Public Service Interpreting and Translation (PSIT) as a Social Integration Tool

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ABSTRACT

Interpreting and translation are an essential tool for the social integration of linguistic minorities, especially in public services, where they are a fundamental means of overcoming miscommunication between professionals and users. The purpose of this paper is to provide a case study of PSIT (Public Service Interpreting and Translation) in Spain from a pragmatic perspective in order to gain new information about specific linguistic minorities and to understand the barriers which are causing communication problems.

At the Universidad de Alcalá we have carried out the design, coordination and monitoring of a team of healthcare mediators (PSIT). Our study is based on the hypothesis that mediators are essential for the proper development of intercultural communicative acts in contexts such as those that concern us, translation and interpreting being in most cases the only means of breaking down communication barriers. We analyzed surveys carried out on health professionals and patients in order to specify the type of difficulties encountered in their quest to improve communication between interactants.

KEYWORDS: healthcare, immigration, intercultural and interlinguistic mediation, interpreting, multiculturalism, PSIT

1. Introduction

In Spain, the process of migration which began in the late twentieth century has generated a set of new concerns which include the integration of the various immigrant communities in the host country. The arrival of large numbers of people from different countries, with

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different languages, cultures and traditions involves radical changes in the host society. This new multilingual and multicultural reality very often creates problems between the local population and immigrant communities in every day communicative situations, amongst which are their interaction with public services personnel. In many cases, professionals and users are not aware that a communication problem has occurred and that a barrier has been built, thus making it difficult for understanding to take place.

One of the main objectives of Public Service Interpreting and Translation (PSIT) is to promote social cohesion, autonomy and social integration of minorities in order to build a common framework of coexistence among people of other cultures/languages and personnel working in public service contexts. Miscommunication can occur in many different contexts, but it is more frequent in multicultural settings (Taibi 2011) and it is sometimes difficult for the parties involved to be aware of the type of problem which is impeding a correct understanding, thus generating a lack of trust. Furthermore, when the respective native languages of the speakers are different, linguistic competence is normally identified as the communication problem, whereas the fact that different origins not only involve different languages and traditions, but also different cultures and thus very distinct ways of perceiving the world and expressing feelings is not normally taken into consideration (Berger & Luckmann 1972; D'Iribarne 1989).

Hall (1983) defines culture as the sum of an individual's learned behaviour patterns, attitudes and material things, which is often a subconscious, invisible control mechanism operating in our thoughts. Thus, we do not become aware of this until we are exposed to a different culture. Furthermore, perception of other cultures is one of the main factors underlying intercultural miscommunication (Ting-Toomey 1999). According to Hofstede (2010), culture relates to the way societies view themselves by comparison to other societies and, in turn, individuals' attitudes and behaviours towards other cultures are affected by their own cultural values. It is thus sometimes difficult to understand people from different cultures and what is often perceived as linguistic miscommunication may in fact be cultural. Pragmatic acts and the use of language may differ substantially from one culture to another, between people who share the same language but a different cultural background, even if the same language is spoken, for example, in the case of individuals from Spain and Ecuador (Pena 2015) or from North America and Britain. In public service encounters, the host country worker (doctor,

administrative staff, etc.) in an intercultural setting will be exposed to issues of this kind of which they are generally not aware.

In face-to-face encounters, nonverbal communication is fundamental to understanding each other, an issue which has already been discussed by many researchers (Ekman & Friesen 1971; Elfenbein & Ambady 2002; Matsumoto, Kasri, & Kooken 1999; Rosenthal, Hall, DiMateo, Rogers & Archer 1979). Interpreting and translation are not just about the transfer of the language itself. Nonverbal communication as well as the use of language, its pragmatics, and its social and cultural conventions are of an equal level of importance to the translation of the linguistic component. Intercultural translation therefore represents a much more difficult task for the translator or interpreter, who has to act as a cultural mediator between different civilisations and needs to be trained in order to carry out this task successfully. In addition to linguistic equivalence, we also find functional equivalence and cultural equivalence, which are factors that need to be taken into consideration when linguistic signs are translated into another language. Accordingly, "translation, understood as effective communication, becomes then the very key to survival in a global world constructed on local variabilities" (Duranti 2001: 67).

As stated earlier, PSIT and intercultural mediation provide a tool which allows communication between two parties. Through the mediation of a third person, who is not only completely fluent in the languages involved but also in the cultures concerned, language problems and cultural barriers that arise in interactions between people with different customs, traditions, system of values and communication patterns can be solved (Ortí, Sánchez and Sales 2006).

In the context of healthcare, communicative and cultural difficulties, such as doctors and patients not sharing the same view of Western medicine, can impede the work of health professionals, in many cases affecting the health outcome for the patient. This can take place between speakers of the same language if cultural differences arise. However, beyond cultural differences, comprehension problems arising from the over-use of specialized terminology by doctors, and limited knowledge of the same by the patients, are further amplified when the latter do not speak the language of the host country (Pena 2005). We are

therefore confronted with cultural, ethical and ideological differences on the one hand and linguistic problems on the other.

The role of the interpreter and cultural mediator is a response to these communication problems. It must be noted at this point that the use of the term "intercultural and interlinguistic mediator" in Spain coincides and overlaps to a large extent with the English "Public Service Interpreter" (PSI) and "Community Interpreter" (CI). However, the historical tradition for this role in Spain is quite different to Anglo-Saxon countries. In recent work by Baixauli (2014), the English terms PSI and CI and their definitions are used to define the Spanish term which combines both: *mediación interlingüística e intercultural en el ámbito sanitario (MILICS),* which he equates with the most frequently used term *traducción e interpretación en los servicios públicos (TISP).* In health contexts in Spain, the interpreter and cultural mediator is a professional person who not only interprets and translates in the interlingual sense, but who also mediates in intercultural settings. Poor financial conditions have led to low wages, reduced training opportunities (which now include only the University of Alcalá's master's degree[2]), a very few short training courses and a large amount of voluntary work. This in turn has damaged official recognition and awareness of this professional role by institutions and hindered the implementation of interpreter services in health centers and hospitals in Spain. These shortages have forced users to turn to friends, family and even their young children to communicate in healthcare settings, as Valero (2001) explains in her study of the poor quality of linguistic communication in health centers as anongoing problem that continues despite the progress made in recent years in the professionalization and training of healthcare interpreters. Since Valero's article, further cuts have taken place, with a resulting, almost entire lack of interpreting services of any kind. Thus the creation of "InterMed", a nationally accredited research project (Ministerio de Cultura y Competitividad, Proyectos I+D+i, Ref.: FFI2011-25500) whose main aim is to provide new advances in the study of the interlinguistic and intercultural interpreter/mediator/PSIT in the area of healthcare, and to contribute to professional and institutional recognition. It is essential that professional interlingual and intercultural mediators are hired by public institutions as they are the only professionals who can combine

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both cultural and linguistic differences and mediate them in order to achieve effective communication.

Regarding research, there is not much literature specifically on translation and immigration by health professionals. However, the few articles where this issue arises consider the provision of further information and explanatory documents for immigrant communities (Tejero 2007) to be of fundamental importance. The existing literature tends to deal with the effects of interpreters who interpret between Spanish and English, and it is interesting that researchers working with non-Western groups advocate an increased role for interpreters (Charienza 2012) as well as for different forms of intercultural mediation (see Kaufert & Putsch 1997: working with Inuit and Indian groups; Arnaert et al. 2006: working with Inuit; Verrept & Louckx 1997: working with Moroccans; Deumert et al. 2010: working with South-African isiXhosa-speakers). Different communities may clearly need different types of mediators.

PSIT is essential for the proper development of intercultural communicative acts, as a social integration tool to help linguistic minorities. With regard to the need for further specific case studies in this area, we analyzed surveys carried out on health professionals and patients as well as the work of PSIT mediators in Spain in order to specify the type of difficulties encountered in their efforts to improve communication between interactants.

As we have seen, cultural differences are among the most important communicative problems. We must remember that the concept of culture is broad, and many aspects come into play in this configuration. As stated by Tylor, culture is a "complex whole which includes knowledge, science, arts, morals, laws, customs and any other capabilities and habits acquired by man as member of society" (1977: 19). We wish to emphasize, first, the idea introduced by the sociologist Durkheim (1994: 1895), that culture is a social phenomenon which involves a long process of acquisition. In other words, these patterns of behavior and thinking are external to the individual. Hence, whoever is suddenly thrust into a new cultural system requires someone to act as a bridge and facilitate the learning process for those preset ways of acting, thinking and feeling, all doubtlesstly necessary to integrate fully into the host society. That integration, as reflected in the "Common Basic Principles for integration policies for immigrants in the European Union", is understood as "a dynamic two-way

process of mutual accommodation by all immigrants and residents of member States" (2004). We should thus deal not only with rights and obligations of immigrants but also with the need for authorities to manage the phenomenon. Accordingly, the means (i.e. resources and tools) and human capital should be provided in order to respond to the various economic, work, education, and health issues arising from contact between different cultures. Otherwise, immigrants risk being left out of this new network into which they ought to be incorporated.

In most European countries, immigrant populations which succeed in accessing the labour market are poorly paid and socially marginalised. The fact that these people are subject to greater risk factors directly impacts on their health and that, in turn, negatively influences their living conditions. Now, if integration is to be adequately organised, intervention measures should be taken to reduce the affective-emotional cost resulting from migration. These measures should ensure access to health services and family planning, promote healthy leisure habits, reduce school failure and promote communication. To ensure that these measures are carried out, the provision of resources and social instruments, such as intercultural and interlingual mediators, is essential.

2. *InterMed:* working towards social integration

The fieldwork which was carried out took place under "InterMed", a nationally accredited research project (Ministerio de Cultura y Competitividad, Proyectos I+D+i), which aims to design, coordinate and monitor a team of mediators carrying out their work in different health centers in Parla, a southern district of Madrid.

Since the start of the project in 2010, an ongoing global economic crisis has been taking place, leading to cuts in social policies and new legislation. One of the most important legal changes which has taken place in Spain is access to public health for immigrants. Before the new legislation, the rights of immigrants to health care in Spain were ensured by Article 12 of the Organic Law 4/2000[3]: foreigners who were enrolled in the Statistics Registry used to be entitled to health care under the same conditions as Spanish citizens, and thus paragraph 3 of Article 12 states that "(…) foreigners, whatever their administrative status, are entitled to services and basic social benefits." With the change of government[4] and the recession that hit

[3] Available at: http://www.boe.es/buscar/act.php?id=BOE-A-2000-544 (accessed March 2016)
[4] From PSOE (labour) to PP (conservative).

the country in recent years, more restrictive laws were adopted and Act 4/2000 was ammended by Royal Decree 16/2012 (20th April) for urgent action measures to apparently ensure the sustainability of the national health system and improve the quality and safety of its services. Under this new law, immigrants and nationals who do not contribute to the national social security system as well as undocumented immigrants are significantly limited in their access to health services which were previously available. Depending on the geographical region (Comunidad Autónoma)[5], local governments have been applying the new law according to their own criteria, so we may find regions where any individual and his/her dependants who does not pay social security taxes cannot acces medical services (including Emergencies) and regions where Emergencies is available universally but primary care is not. Immigrants are a social group which is highly affected by this, as many will not be able to access primary health care and the only health service available to them will be Emergency units – or private care, which is normally beyond their economic reach.

According to statistics provided by the Ministry of Labour and Immigration, it is clear that the economic recession has significantly reduced the flow of immigrants from different countries that are generally poorer and less developed, but has failed to stop the process completely. According to the Ministry of Employment and Social Security (June 30, 2013), there are 5,503,977 foreigners residing in Spain with registration certificates or a residence permit. An overview can be seen in Table 1:[6]

[5] The health care system may have different laws in different geographical and administrative regions (Comunidades Autónomas).
[6] Available at: http://www.un.org/en/documents/udhr/index . shtml # a13 (accessed March 2016).

Table 1: Migrants in Spain by country of origin (http://www.ine.es/prensa/np648.pdf).

Origin	2011	2007	2006	2001	Growth 2001–2011
Romania	798,104	527,019	407,159	31,641	**832,637**
Morocco	769,920	582,923	563,012	233,415	**536,505**
United Kingdom	390,880	314,951	274,722	107,326	**283,554**
Ecuador	359,076	427,099	461,310	139,022	**220,054**
Colombia	271,773	261,542	265,141	87,209	**184,564**
Bolivia	197,895	200,496	139,802	6,619	**191,276**
Germany	195,842	164,405	150,490	99,217	**96,625**
Italy	187,847	135,108	115,791	34,689	**153,158**
Bulgaria	172,634	122,057	101,617	12,035	**160,599**
China	166,223	106,652	104,681	27,574	**138,649**
Portugal	140,706	100,616	80,635	47,064	**93,642**

Specifically, in the district studied by this study, Parla, the largest number of foreign residents are Romanian, Chinese, Moroccans, Latin Americans and Nigerians.

Immigrants from these countries have different needs and communication problems, and although there are many differences between groups of different origin, without getting into further reduced groups and individual idiosynchrasies, there are many common features to all. These include a lack of resources, poor living conditions in the country of origin that may be reflected in a weak body immunity against diseases of the host country, insecurity, lack of confidence and ignorance about where to go in case of health need, among others. Reaching a stable and acceptable way of life for immigrants would result in good social and international development. In many cases, the foreign population has a medium to low level of education[7] and are not fluent in the language of the host country (Cruz Roja 2006; Informe Encuesta Nacional de Inmigrantes 2007). Therefore, to try to avoid possible communication problems, the existence of the translator and interpreter/mediator professional in different public or

[7] Reports (Cruz Roja –Red Cross- 2006; Informe Encuesta Nacional de Inmigrantes -Immigrant Survey Report- 2007, among others) have shown that Latin American and Eastern European immigrants in Spain have a similar or higher level of studies than Spanish nationals, whereas African and Asian immigrants have lower levels.

private health settings for foreign users is essential. Their role being to facilitate and ensure not only the exchange of effective communication between providers of health services and non-Spanish speaking users, but also intercultural mediation considering both verbal and nonverbal aspects of communication (gestures, etc.) and other specific points which are essential: cultural, social and economic information about the health system involved.

3. Project implementation and research methodology

As part of the field research for this project, a translation and interpretation service was set up at four primary health centers in Parla, a southern district of Madrid. This service was formed by three trained professional interlinguistic and intercultural mediators (all hold a master's degree in PSIT) in the languages which were identified as the most widely used in our working context: Spanish and Chinese; Spanish and French; and Spanish and Romanian/English. The Spanish-Chinese mediator is Spanish and works interpreting from Chinese; the French-Spanish mediator is also Spanish and interprets from French; and the Romanian/English mediator is a Romanian living in Spain since she was a child who studied English at undergraduate level and holds a master's degree in Romanian-Spanish PSIT. Their work consisted in translating and interpreting into those languages whenever difficulties in Spanish arose in diverse everyday communicative situations. In addition, they collected data for research, mainly through the implementation of user surveys and recorded medical personnel and mediation interventions.

The ultimate goal of the project was the coordination and monitoring (daily logs, weekly meetings, recordings of interpretations, etc.) to develop methodology and training materials, which, with reference to a theoretical basis designed by the group of researchers, would be suitable for professional realities which linguistic and intercultural mediators face in their everyday work, i.e. action research. The objective is to verify the effectiveness of these adjustments cyclically, in a constant feedback process, which is common to action-research methodology. These adjustments relate to aspects of language training and communication, such as linguistic, discursive and terminological knowledge, the use of multilingual materials (glossaries, written and audiovisual), and interpreting techniques. They also affect cultural aspects, such as knowledge of the health culture, health administration, knowledge of communication patterns in doctor-patient interaction, use of materials and guides and mediation communication techniques. Action research is an interactive inquiry process that

balances problem-solving actions implemented in a collaborative context with data-driven collaborative analysis or research to understand underlying causes enabling future predictions about personal and organizational change (Reason and Bradbury, 2001). This suited our project methodology as our intention was to collaborate between research members, practical everyday work (mediators), and the training programme (the University of Alcalá's MA in Intercultural and Interlinguistic Communication, Translation and Interpreting).

Since the service was provided in four different health centers, it was imperative that the team was well coordinated and that the mediators followed a common working system. Under the supervision of the director of the project, the team organized its work following different systems according to the task type. Weekly deatiled reports and logs of the activities that had taken place in each of the centers, as well as all the translated documents, recordings and information regarding interventions were sent to the project manager.

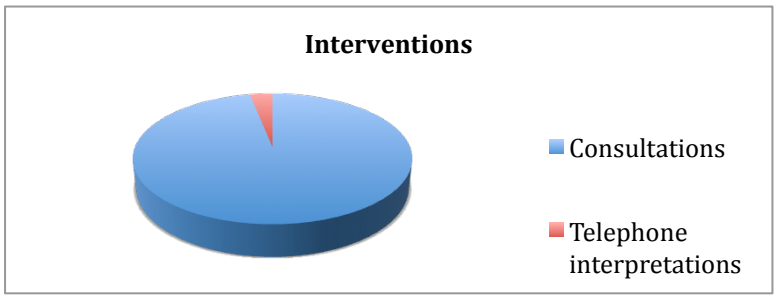
Every time an intervetion was carried out it was recorded and the mediator completed a registration of the intervention that included the date, duration, health center and place of intervention, the number of people present, origin, age, sex, user name, and type of healthcare professional concerned. It also included a summary of the content of the session and a comments section. Before any intervention, users signed an informed consent authorizing the mediator to be present in the consultation as an observer or as a performer. The user, as well as the practitioner, also decided whether authorized audio recording of the intervention was allowed.

Another objective of the research was to assess communication needs and problems of the target population in health care settings. One of the main objectives was to find out to what extent users were able to understand health professionals and adequately express themselves. In addition, we wanted to know if these users had found problems in health centers due to cultural and religious differences, and whether they had previously used an interpreting service. To obtain this information, two questionnaires were designed and mediators were responsible for conducting the surveys during the time spent working in the health centers.

4. General findings

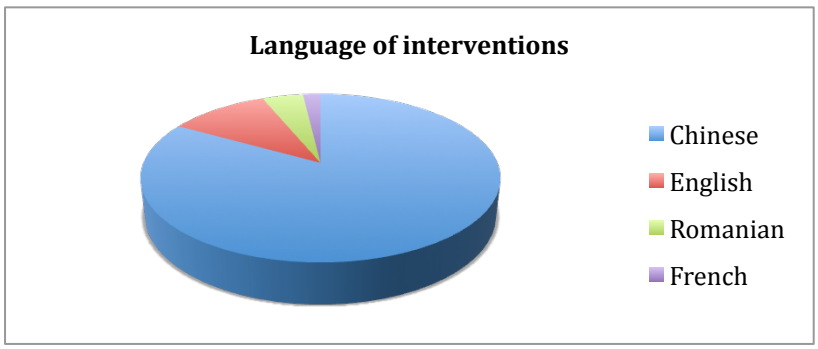
According to the daily log completed by mediators, interventions during the period under review include a total of 160 interventions, 155 were consultation performances (two sight translations) and 5 telephone interpretations. As can be seen in the following graph (Graph 1), users preferred having the mediators present and did not often resort to telephone interpreting.

Graph 1: Percentage of types of interventions carried out by mediators.



Chinese was the most used language of mediation, with 133 interventions, followed by 17 in English, 7 Romanian and 3 French interpretations, as can be seen in the following graph (Graph 2). In this paper we will give an account of the major findings concerning the largest groups: Chinese, Romanian and Nigerians (using the English translator/mediator).

Graph 2: Percentage of language use in interventions.



The translation service was requested seven times by health center staff, either face to face or by hand delivering documents to the mediator; except for a single request through the mail service. The translations carried out consisted of the following: an informative brochure about alcoholism, informational posters on blood collection times and sample collection, feeding instructions for patients, exercise recommendations for patients with back pain, patient instructions requested after a tooth extraction and after application of fluoride, a diet

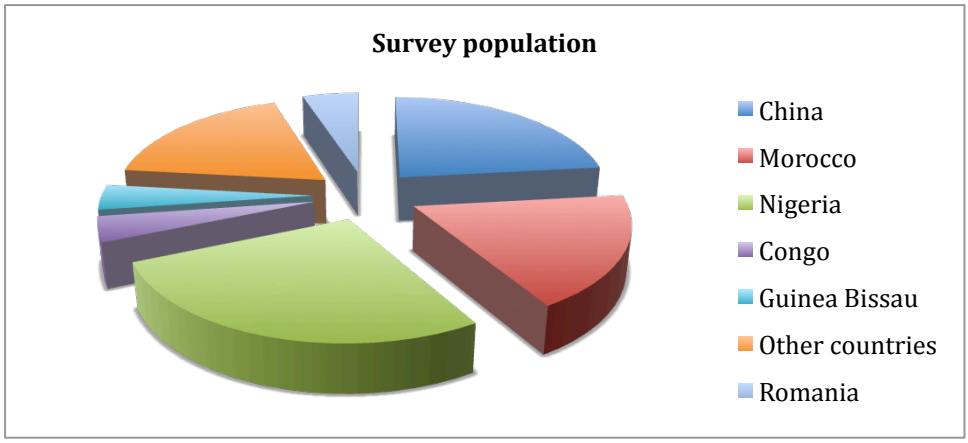
for diabetic patients, and pediatric advice and instructions. All of these documents were general information that health professionals considered vitally important to distribute to patients. Health professionals also had at their disposal different brochures and leaflets on other topics which had already been translated, either by national institutions or previous translators.

5. Surveys

Surveys were conducted in order to assess the awareness and needs of the population under study. Different surveys were used on each of the two focus groups: the user/patient group, and the health personnel group.

A total of 296 user surveys were given to users and professionals in order to investigate the exact communication needs of the target population. As can be seen in Graph 3, respondents were mainly from Nigeria (27%), China (23%), Morocco (18%), Romania (5%), Congo (4%), Guinea Bissau (4%) and other countries (18%). Most of these were patients who came regularly to the health centers, with 57% of them having visited more than 6 times during the past year. It is interesting to see that although there is a higher population of Chinese users overall, this does not coincide with the percentage of survey respondents.

Graph 3: Percentage of survey respondents by country of origin.



One of the main objectives of the survey was to ascertain the Spanish language proficiency of users. About 40% reported having an average level of Spanish, 19% low, and only 6.8% considered themselves to have a very low level of Spanish. 30% reported understanding medical personnel when they spoke in Spanish, compared to 31% who claimed to not

understand all the information. However, a high percentage of users (73%) stated that they did not understand many professionals when they used medical jargon. As for their ability to communicate in Spanish, 31% spoke enough Spanish to read efficiently, compared to 28% who only spoke and could not read or write in Spanish.

Comprehesion levels regarding documents and materials received from the health centre (appointments, forms, information leaflets, medical information, etc.) was also evaluated, with 28.8% of respondents stating that they "more or less" understood these documents, and 18.5% that they understood very little. Many respondents added that they understood documents such as prescriptions, but when a lot of medical terminology was used, as in the case of analysis or hospital reports, many had comprehension difficulties. When asked how they overcame this barrier for those who did not understand such documents, they explained that they resorted to dictionaries or people with a better command of Spanish who could explain the information to them. Users were also asked whether information leaflets and documents translated into their respective languages were available at the health centers. The finding was that 83.4% had not seen any translated documents, and only 15.2% claimed to have acquired some.

Another major objective of the survey was to find out how many users with language difficulties resorted to ad hoc interpreters (family members or friends) to help them overcome language barriers in healthcare interactions. 53.9% replied that they had never used other people to help them communicate. 17.7% had used friends, 10.6% had taken their partner with them, and about 9% had used their children as interpreters. Regarding the use of the latter, 9.2% went to the clinic accompanied by their children in order to communicate. Out of these, 58% responded that they had found no difficulty in communicating through their children, compared to 41.7 % who claimed to have experienced problems. They did not specify which problems.

Another survey objective was to find out whether users had ever requested a mediation and/or interpreting service. The results indicated widespread ignorance on the part of users regarding this service: 88.5% said they did not know any such service existed, and only 5.2% stated they knew they could ask for it but had not requested it. Only 22 people out of how many? or do you mean %? responded that they had previously used an interpreting service.

Out of these, 54% rated it as very useful, and 31% replied that it had been quite useful. Finally, in addition to assessing the language difficulties faced, the survey asked users whether they had encountered interpersonal problems with medical staff due to cultural and/or religious differences. 86.3 % said they had not had experienced any problems of this sort, compared to 13.7 % who claimed to have encountered difficulties due mainly to a lack of patience on the part of health personnel, racism, or differences between the concept of health in their home country and Spain. An important issue was the fact that 91% of these respondents were Nigerian. Many users could explain the general differences between the health systems of their countries and the Spanish health system, and they tended to praise the performance of the latter and the professionalism of healthcare in Spain.

Concerning the survey given to practitioners, in their interactions with foreign populations, 41.9% professionals stated they had found linguistic difficulties only, and 48.4% both linguistic and cultural difficulties; out of the latter, 82% stated that because of these difficulties, they took longer time in consultation with these users. According to health personnel, these communication problems made it very difficult to diagnose these patients, who also tended to discontinue treatments or not return to the doctor. As for the administrative staff, they detected these users had difficulty performing procedures and requesting appointments. Another objective of this survey was to see if practitioners were comfortable working in collaboration with interpreters. 48% had previously used interpreting services including telephone interpreting, compared to 35% who had never used any form of interpreting service.

We also sought to obtain the views of healthcare professionals on the use of ad hoc interpreters, especially children. When asked whether or not they thought proper communication could be carried out through family members or children, 44.4% viewed it as a positive thing, whereas 48.1% said it was inappropriate to resort to this. Regarding the case of children, 48.5 % said that if the user came accompanied by a child to act as interpreter, they would allow this without any problem. 30.3 % said that if the issue were sensitive they would seek outside help. Half of those who had sometimes used a child as ad hoc interpreter claimed that children who help their parents communicate do well: they are more mature than other children and master the language because they go to school in Spain. However, the other half of surveyed healthcare professionals who had used a child as interpreter considered

it wrong to use children, since there are certain issues that a child should not know, or is not able to explain, especially regarding sexuality. They also explain that this issue creates personal ethical conflicts, and that when they have no choice but to resort to minors to communicate, they are not sure if the information is successfully transmitted. It should also be noted that in terms of nationality, users who use children to communicate to a larger extent involves patients of Moroccan origin.

Thanks to the outstanding work done on a daily basis by the mediators, more and more users knew the service and requested it when attending appointments. Over 700 service brochures were distributed to members of the four health centers.

6. The Chinese community: basis for trust

The Chinese population was the largest group to use the mediation service and we therefore achieved more information. The Chinese population of Madrid is growing (over 27000 Chinese who are now Spanish residents)[8] and the linguistic barrier is obviously a very important factor in their communicative settings. However, cultural differences as well as linguistic ones were found to be highly significant regarding this community.

The cultural differences which exist between Chinese and Western societies (as researched, among others, by Garayzábal Heinze et al. 2006; Li,1999; Samovar et al. 2002; Shi 2001; Zhang 2001) in many senses (non verbal communication, medical traditions, etc.) led to strong distrust towards the mediator when the mediation service was set up. A great deal information and explanation was needed before users would decide to give her a chance and begin to trust her, i.e. to use the mediation service. Explaining cultural differences helps individuals to understand others and thus establish a communicative interaction. Word of mouth was very important, and thus information and advertising given outside the consultation room was found to be key, since the mediator had to explain the roles and functions of the service, the confidentiality and ethics elements, much more than to any other population group. Not only was the trust barrier a great issue, but also certain everyday practices like making appointments or arranging for tests constituted a high proportion of

[8] Madrid, Informe de población extranjera (Report on registered population): http://www.madrid.org/cs/Satellite?pagename=PortalInmigrante/Page/INMI_pintarContenidoFinal&cid=1142340982052 (Accessed March 2016).

daily workload for the mediator. In fact, after establishing a trust relationship with the mediator, many Chinese users did not even try to go to the Information/Appointments Desk but instead approached the mediator to ask for further appointments. Thus, the type of work the Chinese mediator had to carry out involved not just interpreting, but also helping users with appointments and other administrative issues.

Consultation times using a mediator turned out to be much longer within the Chinese community, as more explanatory information concerning the health system, how to access healthcare, or Western approaches to healthcare had to be included. Doctors complained that there was very frequently inadequate monitoring of treatment due to Chinese patients not following their recommmendations, taking non prescription medicines and, in general, using Traditional Chinese Medicine (TCM) instead, which resulted in more time spent explaining to the practitioner how Chinese people dealt with health issues.

An important element which was a problem for the mediator was the variational linguistic difference between Chinese people and herself (most users spoke Wu), as not all Chinese users spoke the standard language, Mandarin – which was the one spoken by the mediator. It is is unrealistic to expect that mediators can speak all dialects, and this often led to another family member interpreting from the dialect into standard Chinese, leading to a double interpretation which is not at all recommended in theory, but which was the only way to overcome the language barrier in this context.

Our findings show that there are two general user categories pertaining to the Chinese populaton in our geographical area but which could be extrapolated to the whole country: middle aged adults with chronic diseases such as diabetes, hypertension, and in many cases gastritis or stomach problems. And, on the other hand, pregnant mothers and their newborns. A third important group are children. Although adults avoided going to the doctor out of fear of the language barrier, they did attend much more often when they had children. Pediatric care, the same as in all population groups, is not usually urgent and includes ordinary check-ups and compulsory vaccinations. However, health professionals seemed concerned about the fact that children at a certain age “disappear”, as very often parents send their children to their home country for family members to take care of them during their early years.

For intercultural mediation to be effective, there must be trust on all sides (Bhugra, 2011: 314) and thus medical anthropology is a very important area in healthcare settings; even more so with the Chinese target group which uses a different medical approach to the Western style of medicine used in Spain (Samovar et al, 2001) due to their combination of TCM with Western biomedicine. Knowledge of Chinese medicine, its use, traditions and perceptions, is essential both for mediators and health practitioners, as this may influence the approach used in communication. Throughout the study, there was primarily mistrust regarding the mediator, but also towards the practitioners and the Spanish health system in general.

7. The Romanian community: difference in traditions

The number of Romanian-Spanish interpretations was much lower than the Chinese, and fewer results were thus obtained.

Contrary to the situation with the Chinese population, many Spanish health professionals and patients claim that Romanians learn the language very quickly and easily adapt to the host society. However, even though it is also a Western society with shared linguistic roots, there are cultural and linguistic differences that in certain circumstances can have serious consequences. Again, with interpreters/mediators in health centers, many risks both for the patient and for the healthcare professional could be avoided.

Considering one of the factors that mostly influence the culture of a population, religion, the Romanian Orthodox religion is quite similar to Catholicism. Romanians celebrate religious festivals in a similar way, but what differentiates the Spanish are the different customs related to these events. An example that can affect the monitoring of medical indications is the fasting period (1 month) before Christmas and Easter during which no meat, dairy or eggs should be eaten (Tejero, 2007).

Another case is the postpartum period, when the mother, after leaving hospital has to go straight home and not leave the house with the child until 40 days after giving birth, after a religious ritual in the presence of a priest has been performed. In this situation, doctors' recommendations to go out with the baby during the day or to attend relevant appointments can conflict with these religious or traditional customs.

On the other hand, because most Spanish Romanians resident in Spain are young (age range between 20 and 40), these practices are beginning to fall into disuse as second generation Romanians increasingly adopt local customs of the host country.

Romanian women afford great importance to pregnancy and childbirth, which makes gynecological and pediatric consultations the most common among this population group. The remainder of Romanian citizens, because of their difficult social and economic conditions, do not generally want to miss work to visit the doctor, and either self medicate or go directly to the emergency department in the case of intolerable pain. This is quite frequent in most minority groups: immigrants are usually young people who work hard in the host country and pay little attention to medical appointments or health issues if it interrrupts their working hours. Nonetheless, because of their age range they are not normally prone to health problems, and when they do occur, they tend to use emergency services (Díaz et al., 2014).

The Romanian health system is similar in structure to the Spanish one, however there is a great deal of corruption in Romania (European Commission Anti-Corruption Report 2013: 6), which, together with precarious installations, tools and equipment that doctors should use make the Romanian health system one of distrust for users and presents a continuous struggle for improvement in the quality of customer service and patient treatment. This may in turn cause distrust in the Spanish health system, when some users believe that the situation is the same in Spain. This leads to mistrust of health practitioners and reluctance to follow their instructions and recommendations. Again, as with the Chinese population, the issue of trust appears as one of the most frequently occurring communication difficulties. Knowledge of the other culture and traditions would reduce the mistrust caused by a mutual lack of information.

8. The Nigerian community (English interpretation)

The third community of foreigners who were the subject of this study is, as stated above, the group of English-speaking immigrants. As with the Romanian group, we did not manage to interview or interpret as many individuals as with the Chinese group. In general, citizens living in Madrid who have English as an official language are Filipinos, Africans, followed by the British andAmericans. But of all these nationalities, those who needed interpreting and mediation most frequently were from Africa, and mostly of Nigerian origin.

Among the most common diseases of Nigerian patients are sexually transmitted diseases such as AIDS or syphilis, infectious diseases such as hepatitis B, tuberculosis, and parasitic diseases acquired due to poor living conditions or infections from mosquito bites. Many of these illnesses are brought with them from their country of origin.

Most Nigerian people who come to Spain do not have enough information about the Spanish health system or about diseases that may occur and how to treat them or avoid getting them – especially in the case of sexually transmitted diseases. These problems are added to the fear of going to the doctor when in an irregular situation, the lack of a health card, or fear of being arrested by police and deported. Aside from these factors, the immigrants' own culture and traditional practices also affect medical acts. Traditional medicine and the practice of all kinds of rituals with charms still exist, although not to the same extent as in the country of origin.

Female genital mutilation (FGM) is another important element concerning this group. Although these operations are banned in Spain, they are not easily controlled, especially in cases of foreigners at risk of social exclusion. Often – although it is believed by authorities that the practice of genital mutilation is carried out in Spain – parents claim that it was performed during a holiday in the home country, and thus cannot be punished.

Another example of a cultural difference in the Nigerian case is represented by the symbol of blood. While Spanish doctors consider blood tests a key element for detecting potential diseases, sub-Saharan nationals sometimes consider it a rare witchcraft practice and refuse to have blood tests, which complicates the doctor's work.

9. Concluding remarks

From the study carried out, it is clear that interpreting and translation is a necessary tool for the integration of linguistic minorities, and that mediators are essential for the proper development of intercultural communicative acts in contexts such as those that concern us; translation being in most cases the only solution to break down communication barriers. Through the analysis of surveys carried out on health professionals and patients as well as the activities carried out by mediators in order to specify the type of difficulties encountered in

their efforts to find solutions to improve communication between interactants, we can see that PSIT is a necessary element of all health settings where different cultures need to communicate and understand each other.

Miscommunication often derives from a mistrust of the unknown. A lack of awareness and understanding of the "other" culture gives way to a lack of trust, and therefore to a communication barrier. As we have seen, culture is a broad and difficult term which touches on many aspects and does not only include specificities about a particular group, but also concerns the perception of other communities. Perception involves a lot of subjectivity and relies on stereotypes and generalities which may or may not apply, but which usually imply a lack of knowledge of the "other". This was found in our study in all target groups, among both users and health professionals, and also regarding the interpreter, although this was minimised when a profesional relationship was consolidated; it was then that the interpreting and translation service was very well received both by users and professionals. Users and practitioners made more use of the service as relationships between them and the mediators developed. Word-of-mouth reports of these improvements travelled fast, increasing the number of users daily and proving that a stable and permanent PSIT service builds trust relationships and increases awareness of cultural differences. Due to the number of users from each community, which is also representative of the population groups now living in Spain, we managed to find more information about the Chinese population in Spain and much less about the Romanian and Nigerian communities; however, as we have seen, there is a common basic issue in all conflicts resulting from miscommunication: that of trust.

Both professionals and users manifested a need for further translated material, as users do not have access to information and documents in their language, especially on simple instructions such as how to make appointments, how to request tests, etc. Further information and explanatory documents for immigrant communities are fundamental (Tejero 2007). In many health centers, the few translated documents that are available are uploaded to their web pages; yet there is little scope for web instruction and information as a large percentage of users are illiterate or cannot manage technology well enough. However, this does vary according to the population group in question, i.e. Romanian citizens do use smartphones, tablets and computers, whereas this is not that common for Nigerian users.

Translated material is a real and present need for health and administrative professionals, especially when there are no PSIT mediators (i.e. the typical setting). If health centers could count on a corpus of general, simple translated instructions, the work of professionals could be improved. There are translations for most academic and medical documents; however, instructions and advice for patients are not normally translated and this type of material is the one that could best help integrate minorities by explaining cultural differences concerning Western medical values and practices, thus helping to build acceptance of and trust in the host country health system.

It is obvious that there is a need for PSIT, and there is still a long road ahead, but initiatives to advance professional recognition of the interpreter in healthcare settings, and also to achieve awareness within institutions of the need to place these professionals in health centers with large foreign populations, should be implemented.

It is important to educate not only the users and the mediators to facilitate communication, but also health professionals. This is because, although they seem aware of these needs they are not accustomed to working with mediators, and they also tend to pay scant attention to cultural differences (as opposed to linguistic differences which there is much more awareness of) which may actually be the key to resolving misunderstandings or pose the risk of the patient not understanding instructions, misdiagnosis or general miscommunication.

In conclusion, as has been shown in the InterMed project, it is important to insist on universal right of access to health and to ensure respect and multiculturalism, while offering users of health services a vehicle to communicate efficiently with Spanish health workers, breaking language and cultural barriers that restrict their access to health services. It is therefore important to collect the experiences of interpreters/mediators in other health settings, to verify, as exemplified by the InterMed Project, to what extent cultural differences and a lack of awareness of these among health professionals create miscommunication and health risks for patients. If this is the case, administrations should take the necessary steps to develop this role and allow it to occupy the place it deserves.

Intercultural and interlingual mediation involves a type of interpreting that does much more than simply transmit the linguistic content, but moreover takes culture into account, adapting

linguistic content to the cultural frame of the participants. As social anthropology professor Carlos Giménez Romero states, we see that from the beginning mediation has been linked with the idea of "know-how", a dimension that has to integrate both the ability to listen (to want to) and the domain of theoretical and practical knowledge about the groups s/he is working with (knowledge). Specifically, he understands mediation as follows:

> A form of three party intervention in social situations of significant multiculturalism, oriented towards the recognition of the Other and the understanding of the parties, communication and mutual understanding, learning and development of coexistence, the regulation of conflicts and institutional adaptation between social or institutional ethnoculturally differentiated actors. (1997: 142)

Note that Giménez Romero's definition highlights what should be the objectives, principles and methodological approaches that guide social intervention programs. And it is clear that the thrust of this is interaction, always built on the basis of dialogue, discussion and cooperative action. The enhancement of interpersonal communication (intercultural interaction) depends in turn on the access to sources of information, the ability to network and the acquisition of skills and resources for collaborative work.

Intercultural mediators facilitate the correct exchange of information between health professionals and patients, identifying patients' needs and taking into account culturally sensitive issues which may have very important effects on patient satisfaction (Verrept 2008; Rocheron, Dickinson & Kahn 1988). If cultural differences are not managed appropriately it may affect the quality of healthcare (Bischoff 2003). Elderkin-Thompson et al. have argued that "caregivers may not understand the implications that particular symptoms hold for patients because the perception and interpretation of somatic sensations are frequently defined by cultural idioms" (2001: 4).

Professional PSIT need to be hired in public institutions and furthermore, they must also be trained in awareness actions, concerning the cultures they work with, which they can carry out in different health contexts, both directed towards users and health professionals. Further actions need to be taken in this direction.

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