the cancellation of certain services in Valencia to name one example (Ortega Herráez y Blasco Mayor 2017).

The reality of the situation in Spain with regards to the provision of medical interpreters in the public sector can only be described as sporadic. The issues encountered with these services are also important to note, as seen from the interviews, since even in those hospitals where 'translation' or 'interpreting' provisions are provided, although inappropriate and unqualified, they are difficult to access for those who need it, be it the medical staff from the insurance company organising ongoing treatment and repatriation, or family members calling to check on relatives. This demonstrates that there are still flaws even in the exemplary models, and further improvements must be made in order for an effective solution to be realised. Firstly, official and trained interpreters need to be contracted and also perhaps an improved telephone service developed which allows non-Spanish speakers to reach the interpreting department. The latter solution is specific to the insurance context and would also be a recommendation for the UK.

However, it is important to note that, although these provisions in Spain are inappropriate in terms of training due to the lack of recognition of the profession, the provision for in-house and on-site interpreters was favoured by many professionals in this investigation over the use of telephone interpreting services.

Professionalisation, recognition and training go hand in hand, and therefore, it is necessary for the interpreters to not only tackle the lack of recognition of their professional status but to also appeal to the medical professionals and institutions themselves to assist:

> "*Perceptions are gradually changing: qualified interpreters are proving their worth and their standards are being accepted. They are attracting reasonable fees and being treated with more professional respect in some countries. Where this happens, more and more suitably qualified students are applying for training and assessment. As a consequence, more training is made available leading to responsible standards, and the negative cycle is reversed*" (Corsellis, 2008:58)

The UK has already achieved so much in comparison with Spain, in terms of the National Register, the highly accessible and nationally recognised DPSI qualification, and a regulating body complete with deontological code. However, efforts are being made in Spain to improve the status of medical interpreting and public service interpreting in general, which can be seen through the training courses offered, particularly those with the inclusion of compulsory work experience in the field. If efforts continue in this way, then it could mean that Spain reaches an equal level of recognition and development as seen in the UK.

Nonetheless, these efforts are being threatened by the political stance of both countries with respect to tackling immigration. Spain has suffered from the economic crisis which has led to cuts in funding and tighter restrictions on the availability of healthcare, in terms of the *Real Decreto 16/2012*, as previously explained. The UK however, is currently in the process of major political changes due to the implementation of Brexit.

Whilst we are still yet to see how Brexit is carried out over the course of the two years, and how these new changes are put in place for a life "outside of the EU", it cannot be denied that we have already seen changes in the UK, with respect to the increased crime rates and racist hate crimes. This dire situation is only emphasised by the government's plan to review the current immigration system in order to reduce the number of immigrants accepted into the country; supporting the trending behaviour of xenophobia in society.

Although it is not certain that Theresa May will remain the UK Prime Minister after the general elections on 8th June, should she be voted back in as the UK's leader, the outlook does not seem promising for these immigrants nor the interpreting provision in the medical sector. Whilst leaving the EU, and its austerity measures that were implemented in the Member States, could suggest an increase in funds in the UK, May has already expressed her belief that the acquisition of English should be prioritised over translation and interpreting services, supporting the notion to make further cuts in this area to the detriment of interpreters, patients, and the professionals tending to them.

Lastly, Brexit has already directly impacted the NHS and continues to threaten its future, in terms of staffing and therefore its ability to function under the current staffing shortages. As presented in this work, the international and multilingual staff that make up such a large proportion of the NHS are leaving, feeling unwelcome and unappreciated in a country whose health service depends on them. As mentioned, it is still too early to predict the true effect that Brexit will have on the country particularly in this field, and whilst many believe that it will not have a direct impact, the indirect effects are already being observed and anticipated.

With respect to the future, although the political stance of each country is uncertain, the possible implementation of an EU directive or initiative that regulates medical interpreting in the same way as legal interpreting, could be seen as a promising step forward for Spain. However, the reality of the Directive 64/2010 and the issues that are still being observed must be noted and handled for effective and notable improvements to be seen.

Although England presents itself on paper as a pioneering and well-developed country in terms of its provision and recognition of *ISP* and medical interpreting specifically, the reality of the *ad hoc* solutions still employed are not wholly different to Spain. Efforts need to still be made in both countries in order to promote best practice, by means of training, not only for the interpreters themselves, but also for the medical professionals in the field.

Finally, whilst Spain, in theory presents a country where *ISP* and medical interpreting exist without recognition nor regulation, the reality in terms of the resources invested by researchers and independent institutions on improving this situation seem promising. This can be seen primarily in the area of training, as discussed, where universities are providing courses in *ISP* but also promoting work experience in these fields to better prepare their students for real life situations. Corsellis (2008), the vice-president of the Chartered Institute of Linguists which is the body responsible for the nationally recognised DPSI in the UK, suggested the possibility of extended training and specialisation for healthcare interpreters, such as in the field of oncology. This suggestion, if realised, would be an incredibly positive step for the future of medical interpreting in England.

Yet, without a doubt the most essential step forward for both countries, to improve the services available, and the general situation of medical interpreting, is to invest in the education of not only the interpreters, but also the institutions and the healthcare professionals themselves, so that the skills, requirements, responsibilities and risks of this profession can be recognised and understood.

Bibliografía

Abril Marti, M.I. (2006). *La Interpretación en los Servicios Públicos: Caracterización como género, contextualización y modelos de formación. Hacia unas bases para el diseño curricular,* Universidad de Granada, Septiembre de 2006.

Abril Martí, M.I. (2015). *La interpretación en contextos de violencia de género con referencia al caso español,* Trans-revista de traductológia, No. 19.1, 2015, pp. 77-94

Alexander, C. Edwards, R. y Temple, B. (2004). *Access to Services with Interpreters: User views,* Londres: Joseph Rowntree Foundation/London South Bank University, pp. 65

Álvaro Aranda, C. (2016). *Formación, Perfiles Profesionales y Grupos de Trabajo en Entornos Sanitarios Multiculturales,* FITISPos International Journal, Public Service Interpreting and Translation. Volume 3 (2016) pp.153-163

Baker, C. y Eversley, J. (2000). *Multilingual Capital*, London: Battlebridge en Corsellis, A. 2008, Public Service Interpreting – The First Steps, Palgrave Macmillan.

Bosch March, C. (2012). *Técnicas de interpretación consecutiva: la toma de notas*, Manual para el estudiante, Granada 2012, pp. 3-6

Campos López, José Gabriel. (2004). "*Mediación intercultural y traducción/ interpretación en los servicios públicos: el caso de la atención sanitaria a población inmigrante de origen magrebí*", Jornades de Foment de la Investigació, Universitat Jaume I, pp. 1-10

Codó, E. (2008). Interviews and questionnaires. *The Blackwell guide to research methods in bilingualism and multilingualism*, pp.158-176.

Corsellis, A. (1997). *Training needs of public personnel working with interpreters,* En Carr, S. E., Roberts, R., Dufour, A. y Steyn, D. (eds) *The Critical Link: Interpreters in the Community: Papers from the First International Conference on Interpreting in Legal, Health and Social Service Settings,* Geneva Park, Canadá, 1-4 junui, 1995, Amsterdam/Filadelfía: John Benjamins, pp. 77-89

Corsellis, A. (2002). *Creating a context for public service interpreters,* En: Valero-Garcés, C. y Mancho, G. (eds) *Traducción e Interpretación en los Servicios Públicos: Nuevas Necesidades para Nuevas Realidades.* Alcalá de Henares, Madrid: Universidad de Alcalá-Servicio de publicaciones, pp.29-36

Corsellis, A**. (**2005). "*Training Interpreters to Work in the Public Services."* Martha Tennent (ed.) (2005) *Training for the New Millennium*. Amsterdam/Philadelphia: Benjamins, pp. 153-173.

Corsellis, A. (2008). *Public Service Interpreting. The First Steps,* Palgrave Studies in Translating and Interpreting, 2008, Palgrave Macmillan UK.

Corsellis, A. (2014). en Valero-Garcés, C. y Sánchez-Ramos, M. 2014, *Interview with Ann Corsellis*, FITISPos Internatioanl Journal, Volume 1, pp. 92-102.

De Pedro Ricoy, R. (2010). *Training Public Service Interpreters in the UK: A fine balancing act*, The Journal of Specialised Translation, Issue 14, 100-120

Del Pozo Triviño y Campillo Rey, (2016). *La interpretación telefónica y su práctica profesional. Estudio de caso sobre dos empresas proveedoras del servicio en España,* Sendebar No. 27, Universidad de Vigo, 2016, pp.73-95

Ertl, A. y Pöllabauer, S. (2010). *Training (Medical) Interpreters?the key to good practice. MedInt: A joint European training perspective*, The Journal of Specialised Translation, Issue 14, July 2010, pp. 165-193.

García Beyaert, S. y Serrano Pons, J. (2009). *Recursos para superar las barreras lingüístico-culturales en los servicios de salud,* en Manual de atención al inmigrante. Barcelona:ERGON, pp. 53-65

Gentile, P. (2014). *Interpreting democracy*. Interpreters as drivers of democratization. VAKKI Publications 3, 86–98

Gentile, P. (2017). *Political Ideology and the De-Professionalisation of Public Service Interpreting: The Netherlands and the United Kingdom as Case Stuies,* Ideology, Ethics and Policy Development in Public Service Interpreting and Translation, Multilingual Matters Edited by Carmen Valero-Garcés and Rebecca Tipton, 2017. P. 63-84

Gerrish, K. Chau, R. Sobowale, A. and Birks, E. (2004). *Bridging the language barrier: the use of interpreters in primary care nursing,* Health and Social Care in the Community, Volume 12(5). pp. 407-413

Hale, S. (2007). *La Interpretación comunitaria: La Interpretación en los sectores jurídico, sanitario y social,* Granada: Comares. Una traducción de *Community Interpreting. Londres:Palgrave, 2007,* pp.143-168

Hale, S. (2007). *Community Interpreting,* Research and Practice in Applied Linguistics, Palgrave Macmillan pp. 200

Lema Tomé, M. (2014). *La reforma sanitaria en España: Especial referencia a la población inmigrante en situación administrativa irregular,* Eunomia. Revista en Cultura de la Legalidad. No. 5, septiembre 2013 – febrero 2014, pp.95-115

Leman, P. y Willams, D. J. (1999). *Questionnaire survey of interpreter use in accident and emergency departments in the UK,* British Medical Journal, Volume 16, pp. 271-274

Lenneberg, E. (1967). *Biological foundations of language,* New York:Wiley.

Martin, A. (2000). *"La interpretación social en España"*, en Dorothy Kelly (ed.) La traducción y la interpretación en España hoy: Perspectivas profesionales. Granada: Comares, pp. 207-223.

May, T. (2015). *A Stronger Britain, Built On Our Values, speech*. De Gentile P. 2017. See https://www.gov.uk/government/speeches/a-stronger-britain-built-on-our-values (accessed by Gentile on 22 April 2015).

Ortega Herráez, J. M. (2015). *Reflexiones en torno al binomio formación-acreditación como elementos constitutivos de la profesionalización de la interpretación jurídica*, Trans, 19 (1). Pp. 131- 152.

Pena Díaz, C. Echauri Galván, B. y Olivares Leyva, M. (2014). Las funciones del mediador intercultural en el ámbito sanitario: habilidades y conocimientos, Revista de Estudios Filológicos, Nº26 Enero 2014

Rillof, P. 2014, From Valero-Garcés, C. (2014). *Interview with Pascal Rillof*, FITISPos International Journal, Edited in Alcalá de Henares by FITISPos-IJ Universidad de Alcalá

Sales, D. (2005). *Panorama de la mediación intercultural y la traducción/interpretación en los servicios públicos en España*, Grupo CRIT Departamento de Traducción y Comunicación, Universidad Jaume I de Castellón.

Tipton, R. (2017). *Interpreting-as-Conflict: PSIT in Third Sector Organisations and the Impact of Third Way Politics,* Ideology, Ethics and Policy Development in Public Service Interpreting and Translation, Multilingual Matters Edited by Carmen Valero-Garcés and Rebecca Tipton, 2017. pp. 38-62

Turner, D. W. (2010). *Qualitative Interview Design: A Practical Guide for Novice Investigators*. The Qualitative Report, 15(3). pp. 754-760

Valero-Garcés, C. (2014). *Health, Communication and Multicultural Communities: Topics on Intercultural Communication for Healthcare Professionals*. Newcastle Upon Tyne: Cambridge Scholars Publishing.

Valero Garcés, C**. (**2009). "*Training and curriculum design: The value of internships in Community Interpreting. Pros and cons."* Paper presented at the *CIUTI Symposium: Community Interpreting. Training and Research at University Level* (University of Graz, 17-19 September 2009).

Valero-Garcés, C. y Pena Díaz, C. (2016). *Materiales de clase: Aspectos generales, Módulo 1 sobre Comunicación Interlinguistica e Intercultural: Comunicación Institucional con Población Extranjera*, Máster en Comunicación Intercultural, Traducción e Interpretación en los Servicios Públicos, Acceso: Oct 2016.

Wadensjö, C. (1998). *Community interpreting*, Routledge Encyclopaedia of Translation Studies. Ed. M.Baker. Londres/Nueva York: Routledge. 33-37.

Páginas web:

Allianz Assistance, (2017). Travel and Medical Assistance, http://www.allianz-assistance.com.cn/corporate/what-we-do/travel-insurance-and-medical-assistance/, Acceso: 06/02/2017

Arnett, G. (2015). *Which summer holiday destinations do Brits search for most?,* The Guardian, Publicado el 24 de julio de 2015, https://www.theguardian.com/news/datablog/2015/jul/24/which-summer-holiday-destinations-do-brits-search-for-most, Acceso: 20/05/2017

Axa Assistance, (2017). Travel Assistance, Capabilities, http://www.axa-assistance.co.uk/bassline.php?p=710, Acceso: 06/02/2017

BBC, (2017). Brexit: All you need to know about the UK leaving the EU, http://www.bbc.com/news/uk-politics-32810887, Acceso: 18/04/2017

Channel 4, (2017). *Brexit: Crisis on the Wards: Channel 4 Dispatches*, New Releases, 13 de Marzo de 2017, http://www.channel4.com/info/press/news/brexit-crisis-on-the-wards-channel-4-dispatches, Acceso: 03/04/2017

CIOL, (2015). *Code of professional conduct*, Chartered Institute of Linguists, July 2015, http://www.ciol.org.uk/code, Acceso: 26/04/2017

DPSIOnline, (2017). DPSI Course – English Health Option 2017-2018, Our Courses, http://dpsionline.co.uk/courses/dpsi-health/, Acceso: 06/05/2017

Dualia, (2017). http://www.dualia.es/?atala=1 , Acceso: 27/04/2017

El Mundo, (2012). *Protesta contra la 'xenofobia sanitaria',* el 2 de septiembre de 2012, http://www.elmundo.es/elmundo/2012/09/02/valencia/1346579604.html, Acceso: 16/05/2017

Forster, K. (2016). *Hate crimes soared by 41% after Brexit vote, official figures reveal*, The Independent, http://www.independent.co.uk/news/uk/crime/brexit-hate-crimes-racism-eu-referendum-vote-attacks-increase-police-figures-official-a7358866.html, Acceso: 17/04/2017

Gan, S. (2012). Lost in Translation, 2020Health, http://www.2020health.org/2020health/Publications/publications-2012/Translation-Services.html

Gov.uk, (2017). Review of public sector Equality Duty, https://www.gov.uk/government/groups/review-of-public-sector-equality-duty-steering-group, Acceso: 27/04/2017

Hammersmith and Fulham Adult learning and skills service (HFALS). (2017). Courses > Interpreting > Diploma in Public Service Interpreting, http://www.hfals.co.uk/courses/interpreting/diploma-public-service-interpreting/dpsi-spanish/, Acceso: 04/05/2017

Healix International, (2017). International Medical Assistance, http://www.healix-international.com/services/international-medical-assistance/ Accessed: 06/02/2017

Interpret Solutions, (2017). Compania, http://www.interpretsolutions.com/index.php?page=compania , Acceso : 27/4/2017

InTran, (2017). About Us, Why Choose Us, http://www.intran.org, Acceso: 26/04/2017

Language Line, (2017). Our Company, https://www.languageline.com/uk/company/, Acceso: 26/04/2017

Latingua, I.F. (2016). *La población en España crece por primera vez en más de tres años debido a la inmigración*, El Mundo, Publicado el 16 de diciembre de 2016, http://www.elmundo.es/sociedad/2016/12/16/5853c82dca47411b518b4585.html, Acceso: 25/03/2017

London Metropolitan University, (2017). *Interpreting – MA,* http://www.londonmet.ac.uk/courses/postgraduate/interpreting---ma/, Acceso: 04/05/2017

Middlesex University London, (2017). *Interpreting and Translation BA Honours,* http://www.mdx.ac.uk/courses/undergraduate/interpreting-and-translation, Acceso: 04/05/2017

MOOC, (2017). ¡Atrévete a traducir y a interpretar en los servicios públicos, Universidad de Alcalá, https://openeducation.blackboard.com/mooc-catalog/courseDetails/view?course_id=_1077_1, Acceso: 08/05/2017

NHS Choices, (2017). The NHS in England, http://www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx, Acceso: 10/03/2017

Nicholas, A. (2016). *Brits insist UK immigrants speak English - so why don't expats in Spain learn Spanish?*, The Telegraph, http://www.telegraph.co.uk/expat/education-and-family/brits-insist-uk-immigrants-speak-english---so-why-dont-expats-in/, Acceso: 26/03/2017

NRPSI, (2017). National Register of Public Service Interpreters, http://www.nrpsi.org.uk/, Acceso: 28/03/2017

NSPCC, (2017). Case reviews published in 2014, Case Reviews, https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/2014/, Acceso: 01/05/2017

Pokorn, Nike K. (2008). MedInt: Development of a Curriculum for Medical Interpreters, Final Report, http://eacea.ec.europa.eu/LLp/project_reports/documents/grundtvig/multilateral_projects_2007/progess_reports_2007/grundtvig_medlnt-v2.pdf Acceso: 23/04/2017

Rillof, P, (2014). *The European Network for Public Service Interpreting and Translation,* GALA: Globalisation and Localization Association, https://www.gala-global.org/publications/european-network-public-service-interpreting-and-translation, Acceso: 21/04/2017

Travis, A. (2016). *Immigration to UK hit record levels prior to Brexit vote, data shows*, The Guardian, Publicado el 1 de diciembre de 2016, https://www.theguardian.com/uk-news/2016/dec/01/immigration-to-uk-hit-record-levels-in-run-up-to-brexit-vote-latest-figures-show, Acceso: 25/03/2017

The Guardian (2015). *The Guardian view of Europe's populists: left or right, they are united by a worrying xenophobia*, editorial. http://www.theguardian.com/commentisfree/2015/feb/01/guardian-view-europe-populists-left-right-unitedworrying-xenophobia en Gentile, P. 2017,

The Guardian, (2017). *Theresa May calls for UK general election on 8 June,* UK politics, 18th April 2017, https://www.theguardian.com/politics/2017/apr/18/theresa-may-uk-general-election-8-june , Acceso: 18/04/2017

The University of Southampton, (2017). *LANG3006, Public Service Interpreting*, Undergraduate Courses, Fourth Year, http://www.southampton.ac.uk/courses/modules/lang3006.page#aims_and_objectives, Acceso: 24/04/2017

UAH, (2017). *Máster Universitario en Comunicación Intercultural, Traducción e Interpretación en los Servicios Públicos*, La Universidad de Alcalá, http://www3.uah.es/master-tisp-uah/plan-de-estudios/, Acceso: 08/05/2017

UGR, (2017). *Introducción a la Interpretación en los Servicios Públicos B/C-A Inglés,* Grado en Traducción e Interpretación, http://grados.ugr.es/traduccion/pages/infoacademica/guiasdocente/guias-2016_2017/optativas/interpretacion_servicios_publicos_bc_ingles_revisada, Acceso:08/05/2017

UM, (2017). *Interpretación en la empresa u en los servicios públicos B-A / A-B,* Grado en Traducción e Interpretación (Francés), https://aulavirtual.um.es/umugdocente-tool/htmlprint/guia/RNAK1vnVz0uciaejB3YucbzyvVjClFghDBnqIgJQrow4YjM3uB3, Acceso: 08/05/2017

UPO, (2017). *Máster Universitario en Comunicación Intercultural, Traducción e Interpretación*, La Universidad Pablo de Olavide de Sevilla, https://www.upo.es/postgrado/Master-Oficial-Comunicacion-Internacional-Traduccion-e-Interpretacion, Acceso: 08/05/2017

Westminster University, (2017). *Translation and Interpreting MA*, https://www.westminster.ac.uk/courses/subjects/languages/postgraduate-courses/september/full-time/translation-and-interpreting-ma, Acceso: 04/05/2017

PDFs:

Heart of England NHS Foundation Trust, (2011). *Interpreting and Translation Services Operational Policy,* Version 3.0, August 2011, pp. 1-20

NHS England, (2015). *Principles for high quality interpreting and translation services,* Version 1.19, 2015: 1-15

NHS Tayside, (2010). *Communication. Interpretation and Translation Policy,* NHS Tayside, January 2010, pp. 1-27

South London and Maudsley, (2015). *Interpreting and Translation Guidance,* South London and Maudsley NHS Foundation Trust, 7th October 2015, pp. 1-18

Otras fuentes:

Auzmendi, L. (2016) en Mesa Redonda: Una década de cambios 2006-2016 en la traducción e interpretación en los servicios públicos en España, TISP 2017, 08/03/2017

Baigorri, J. y Travieso, C. (2016) en Mesa Redonda: Una década de cambios 2006-2016 en la traducción e interpretación en los servicios públicos en España, TISP 2017, 08/03/2017

Ortega Herráez, M. y Blasco Mayor, J. (2017) en Mesa Redonda: Una década de cambios 2006-2016 en la traducción e interpretación en los servicios públicos en España, TISP 2017, 08/03/2017

Anexo A:

Study: Teoría vs Realidad: la interpretación médica en los servicios públicos de Inglaterra y España. Un estudio comparativo desde las perspectivas de profesionales sanitarios del día de hoy y el futuro.

Theory vs Reality: medical interpreting in the English and Spanish public services. A comparative study from the perspectives of healthcare professionals on the present day and the future.

Interview questions

Profession (where do you work, what position/speciality, years of experience):

Do you currently or have you worked for the NHS (where, what position/speciality)?

What languages do you speak and to what level?

Can you give me a brief explanation of your role working internationally for insurance?

What experience and type of communication have you had or do you have with Spanish public hospitals?

- **In UK:**

What current translation or interpreting provisions are you aware of being used by the NHS in the UK?

Are these official services? And are they always used? What about family members, hospital staff etc?

Has this changed in recent years or since you started working for the NHS?

How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

- **In Spain:**

What translation and interpreting provisions, if any, do you find in Spanish public hospitals? Does it differ greatly from the UK?

If nil, who helps with communication with these hospitals? Family members, hospital staff, staff in UK insurance office?

How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

How would you compare the two public healthcare systems in Spain and England with respect to these linguistic services?

What do you think about using non-registered or untrained translators and interpreters? Can you notice a difference between trained and untrained interpreters?

How important do you believe training in this field to be? Why? (Would you consider an Ethics code to be important in this field?)

What experience do you have working with interpreters and have you received training regarding working with them?

With respect to the England and Spain, do you see any changes taking place in these areas in the future? Why? Brexit is on the horizon, do you think this will have any impact?

Do you have any suggestions on how these provisions and services in each country could be improved?

Information relating to study

Title: Teoría vs Realidad: la interpretación médica en los servicios públicos de Inglaterra y España. Un estudio comparativo desde las perspectivas de profesionales sanitarios del día de hoy y el futuro.

Theory vs Reality: medical interpreting in the English and Spanish public services. A comparative study from the perspectives of healthcare professionals on the present day and the future.

Please read the following information before you decide whether to participate in this study. If you do decide to participate, please sign the consent form attached.

If you have any questions, please don't hesitate to ask.

What is the study about?

I am currently a Masters Student at the University of Alcalá de Henares, Madid, Spain, where I am studying Public Service Translation and Interpreting. For my thesis, I am carrying out a study which will compare the translation and interpreting services between the public healthcare systems in England and Spain, and how the reality differs from what is described 'on paper' with respect to the relevant provisions and training in this area. In order to do this, I would like to interview you, as a medical professional with experience in this area, in order to present this reality – which I will then compare to relevant UK and Spanish legislation, certifications and training programs that are in place.

As there have been many studies and projects dedicated to evaluating and improving this field, I believe this study will give a great insight in how each country has progressed, and also present not only the current situation, but what we could possibly expect in the future.

What does the interview involve?

The interview, which I would like to carry out, would ideally be in person and about 10-15 minutes in duration. The questions will be based on experiences you have in working for the NHS and also your experiences of the Spanish public healthcare system – relating to the language provisions available and your opinions of these.

There are no right or wrong answers, any information you can provide would be greatly appreciated.

If you are unable to be interviewed in person, but are still willing to participate, there is always the possibility of organising a skype interview or you may be sent a questionnaire – which ever would suit you best.

The interviews will be recorded but will only be used for the purposes of this study.

Please note – the interviews will be completely anonymous. Neither your name nor any information or affiliation to a specific organisation that could be used to identify you, will be used in this study.

Are there any benefits to your participation?

Although there are no direct benefits for yourself, your participation in this study will provide an invaluable insight that could be used to improve the field of medical translation and interpreting in the future.

Are there any risks to your participation?

Your participation in this study will not pose any risk to you. As mentioned, your participation in the study, should you consent, will be completely anonymous and you have the right to withdraw your consent or involvement in the study at any point.

Will your participation be confidential?

Yes.

Any information that is obtained in this study (interview recordings, transcriptions and questionnaires) will be stored safely on my computer, locked with a password, and only ever in my possession. Participation is completely anonymous, where each participant will be given a number or letter of the alphabet in order to identify their comments or remarks on the topic.

What do you do if you want to withdraw from the study?

You have the right to withdraw from the study at any time, without providing any reason or there being any consequence for this decision. If you decide to withdraw from the study, any information you have provided me will be destroyed immediately and not used in my thesis.

Informed Consent relating to Master's Thesis Interviews

Name of Study: Teoría vs Realidad: la interpretación médica en los servicios públicos de Inglaterra y España. Un estudio comparativo desde las perspectivas de profesionales sanitarios del día de hoy y el futuro.

Theory vs Reality: medical interpreting in the English and Spanish public services. A comparative study from the perspectives of healthcare professionals on the present day and the future.

Please read the below statements and sign below to confirm your consent:

I have read and understood the information provided to me about the purposes of this study, and I have been given the opportunity to ask any questions that I may have.

As such, I, hereby, give my consent to participate in this study by means of a recorded interview, knowing that the information I provide will be used anonymously and only for the purposes of this investigation.

I also understand that I have the right to withdraw my participation at any point during the study.

Participant number/letter:

Name of participant:

Signature:

Date:

Name of investigator:

Signature:

Date:

Anexo B:

Interview transcriptions

Interview A

What is it you do?

I'm a registered general nurse, the head of medical services.

For the NHS I worked within Acute Hospital Trusts in the South East of England – the departments varied from A&E through to acute surgical, acute medicine and outpatients' department.

What languages do you speak and to what level?

I'm an English native speaker.

Can you give me a brief explanation of your role working internationally for insurance?

So I oversee all medical cases in the UK for XXXXXXXX travel insurance.

What experience and type of communication have you had or do you have with Spanish public hospitals?

So I regularly speak to…to get verbal medical reports from public hospitals and private hospitals in Spain.

- **In UK:**

What current translation or interpreting provisions are you aware of being used by the NHS in the UK?

So Language Line is the only one or is the only authorised one that we should use in the UK.

You work for the NHS as well?

Yeah, worked for the NHS for 20 years.

Are these official services? And are they always used? What about family members, hospital staff etc?

So if Language Line cannot produce anything, we have to err we have to wait for Language Line to provide a service, we are not allowed to go outside Language Line. Only official service and always used.

- **What about family members or staff used?**
  Had been up until about 5 years ago then has been discouraged because of the clarity of the translation.

Has this changed in recent years or since you started working for the NHS?

How do these provisions (or lack of provisions) affect your work and does this impact the patients?

Initially medical care is given on presentation of symptoms or injuries so we don't need to have a language communication system to treat someone because we treat people who are unconscious anyway but obviously to get any past medical history that might be relevant to that disease or illness is very important for an ongoing care basis.

I think more from a social point of view umm, because people have frustrations regarding what they want to express, like simple things like wanting to go to the toilet or wanting a cup of tea or something like that – is as important to a nurse for a patient as it is giving them an injection or two paracetamols. Umm so their wellbeing and their mental state is as important to their recovery as the medical treatment itself.

- **In Spain:**

What translation and interpreting provisions, if any, do you find in Spanish public hospitals? Does it differ greatly from the UK?

It's very sporadic to be honest, depending on which area and which hospitals umm… generally there is some form of translation service or international department in the hospitals that I've encountered, umm but again the level of translation is difficult sometimes and availability is very difficult. Some public hospitals not all. Generally, in the more tourist areas they are more available.

If nil, who helps with communication with these hospitals? Family members, hospital staff, staff in UK insurance office?

If for example a medical escort went out to try and then get information from the hospital, we would then use other members of staff that may speak English there – it may be down to the basics of google translate – it could be family members that are there – maybe even the patient may speak some Spanish language, it's very piece by piece, there's no complete process because there are a lot of people that can speak some language but can't translate medical… and so it is very difficult.

How do these provisions (or lack of provisions) affect your work and does this impact the patients?

I think it is very similar because we are not aware of any service of like Language Line that they have in Spain for…if we were in the UK we would phone Language Line…in Spain they don't have…that we're aware of…they don't have the same system so the provision of emergency care would definitely be affected, mainly because we would need to know exactly what treatment has been given and how it has been given and what the prognosis or diagnosis is.

[Patients – language affects them?]

Yes, very much so (difficult). The patients themselves feel isolated…because sometimes they rely on other members of staff that speak English, umm then different shift changes happen and so they are left isolated again…as some come to this country without a translation service

would be…so again care can't be given because they might not understand the consent process…so yes it does affect it.

How would you compare the two public healthcare systems in Spain and England with respect to these linguistic services?

UK – no sort of timeframe or SLA – really the availability of the translator…generally when you phone Language Line they have a list of people who speak different languages, availability, obviously with Spanish it is a bit more common than Mandarin or Korean so actually it is easier to get Spanish translation. If in the meantime…we generally, if it is something that doesn't involve consent or a serious medical intervention we do use members of staff occasionally if it is simple basic requests.

What do you think about using non-registered or untrained translators and interpreters? Can you notice a difference between trained and untrained interpreters?

Untrained in basic care needs. Cannot tell the difference. I think it is very difficult if you are a non-language speaker to identify the pitfalls in someone's translation of what they are actually asking…its.. I have been witness to a translator, actually a Spanish translator intervening with patients that came in to us…I had a Spanish nurse standing next to me and she did actually lean over and say that that's not what you asked them to say which was quite good because I knew what I wanted to say, I wanted to ask the patient but actually it wasn't being relayed directly, it was being changed slightly – they had been called in (the interpreter).

How important do you believe training in this field to be? Why? (Ethics code?)

Yes – ethics. Definitely I mean it's a big responsibility to translate any document or a service, anything medical has to be a priority because if you get something wrong or you change the exact question that you needed answering, it actually affects the response and then obviously the treatment and diagnosis of someone's care – it needs to have a huge ethics attached to it.

Seen a difference in this over the years?

Yes. So when I first started off as a nurse for the NHS – the role of a translator didn't really exist, it was always the operators in the hospital – had a list of people that worked within the hospital that spoke or had different nationalities that they could refer to – so you could be a porter who spoke Portuguese or it might be a theatre nurse that was Cantonese or something so there would always be someone or it would be word of mouth that someone else spoke a different language.

Throughout the years more litigation has come in and obviously the importance to be exact on the translation from a medical-legal point of view and so that's when the transition to Language Line happened – so that we were, if it ever went to court, that we were – we could guarantee that the person translating had a certain degree and level or understanding of translation.

What experience do you have working with interpreters and have you received training regarding this?

No.

With respect to the England and Spain, do you see any changes taking place in these areas in the future? Why? (Brexit)

No. I think with Brexit, I don't think actually it will affect the way we translate too much, I think we'll still have a movement of people within the UK, to the continent and vice versa – I think the translation service at the moment is almost adequate for Language Line – the availability is the issue we have – is being the person on the other end of the phone when you need them – for certain times, rather than making the appointment to gain consent for an operation, umm so the urgency needs to be stepped up but umm I think, I don't think Brexit will affect it or where it's going – I think we are probably looking at a more robust translation service within trusts – maybe to the point that we use someone else rather than Language Line or have an alternative so we have – if there is an urgent need we have an alternative.

Trusts – most trusts use Language Line because that seems to be the Gold Standard but the general go-to if we need something, umm there are other alternative ones out there but again the – Language Line seems to be the biggest and has the biggest availability as well – the biggest languages.

Do you have any suggestions on how these provisions and services in each country could be improved?

Umm really the UK is the only one I can really comment on, I think over the next couple of years we need – because we have such a big movement of people in and out of the country – from different countries – from different languages, I think we need to move towards a more robust translation service within the trusts – within trusts in the UK, but I think that is something that Language Line or an alternative translation service may have to look at as well to provide a more umm maybe an alternative, maybe a more competitive service as well.

Interview B

What is it you do? (profession, speciality, years of experience)

Well I work at XXXXX insurance, been working here for one year and I've been a qualified nurse since 2001.

Do you work for the NHS?

Not really. I can work the odd shift whenever I choose to.

What languages do you speak and to what level?

English, full English.

Can you give me a brief explanation of your role working internationally for insurance?

I work as a repatriation nurse and what the role involves is that you work on a medical desk managing cases, okay, for patients that are abroad and they become ill and also my role is also to actually travel and collect the patients – repatriate them back to the UK, okay so two – working on a medical desk actually looking at cases that come in for patients that become ill abroad and also travelling abroad to bring the patients back.

What experience and type of communication have you had or do you have with Spanish public hospitals?

I've had Spanish notes, made calls to Spanish hospitals, been to collect patients from Spanish hospitals and spoken to Spanish doctors or nurses on the phone.

- **In UK:**

What current translation or interpreting provisions are you aware of being used by the NHS in the UK?

In the NHS we can use, we've got an interpreter line so we always have access to the majority of languages, not just Spanish, so if there's a language that you cannot speak and you've got a patient, you're able to call Language Line and you'll be able to have a conversation through an interpreter, a trained interpreter with Language Line and there are a few flaws sometimes – because I have worked in different systems and one of the flaws are thinking the NHS in a hospital – sometimes you can't listen to what the patient is saying – you've only got one line so you only speak – you haven't got the 'three-way' – okay and I have worked in the NHS establishment but in a prison where we do have a three lines so when you have the three lines at least you can listen to the interpreter, you can listen to the patient and the conversation is much more fluent with three of you on a three-way call but previously in the NHS, I don't know if they have improved in hospitals now but they used to be just two of you speaking – just the option for both of you to speak – so therefore you would speak to the interpreter, the interpreter would speak to the patient and then you go back so the communication is not as accurate when it isn't a conference call.

Two-way communication: I might ask the interpreter to ask the patient if they're short of breath and if they have any chest pain, I might ask three questions – I don't speak the language but what happens is – is by the time you pass it back to the interpreter and the interpreter says – A. I don't know what the interpreter is saying to the patient and then sometimes she doesn't answer all the questions fully – when I'm on the line I can – I've got my 3 questions there and I can ask – have you answered those three questions that I've just asked – but when you keep passing it backwards and forwards things get lost on a long conversation – if it is like about 4 questions and you're asking the 4 questions, it's easier to ask 4 questions and you can get your 4 answers back but when you're having that conversation and then the interpreter is speaking back to you somethings can get lost, but when you are all on the call it's much easier, you are less likely to lose…

.

Are these official services? And are they always used? What about family members, hospital staff etc?

That is the only one that they use – Language Line, but I do know, working with the NHS that if you, if someone is going to, I know you can get actually interpreters that come in – not just through LanaguageLine, if you need an interpreter to come in in person, you can get it and you can order an interpreter in person to come in, because sometimes communication may be really difficult over the phone and a person will need someone actually, an interpreter there.

How? - Same thing with language line – it gives you an option, if I can recall rightly when I worked for the NHS, it gives you an option so you can phone and if you decided that you wanted an interpreter to come in person, say for example if someone had mental health issues, and they couldn't communicate over the phone and it was just difficult and you wanted the person to come in, what you can do instead of just doing a verbal call, you can say that you want an interpreter in person and then you go through a different process – I've never had to use is, we always used verbal but there is an option to get an interpreter in in person – and you will need it for certain patients.

What about family members or staff used?

Definitely, when I worked for the NHS, there was a case in A&E a patient that couldn't speak, they were deaf, and there was a trained nurse that could do sign language and she was an interpreter for the patient instead of getting a correct interpreter in they used a nurse, and the patient decided to self-discharge and go home – and the patient actually died – the patient actually died – and there was a big issue about the interpretations that we used and if the person wasn't trained – she was open to scrutiny – and if the person wasn't…and from then we learned that we should never use an interpreter if it wasn't a trained interpreter by the trust – so there was a lot of work that went into it and so even if it was domestic staff they often spoke different languages – they were called – with no confidentiality – so there was a lot of work done in that area because of that incident that happened – so personally for me, I have learned in my training that if you are not recognised to be the interpreter – then I don't want you to interpret anything for me – because when it comes to a court of law, I have got no leg to stand on.

Has this changed in recent years or since you started working for the NHS?

These changes happened for this particular trust that I worked for – there was a lot of work that went into it – if things have changed when I went to other trusts, and I have worked in other trusts – because I think because of the nature of places where we work, especially for the NHS, its so busy, if you work somewhere so busy, although the rule stands as a rule it sometimes as a shortcut – sometimes you know if you're too busy, sometimes people might take a shortcut – that still happens. Case roughly about 8 years ago. – changes since then.

How do these provisions (or lack of provisions) affect your work and does this impact the patients?

It is always going to impact because Language Line is time consuming so even if it doesn't impact on that particular patient, it impacts on other patients because you're always going to take longer to deal with that patient and I've worked in an establishment where people have about 50 languages and when somebody has 50 languages it actually puts their health at risk – because I have worked in a prison setting and a large prison with 1700 men in there and when you work and they go in and out of the prison so its almost like a revolving door, so you will always have different people coming in, I think there was a survey done and people spoke over 50 languages in there so if you've got people coming in and out and they need medical assessments – when you come in you need a medical assessment and when you go out you probably need a medical screen just to make sure everything is correct and with someone speaking 50 languages it's definitely – and not definitely it has been cause to their health.

- **In Spain:**

What translation and interpreting provisions, if any, do you find in Spanish public hospitals? Does it differ greatly from the UK?

No, the provisions don't differ, from what I have seen they have got similar provisions what we have in the NHS.

They've got "a translator" so most things are done through the translator so if you come to the ward – some of them speak very limited English and they can't help you and they call the translator who speaks fluent English – but they're not medical the translator is not medical so the translator doesn't understand everything that goes on so sometimes can get missed and so they'll translate what you need and the information that you ask for, its mainly what you're asking for, what you're requesting and what you read – but the actual care is done by the nurses and so you won't really – for example if the patient was short of breath this morning more than usual I will only read the notes that maybe his oxygen level is okay but I would probably have liked to have known that he was short of breath this morning, to be aware that he had been short of breath – you may miss our tiny bits of information because it goes through the translator rather than the nursing staff and the nursing staff are limited in what they can…what they tell you because most of the things are done by the treating doctor as opposed to…whereas in the NHS here the nurses have got more scope in caring for their patient and we can give out more information compared to Spain.

Quality the same in Spain as UK? – I think it's different and I say that because I am doing the full assessment myself when I am here on occasion and I am asking for someone to interpret it and its more time… when you get to the hospitals in Spain and you're relying on the translator I think that the nursing staff are really busy…and you've come at a time maybe when they are doing their medication…they've got their patients…so it's interrupted for them, they haven't got the time so your translation will never been the same because you're relying on their assessment and you're getting your information from someone who is non-medical.

Nursing staff can be really busy (in Spain) so you walk in… (14.20 – 14.40 = completely irrelevant)

If nil, who helps with communication with these hospitals? Family members, hospital staff, staff in UK insurance office?

Yeah definitely if you go there and you want help and you go to Spain and the doctor is not around or the nurse don't speak then someone…it might not even be a relative or a patient, it might be a relative or somebody in the next bed, they start speaking English and doing the interpretation for you – but where you take that information as a nurse – you may listen but for me as a nurse I wouldn't take whatever they have said as factual – so I would listen to them and it is nice for the information but I need to hear it from a medical person.

If I am here in the office and we've got interpreters that can speak different languages I can rely on the interpreters but the problem sometimes with interpreters here is that they are not medical either and so I am relying on them to read what is in the notes and what I have learnt to understand is that not all the words are exactly the same when they are interpreting and especially if for example Spanish is not their first language and they're a French speaking person and they speak English and they speak Spanish and Spanish is not their first language

– they still struggle too with words so when there is a lengthy report or something a bit more complicated I have to send it to a medical person like a medical team because I don't want to miss anything…so if it is a more simpler one…so if someone is interpreting something for me and they are non-medical and it is like a fracture to your lower limb I can kind of be okay with that to a degree but if it is more complicated like cardiac – so there is a little bit of a limitation…

= Medically trained. So for example there has been times when I have needed to ask Barcelona's medical team to interpret a report which I would never give to the operations team – especially if the patient is really ill and it is a lengthy report, I just think it is too much for them to interpret and there is too much medical information and so it is better for a medical person to interpret it.

How do these provisions (or lack of provisions) affect your work and does this impact the patients?

I think that the care in Spanish is different to the care here in the NHS and I think that patients have complained about the language barrier so for example they might be in pain for longer than needed to because they can't communicate it in the normal way or they are not confident enough to communicate it so it is not that they wouldn't treat their pain in Spain but I think that when you are not – even myself when I go as an escort – it makes it harder to communicate what I want because I don't speak the language – so if you're a patient you're a little more vulnerable as well, so therefore you are a bit more vulnerable and you are in a lot of pain maybe it is even harder for you to communicate so if you've got two things – you've got your condition and you've got the barrier which doesn't help, which in an English hospital or English speaking hospital it would be a lot easier.

How would you compare the two public healthcare systems in Spain and England with respect to these linguistic services?

What do you think about using non-registered or untrained translators and interpreters? Can you notice a difference between trained and untrained interpreters?

They all have a number – when you phone language line – a trained interpreter is supposed to give you their number so you can put their number in the notes and so their number is on the files and that is what I call a trained interpreter.

No. I don't understand the language so it would make no difference to me.

How important do you believe training in this field to be? Why? (Ethics code?)

Yes I think anyone looking after patient should have an ethics code – when you are caring for somebody, especially people that are vulnerable as well.

What experience do you have working with interpreters and have you received training regarding this?

No, no one.

With respect to the England and Spain, do you see any changes taking place in these areas in the future? Why? (Brexit)

Just to go a little bit back, one thing I didn't mention is that sometimes we've got translating like "Google Translate" and sometimes if you get a report its going to translate it by using the translation app and that gives you the information but you still can't rely on it as well.

In terms of what I see in the near future – is the answer for English people to learn Spanish or Spanish people to learn English? Is that going to be an answer? We've been going for years and years and years and we haven't cracked it so I don't think that is going to happen any time soon and what's a way around it…there probably needs to be, just like in the hospitals employed a translator and the translator translates and helps to cut down that barrier by translating things – maybe they are needing to look at a more – like for example the hospitals in Spain that – that admin staff needs to be- could be medical admin – because they are given a lot of medical notes and I think that what they need to do is maybe need to mix the teams up like in an insurance company – like here – you need to probably – like I worked in a prison before and you've got healthcare and you've got security and you've got two services in one and the only way to get a better outcome is to mix the two so if you have for example and operational language person sitting on the desk with the medical team and maybe even the other way around – the medical team sitting on the desk with the operations and you have a fair mix so it's getting better communication – the only way to get better communication is to cut down barriers.

The translator should be medically trained – some of the things that the translator – you'll know the importance when you get a case and you read a case and this person is to be repatriated back to the UK or you're dealing with a country that doesn't speak English – you'd know everything medical about that case so you'll make sure you cross the T and dot the I because you are medically trained – if the interpreter is an admin staff and she is not medically trained she is going to have experience like the operational people that work here – they have a lot of experience because they are dealing with medical notes all the time but when you actually work as a nurse you see things a little bit different to how they see things and so that – it adds to that missing puzzle – so to me you have got to close down those barriers so a medical person changes to admin and they're medial admin so that means that they are a bit more far up and you are less likely to get mistakes and here when you're working together – as I said if there was an operational person that worked on the operation side and knew a lot more about operation things than I did and they spoke Spanish and they worked on the medical desk – at least there would be more – it would cut down that little bit of barrier – interdisciplinary training so mix them rather than keeping them separated and segregated.

Do you have any suggestions on how these provisions and services in each country could be improved?

Interview C

What is it you do? (profession, speciality, years of experience)

Staff nurse – I have been working for a very long time – currently I'm in paediatric intensive care, still working at the Brompton Hospital in Chelsea – that's cardiac mainly – and I've been in assistance for – in medical assistance for, gosh, about 11 years.

What languages do you speak and to what level?

A few words of French and that's it.

Can you give me a brief explanation of your role working internationally for insurance?

Umm liaising with medical teams worldwide, assessing medical information and translating that into repatriation.

What experience and type of communication have you had or do you have with Spanish public hospitals?

Any, umm, any medical case that we have in a public hospital in Spain is very difficult. Generally, the only way I can ever get any medical information is via a patient themselves or the relative, and say "is there anybody there that speaks English? Can I speak to them?" – it's one of the only ways unless I beg Barcelona (another office) to help.

- **In UK:**

What current translation or interpreting provisions are you aware of being used by the NHS in the UK?

I know in my own hospital where I still work – there is a number of interpretive services which include every language under…well many languages: all the indian languages, all the Pakistani languages, pretty much worldwide really, all the arabics, all the erdus, everything like that..umm…polish, all of…you know…eastern European…and they put out a…they send requests out on the emails all day, err like every day they'll be several saying "Polish, indian…you know…whatever is required.

Agencies? – It must be, I actually don't know to be quite honest – unless we've got a database of people on our…I think they might have a database of people on their list and they can call them or they can send out an email to them…I am not 100% sure how it works – it's actually a good question – I could find out…

Have you had to use these services when working for the NHS?

Yeah, I just asked my ward clerk to find me an interpreter – not sure how they do it – just try and find one – sometimes the staff help like lots of our staff speak different languages – sometimes the staff like, we've got Arabic doctors, we've got German doctors, we've got nurses from, like all our…half our nurses are from…Spanish or Portuguese…so some of the staff….

Are these official services? And are they always used? What about family members, hospital staff etc?

Hospital staff used are natives of the other language.

What about family members?

Yeah, sometimes…you can use family members…yeah… they often, like children, you know children speak…the younger members of the family will speak better English than the parents and they'll translate, or another…sometimes an aunt or an uncle, someone like that, some

relative will translate and we do use them, even though they are not medically 'au fait' will it all they can generally…and we do use them.

Cleaners/housekeeping? – occasionally yep, occasionally we do.

Has this changed in recent years or since you started working for the NHS?

Used language line at other job. I haven't used them since my other job, but it was good you could ring them up and say I need…the last one I ever used was Japanese, for assistance job.

How do these provisions (or lack of provisions) affect your work and does this impact the patients?

Yes it is an issue but at the moment I work with children so its not quite the barrier it could be if it were adults.

- **In Spain:**

What translation and interpreting provisions, if any, do you find in Spanish public hospitals? Does it differ greatly from the UK?

In public hospitals in Spain…I am sure some hospitals do have them, it's actually trying to get through to them to help us. Because once again you almost need Spanish help to get through to the Spanish helpers so… I guess its like they might have…some hospitals must have a system similar to a private… it's just more difficult to access, and maybe we don't know about it.

Comparison to UK

Umm it is probably similar, say if the boot were on the other foot and you were Spanish calling England you'd have the same trouble.

If nil, who helps with communication with these hospitals? Family members, hospital staff, staff in UK insurance office?

Always easier to communicate when you are there because when you are on the ground you can generally…you can generally work out more…even if you can speak the language, you can generally, together you can work out something – or find somebody who can speak a little bit of English and you know, what have you…definitely easier when you are there – although that could be too late.

In the office (who to rely on) – that's difficult too – depends on, we just try and find someone who can speak Spanish really, there is one or two that can – members of staff in the office – if not – try and ask Barcelona to see if they can help us.

How do these provisions (or lack of provisions) affect your work and does this impact the patients?

How would you compare the two public healthcare systems in Spain and England with respect to these linguistic services?

What do you think about using non-registered or untrained translators and interpreters? Can you notice a difference between trained and untrained interpreters?

Yes, definitely, and the reason I would say that – like medically trained? Or? (trained as an interpreter with specialism in healthcare) – I get the impression that many would not have it (DPSI), people who speak both languages, live there and start working in the hospital helping and act as a go-between…some of the translators with just basically help the patients rather than do a whole lot of medical stuff because if you call them up and say oh no – I can say "how is Mr XXX" "what's the update" – and they reply "oh I am not medical, I can't tell you. All I can tell you is that I saw him this morning and he is fine etc" – so therefore…

Very seldom that I've got like a conference call – you see I haven't had a conference call since I have been here really because A – our lines don't allow it really and yeah that would be helpful so if you could do a conference call and you had a proper interpreter in the middle and I could ask the questions and the questions were relayed – backwards and forwards – doesn't really happen as you can't find someone to do it but would work quite well.

How important do you believe training in this field to be? Why? (Ethics code?)

It would definitely definitely help – it would be really helpful. Yes exactly, I think that is important – I think that it's missed because all we want to do is try and find the first person we can who can help us in any way they can. Finding someone causes a delay….so you just find a relative, you find a cleaner you find somebody who can help.

What experience do you have working with interpreters and have you received training regarding this?

No. Never.

With respect to the England and Spain, do you see any changes taking place in these areas in the future? Why? (Brexit)

Umm no, I don't think it would affect it much – might – um I wonder whether it will affect us the other way around – us calling Spain… umm I would like to think it wouldn't – that what we've got wouldn't diminish.

Do you have any suggestions on how these provisions and services in each country could be improved?

On site interpreters or better telephone interpreters I suppose.

Interview D

<u>Interview questions</u>

Profession (where do you work, what position/speciality, years of experience):

I am a nurse, a registered general nurse, I work a XXXX Assistance Insurance in the international emergency medical assistance as an assistant – my speciality is travel medicine and aviation medicine with a background in intensive care and I have been a nurse for 38 years.

Do you currently or have you worked for the NHS (where, what position/speciality)?

I worked for international SOS before I worked here.

What languages do you speak and to what level?

None really, I did French, German and Spanish at school…bits and pieces – I can order a cup of tea in about 4 or 5 languages, I used to speak Japanese but I cant remember any of it.

Can you give me a brief explanation of your role working internationally for insurance?

To review medical reports and offer medical opinions as to appropriate treatment, centres of medical excellence and care available and arrange evacuations and repatriations.

What experience and type of communication have you had or do you have with Spanish public hospitals?

Thankfully very limited, due to language issues – so most of the experience is actually turning up and doing repats and actually speaking to the nursing staff and medical staff when you go to get a patient – have tried but fail on most occasions to call and actually speak to staff in public hospitals due to language issues – so we tend to ask native Spanish speakers or good Spanish speakers.

- **In UK:**

What current translation or interpreting provisions are you aware of being used by the NHS in the UK?

Well I haven't worked for the NHS for about 9 or 10 years but the last hospital that I worked in – we had a list of foreign language speakers – we also had a facility to telephone interpreters – I think it was Language Line – these were the official services.

Are these official services? And are they always used? What about family members, hospital staff etc?

From what I can remember there were Spanish speaking staff in the hospitals, but it depended on who you were trying to talk to and what information you were trying to gain so if it was relatives they would use the staff, if it was medical then they tended to use…I don't / cant remember an instance when we needed to use Spanish in medical translation services.

Has this changed in recent years or since you started working for the NHS?

How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

- **In Spain:**

What translation and interpreting provisions, if any, do you find in Spanish public hospitals? Does it differ greatly from the UK?

A lot of the hospitals have international departments because we tend to access or have patient sin high tourist areas so they will have international departments or interpreters – a lot of the staff will try to speak English for you – a lot of the doctors will – not a lot some of doctors have had experience in the UK and will speak English as well but it is quite limited – it is very hit and miss. I am not aware that – if they don't have an international department what other facilities or dealing with any type of they have…(this service on site) that tends to be office hours and around the afternoon siestas so it's the morning – if you phone in the afternoon: no chance. Sometimes you're lucky if you can then phone back in the evening – and at the weekends almost certainly not. Only mornings.

If nil, who helps with communication with these hospitals? Family members, hospital staff, staff in UK insurance office?

We would use the language speakers in the office or in Barcelona – the DZ.

How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

Yes it affects our work. Because they are obviously very busy because they are high tourist areas and you may again – you may phone the international department and you get a Spanish speaker but they don't speak English – it may be the Spanish speaker that speaks Portuguese and german or Italian so you are not always guaranteed in the international department that English will be the language that you get. Getting through and getting answered because they are out and about on the wards – some do carry bleeps – some carry contact phone numbers – but sometimes you just cant get through – and again you know they're on the phone and they're engaged and you cant get through so again it is a bit hit and miss.

It delays making necessary judgements or calls on the work – in public hospitals in spain you are not normally concerned at the level of care but it may delay getting the information as to what the diagnosis is, what the treatment is and when are they going to be discharged – when they can be repatriated…so it causes delays rather than…it doesn't, I don't think it would cause an impact on the actual patient care. Patients always mention the language barrier – because it is again hit and miss and particularly English people they are not normally…encouraged to try to speak a different language…it is a very arrogant thing that they think everybody should speak English when in fact they are in Spain and there is no 'legal' requirement to speak English, its not their native language but the English expect Spanish people to speak English.

How would you compare the two public healthcare systems in Spain and England with respect to these linguistic services?

Big difference, It is better in Spain because they are more geared to tourists and foreign nationals – particularly in high tourist areas – they expect to have a certain amount of non-spanish speaking patients – the UK don't have any facility – make very limited facility because they expect 99.9% of all patients to speak English.

What do you think about using non-registered or untrained translators and interpreters? Can you notice a difference between trained and untrained interpreters?

Um yes, because of the nature of what we are asking for – so it is okay to have conversational Spanish but we're asking for very intricate medical information – they don't understand, even if you asked them in Spanish – they may not understand what you're asking for so when you ask in English they find it difficult, they have difficulties then knowing what the Spanish equivalent is or the relevance of it – we don't expect them to interpret the results but they don't understand what is it that you are asking for even if you asked them in Spanish.

In the office – yes can tell the difference between trained and non-trained interpreters. Only again because you can have naïve Spanish speakers and very good English speakers only conversational – but ask them a medical question and rarely do they know without having worked here or in another assistance company – favourable to have someone specifically trained in healthcare.

How important do you believe training in this field to be? Why? (Would you consider an Ethics code to be important in this field?)

Yes it is important – yes to ethics code – because youre also not only…data protection and confidentiality, we are governed in the UK by things like Caldicott and Clinical governance which I would imagine, I don't know, being still within Europe, Spain would have to have the same so it is important that information – they check because you know anyone could ring the interpreters line and say "I'm from the medical team" – I have never been asked to prove who I am when I ask and then they will give me medical information over the telephone – there is a level of trust with common hospitals but you can just ring up and get medical information without any form of data protection.

What experience do you have working with interpreters and have you received training regarding working with them?

No.

With respect to the England and Spain, do you see any changes taking place in these areas in the future? Why? (note. Brexit is on the horizon, do you think this will have any impact?)

I haven't noticed, well not from the interpreters service – but there are, there are a lot – there are more English speakers – native English speakers who have gone to spain to improve their Spanish who are working as interpreters – there Is only I know in Son Espaces – but they are not, it may well be a move – I have nothing to base that on… they went to improve their Spanish but again they didn't have a medical background, so they have gone to improve their conversational Spanish but in fact they are working in an environment that has its own language.

Do you have any suggestions on how these provisions and services in each country could be improved?

From our point of view, if we had requests for medical reports , ITU templates, if we could send already translated documents that we had written – so we have the English version and it is translated into Spanish so that people can see what it is we want without having the

language barrier and necessarily having to speak over the telephone and you know and make an on the spot judgement – I either know or I don't know – whereas if we could send pre-translated requests for information it would be good, particularly with things like repatriations when you want to get discharge medical reports, scans, xrays, drugs, things like that. The escorts carry them but we don't get send them and in fact quite often you get to a particular public hospital and they have no idea – still language barrier on arrival - nurses and doctors have Spanish requests for what they need but that should have gone beforehand - for patients like ITU patients to get all the information you need in a day – that is a lot of information and people are too busy to do that – I wouldn't want to to that even in England – we've got an ITU template but it is in English – I think if it was translated and you send it – it doesn't need a doctor – it could be a nurse – other people can fill in the information without breaching data protection and then you would get the information better – whereas if you send it in English again it is a very arrogant thing to send all requests to a foreign language in English – at the end of the day you want the information so if you can ask – and whilst it takes a bit of time to do it initially it could save hours and hours in the future if you actually…we've got several things that we send that are all in English and as I say it is very arrogant to do that.

Interview E

Profession (where do you work, what position/speciality, years of experience):

I am a registered nurse in the UK, I have done an Aeromedical diploma, I've done a counselling and hypnotherapy diplomas which overlap slightly into what I do and I have been a nurse over the last 50 years and I have had experience in all sorts of different fields including Accident and Emergency, Surgery and Cardiac and Orthopaedics, I could name a lot of other things but those are the main things.

Do you currently or have you worked for the NHS (where, what position/speciality)?

Yes previously.

What languages do you speak and to what level?

I speak French at very basic level and I can read the Latin languages basically, Spanish, Italian.

Can you give me a brief explanation of your role working internationally for insurance?

My role is to act as an intermediary really between the patient overseas and the insurance agents in the UK and to that end what I do is to seek medical information, interpret medical information from the point of view of what we are going to do with that information and use it to assist people who have got medical problems abroad – so that I am trying to give them the best and safest assistance we can medically but also one of my roles there is to contain insurance company's costs.

What experience and type of communication have you had or do you have with Spanish public hospitals?

As little as I possibly can because I don't speak Spanish and in Spanish public hospitals very very often they either wont or don't speak English adequately. If it is a Spanish State

hospital I will do everything I can to get somebody else to speak to them because even if I can speak to a treating doctor for example in a Spanish hospital whose English might be very good the difficulty for me to get through to that doctor, past the reception and telephonists etc can be very time consuming and quite difficult so I rely on the people who speak Spanish around me, that might be a doctor in our case or it might be the operations team to get through to a doctor who speaks English.

- **In UK:**

What current translation or interpreting provisions are you aware of being used by the NHS in the UK?

I am not aware of any. The last NHS work I have done was many years ago so I am not familiar with how the NHS works in terms of interpreters, I am only familiar with occasionally we might get a foreign patient in a UK hospital and I know that in some hospitals particularly the bigger hospitals, the teaching hospitals they will get somebody within that hospital to speak in that language for that patient but how that works and how widely available that is and to what level of expertise I've got no idea.

Are these official services? And are they always used? What about family members, hospital staff etc?

Has this changed in recent years or since you started working for the NHS?

How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

- **In Spain:**

What translation and interpreting provisions, if any, do you find in Spanish public hospitals?

Limited – just talking about State hospitals now – I mean I think in some of the state hospitals where we've got patients going regularly in Spain because there isn't a private facility close by for example, and we've got tourists going there regularly I…you know sometimes will, we'll actually speak to somebody who is, by job allocation, has got a designated role to help and to assist and interpret and that we do come across sometimes, and that is really helpful and really good. My problem is, is that I am not really aware of what that person's capabilities are and we've got the same old problem all over again and the same does exist with private hospitals in Spain that is all very well being able to speak Spanish and English fluently but whether you have got the knowledge to understand the medical side of things added to that, that's always a great big problem even when there are dedicated and designated interpreters…it's a question of just translating Spanish to English or English to Spanish – it's always the problem (lack of medical knowledge) so sometimes I might here – get a Spanish

speaker to speak to a Spanish doctor with me sitting next door to them so that I can actually give them English questions which can be translated – I will then hear back from our linguist the answer so I can then put in the appropriate next question so then the translator is acting more safely as an intermediary rather than trying to interpret actual medical information which can get very difficult.

If nil, who helps with communication with these hospitals? Family members, hospital staff, staff in UK insurance office?

Occasionally (family members), yes occasionally that happens but I would say that it doesn't happen very often but then the difficult that one has then is that is a subjectivity involved of the family member and so you are never quite sure that you can totally rely on what is being said or what the treating doctor is being urged to recommend.

How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

I think the problem is that there are often delays because it is difficult for us to get hold of the treating doctor and because it is a state hospital and their attitude is very much "why should we give you information" – you know "you're not paying for it – it's not a private facility" so you know I am far too busy as a treating doctor, surgeon particularly, to be spending time speaking to some assistance company in the UK – so therefore, because that channel isn't as open as it could be then there are delays in helping the patient in getting home and those delays can have effects on their treatment and their recovery sometimes – if we had the information quickly and accurately things would be different, but we do – I certainly take the view that in, as far as I am concerned here, I can only act on the information that I have – I am not the treating doctor, I can't see the patient so I have to rely on the snippets of information sometimes that I get and act on those and that might be wrong and that can sometimes be wrong so that you get a treating doctor wanting to get rid of the patient quickly because it is a state hospital but in actual fact they might not be fit to fly or we haven't had the right advice about how they come home.

How would you compare the two public healthcare systems in Spain and England with respect to these linguistic services?

What do you think about using non-registered or untrained translators and interpreters? Can you notice a difference between trained and untrained interpreters?

Yes, a significant difference – much more confidence and the preparedness to question the treating doctor more: "I don't quite understand what you have said – can you explain that to me?" – whereas somebody who isn't familiar with this side of things is too sometimes intimidated by a treating doctor who is in a hurry and realises he is not speaking to a medically qualified person.

How important do you believe training in this field to be? Why? (Would you consider an Ethics code to be important in this field?)

It would be hugely useful to have specialised training but it is quite difficult – I think it would be quite difficult to work out to what level the interpreter was expected to understand

medical problems, I mean it is difficult enough for us on the medical desk and our experience is very broad and our medical knowledge is very good to do this job – even so we sometimes treatments that are different, we find it difficult to understand what is being told to us because the name given to something is different in Spain than it is here so…our knowledge has to be as encyclopaedic as it can possibly be – to what extent should an interpreter understand in order to be useful…I would think that would be difficult.

Ethics…that's a difficult one really…it is all to do with honestly recording and passing on the information that you are competent to pass on, it would be very easy for an interpreter to assume what they have understood and then there are ethical issues with that…

What experience do you have working with interpreters and have you received training regarding working with them?

With respect to the England and Spain, do you see any changes taking place in these areas in the future? Why? (note. Brexit is on the horizon, do you think this will have any impact?)

I am not sure that it is going to make that great a change, I am really not you know I – my views about Brexit are that at the end of the day we are not going to notice in this particular area any great change at all – I very much doubt that Spanish hospitals are going to invest in a whole medico-legally acceptable interpreter training because of money it is all down to money and you know more and more people are travelling every year, more and more people are pushing on to state hospitals that should really be used for the local population and the state hospitals want to get British people out so I can't see them investing in this particular thing, why should they?

Do you have any suggestions on how these provisions and services in each country could be improved?

Well, I mean to have at least some sort of basic – so that every state hospital, certainly in a tourist area has somebody who is designated to speak to people like us in order to give better care and better planning for the patients that they've got but you know it is a question of money, it's always a question of money.

Interview F

Profession (where do you work, what position/speciality, years of experience):

I have been a critical care nurse for 10 years, I work in private medical assistance, I've worked for the government, I still work for the NHS.

Do you currently or have you worked for the NHS (where, what position/speciality)?

Yes – in critical care.

What languages do you speak and to what level?

I am a native English speaker, with some French and Spanish, but to a very rudimentary level.

Can you give me a brief explanation of your role working internationally for insurance?

We manage cases of people with private medical insurance who are either ill or injured abroad, arranging their care locally, monitoring their care locally, including speaking with hospitals internationally, reviewing medical reports which are sent to us in written format and liaising about the safe repatriation or discharge of the patients.

What experience and type of communication have you had or do you have with Spanish public hospitals?

Dealing with Spanish public hospitals is very difficult because despite the level of Spanish spoken by an English medic, though that is not to a great level but the sort of language, they are quite resistant to speak to us and even if they speak English they would be quite resistant to it – they would much prefer to speak to a Spanish native, a native Spanish speaker and that is apparent.

- **In UK:**

What current translation or interpreting provisions are you aware of being used by the NHS in the UK?

Most translation that's utilised within the NHS is not professionally done in that the NHS is – the people that work for the NHS are so multicultural that you generally use other people working there in whatever format so not necessarily medical to do basic translations for you and there's an international workforce so you can often in a large trust, get any language you want. The only formal professional use I have experience of is Language Line which is a telephone translation service.

Language Line: Not very instant – there is generally a delay on that and you will sort of book an interview in – so you get a prompt response but you would then have to book to have a translation service available.

Are these official services? And are they always used? What about family members, hospital staff etc?

Hospital staff used (as above). Family members – yes. Where there are family or friends – anybody socially who may speak, have a better standard of English – you'd use those.

Has this changed in recent years or since you started working for the NHS?

Not really, not beyond the general changes and provision is very tight and resources are few and far between – increasingly so – and you're encouraged where possible not to use a fee-paying translation service but you have to use whatever is required at the time – because I work in critical care, it is often not acute in that the team responsible for a patients care will do whatever is in that patient's best interests and they may not, whether they are native English speakers or not be capable of giving consent or information except for just due to the nature of their condition – family members can be utilised but where is it somebody foreign – they may

not be available, they may not if they are English, I have spent a lot of time in a burns unit and the demographic of patients you have there means that it is often very difficult to either give or get information from a patient and there may be nobody socially around so in that kind of area it's not always hugely different according to language but …at some point language can become an issue and that can be very difficult.

How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

It is difficult – but possibly slightly less so in that where you have a patient with no English they are generally living and working in a country where they don't speak the language at all and so it is not always beyond their day-to-day life though obviously it is such a key and important issue – it causes more anxiety – I am sure they are used to experiencing the language barrier.

- **In Spain:**

What translation and interpreting provisions, if any, do you find in Spanish public hospitals? Does it differ greatly from the UK?

None. The only options we have are utilising Spanish speakers based here in England that we work with.

If nil, who helps with communication with these hospitals? Family members, hospital staff, staff in UK insurance office?

We try to use them but it can be quite difficult having a medical conversation with somebody completely untrained and also who is emotionally involved in the situation – that's not always helpful – sometimes close relatives or people who care about the patient can be the worse people to converse with in any language. There is a very strong bias, there is a lot of anxiety, there is a lot of upset so any conversation is very emotionally driven, that's true even without any language considerations across the board in healthcare, it can be very difficult conversing with loved ones.

How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

Yes, definitely, there is often a conversation that patients particularly want to have about having treatment abroad vs coming back for treatment – we would have strong recommendations in many ways which is based solely on the safety of the patient so certain things should be treated locally prior to transfer because the condition could be destabilised by the transfer if not – If the patient isn't stabilised pretransfer – so it is difficult not being able to have that conversation because they're facing a language barrier – they and loved ones are often very keen to come home because they don't really understand what is happening to them even though that might not be in their best interests. There is also a lot of fear of the unknown and many people, though they travel to countries abroad, have quite biased views of healthcare abroad and so managing patients and ensuring that they receive the best care has to be based solely on conversation and that can be very difficult in those circumstances.

Repats: It's much better when I am in the hospital, more commonly in countries like Spain we would – they would be in private clinics and predominantly because that is where they are taken – ambulance services have a bias for taking British people to private hospitals where there is need for acute care – are a receptive to that and they tend to stay there so more repatriations are done from private clinics and you can converse freely with those private clinics and obtain all the medical information you need – language skills there are good. That said, even in public hospitals, when you are there, you can have access to medical reports etc because we are used to seeing them even without any fluent command of the language – we can, I would say all our medical staff – can review a medical report in Spanish.

How would you compare the two public healthcare systems in Spain and England with respect to these linguistic services?

Formal interpretation services in the UK aren't great, I haven't really seen any in public facilities in Spain, and that may just be that there is far greater access to private healthcare in Spain and certainly a bit of – it is preferred locally for foreign patients to be utilising private healthcare rather than public healthcare.

What do you think about using non-registered or untrained translators and interpreters? Can you notice a difference between trained and untrained interpreters?

Yes you definitely can though again medical care should and gold-standard care would be based on a conversation – so it is not just relaying of information but for each piece of information given you would generally – that would just produce more questions so we need to be able to converse rather than just review a medical report or just be handed information – it's very contextual as well so things can be missed quite easily when you are not able to that – when it is just somebody offering a direct translation given to me.

How important do you believe training in this field to be? Why? (Would you consider an Ethics code to be important in this field?)

I think absolutely it can only benefit patient care to have somebody that is trained, knowledgeable and experienced in healthcare – working in medical translation.

Ethics? Yes. Because as I say so many things are contextual and it is very difficult if somebody perhaps who has language skills but no medical knowledge will then maybe make assumptions that aren't correct based on a direct translation.

What experience do you have working with interpreters and have you received training regarding working with them?

No.

With respect to the England and Spain, do you see any changes taking place in these areas in the future? Why? (note. Brexit is on the horizon, do you think this will have any impact?)

Yes. I think and already we are starting to see the signs that resources are very tight both in the UK and abroad but because … CUT OUT…I think that Spain in particular would prefer foreign nationals to use private healthcare and utilise their interpreters rather than accessing public healthcare although currently they still have a right to and treatment that can be delayed will be and people will be encouraged to return home for healthcare.

Take 2:

Yes I do, I think in Spain where resources are already tight in the public healthcare it means that there will be even more encouragement for patients who don't speak the language to seek medical care, either privately and pay or have insurance companies pay, or even return home for further treatment and the patient experience will be made far more difficult as a result and necessary care may not be there – I am not suggesting acute care won't be offered but where it is safer and better for people to receive immediate care there – they will be encouraged to go back home to seek care. Less likely to improve public sector as more likely to send them elsewhere. And I think across the board funding in private (PUBLIC?) healthcare in all countries is very very difficult and there will be less inclination to treat people certainly in longer term care locally – even though that might be better, people will be encouraged to leave, to seek definitive care in their country of origin even though that may not give the best medical outcome.

In England: I think the same thing and I think also there is a huge bent now where people are very concerned, it's very political that people may be accessing free care here that they are not fully entitled to and again people are being – they are looking much harder at what care should be available for people and finance is becoming far more key and could perhaps overtake good patient care.

Do you have any suggestions on how these provisions and services in each country could be improved?

I think that it could have been useful, but we may have missed the boat a bit if it became an EU wide policy because the same resource could be utilised by all countries so if there were an interpreting service and people were either bi or multilingual that could be utilised for foreign nationals in the UK or UK nationals in foreign hospitals and it could have been a European wide initiative – whether that is still possible, I don't know – but that would have certainly helped with patient care and made cost savings for all countries involved.

Interview G

Profession (where do you work, what position/speciality, years of experience):

Children's nurse at Ashford's and St. Peter's Trust and qualified since October 2016.

Do you currently or have you worked for the NHS (where, what position/speciality)?

Currently working for NHS – as above.

What languages do you speak and to what level?

English… to an okay level I guess (joke).

Can you give me a brief explanation of your role?

At the minute, I work on a children's day unit which does day surgery and transfusions and things like that.

- **In UK:**

What current translation or interpreting provisions are you aware of being used by the NHS in the UK?

There is the "Intrans" service which is the 'over-the-phone' one which I have seen used a couple of times but I have also seen staff members being used.

Are these official services? And are they always used? What about family members, hospital staff etc?

Intrans is the official service. I think sometimes in emergency situations they will use family members but a lot of the time also with the children, the children tend to translate for their parents – the children are at school and can speak better English.

Hospital staff: Can be anyone really, I have seen cleaners being used because we needed something to be done then and there and we knew she spoke the language that we needed.

Context of using staff: for official things like consent and things like that for surgery – It needs to be…they wouldn't let it be a staff member, it has to be through an interpreter or through Intrans, whereas if it is just relaying messages – less formal things…

With regards to family members, it depends on the situation, because you never know that they are going to be translating it the right way or they're just sugar coating it or saying something completely different. Then you have the issues around domestic violence and if they can completely lie and say something completely different to what the patient is actually wanting to tell you –(can't guarantee accuracy).

How do these provisions (or lack of provisions) affect your work and does this impact the patients? If so, how?

What do you think about using non-registered or untrained translators and interpreters? Can you notice a difference between trained and untrained interpreters?

Not sure entirely I think, sometimes the non-trained people aren't necessarily going to know the words that they are translating, if it something medical they are not really going to know or understand what they are saying so if the person has any questions, then it might be harder.

How important do you believe training in this field to be? Why? (Would you consider an Ethics code to be important in this field?)

I think so because you need to be able to understand almost what you're saying, because if it is said slightly differently, it could mean a completely different thing. Yeah I think an ethics code – because then you've got a similar…like all the rules we have to follow with like confidentiality and making sure you don't…that you are bound to something…that you cant then discuss it with someone down the pub.

What experience do you have working with interpreters and have you received training regarding working with them?

No and no training in how to request the interpreter – number on the website. Any staff member can request an interpreter.

With respect to the England and Spain, do you see any changes taking place in these areas in the future? Why? (note. Brexit is on the horizon, do you think this will have any impact?)

Not really heard anything at the minute but I don't think…a lot of it…I don't think it will affect it that massively to begin with because I think a lot of the people who already work there shouldn't be affected as much, so you are still going to have the people in the trust who can speak all the different languages. Usually the hospital staff who speak other languages are native from that country, not sure if have any relevant qualifications, but it's just their language.

Do you have any suggestions on how these provisions and services in each country could be improved?

I think the thing that stopped people using the interpreters is if we don't know that we are going to need an interpreter because a lot of our stuff is planned stuff, yet we still…when it is booked they should book the interpreter as well instead of trying to find one last minute when you've got surgery booked at half 8 when they only arrive at half 7 – trying to then get it within the hour is quite hard to then find the right person…if you've got a planned appointment and you know they don't speak very good English or their English is not their first language then its planning for that in advance.

As a student, we had interpreters – there was a couple of times where we would use interpreters – actual interpreters actually came in – I think they find Intran hard sometimes because you need a two phones, or you need it on speaker phone which you obviously can't do in the middle of the room when there is loads of other people because it is not confidential then.

There aren't many delays with Intran but with the interpreters you to have plan when they are going to come in and make sure the family is there at the same time – it's the logistics there but sometimes we've had them on the unit so we have quickly borrowed them for someone else whilst they were there.