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Do healthcare providers trust interpreters? A qualitative survey on interpreter use in a clinical setting

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INTRODUCTION

In recent decades, language barrier in healthcare has increased as international migration has seen an exponential rise, with migrants seeking medical assistance in their host country (Khoong & Fernandez, 2021). Hence, the presence of interpreters within medical settings is increasingly necessary to facilitate physician-patient communication and access to medical care. Existing literature widely supports that the use of interpreters in clinical practice leads to better patient outcomes, and this elicits positive responses from healthcare providers toward language assistance (Michalec et al. 2015; Hsieh, 2006; Silva et al., 2021).

However, within the same body of literature, it is highlighted that some healthcare providers prefer not to use interpreters or opt for other means of translation to bridge the communication gap with patients speaking different languages (Bonacruz & Kazzi, 2003; Flores et al. 2005; Lee et al., 2006; Karliner et al., 2007; Patel et. al., 2016). The reasons behind this choice are varied, including low levels of interpreting service availability and competence and general lack of awareness of the critical role played by interpreters in avoiding medical malpractice and adverse patient outcomes (Hadziabdic et al., 2010; Quan & Lynch, 2010; Thompson et al., 2013; Juckett & Unger, 2014; Ono & Jinghua, 2024).

The present dissertation aims to further investigate healthcare professionals' opinions and beliefs on employing interpreters in the medical setting by building on the body of previous research. The primary goal is to explore whether healthcare providers trust interpreters by delving deeper into the factors that influence some providers' decisions to seek language assistance and the arguments presented by others against this practice.

The motivations underlying the present study are both academic and personal. The interest in translating specialized texts stems from the educational experiences offered by my Master's Degree Program. The critical role and human impact of translating medical texts, especially when assisting patients who do not speak Italian in comprehending their reports and complying with medical advice, was the primary driving force to apply for an Interpreter and Translation position at the medical centre where the survey was administered. Several years into the position, it appeared sensible to investigate whether healthcare providers actually trusted their interpreters and what they thought of the Service available to them.

To this end, a study was conducted within a private Italian medical centre, where an in-house Interpreting and Translation Service was established to meet significant demands for language assistance during outpatient and inpatient encounters. The medical centre partners with overseas healthcare programs for the U.S. military serving on the Italian territory. With hundreds of English-speaking patients seeking medical care every year and with an equally high number of resident providers with limited English proficiency, introducing interpreters into the medical team was deemed essential by the higher management for maintaining optimal quality of care.

To determine whether providers trust the in-house interpreters to translate medical information accurately – and the reasons behind potential mistrust – a survey was designed and administered to the entire healthcare population of the medical centre. The population that was addressed encompassed 167 individuals, including internal medicine clinicians, surgeons, nurses, physical therapists, operating room specialists and radiology technicians.

The survey was anonymous and was created on Google Forms, which was deemed the best research tool for the purpose of this study due to its features, user-friendly interface and sharing settings. It comprises 22 questions aimed at profiling the providers' personal and educational background in terms of language proficiency and investigating the factors that most influenced them to call for interpreters' support on a regular basis and the reasons that motivate others to provide medical care to U.S. patients independently. The survey was circulated from May to June 2024. Upon survey time expiration, data was extracted and processed. Aggregated data analysis was then conducted, and findings were presented with complementary figures to draw a critical picture of interpreter use within the given clinical setting, specifically focusing on the providers' feedback about their trust in the interpreters they work with, as well as their opinions and beliefs thereof.

The dissertation is organized into three chapters. The first chapter introduces the topic of healthcare interpreting and is divided into three subsections. First, the definition and role of the healthcare interpreter are explored. After a general overview of existing research conducted on the professional role embodied by language assistants in the medical setting, the concept of *ad hoc* vs qualified interpreter is illustrated. Further insight into interpreter use is then provided, with adequate emphasis on the perception of healthcare providers on interpreters throughout a wide body of existing research. Cases of medical malpractice derived from misuse of *ad hoc* interpreters and evidence of better patient care secondary to qualified interpreters are presented. Furthermore, different reasons behind providers' choices of interpreter use are discussed. Specifically, four common key themes were identified among the reviewed literature: cultural diversity, awareness of interpreters' use, interpreters' availability, training and

qualification. These four themes are analyzed to draw conclusions on the views of providers on interpreters with regard to European and Northern American medical settings. Finally, the chapter delves deeper into the acknowledgement of interpreters as full-fledged professionals in Italy, with a focus on the challenges derived from the lack of national consensus on requirements and criteria language professionals would need to meet to access the medical environment. The roles of language mediator and interpreter are compared and discussed, and a brief overview of Italian regulations is presented.

The second chapter is built on four sections. The first one outlines the purpose and scope of the project. Differences are drawn between the medical center within which the present research was conducted and the facilities presented in the literature reviewed in the first chapter. Features such as immediate accessibility of in-house service, as opposed to on-call or telephone interpretation, were recognized as factors that could impact providers' decisions on interpreter employment. The research design and tools are then presented, including all the steps that led to finalizing a 22-question survey and its structure (cf. Appendix 1). The chapter concludes with a general overview of the chosen demographic with a brief focus on their native language(s).

The third chapter presents all data collected and critically outlines the main findings. Aggregated data was first analysed and then filtered by criteria such as age range and self-assessed language proficiency. The chapter is divided into three main subsections. The first one explores the data collected on the respondents' demographics: age groups, genders, fields of medical specialty and timeframe during which they were active members at the medical centre. The analysis then focuses on the questions about self-reported English proficiency, stays in English-speaking countries, and attendance at English language classes. The findings concerning the sample's profile and background

are then discussed in a separate subsection to observe evidence of any inconsistency. The third section is where the perceptions of providers towards the in-house Interpreting and Translation Service are presented. Here is where the answer to the research question "Do healthcare providers trust interpreters?" takes shape as respondents were presented with a major contingency question regarding whether or not they used the Service. The answers by users vs non-users of this service are analysed and discussed in separate subsections. Particularly, the providers who were found to seek language assistance were asked if they actually trusted what interpreters translated to and from English. This question proved essential to reach final conclusions on providers' views, beliefs and trust levels. Conclusions about users' perceptions and opinions are presented in a separate section to include considerations on the reasons that lead some providers to seek language assistance during outpatient or inpatient medical practice and on the rationale supporting independent handling of bilingual medical encounters. In doing so, final conclusions summarize the factors influencing each choice with respect to respondents' language backgrounds. Ultimately, the limitations of the study are outlined, and final recommendations on better communication practices in the medical environment are provided.

1. HEALTHCARE INTERPRETING

Medical encounters involve interactions between Healthcare Providers (henceforth referred to as “HCPs”) and patients that occur within a specific cultural, social, and political context (Michalec et al., 2015). Physicians, by virtue of their professional authority, have the power to control patients' access to and understanding of medical information. This disparity in medical expertise can lead to a sense of distance between the physician and the patient, resulting in feelings of distrust and negative attitudes (Wu et al., 2021). When HCPs and patients do not share the same language or cultural background, this communication barrier is further amplified. This pre-existing communicative gap can thus be viewed as multi-layered, with one level being the inability to effectively communicate due to language barriers, and another level being the discrepancy in medical knowledge. When medical interviews are conducted in a language not fully understood nor sufficiently spoken by the receiving end of clinical care, concerns, beliefs, and cultural perspectives are potentially overshadowed by the dominant medical discourse, creating a situation where patients’ voices are not fully heard (Anspach, 1988). This double layer of limited language proficiency paired with similarly limited medical knowledge could not only deter patients from seeking care, but also lead to HCPs’ frustrations and negative attitudes towards them. Healthcare interpreters are an important part of the solution to address these barriers in culturally and linguistically diverse medical settings.

Healthcare interpreters are professionals who facilitate communication between HCPs and patients with limited proficiency in the primary language spoken in the healthcare setting (Flores, 2005). In doing so, they play a crucial role in ensuring accurate and

effective communication during medical consultations, treatments, and surgical procedures (Hsieh, 2006). In this framework, these professionals operate along two separate yet closely connected lines.

On one hand, healthcare interpreters enable patients to comprehend critical medical information and make informed decisions about their health management plans going forward, such an understanding that patients could not otherwise achieve without the assistance of a professional dedicated to bridging the language gap existing between them and their HCP (Ortega et al., 2022).

On the other hand, interpreters are responsible for working in close cooperation with HCPs so that the information relayed during encounters is medically accurate, prompt and culturally sensitive.

Given that healthcare interpreters work with two distinct entities which do not share the same linguistic, cultural and educational background, several perspectives, demands, expectations and challenges may arise from both sides. While the patient's viewpoint is undoubtedly crucial to identify key aspects and areas of improvement in interpreting services, this dissertation aims to explore healthcare providers' perspectives regarding the role and intervention of medical interpreters. This chapter first reviews recent literature on healthcare interpreting in order to outline the role of these professionals and to provide an overview of the expectations and perceptions of interpreters operating in modern medical settings.

1.1 Definition and role of healthcare interpreters

There is limited literature documenting the very initial instances of healthcare interpreting. Recent studies argue that this practice has been emerging in Western cities over the last 25 years thanks to the rise of globalisation, migration, and the influx of refugees ultimately leading to the development of language assistance initiatives in the healthcare sector (Bischoff, 2020). Several reviews have identified the US as the most productive country in research publications on healthcare interpreting, due to its extensive federal and state legislative efforts to ensure language access in healthcare settings (Youdelman, 2013).

A relevant study on this matter is that of Bischoff et. al (2020), who identified five phases of the "service evolution". Despite its limited scope, focused the development of language assistance programs at Geneva University Hospitals from 1992 to 2017, it offers an important and informative overview of the recent history of healthcare interpreting in Europe. Initially, interpreting was considered a service targeting small audiences, i.e. mainly refugees and asylum seekers. Subsequently, due to a considerable influx of Albanian-speaking asylum seekers, the interpreters working with that language were appointed to all divisions of the Geneva Hospitals. The main objective of this practice was to guarantee high-quality care for all patients, regardless of their language skills. As a result, this action sparked further investigation into the standards of patient-provider communication. The fourth phase of this research also addressed the lack of guidelines regarding interpreters' financial support and the lack of clarification on interpreters' responsibilities. Indeed, as of today, there is no cohesive, global consensus on what is expected of healthcare interpreters in terms of level of expertise, required

skills and mandatory certification to access medical environments. (Nielsen et al., 2020).

In their 2010 study, Bischoff and Hudelson used the term "*ad hoc* interpreters" to refer to medical personnel or family members who are proficient enough in the languages spoken by the patient and the HCP, who are therefore called on as interpreters, although not specifically trained as such. Interestingly, the authors maintain that "preference for *ad hoc* interpreters has been found in a number of countries including Austria, Germany, Norway, UK, Ireland, Australia, USA, Canada and South Africa" (Bischoff & Hudelson, 2010). They explain this trend in terms of a lack of awareness of the risks associated with *ad hoc* interpreters, also supported by other scholars (Flores et al. 2005; Lee et al., 2006; Karliner et al., 2007), as they argue that "practical issues are an important influence on health care professionals' approach to dealing with language barriers" (Bischoff & Hudelson, 2010: 2842). This approach can lead to misunderstandings resulting in detrimental consequences for patients' health (Lesch, 2020).

Further literature expanding on malpractice-related risks highlights that untrained healthcare interpreters have been found to unintentionally add, omit, or substitute for the speaker's words and omit essential information. For instance, audiotaped encounters in a pediatric clinic (Flores et al. 2003) demonstrated that the errors made by *ad hoc* interpreters were 24% more likely to have clinical consequences than those made by hospital interpreters (77% vs. 53%).

Furthermore, an increased rate of misunderstanding and a longer information exchange is registered compared to using professional interpreters, due to misunderstandings requiring explanations and re-explanations (O'Donnell et al., 2007).

Additionally, untrained healthcare interpreters are not specialized in medical terminology, a condition that not only increases episodes of miscommunication but can also become the root cause of misdiagnosis and of administering incorrect drugs, leading to questions of competence or malpractice lawsuits (Juckett & Unger, 2014; Ono & Jinghua, 2024).

A study conducted by Quan & Lynch in 2010 analysed 35 medical malpractice claims to identify instances when language difficulties caused adverse health outcomes. These cases report that patients died or suffered irreparable harm, prompting the filing of lawsuits. Moreover, in 32 out of 35 cases, HCPs did not use qualified interpreters, with two children and three adults passing away. In one case, the deceased child served as an interpreter before dying due to respiratory arrest. In another instance, the deceased child's 16-year-old sibling served as the interpreter. One patient was rendered comatose, one had a leg amputated, and a child had significant organ damage. In 12 cases, of which two involving minors, family members or acquaintances acted as interpreters.

In the light of the above, it appears that there exists solid evidence and extensive research on the vital importance of qualified healthcare interpreters in medical settings. Compared to other modes of interpretation, the employment of trained interpreters is associated with improved patient outcomes (Hampers et al., 2002, Ku et al., 2005, Karliner et al., 2017). Hence, it appears ineffectual for HCPs not to push for qualified translators to be readily accessible.

One reason behind this behaviour might be the lack of official recognition of this profession and that of shared professional standards. While several university-level programs provide quality interpreting training combined with specialized medical terminology, the role of the “healthcare interpreter” is not yet subject to solid legislative

regulations requiring one specific degree and a professional license to access healthcare settings.

Another reason might be a general lack of awareness, despite literature-based evidence, and a matter of practicality. As a study by Diamond et al. (2009) suggests, specialists tend to normalize *ad hoc* interpreters due to the practical constraints and time limitations that hamper the opportunity to call on professionals. Therefore, while fully aware of the potential adverse clinical outcomes, some HCPs prioritize logistics over quality.

The absence of professional standards naturally leaves room for different expectations and viewpoints.

1.2 Existing research on the perception of healthcare interpreters

As suggested in the previous section, the reasons why certain HCPs value, trust, and see interpreters as irreplaceable medical personnel under certain circumstances while others favour *ad hoc* professionals might be several. The aim of this section is to present, compare and analyze existing studies investigating HCPs' perspectives on healthcare interpreters in the US and Europe to identify the reasons behind their communication choices. For the purpose of this dissertation, only the studies based on surveys and interviews were taken into consideration, as they share the same approach of this investigation and provide empirical evidence on case-specific choices.

In 2018, Schwei at al. conducted 11 semi-structured interviews to understand the different roles that interpreters play in pediatric limited English proficient (LEP) healthcare encounters. It resulted that HCPs considered interpreters as language conduits, flow managers, relationship builders, as well as cultural insiders. While the

first two roles of the bilingual communication facilitator can be easily guessed, these results show that respondents expected more from interpreters than mere language transmission and communication handling. As a matter of fact, building rapport between the provider and the patient was found to foster better care outcomes and a high percentage of respondents saw it possible only in the presence of an interpreter curating the bilingual exchange. However, other physicians stated that they preferred interpreters to be inconspicuous during encounters, limiting their involvement to language transmission and leaving the role of rapport-builder to the provider. Moreover, this study sheds light on the type of interpretation these respondents favored. Most HCPs wanted language delivery to echo their own speech. Indeed, the preferred method of conducting bilingual communication was translating almost simultaneously what the provider said. In this setting, only in-person interpreters were taken into consideration, but no mention of qualifications or proficiency in specialized medical terminology was made.

A study by Hadziabdic et al. (2010) suggests that, in several Swedish healthcare settings, in-person interpreting performed by a trained professional with a good knowledge of both languages and medical terminology was perceived positively. Qualified interpreters were viewed favourably due to their ability to relay information "literally and objectively" (Ibidem). Other factors influencing perception were also identified: organizational aspects, namely functioning or non-functioning technical equipment, calm in the environment where interpreting occurred, documentation of the patients' language proficiency, respect for the appointed time and, above all, the level of service availability.

A few years after this study, Michalec et al. (2015) demonstrated that US healthcare providers shared a similar experience as their Swedish colleagues. Providers' perceptions of medical interpreter's services supporting communication with Limited English Proficiency (LEP) patients were investigated in U.S. obstetrical care, including the Neonatal Intensive Care Unit personnel. This study found that while HCPs recognized the value of in-person (vs. telephonic) medical interpreting in helping them communicate with and care for their patients, they also identified several barriers. Providers reported that they often had to resort to telephonic interpretation due to a remarkable lack of available in-person interpreters, as observed by the Swedish respondents (Hadziabdic et al. 2010). While over-the-phone oral translation was perceived as "unreliable" (Michalec et al., 2015: 160), this solution was often the only one providers could turn to. Further analysis of the obstacles suggests that, as in Hadziabdic et al. (2010), the utilization of interpreting services is just a small part of the larger organizational issue. Yet, in Michalec et al. (2014), such issues encompassed the delivery of care to a culturally diverse patient population. It is believed that addressing cultural challenges, regardless of the presence of interpreter services, can have an impact on providers' capability to ensure effective and efficient care. The mere increase of communication resources was not considered enough to influence providers' attitudes, behaviours, or the overall organizational culture in relation to LEP patients.

Perception of healthcare interpreters in another culturally diverse setting was further examined by Kale and Syed (2010). Their survey-based study investigated General Practitioners' (GP) expectations of interpreters in Oslo, where 26% of the population was immigrants, which was the highest proportion in Norway at that time. The study was aimed at assessing when Norwegian-speaking GPs needed language assistance,

how they acted in such situations and their evaluation of competence. The survey was administered at primary care clinics in the city districts with the highest concentrations of non-Western immigrants. In this scenario, the use of interpreting services appeared to be "incidental and dependent on the health-care practitioner's own initiative" (Kale & Syed, 201: 190) and knowledge of how to handle a bilingual patient-provider contact with an in-person interpreter. Interestingly, many respondents were dissatisfied with their own approaches when interacting with interpreters. For instance, some HCPs were aware of their difficulties in recognizing the need for an interpreter when the patient spoke limited Norwegian, as they questioned whether having some command of Norwegian was enough and whether language support was actually necessary. Given the existing issue of language barriers in their workplace, many HCPs who were aware of their limitations expressed the will to receive training on how to effectively work with interpreters in order to learn new strategies and obtain better outcomes.

In this regard, Silva et al. (2021) demonstrated that a longer experience in working with interpreters and training in handling such interactions were associated with more positive opinions concerning the function of healthcare interpreters and better communication techniques. The survey respondents who had received this type of training exhibited higher aggregate scores, indicating greater awareness of interpretation roles and support for effective communication practices.

Another survey-based study aimed to explore HCPs' awareness when dealing with LEP patients is that of Patel et al. (2016). In particular, the study examined OBGYN surgeons' self-assessment of their non-English language proficiency levels, the relationship between self-assessed non-English language proficiency, and self-reported use of interpreters during the administration of preoperative informed consent. The

findings showed that if a professional interpreter was not available in a timely manner, surgeons used *ad-hoc* interpreters or their own nonfluent language skills to obtain informed consent from LEP patients. Even when a trained telephone interpreter was immediately available, some practitioners still reported they would favour *ad-hoc* interpreters. Additionally, it was found that surgeons would leave it to the patients or their families to choose whether to employ or not a professional. While providing insights into the barriers faced by physicians when seeking readily available professional interpreting services, these findings also reveal that some HCPs are not yet fully aware of the risks of malpractice and adverse outcomes that may come with engaging *ad hoc* interpreters. Furthermore, by choosing them, surgeons appear to consider trained interpreters as optional providers of an otherwise time-consuming service, which is overall not reliable in terms of availability, and which is thus discarded in favour of more readily available solutions.

Further insights into the perceived value of trained interpreters during outpatient clinical encounters are provided by Rosenberg et al. (2007). The study was conducted in Canada by video recording 12 encounters with an *ad hoc* interpreter and 12 encounters with a professional one. The participants' perceptions of the consultation were subsequently elicited during interviews. Responses regarding personal anticipations highlighted that physicians equally expected trained and *ad hoc* interpreters, e.g. family members and/or close friends, to translate remarks between doctors and patients into their languages. While professional interpreters were expected to act as cultural bridges as well as communication facilitators, all family interpreters were supposed to also fulfil the role of caregivers and were judged as less skilled than qualified ones. However, physicians found it more challenging to build rapport with patients while using an

interpreter compared to standard doctor-patient encounters, as opposed to Schwei at al. (2018) findings mentioned above, where rapport building was found to be facilitated by the presence of interpreters and appreciated by most of the respondent population.

In sum, this review led to the identification of four common themes impacting healthcare professionals' views on and use of healthcare interpreters, i.e. cultural diversity, awareness on interpreters use, interpreters' availability, training and qualification. These key aspects are strictly intertwined as they highlight common beliefs and perceptions but also paint a rather complex picture of interpreters' working conditions and their interactions with other health professionals.

Cultural diversity

Culturally diverse settings require special attention when care is delivered. The existing literature shows that some HCPs harbour personal biases towards patients who have limited language proficiency (Kale & Syed, 2010: 189). The findings of the studies analyzed in this section show that the participants were aware of persistent bias, and even ethnocentrism, among their colleagues. Some HCPs have declared that patients coming to their country should be able to sufficiently express themselves in their language of reference (Kale & Syed, 2010: 189). Other participants indicated concern about their lack of cultural competence when treating patients with uncertain backgrounds or coming from countries they were not familiar with (Gerchow et al., 2020: 30; Michalec et al., 2015: 163). Physicians and nurses often feared offending them, especially when patients were suspected of having substantially different sets of values. This led to a general feeling of inadequacy and frustration among participants, affecting their interactions with patients and care delivery (Michalec et al., 2015: 163).

When interpreters were not available, neither in-person nor via phone call, to facilitate this type of exchange and help providers better understand their patients' background, the former often resorted to other forms of mediation, mostly family members or, in few cases, even machine translation (Michalec et al., 2014; Rosenberg et al., 2007).

Considering this commonly reported behaviour, it can be argued that research suggest a substantial lack of awareness of the awarene, including legal risks to the hospital and risks to the patient's health and safety.

Awareness on interpreter use

Almost all studies (Bonacruz Kazzi & Cooper, 2003; Kale and Syed, 2010; Thompson et al., 2013; Patel et. al, 2016; Silva et al. 2021.) reported issues with providers awareness. Typically, physicians were unsure when to seek language assistance as they did not know how to judge if their understanding and active proficiency of the patient's language was adequate or otherwise insufficient to offer accurate and safe care (Bonacruz Kazzi & Cooper, 2003; 262; Kale & Syed, 2010; 188; Thompson et al., 2013: 1487). In one study (Kale and Syed, 2010: 188), the frequency of interpreters' use was solely dependent on HCPs' own initiative and degree of awareness of their language level. Therefore, several cases have been registered where respondents did not ask for specialized assistance but rather relied on family members to bridge the communication gap (Bonacruz Kazzi & Cooper, 2003: 263; Patel et. al, 2016: 520; Bischoff & Hudelson, 2020: 164). However, in other studies providers who were aware of their poor language skills expressed the desire to receive training to work effectively with qualified translators to achieve better care outcomes (Kale & Syed, 2010: 189).

Moreover, providers who had received this type of training showed favorable attitudes towards interpreters and positive communication practices (Kale & Syed, 2010: 189).

It is therefore clear that further and consistent action is needed to increase awareness among medical personnel, including nurses, physicians, surgeons and generally providers offering care services to patients that have limited language proficiency. An extensive body of literature – of which the reviewed studies represent only a small portion – offers evidence of malpractice and negative health outcomes when using unqualified interpreters. Early training on how to work with interpreters and their importance within the medical setting, with references to the existing literature, should be included upon providers' onboarding to raise awareness on this subject.

Interpreters' availability

Some studies specifically reported a remarkable lack of promptly available professionals qualified to facilitate bilingual encounters (Michalec et al., 2015: 157; Patel et at. 2016: 517).

However, all studies mentioned the same issue as one of the main barriers preventing providers from accessing high-quality language assistance (Michalec et al., 2015: 157; Patel et at. 2016: 517; Rosenberg et. al, 2007: 289; Thompson et al., 2013; Hadziabdic et al., 2010; Kale & Syed, 2010: 189¸ Schwei et al. 2018: 2; Bonacruz Kazzi & Cooper, 2003: 261). HCPs were frequently found to be unaware of when to call interpreters (Silva et al., 2021: 5) while qualified professionals were not always available to assist providers who did ask for interpreters (Michalec et al., 2015: 157; Rosenberg et. al, 2007: 289; Thompson et al., 2013). Interpreting over the phone was considered unreliable by some providers (Patel et at. 2016: 517), while in-person interpreting was

generally viewed positively by most respondents (Michalec et al., 2015: 158). When only phone interpreting was available, providers tended to rely on patients' family members or other readily available solutions, such as their own poor linguist skills or automated translation platforms (Patel et at. 2016: 517).

A solution to this predicament could be the establishment of resident interpreters in healthcare facilities admitting high numbers of patients with limited proficiency. If language assistance could be promptly delivered whenever needed, providers would also be relieved of the burden of choosing impromptu solutions to bridge the communication gap, as a professional employed for that purpose would do it in their stead. In addition, this practice would foster higher quality of care and reduce the risks identified when using other forms of language assistance, as highlighted in the previous paragraphs.

Training and qualification

Given that most respondents were either unaware of the reasons why interpreters are crucial to successful care outcomes in bilingual exchanges () or favored *ad hoc* interpreters (Rosenberg et. al, 2007: 288), not much reference was made to interpreters' qualifications. Providers had no expectations as to academic careers and certified level of expertise. No concerns were raised regarding potentially uneducated or inexperienced interpreters interacting with patients and the medical environment. General references to "qualified" or "trained" interpreters (e.g. Rosenberg, 2007: 186) were the only ways both respondents and authors addressed their level of competence. This behavior suggests that insufficient emphasis has been placed on the formal training and workplace experience necessary to provide a reliable, safe and ethical service. Raising

providers' awareness of the importance of employing qualified or licensed interpreters is yet again crucial to change this pattern.

As highlighted in section 1.1, however, a national register of interpreters does not currently exist. As a result, no mandatory requirements must be met in order to practice this profession and to be qualified to work as an interpreter, as is the case with physicians, surgeons, lawyers, physical therapists or notaries, to mention but a few. Anyone with perceived moderate to high language skills and who may also happen to have some measure of medical knowledge can work as an interpreter without receiving formal training and without holding a qualification or a degree. This results in individuals with formal training potentially being placed on equal terms with untrained and inexperienced ones or being discarded in favor of *ad hoc* interpreters.

Despite the general lack of a formal licensing system observed both on a global scale (Nielsen et. al., 2020) as well as on a national scale (Pittarello, 2009) Italian public and private institutions offer training programs for translators and interpreters through which official degrees or certifications can be obtained.

1.3 Current state of healthcare interpreting in Italy

According to the Italian National Institute of Statistics (Istat), as of January 1, 2024, the resident population of foreign citizens is 5,308,000, accounting for 9% of the total population. 58.6% of foreigners reside in the northern regions, 24.5 % prefer the central areas, and the remaining 16.9% live in the southern regions. Foreign residents appear to have increased by 3.2% as compared to 2023. Since the population of foreign residents is on the rise, it becomes apparent that more and more individuals need access to a vast array of public and private services, from administrative offices to schools, real estate

agencies, and primary or outpatient healthcare, to name a few. It can thus be maintained that interpreters play an essential role as they help individuals with poor command of the Italian language access those services.

Recent studies on interpreting have paid increasing attention to medical settings as one facet of a new field of research, known as Community Interpreting (Pittarello, 2009). At the present date, there is an extensive body of foreign and Italian literature on the identity and tasks of the community interpreter (Mead, 2001; Grbić, 2006; Hale, 2007; Merlini, 2009; Pittarello, 2009; Mikkelson, 2014). All studies agree that Community Interpreting is a service provided to and found in communities with a large number of ethnic minorities, allowing those minorities to access services that would otherwise be inaccessible due to a language barrier.

In Italy, two phrases seem to coexist to designate the same interpreting type, namely "interpreting in the social field" and "linguistic-cultural mediation" (Merlini, 2009). Additionally, the term "mediator" is often coupled with adjectives such as "linguistic", "cultural", "intercultural", "social", and "socio-cultural" (Pittarello, 2009). The definitions of interpreter and cultural mediator are highly debated by the existing literature. Most Italian and foreign scholars try to outline the two roles by determining whether interpreters are highly trained professionals who are solely committed to aseptically translating concepts from one language to another, compared to cultural mediators being hypothetically less trained, although encompassing the role of rapport builders and cultural gap-bridgers (Martin, 2010; Tomassini, 2012; Falbo, 2013; Archibald & Garzone, 2015; Wang, 2017). In this framework, the dichotomous relationship between language and culture is often discussed.

Indeed, Wang (2017) maintains that the primary distinction between an interpreter and a cultural mediator is that an interpreter passively transfers messages from one language to another, whereas a cultural mediator can actively shape the discussions between two parties. In this sense, interpreters are not accountable for the contents of the exchanges between two parties, while cultural mediators may take action if they believe the contents of the communication are detrimental to the participating cultures.

With reference to the Italian panorama, Falbo (2013) and Archibald and Garzone (2015) share different views. Falbo compared both roles during interlingual communication in the legal domain. In this context, she argues that the relationship between language and culture is indissoluble, and therefore the activity of an interpreter is fully integrated into the complex communicative process created in the verbal interaction between different languages and cultures. As such, it does not seem to differ from the activity of the cultural mediator. In light of this statement, the author hoped that consensus would be reached so that the roles of mediator and interpreter would be merged in a single and well-defined profession, that of “interpreter-mediator” (Falbo, 2013: 12).

Archibald and Garzone (2015: 7) maintained that the concept of "linguistic and cultural mediation" should be viewed as an umbrella term including a variety of practices, activities, and professional profiles sharing the purpose of fostering language and culture accessibility. The authors refer to the various names used in different countries to describe these professions, highlighting how in all these definitions a translation component is always present, although a strong emphasis is often placed on the cultural component. Interestingly enough, the authors note the primary task of a cultural mediator is undeniably to facilitate communicative exchange through oral

translation. Trying to defy this evidence by stressing the cultural component can lead to problematic consequences, because giving little importance to the translating component can lead to thinking that there is no need for specific professional training for this practice, thus increasing the number of untrained individuals accessing this role (Archibald & Garzone, 2015: 12).

In light of the literature examined in this section, it appears that scholars believe that, in the Italian context, interpreters and cultural mediators share superimposable roles. Both terms appear to be conceived and used as synonyms, in that they share the same meaning and can be applied in the same contexts. However, the current body of Italian law appears to endorse the notion of cultural mediator over that of interpreter as several mentions of the former are made compared to the latter.

Art. 38 of Italian Legislative Decree no. 286/1998 (Consolidated Law on Immigration) on intercultural education references cultural mediators as an aid in communications with families of foreign students. The implementing regulation of the Consolidated Law (art. 45 of Italian Presidential Decree no. 394/1999) entrusts schools with the formulation of proposals regarding the criteria and methods for communication with the families of foreign students, also through qualified cultural mediators. In addition, according to the provisions of Art. 42 of the Consolidated Law, social integration measures should be facilitated by the creation of agreements with associations for the employment of foreigners within their own structures as intercultural mediators, in order to facilitate relations between individual administrations and foreigners belonging to different ethnic, national, linguistic and religious groups.

Moving from these premises, with Memorandum no. 24/2006, the Italian Ministry of Education, University and Research indicates that cultural mediators should focus, among other tasks, on the reception of foreign students, development of school-family interaction and promotion of intercultural education.

Provisions concerning the role of cultural mediators are also found in Italian healthcare legislation, where references are made to the training of specialized professionals and their necessary presence in hospital facilities. Yet, these provisions are region-specific, thus inhomogeneous across the country (Tomassini, 2012).

According to what is reported in the current literature and in light of this regulatory framework, it can thus be maintained that a clear and formally recognized distinction between linguistic mediator and interpreter has yet to be drawn, particularly in the medical field. On one hand, scholars agree that the linguistic and social-cultural components characterizing both profiles seem to be inseparable. On the other hand, the Italian regulatory framework on the subject makes no to very limited use of the term "interpreter". This is particularly true when it comes to public healthcare settings, be it emergency rooms or outpatient facilities, where a cultural-centric approach is favored by the many people with diverse ethnicities and different beliefs regarding personal care seeking medical attention. In this scenario, a cultural meditator sharing the same cultural background as the patient may be better equipped to navigate challenging interactions.

Lack of national professional criteria notwithstanding, public Italian universities have attempted to distinguish between the two profiles. A three-year undergraduate program in Language Mediation is generally primarily centred on theoretical linguistics and foreign culture and literature, where not much attention is paid to practical language aspects in favour of a more cultural and literary approach. Contrarily, a master’s degree

in Translation and Interpreting provides specialized training in which language command is given prominence above cultural and literary aspects and the development of translation and interpreting abilities is emphasized. However, undergraduate curricula for prospective cultural mediators and master's degrees in interpreting and translation studies do not currently include a separate syllabus on communication in medical settings. University lecturers may, on their own initiative, choose to focus on healthcare-related topics, but there is no clear ministerial indication of specific training programs on this matter (Tomassini, 2012). Although undergraduate and post-graduate academic courses provide an excellent foundation for learning the fundamentals of cross-cultural and interlingual communication, it is clear that a lack of attention to healthcare-related topics results in insufficient preparation on specialized medical terminology and physician-to-patient interactions. To adequately prepare healthcare interpreters who possess the skills to effectively negotiate and convey biomedical meanings, as well as fulfil the necessary requirements to deliver high-quality services, healthcare interpreter education programs should formulate specific teaching strategies. It is imperative that the education of healthcare interpreters be carefully structured to facilitate the development of professional healthcare interpreters who possess a comprehensive understanding of the various roles encompassed within the healthcare encounter continuum. By ensuring that interpreters receive training that promotes continuous learning throughout their careers, their personal growth and professional development can be effectively nurtured (Ortega et al., 2022).

Therefore, educational programs must strive to provide a simulated environment that encompasses a diverse array of healthcare formats. By exemplifying the practicality and significance of authentic healthcare encounters, students will be equipped with the

necessary skills and knowledge to effectively navigate these scenarios. Furthermore, offering ample opportunities for students to both practice and observe different interpreting roles will undoubtedly contribute to the successful preparation of graduates for their future healthcare encounters.

Another organization that seeks to compensate for the lack of a national register is the Italian Association of Translators and Interpreters (AITI). Founded in 1950, AITI comprises 1,219 members as of the last census in 2023 and brings together language professionals specialized in technical, scientific, medical, editorial and legal domains. All members are required to comply to the Association's Code of Ethics and Conduct to guarantee good practice to colleagues and clients. Moreover, AITI favours candidates with a degree in Translation and Interpreting who can prove to have at least 24 months of experience in one of the abovementioned domains. This preference indicates that the association tends to be less inclusive towards cultural mediators, who can otherwise unite in the several existing national, regional and local groups dedicated to this practice.

When weighing the current status of Italian healthcare interpreters against physicians' perceptions, as reported in the existing international literature (see 1.2), it is abundantly evident that this profession lacks visibility, legitimacy, and relevance. Globally, providers do not seem to take an active interest in qualified professionals when patients speaking different languages seek medical attention. In theory, this might imply that the same applies to Italy. As a matter of fact, the lack of national standards (Pittarello, 2009) might pave the way for misrepresentations and misconceptions, just as in other European and non-European countries. In fact, if Italian prospective interpreters may still be insufficiently trained to withstand medical encounters, providers might

have contrasting opinions on this not-yet-regulated profile. Research at the national level to survey stakeholders in this debate appears to be much needed.

2. RESEARCH OBJECTIVES AND METHODOLOGY

The study presented in this dissertation aims to expand on the existing body of research by further exploring the role of healthcare interpreters from the perspective of medical personnel. Specifically, this chapter aims to outline the purpose and scope of this research, and the method, i.e. a qualitative survey, employed to obtain insight into HCPs' views and beliefs regarding healthcare interpreters.

The chapter is divided into three sections. Section 2.1 expands on the purpose and the scope of the study. Section 2.2. outlines the survey design and discusses the research tools considered when laying out the project and those better fitting the purpose and scope of the study (cf. Section 2.2.1). The structure of the survey is outlined in Section 2.3 by presenting the content and intent of each question. Separate subsections describe the profiling questions (cf. Section 2.3.1) and other contingency questions (cf. Section 2.3.2). The methods employed to administer the survey to the selected population are then presented in Section 2.4. Finally, Section 2.5 draws a general picture of the sample with some brief insights into the respondents' language background.

2.1 Purpose and scope of the study

The purpose of this study is to determine whether HCPs trust healthcare interpreters by exploring their views, beliefs and perspectives on interpreter use.

Existing literature suggests that, although residents HCPs knew how to access interpreter services within their medical setting of reference and acknowledged that interpreters contributed to better care, they made decisions about interpreter use after

weighing the benefits of accurate communication against competing demands on their time (Diamond et al., 2009). This is why the present research explores a context where an Interpreting Service is already integrated into the hospital environment, unlike other studies (Hadziabdic & Hjelm, 2014; Flores et al., 2012 among others). This choice was made in order to understand the reasons why some respondents opt to independently manage communication with patients in a language other than their native language despite being aware of the existence of a qualified and readily available service on site. It is evident how crucial it is to determine whether HCPs opting out of the Service believe that their level of English is appropriate for conducting an outpatient or instrumental visit successfully, or if it is because they mistrust interpreters, or if the reason why they do not use the Service lies in-between.

The scope of this study is limited to a private Italian medical centre located in the Padua province of the Veneto region, providing outpatient and inpatient care, surgical services, physical therapy, and a wide range of diagnostic tests, including high-field MRI, MRA, x-ray and ultrasound. The clinic is a private facility and is thus not contracted with the Italian health care system.

It differs from other centres investigated in the literature (cf. Chapter 1) as well as from others in the Italian territory because of its affiliation with the U.S. NATO military bases established in its surroundings. Precisely, the clinic primarily serves Camp Ederle (Vicenza), Aviano Air Base (Pordenone), and Poggio Renatico Base (Ferrara). Italy is one of NATO's founding member countries, having signed the Atlantic Pact in 1949. By virtue of that pact, several military bases with different purposes and organizational structures have been established in its territory. As of 2024, the number of bases known to be located in Italy accounts for 120 military outposts. However, the partnership

between the bases and the medical centre within which the present study was conducted is and remains exclusively medical, with hundreds of patients receiving outpatient and inpatient care yearly. All patients coming from these military bases have perfect command of the English language, although some are not native English speakers.

Interestingly, patients with Hispanic or Latino cultural heritages may understand part of a discourse held in Italian due to Spanish being their second or even primary language. Some US-based patients are indeed of Mexican, Puerto Rican, Cuban, Salvadoran, Dominican, Colombian, Guatemalan, Honduran, Ecuadorian, Peruvian, Venezuelan or Nicaraguan origin. However, only a limited number of Spanish-speaking patients have been found to have the necessary proficiency to understand the nuances and technicality of medical discourse, interact with the treating HCPs and follow up on recommended medical care without an interpreter.

Regardless of their linguistic background, the vast majority of U.S. military are deployed to Italy for a brief period of time, typically not exceeding a couple of years, although this time may vary and be even shorter if members are needed abroad for military exercises or missions. This is why U.S. active-duty members and their families mostly have little to no command of the Italian language, as they do not feel the need to learn a language spoken in a country they will only live in for a short period.

In light of their limited Italian proficiency and because of the large number of patients visiting the clinic daily, an in-house Interpreting and Translation Service was established within the medical centre. The primary purpose of this Service is to facilitate communication between non-English speaking HCPs and non-Italian speaking patients. The Service is therefore concerned with delivering high-quality interpreting and supporting doctor-to-patient interaction along every phase of the patient's diagnostic

and treating course, from regular outpatient encounters to preparation for instrumental tests and surgical procedures to discharge from inpatient care and follow-up appointments. In addition, after consultations are over, the Service is likewise responsible for translating medical reports into English. Reports are otherwise issued in Italian only. Written translations help American general practitioners, who typically work for on-base military healthcare networks, understand the outcomes of consultations, diagnostic and laboratory tests and discuss findings with their patients. Likewise, patients who are given agency to communicate with HCPs through an interpreter can also have written proof that what they communicated was relayed correctly and that medical advice was provided accordingly.

Thus, it is evident that, unlike other on-call language-assistance programs investigated in the literature (cf. Chapter 1), the Interpreting and Translation Service that is the object of this study is a consistent, always-available resource that is operated by qualified staff members to whom medical professionals can turn for any language needs at any time. Interpreters are indeed full-fledged employees of the clinic and not freelancers. In addition, they have an internal telephone number and an office that is easily accessible to medical staff.

Another crucial difference which sets this medical centre apart from other healthcare facilities where studies on the relationship between medical personnel and interpreters have been conducted is the lack of an intensive care unit and an Emergency Room. This implies that every medical encounter is scheduled in advance. Hence, physicians know the nationality of patients before the appointment day and, more importantly, the Interpreting and Translation Service staff know in advance on which day, at what time and for how long interpreting will be needed. Moreover, interpreters have the time to go

through any available past medical history of the patient and can thus prepare on medical terms that might recur during the encounter. Further, scheduled appointments help staff to ensure full coverage whenever language assistance is required.

Despite the fact that the Service has been in operation for almost a decade now and has undergone numerous restructurings and improvements, the opinions of the medical professionals who regularly interact with it have never been openly investigated before.

2.2 Research design

An online survey was determined to be the most suitable method for investigating how medical staff members view the Interpreting and Translation Service. This choice was made after thoroughly reviewing a variety of research papers that considered the opinions of medical professionals working in European and United States hospitals (Rosenberg et. al, 2007; Pittarello, 2009; Kale & Sayed, 2010; Thompson et al., 2013; Bridges et al., 2015; Silva et al., 2021). In addition to survey administration, some of these studies (Rosenberg et. al, 2007; Bridges et al., 2015) involved videotaping outpatient encounters with an interpreter. Shortly after, the medical staff who took part in the filming had the chance to watch themselves interacting with the patient and the interpreter. At this point, they were presented with questions to analyze the interaction. With questions administered during the playback of the videotape, respondents provided detailed commentary on their perceptions, which were limited to a single appointment. This resulted in answers being extremely relevant and meaningful.

As much as videotaping was found to be a valid and proven ally in collecting qualitative data, the research instruments of this study were restricted to an online survey only. This choice was made for two main reasons. Firstly, this method ensured

the absolute anonymity of both HCPs and patients. The patients for whom it is necessary to provide language assistance are active U.S. military personnel and their families, members of the Air Force, Infantry or Navy, currently involved in intercontinental missions, operations, and exercises. Therefore, ensuring complete anonymity is paramount, which would be compromised if patients' voices and faces were captured and filed with the intention of presenting the recording to medical staff to elicit more detailed responses in addition to the survey. Secondly, the ultimate goal of this study was to represent the perspective of the medical staff only, who were thus the only population involved in the study as they are not connected to the military network in any way or form.

2.2.1 Research tool: Google Forms

After identifying the data collection method that best suited the goal of the study, the tool for setting up and administering the survey was identified. The online survey was chosen over the paper survey for ease of distribution and data collection. The interactive digital tool *Google Forms* was the tool of choice. Two other platforms, *Survey Monkey* and *Typeform*, were also considered. The latter, in particular, allowed for the creation of visually pleasing surveys through a wide range of graphical options and transitions, transforming the survey into a fluid and interactive presentation. However, a decision was taken based on functionality. *Google Forms* is a wider known tool than the other two platforms and can be easily accessed with an e-mail and a link. Additionally, *Google Forms* was found to be more user-friendly for both creators and respondents.

More importantly, unlike *Survey Monkey* and *Typeform*, *Google Forms* surveys can be built on contingency questions. Contingency questions are used in studies and surveys

to target respondents and route them to questions that apply to them, which was found to be the most effective method to address the entire medical population of the clinic and tailor the set of questions to the specific profile of each respondent.

2.3 The survey: structure and questions

All the questions in the survey (Appendix 1) were designed to explore the medical staff's perceptions of and opinions about the Interpreting and Translation Service. The survey included a total of 22 questions. Eleven were close-ended multiple-choice questions, four were open-ended, three were multiple-choice checkboxes, three were Likert linear scales, and one was a rating question based on a multiple-choice grid. All questions were mandatory and worded in Italian only because the primary language of the responding population was Italian (cf. Section 2.4).

2.3.1 Profiling questions

Seven initial questions were designed to profile the respondents and collect data on their demographics and language competence. Specifically, four profiling questions addressed their (Q1) age, (Q2) gender, (Q3) medical field of expertise, and (Q4) period of service at the clinic. Three questions proceeded to investigate their language competence by inquiring about their (Q5) English proficiency, (Q6) any prior study or work stay in English-speaking countries, and (Q7) any English language courses attended.

Q1 on respondents' age was a close-ended question that allowed form-fillers to select one among six options, corresponding to the following age groups: 18-25, 26-30, 31-40,

41-50, 51-60 and over 61 Age groups were created to facilitate data collection and simplify the identification of age-related tendencies.

Q2 was a close-ended question on gender where respondents could choose one among the following options: “Man”, “Woman”, “Non-binary” or “I prefer not to respond”.

Q3 was a multiple-choice checkbox question inquiring about the area of medical specialization. Respondents were prompted to select one or more among the following thirty-one options: allergology, anaesthesiology, pain management, biology, cardiology, general surgery, plastic and aesthetic surgery, vascular surgery, dermatology, diabetology, endocrinology, gastroenterology and endoscopy, food sciences, foot analysis, obstetrics and gynecology, sports medicine, general medicine, nephrology, neurosurgery, neurology, nursing, ophthalmology, orthopedy, otolaryngology, physiatrics, physical therapy, psychiatry, psychology, radiology, rheumatology, urology and andrology. The respondents not belonging to any of these specialities or specializing in a secondary field not included among the thirty-ones listed above could add their area of expertise through the open-ended option “other” included at the end of the list.

Q4 was a close-ended question that asked respondents to state how long they had been active members of the medical team by choosing one among four time ranges: “1 to 6 months”, “From 6 months to 1 year”, “From 1 to 5 years” and “From 5 to 10 years”.

Q5, “Please indicate your level of English proficiency on a scale of 1 to 5”, presented with a 5-point Likert scale, where 1 represented the lowest level, 2 equalled a low-

intermediate level, 3 meant an intermediate level, 4 was an intermediate-high level, and 5 represented the highest level.

Q6 investigated respondents' professional or academic experiences in English-speaking countries. In order to do so, HCPs were presented with a close-ended multiple-choice grid that focused on the length of their stay. Options included "3 to 6 months", "From 6 to 12 months", "For more than 1 year", or "No, never."

Q7, "Have you ever taken any English language classes? If yes, which level were they?", meant to study respondents' educational background in terms of attended language courses and their level according to the Common European Framework of Reference for Languages (CEFR). Only one option could be selected among the following: "A1/A2", "B1/B2", "C1/C2" or "No, never".

These seven questions were asked to all respondents, regardless of whether they had ever requested assistance from the in-house Interpreting and Translation Service.

2.3.2 Contingency question (Q8)

At this stage of the survey, respondents were prompted to respond to a contingency yes-or-no question: (Q8) "Have you ever used the medical centre's in-house Interpreting and Translation Service (English-to-Italian translator during outpatient encounters)?". Based on their answers, they were directed to a tailored series of questions. Respondents who selected "Yes" are henceforth referred to as "users", whereas respondents who selected "No" are referred to as "non-users".

To better represent questions numerically, these were divided into two categories: questions for users and questions for non-users.

The questions for users included Q8.1.1, Q8.1.2, Q8.1.3, Q8.1.4, Q8.1.5, Q8.1.6, Q8.1.7, Q8.1.8, Q8.1.9 (cf. Section 2.3.2.1)

The questions for non-users included Q8.2.1, contingency Q8.2.2, which could route to Q8.2.2.1, contingency Q8.2.3, which could route to Q8.2.3.1. (cf. Section 2.3.2.2).

2.3.2.1 Questions for users

If respondents answered "yes" to Q8 and were thus found to have relied on one of the in-house interpreters at any point in their career within the clinic, specific questions were asked about their satisfaction with the Interpreting and Translation Service.

Q8.1.1 asked, "How often do you use or have you used the Interpreting and Translation Service?". Respondents could choose one of these four options: "Only once or occasionally (3-4 times a year)", "At least once a month", "At least once a week", and "More than once a week".

Q8.1.2, "Why did you request the Service? Select one or more options", then investigated the reasons behind their choice to ask for language assistance. Respondents could select one or more among these three options: "My knowledge of the English language and/or medical terminology in English is not sufficient to ensure safe and quality service", "I am not comfortable communicating clinical/therapeutic information, even sensitive information, in a language other than Italian", "I think this type of specialized communication should be handled by professional interpreters". If the listed options were not representative of their own experience, HCPs were given the chance to expand more on their reasons for interpreter use by selecting the open-ended option "other, specify".

Q8.1.3 asked respondents to rate their perception of interpreters' professional competence on a 10-point Likert scale. Value 1 represented low levels of competence, while value 10 represented the highest level of competence.

Q8.1.4 presented HCPs with another 10-point Likert scale to inquire "How helpful do you think the Service is to doctor-patient communication on a scale of 1 to 10?". Again, value 1 meant interpreters were least helpful, while value 10 represented meant interpreters were most helpful.

Q8.1.5, asking "Do you trust the translation of medical information that interpreters carry out to and from English, including sensitive and delicate details?", aimed to respond to the primary question, i.e. the purpose of this study, as to whether or not HCPs trust interpreters to relay accurate medical information. The question offered close-ended "Yes" or "No" answers.

Subsequently, open-ended Q.1.6, "Briefly motivate your answer", aimed to explore the reasons behind respondents' positive or negative choices.

A rating question based on a multiple-choice grid, i.e. Q.1.7, asked to "Please indicate on a scale of 1 to 5 how much the following factors influence your decision to continue to rely on the Service". The factors included: "Interpreters are qualified", "Limited ability to communicate in English on my own", "Reduced consultation time thanks to the service", "Increased feeling of safety and trust given by the presence of an interpreter", "Not having to make an effort to speak another language".

Finally, question Q8.1.8, "Would you recommend the use of the Service to your colleagues?", offered close-ended "Yes" or "No" answers. A short mandatory rationale was then requested by Q8.1.9 "Briefly motivate your answer". Answers to this final

question landed on the conclusive page, where respondents were thanked for their participation.

2.3.2.1 Questions for non-users

The respondents selecting “No” to contingency Q8, were directed to Q8.2.1, which asked, “Why do you not use the Interpreting and Translation Service? Select one or more options”. One or more of these options could be selected: “I was not aware of its existence”; “I chose not to provide medical services to U.S. patients from NATO bases”; “I have a sufficient level of English to communicate with the patient without any intermediary”; “I do not trust the Interpreting Service”; “Communication through an interpreter is too slow. I prefer to talk directly with patients by myself.” At the end of the list, the open-ended option “other” could be checked if none of the listed default answers applied.

Subsequently, respondents were prompted to give their opinion on possible interpreter use through contingency close-ended multiple choice Q8.2.2, “Do you think you will ask for its support in the future?”. If “Yes” was selected, a mandatory rationale was prompted by open-ended Q8.2.2.1.

Finally, through contingency Q8.2.3, the survey intended to investigate whether non-users decided to conduct bilingual encounters with the aid of other means of communication such as gestures, pictures, sounds, videos, patients’ family members, practical demonstration or machine translation, e.g. Google Translate. Respondents could select between “Yes, often”, Yes, sometimes”, or “No, never”. “Yes” answers directed to Q8.2.3.1, which asked HCPs to choose one of the following means of communication: “Machine translation (e.g. “Google Translate)”, “Gestures”, “Patients’

family members" "YouTube/videos", "Pictures", and "Practical demonstration". "No" answers landed on the conclusive page, where respondents were thanked for their participation. This aspect, i.e. the use of alternative means of communication in the absence of an interpreter, required due attention as the reviewed literature suggested extensive use of *ad hoc* interpreters as well as the employment of third-party digital tools to aid physician-patient communication where prompt, qualified language assistance was not available (Bonacruz & Kazzi, 2003; Patel et. al, 2015).

2.4 Administration of the survey

Before circulation, a survey sample was generated and submitted for review to the Medical Chief and Management Office. The sample was comprehensive of all questions and possible answers. First of all, it was checked for content quality. Both parties verified that the content was appropriate to the corporate image and did not violate the respondents' privacy. The anonymity of responses was ensured by toggling the relevant option built into Google Forms. Subsequently, the Management Office was asked to verify if contingency question Q8 triggered the relevant set of questions targeting, respectively, users and non-users.

The official survey was generated and administered to the target healthcare population only after the sample survey received explicit consent from the Medical Chief and the Management Office for data collection, data analysis and publication of this study.

It was circulated via e-mail including a brief explanation of the purpose of the study and the link to the survey. The body of the text (Appendix 1) duly explained that the survey would be a pooled analysis with anonymous data gathering for research purposes

only and that the inherent quality of the Interpreting and Translation Service was not being questioned. Regardless of the answers, the service would not be subject to any administrative audit. The survey remained available for compilation for six weeks.

2.5 Population

The clinic's entire healthcare population, i.e. 167 HCPs, was sent a link to complete the survey. The population consisted of resident internal medicine physicians of different specialties (cf. Chapter 3), ultrasound technicians and radiology specialists, surgeons, anesthesiologists, nurses, and physical therapists. The entire population had Italian as their first language. Only an exceedingly small percentage of respondents were bilingual, with both primary languages being Italian and Spanish, but none were Italian-English bilingual, and none had origins in the United States or other English-speaking countries. It is important to note that the study involved the entire medical personnel irrespective of whether they had previously had access to the interpreting and translation service.

The surveyed population also includes HCPs who have chosen to avoid treating patients who do not speak Italian altogether and personnel who typically do not conduct medical encounters on a regular basis. This might be the case with anaesthesiologists or operating room personnel. They might request an interpreter to help them communicate with patients or family members before surgery or upon discharge, but this occurs sporadically compared to routine outpatient consults and follow-ups.

This comprehensive approach is fundamental to get as complete and three-dimensional a picture as possible of the medical staff's perceptions of the medical interpreters available. Involving only the HCPs who are known to routinely employ the

in-house Interpreting and Translation Service would have yielded incomplete results, which only represented a portion of the whole healthcare population within the medical centre.

Furthermore, including every resident member of the medical team, irrespective of their field of medical specialization, allowed the investigation to avoid any biases and focused on an impersonal review of each HCP's professional decisions on interpreter use based on their opinions and beliefs.

3. DATA ANALYSIS AND FINDINGS

This chapter analyzes the results of the survey, the design of which was illustrated in Chapter 2. The survey was made available to a total of 167 HCPs to include the entire resident healthcare population. The final number of respondents was 78 (46.1%), nonrespondents were 89 (53.9%).

This chapter draws a global picture of respondents' demographics (cf. Section 3.1) by reporting their age groups (Q1), gender (Q2), medical specialty (Q3) and the timeframe during which they were active members of the medical centre where the survey was administered (Q4).

The data about the respondents' language competence are illustrated in Section 3.2, which reports on the questions about self-reported English proficiency (Q5), stays in English-speaking countries (Q6) and attendance at English language classes. The general tendencies are then discussed in a separate subsection (cf. Section 3.2.4) to observe evidence of any inconsistency.

The perceptions of HCPs towards the in-house Interpreting and Translation Service are then presented (Cf 3.3). The answers of the respondents having accessed or not having used the service (cf. Sections 3.3.1 and 3.3.2, respectively) and then discussed in separate subsections (cf. Sections 3.3.1.1 and 3.3.2.1, respectively). These subsections also consider findings from existing literature (Bonacruz Kazzi & Cooper, 2003; Kale & Syed, 2010; Thompson et al., 2013; Patel et. al, 2015; Silva et al. 2021) with surveyed HCPs behaviours to determine consistency while taking into account their current demographical and language competence findings.

3.1. Demographics

This section outlines the demographic profile of the survey respondents based on Q1, Q2, Q3 and Q4.

Q1 explored respondents' age by dividing them into six main age groups: 18-25, 26-30, 31-40, 41-50, 51-60, and over 61. The bulk of the surveyed sample, i.e. 27 (34.6%) of the 78 total respondents, were over 61 years old. However, 16 respondents (20.5%) were aged between 31 and 40, accounting for the largest percentage of respondents who were under 61. In decreasing order, 15 respondents (19.2%) were between 51 and 60, 13 respondents (16,7%) were between 41 and 50, 6 respondents (7.7%) were between 26 and 30, and just one respondent (1.3%) was between 18 and 25 years old (Figure 3.1).

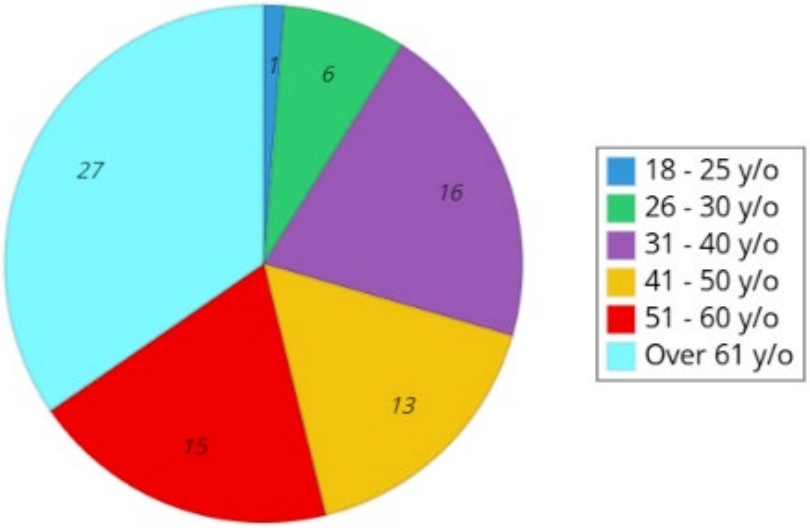

Figure 3.1. Distribution of participants per age group

Q2 inquired about respondents' gender by asking them to identify as men, women and non-binary. Respondents could also select the "I prefer not to respond" option. Of 78 respondents, 47 (60.3%) identified as men, 30 (38.5%) identified as women and 1 (1.3%) preferred not to respond (Figure 3.2).

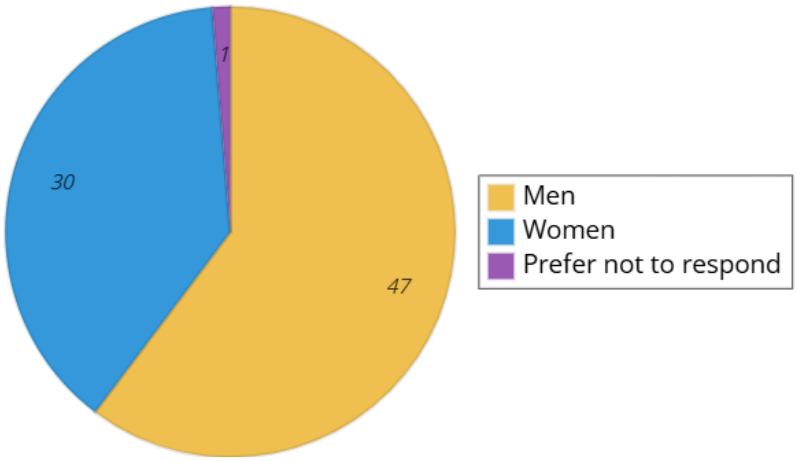

Figure 3.2. Distribution of respondent's gender

Overall, as shown in Figure 3.3, the majority of respondents identify as men who are over 61 years of age, while women are mostly found within the 31-40 age group.

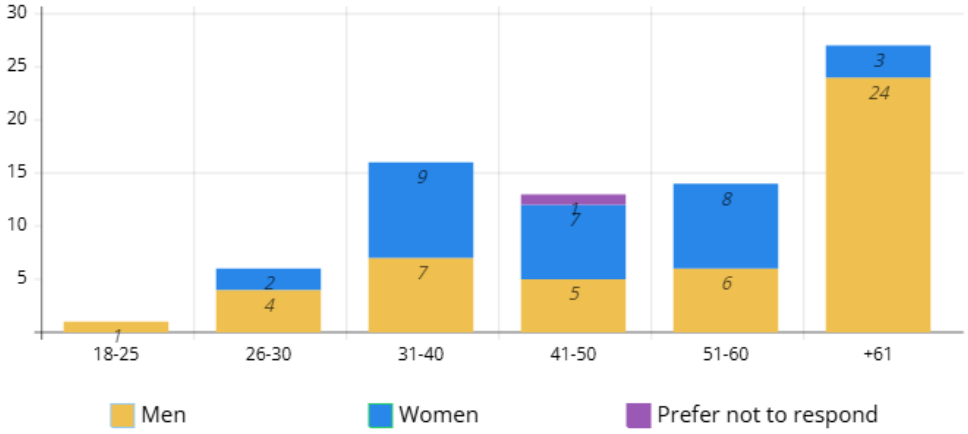

Figure 3.3. Age groups per reported gender

Q3 aimed to paint a global picture of respondents based on their area of medical expertise. The following specialities, in decreasing order, were identified: nursing (11.6%), physical therapy (10.3%), orthopedy (9%), radiology (7.7%), general surgery (6.4%), plastic and aesthetic surgery (6,4%), gastroenterology and endoscopy (5.1%), obstetrics and gynecology (5.1%), otolaryngology (5.1%), pain management (4.9%),

cardiology (3.8%), food sciences (3.8%), neurosurgery (3.8%), neurology (3.8%), ophthalmology (3.8%), urology and andrology (3.8%), anesthesiology (2.6%), vascular surgery (2.6%), dermatology (2.6%), diabetology (2.6%), allergology (1.3%), biology (1.3%), endocrinology (1.3%), physiatrics (1.3%), sports medicine (1.3%), general medicine (1.3%), nephrology (1.3%), psychiatry (1.3%), psychology (1.3%), rheumatology (1.3%). Other respondents were operating room technicians (1.3%), radiology technicians and ophthalmology imaging technicians (1.3%). Although not all of the enrolled population (167 HCPs) participated in the study, there was at least one HCP from each field of medical specialty to have responded to the survey.

Q4 investigated respondents' medical experience at the clinic. Of the 78 responders, 33 (42.10%) had been working within the clinic for three to six years, 30 (38.5%) for one to five years, 8 (3.5%) for ten months to a year, and only 7 (9%) had been part of the medical team for less than a year (Figure 3.4). Consequently, most respondents had ample opportunity to be exposed to English-speaking patients or to choose whether to provide medical services to patients from NATO bases.

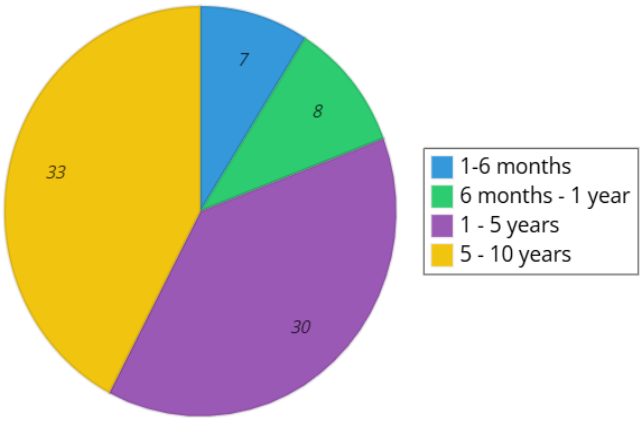

Figure 3.4 *Respondents' medical experience at the medical centre*

Overall, the findings from Q1, Q2, Q3 and Q4 show that among the total responding sample, most HCPs are men (34.6%) over 61. They specialize in a wide range of medical fields, with the three main specialities being nursing (11.6%), physical therapy (10.3%) and orthopedy (9%).

3.2. Language competence

The section specifically focuses on the participants' self-reported level of command of the English language and any professional or academic experience involving active language use. These data were necessary to contextualize the participants' perception of the interpreting and translation service, as well as their choice of whether or not to rely on such service. All participants, regardless of age or gender, were asked three questions: one concerning their self-reported level of English proficiency (Q5), their work, study, or research experience overseas (Q6), and whether they were or had ever been enrolled in language classes (Q7).

3.2.1 Self-reported level of English proficiency (Q5)

In Q5, the participants were asked to rate their level of English on a scale of 1 to 5.

As shown in Figure 3.5, 32 respondents (41%) reported a moderate command of the English language, 19 (24%) reported an intermediate-high level, 13 (16.7%) selected an intermediate-low level, while 9 (11.5%) stated to have a poor command and 5 (6.5%) reported a high level of command.

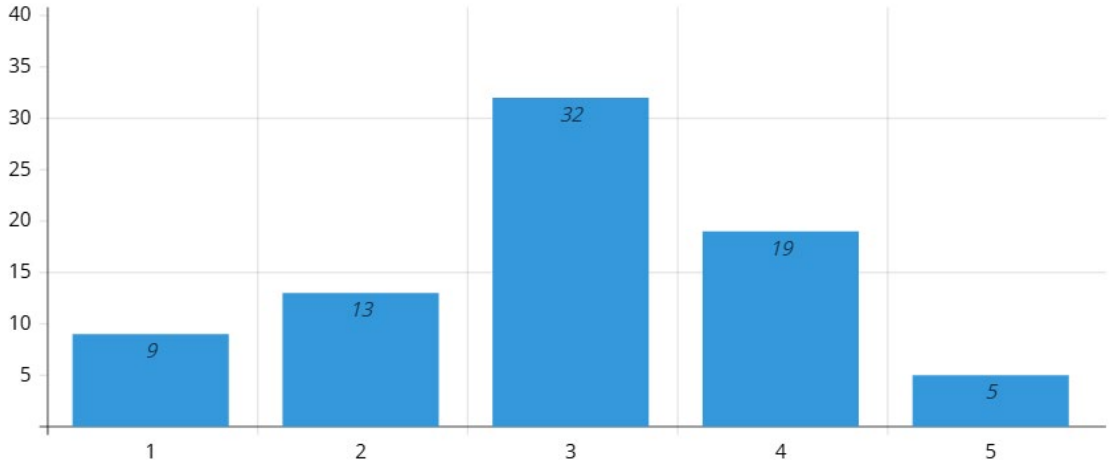

Figure 3.5 *Perceived English level on a scale from 1 to 5 (1= lowest level; 5= highest level).*

When considering the distribution per age range, of the 27 respondents over 61, 5 (18.5%) reported values 4 or 5, 12 (44.4%) selected the score 3, i.e. an intermediate level, while the remaining 10 (37%) reported values 1 and 2.

Of the 15 participants aged between 51 and 60, only one (6.6%) reported a high level of English, whereas value 2 was more common (5 respondents, i.e. 33.3%) and no one selected value 1.

Respondents aged between 41 and 50 had self-reported intermediate and intermediate-high levels of English, with 4 (30.7%) out of 13 people selecting the value 3 and 7 (53.3%) selecting value 4, while only 2 respondents (15.3%) selected value 2. No one selected value 1.

Of the 16 respondents aged between 31 and 40, 6 (37.5%) selected value 3,while 5 (31.2%) selected values 1 and 2. In this age group, 5 respondents (31.2%) reported their English level as being intermediate to high, i.e. corresponding to values 4 and 5.

Among the 7 respondents between the ages of 26 and 30, an overall intermediate English level was recorded, with 5 participants (71.4%) out of 7 selecting the intermediate value 3 and 2 (28.5%) declaring an intermediate-high level, i.e. 4.

Finally, the only respondent between 18 and 25 declared to have an intermediate level.

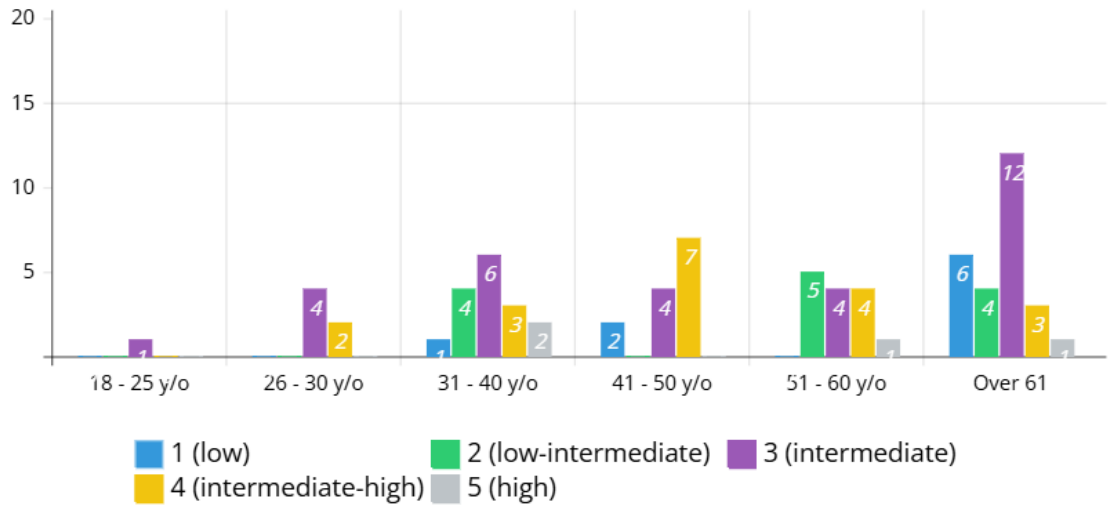

Figure 3.5 *Level of English per age group*

In light of these findings, which are summarised in Figure 3.6, it can be maintained that the bulk of the total surveyed sample retains an intermediate level of English command (41%), while only a minor percentage (6.5%,) included respondents who believed to possess the highest level of proficiency. The most confident respondents belonged to the 31-40 age group, with 5 respondents (31.2%) out of 16 selecting values 4 and 5. Another confident age group appears to be that of respondents aged 41-50, with 7 (53.3%) out of 15 selecting value 4, although none of them selected value 5 as opposed to the 31-40 age group.

However, it should be noted that these figures do not correspond so much to the actual proficiency level of the respondents as to their perception of their language skills.

Therefore, the study also considered the relationship between the self-reported language level of respondents in the different age groups and their educational background, with special reference to the experiences that may have contributed to increasing their language proficiency, such as studying or working abroad or taking classes to improve their English language skills (cf. Section 3.2.2).

3.2.2 Stays in English-speaking countries (Q6)

Q6 explored any previous experiences in English-speaking countries by asking the participants to specify if they had ever spent time abroad for personal, professional, research or study purposes with English as the primary language spoken in such frameworks.

As illustrated in Figure 3.7, it was found that 57 (73.1%) of the 78 respondents had never spent time abroad for any of the reasons mentioned above. Moreover, 11 respondents (14.1%) stated that they did spend 3 to 6 months overseas, while 3 respondents (3.8%) declared that they had worked or studied in an English-speaking country for 6 to 12 months. Respondents who had spent more than one year abroad accounted for 7 (9%) out of 78 HCPs in the sample.

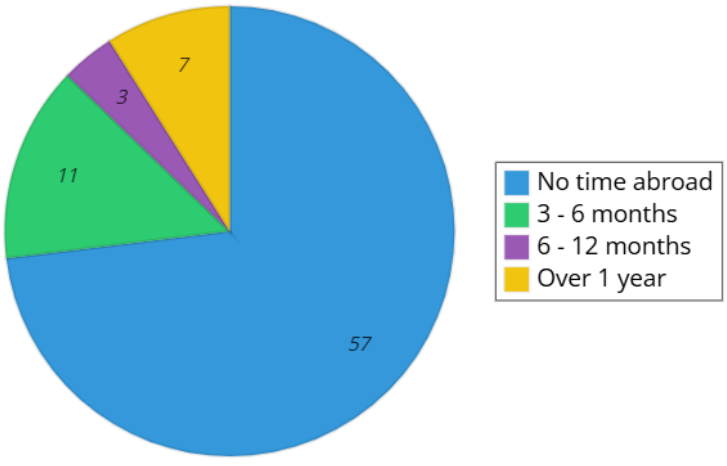

Figure 3.6 *Time spent abroad by the participants*

The distribution of the respondents per age group are summarized in Figure 3.8. Specifically, among the 57 respondents (73.1%) who never spent time abroad, 21 (36.8%) were over 61, 9 (15.7%) were between 51 and 61, 9 (15.7%) were between 41 and 50, 12 (21.5%) were between 31 and 40, 5 (8.7%) were between 26 and 30, and the only 1 respondent (1.7%) between 18 and 25. At least one respondent from each age group selected this answer.

The 11 respondents (14.1%) who declared that they did spend 3 to 6 months overseas where they had actively spoken in English included 3 (27.2%) from the over-61 group, 4 (36.3%) from 51-61, 2 (18.1%) between 41 and 50, and 2 (18.1%) between 31 and 40. None of these respondents were between 26 and 30, or between 18 and 25.

Among the 3 respondents (3.8%) who had worked or studied in an English-speaking country for 6 to 12 months, 2 (66.6%) were between 51 and 60, while 1 (33.3%) was between 26 and 30. None of these respondents were over 61, or between 41 and 50, 31 and 40, or 18 and 25.

Finally, among the 7 respondents (9%) who spent more than one year abroad, 3 (48.8%) were over 61, 2 (21.5%) were between 41 and 50, and 2 (21.5%) were between 31 and 40. None of these respondents were between 51 and 60, 26 and 30, or between 18 and 25.

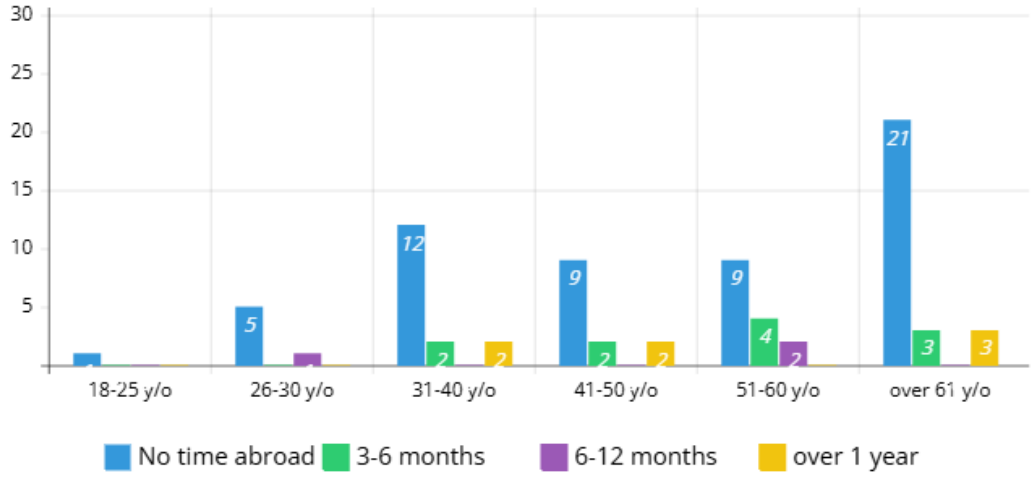

Figure 3.8 Age range per time spent abroad

In light of the findings highlighted in this section, it can be maintained that the bulk of the responding sample, i.e. 57 (73.1%) out of 78 respondents, was found to have never spent more than 3 months abroad. In fact, only 7 (9%) of 78 respondents spent more than 1 year overseas for professional or academic reasons. It can thus be stated that the percentage of experiences of any nature overseas is overall homogenous among all age groups, with no age group having spent a remarkably significant period of time working or studying in an English-speaking setting.

3.2.3 Attendance of English language classes (Q7)

Q7 aimed to investigate whether respondents had ever enrolled in English classes.

The data (Figure 3.9) show that 34.6% (27) of the total respondents maintained that they had taken intermediate language classes, i.e. level B1/B2 of the Common European Framework. Another significant number of respondents, i.e. 23 (29.5%) stated that they never attended any language class of any level. In descending order by number of

respondents, 17 (21.8%) enrolled in base-level English classes, i.e. A1/A2, while 11 (14.1%) attended advanced course i.e. C1/C2.

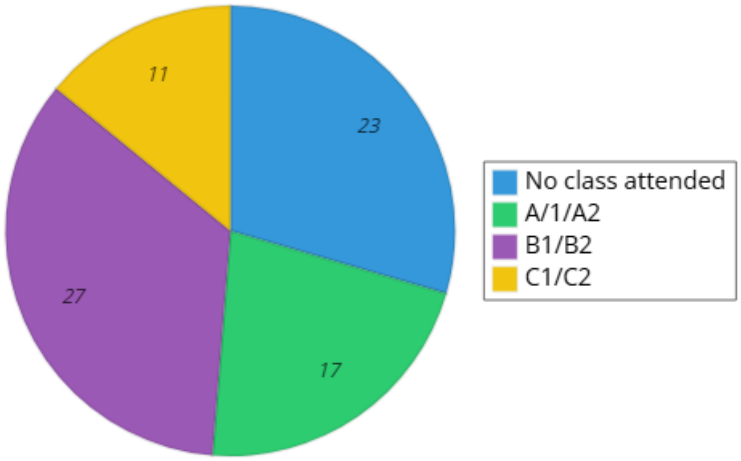

Figure 3.9 *Distribution of total respondents per English class attendance*

When considering English class attendance per age group (cf. Figure 3.10), it can be noted that among the 27 (34.6%) of the total 78 respondents who maintained that they had taken intermediate B1/B2 language classes, 3 (11.1%) were over 61, 5 (18.5%) were between 51 and 60, 6 (22.2%) were between 41 and 50, 8 (29.6%) were between 31 and 40, 4 (14.8%) were between 26 and 30, 1 (3.7%) were between 18 and 25. At least one respondent from each age group selected this answer.

Among the 23 respondents (29.5%) who stated that they never attended any language class of any level, 12 (52.1%) were over 61, 3 (13%) were between 51 and 60, 4 (17.3%) were between 41 and 50, 2 (8.6%) were between 31 and 40, 1 (4.3%) were between 26 and 30. None of these respondents were between 18 and 25.

Among the 17 (21.8%) enrolled in base-level English classes, 9 (52.9%) were over 61, 3 (17.6%) were between 51 and 60, 1 (5.8%) were between 41 and 50, 4 (23.5%)

were between 31 and 40. None of these respondents were between 26 and 30, or 18 and 25.

Finally, among the 11 (14.1%) who attended advanced courses i.e. C1/C2, 3 (27.2%) were over 61, 3 (27.2%) were between 51 and 60, 2 (18.1%) were between 41 and 50, 2 (18.1%) were between 31 and 40, 1 (9%). None of these respondents were between 18 and 25.

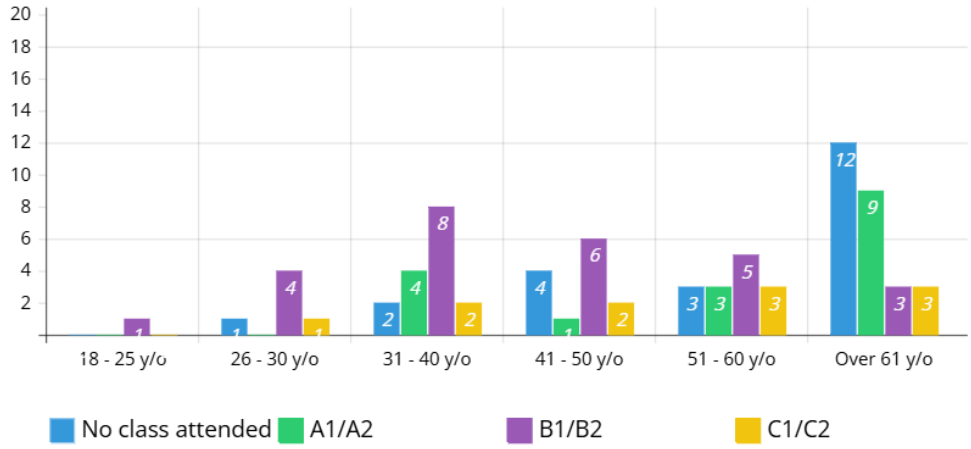

Figure 3.10 *English class attendance per age group*

These findings show that a significant percentage (34.6%) of the 78 respondents did attend intermediate-level English classes. This trend is homogenous as it was observed across all age groups with a predominance of attendance to B1/B2-level classes in the 31-40 age group with 8 respondents (29.6%) out of 27. It can also be maintained that, while the sample over 61 represents the bulk age group (cf. Section 3.1) in the total sample, this is also the majority of respondents who never attended any language course of any level.

3.2.4 Language competence against experiences overseas and attended English classes

The findings in sections 3.2.1, 3.2.2 and 3.2.3 were found to be more or less consistent with each other. Thedata recorded on attended English classes (cf. Section 3.2.3) reflect the findings on English proficiency (cf. Section 3.2.1.) where 32 respondents (41%) of the total 78 respondents declared to have an intermediate English level and 27 (34.6%) maintained that they had taken intermediate B1/B2 language classes.

However, inconsistencies were found when comparing high self-reported levels of English proficiency against the findings on attended advanced language classes. Although 24 respondents (30.8%) stated that they had an intermediate-high and high level of English (i.e. scores 4 and 5), only 11 respondents (14.1%) declared that they attended English courses as advanced as C1/C2.

Considering that 57 of the total respondents (73.1%) have never spent more than three months abroad and that only 7 respondents (9%) have been abroad for more than a year (cf. Section 3.2.2), it can be maintained that findings on self-assessed English proficiency are conflicting.

Some respondents believed they had adequate English command, although this belief was not supported by factual evidence such as pursuing advanced classes or having pursued significant academic or professional endeavours in an English-speaking country. Potentially, their perception might not reflect actual levels of English proficiency. These findings are consistent with what the findings by Bonacruz Kazzi & Cooper (2003). In their study on the use of interpreters in the medical setting, several self-declared English-proficient respondents reported having trouble understanding patients, and several English-proficient respondents sought the assistance of other

language-proficient HCPs. In the case of the present study, a minor percentage of respondents significantly exhibited this behaviour, equal to 4 respondents out of 78, i.e. accounting for 5.1% of the total responding sample (cf. Section 3.1).

However minor, this finding is still relevant to the analysis of recorded data that will be presented in the next section. In fact, this finding sheds light on HCPs' self-efficacy in determining whether and when they needed an interpreter with regards to their perceived English command. Particular attention will be paid to this percentage of respondents in Section 3.3.2.1.

3.3 Perceptions on healthcare interpreters

In response to contingency Q8 "Have you ever made use of the in-house outpatient English-Italian Interpreting and Translation Service?", 34 (43.6%) out of 78 respondents replied positively, while 44 (56.4%) replied negatively.

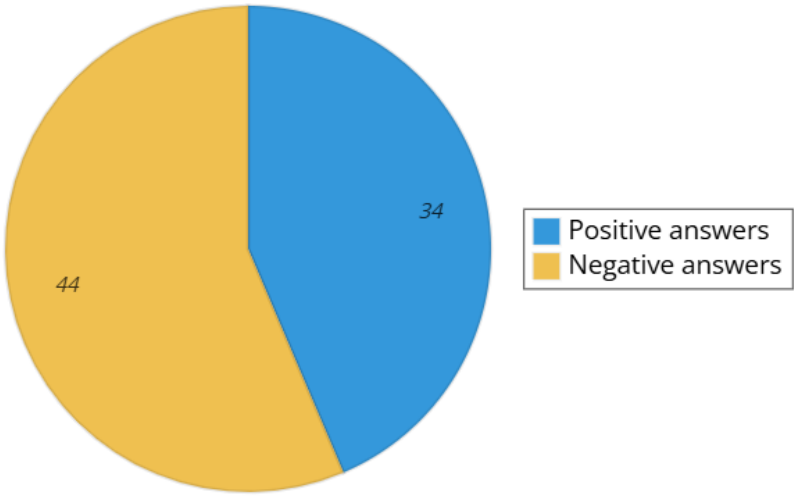

Figure 3.7 *Participants having/not having accessed the interpreting service*

The contingency question allowed to divide the population into two main groups based on their answers and address each group separately. Nine questions (Q8.1.1, Q8.1.2, Q8.1.3, Q8.1.4, Q8.1.5, Q8.1.6, Q8.1.7, Q8.1.8, Q8.1.9, cf. Appendix 1) were designed

to investigate users' motives, while five (Q8.2.1, Q8.2.2, Q8.2.2.1, Q8.2.3, Q8.2.3.1, cf. Appendix 1) targeted non-users.

To represent both categories of respondents, this section branches into two main subsections. In the first subsection (3.3.1), the responses of those who have chosen to rely on the Interpreting and Translation Service are studied. The frequency of use of the Service (Q8.1.1) and the reasons that led to this choice (Q8.1.2) are analysed in the first place. The survey then shifts its focus toward this group of respondents' perceptions of Service interpreters. HCPs were questioned on whether they believed interpreters were adequately competent (Q8.1.3), useful (Q8.1.4) and trustworthy (Q8.1.5, Q8.1.6) Finally, the factors influencing their choice to continue to rely on the Service long-term (Q8.1.7) are examined, along with HCPs answers on whether they would recommend the Service to their peers (Q8.1.8) and why (Q8.1.9). It is evident that great attention is paid to HCPs' perceptions of the Service and their beliefs thereof. Specifically, the trust established between HCPs and interpreters is inquired. Aggregated data is then discussed and commented on to compare with existing literature on HCPs' behaviors towards interpreters (Bonacruz Kazzi & Cooper, 2003; Kale & Syed, 2010; Thompson et al., 2013; Patel et. al, 2016; Silva et al. 2021; Truong et al., 2023).

In the second subsection (cf. 3.3.2), the responses of those who have not chosen to rely on the Interpreting and Translation and Service were studied. This subsection presents the reasons that led to this choice (Q8.2.1) and whether non-users were interested in a future use of the Service (Q8.2.2). Positive responses to this contingency question triggered a question inquiring in which occasions future use is warranted (Q.8.2.2.1). The goal was to examine whether the underlying reasons for the non-utilization of a readily available service stem from a lack of trust in the Service due to it

being perceived as insufficiently robust from a linguistic-professional perspective to assist a healthcare professional in delivering medical services.

3.3.1 Participants having accessed the Interpreting Service

In order to obtain as complete and clear a picture as possible of the HCP-interpreter interaction, it is useful to relate these findings with the frequency with which the 34 respondents received English-speaking patients and, consequently, the frequency with which language assistance was required (Q8.1, Figure 3.12). In this regard, 18 out of 34 respondents (52.9%) used the Service only once or occasionally during their work at the clinic, i.e. approximately 3-4 times per year, 11 respondents (32.4%) requested it at least once a month, 4 respondents (11.8%) declared to rely on the Service at least once a week, while only 1 respondent (2.9%) required language assistance more than once a week.

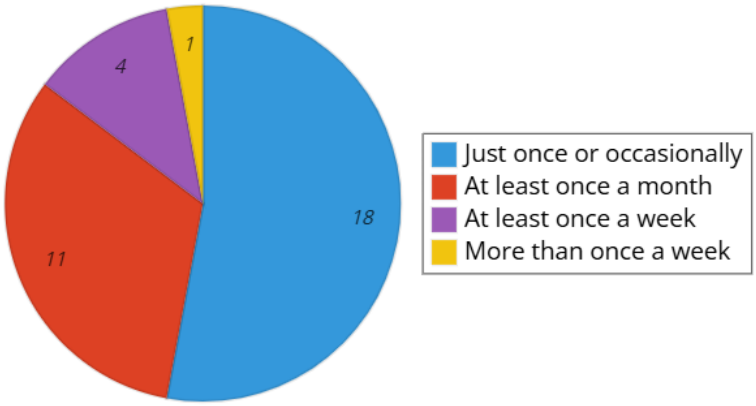

Figure 3.8 *Distribution of frequency of interpreter use among users.*

Hence, HCPs mostly accessed the service occasionally when providing medical services to US NATO military patients.

This finding reflects the organizational structure of the clinic in which the survey was administered. As mentioned in Chapter 2, all HCPs having accessed the Service had opted to be assisted by in-house language professionals on all relevant occasions and without exception upon being registered in the clinic roster. As a result, the reason behind the fact that most HCPs just occasionally accessed the Service does not mean that they chose to sporadically attend to U.S patients. In other words, a sporadic request for language assistance corresponds to an equally sporadic influx of patients.

Q8.1.2 explored the reasons that drove HCPs to rely on the Interpreting and Translation Service. With regards to the main reason that leads most of the 34 respondents analyzed in this section to rely on the Service more or less frequently is their language skills (see Figure 3.13). Precisely, 16 (47.1%) of the 34 respondents perceived themselves as unable to effectively communicate with English-speaking patients, i.e. they believed that their command of the language and/or of English medical terminology was not sufficient to guarantee safe and quality medical services.

The other two reasons behind this behaviour are to be found in the consideration that this type of specialized communication must be handled by professional interpreters, which was selected by 14 (41.1%) participants, as well as the feeling of discomfort in communicating clinical, at times sensitive, information in a language other than their own, which was chosen by 4 (11.8%) out of 34 respondents. The third value is a more meagre statistic than the former two findings.

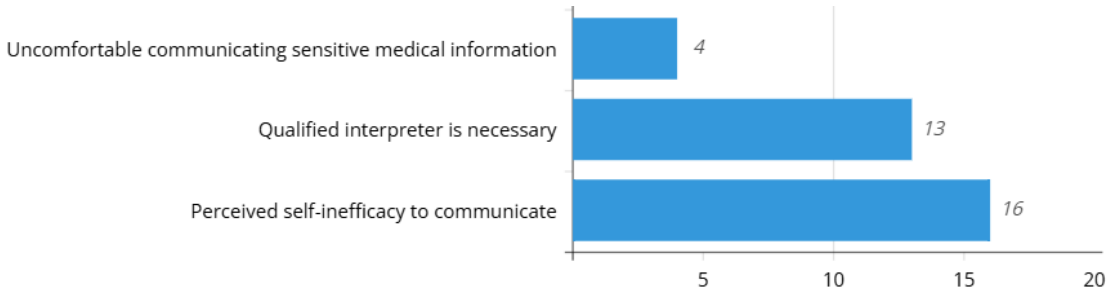

Figure 3.13 *Distribution of primary reasons for interpreter use among users.*

Finally, among the 34 respondents who stated that they relied on the Service, 5 (14.5%) selected the "other" option to expand on the proposed default answers listed above. The reasons illustrated by these 5 participants mostly regarded concerns about HCPs inability to understand their patients, rather than communicate with them in English and concerns about relying on instructions on patients' health insurance coverage.

For instance, one respondent stated that: "Although I have no trouble conveying the negative results of an examination, I do want to make sure that I have done so accurately. I also pay close attention to the interpreter's translation to ensure that the patient and the interpreter both understand what I have said." This consideration shows that there may be reservations about the perceived competence of the interpreters or that there is, to some extent, a lack of confidence of the HCPs towards the interpreters about how much and how the latter report the information to patients.

To shed further light on the perception of HCPs on in-house medical interpreters, respondents were asked to rate the perceived degree of professional preparation of the interpreters on a scale from 1 to 10, 1 representing the lowest and 10 the highest rating (Q8.1.3; cf. Table 3.14). In particular, HCPs were asked to judge whether interpreters were sufficiently qualified to assist healthcare staff during an outpatient visit or treatment. Out of 34 respondents, 18 (52.9%) reported that interpreters were very

competent by rating 10; 12 (35.3%) selected 9, 2 (5.9%) selected 8, 1 (2.9%) opted for 7 and one (2.9%) opted for 6. None of the respondents rated below 6.

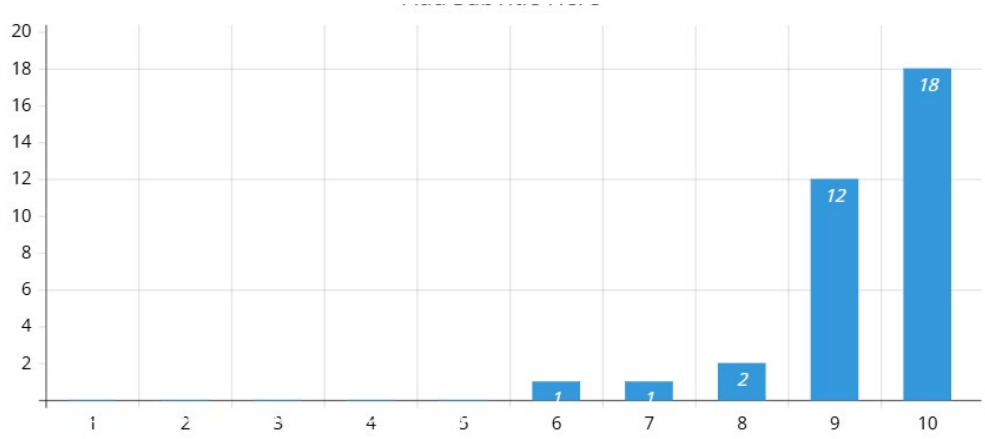

Figure 3.14 Perceived interpreters' competence from 1 to 10 (1=lowest level of competence; 10=highest level of competence)

This finding goes hand in hand with the data gathered from the answers to Q8.1.4, about the extent to which the in-house Interpreting and Translation Service was perceived as useful to HCP-patient communication on a scale from 1 to 10, 1 being a low degree and 10 a high degree of usefulness (see Figure 3.15). Consistently with the answers to the previous question, 26 respondents (76.5%) out of 34 selected 10, 4 (11.8%) selected 9 and another 4 (11.8%) selected 8. No respondents rated below 8.

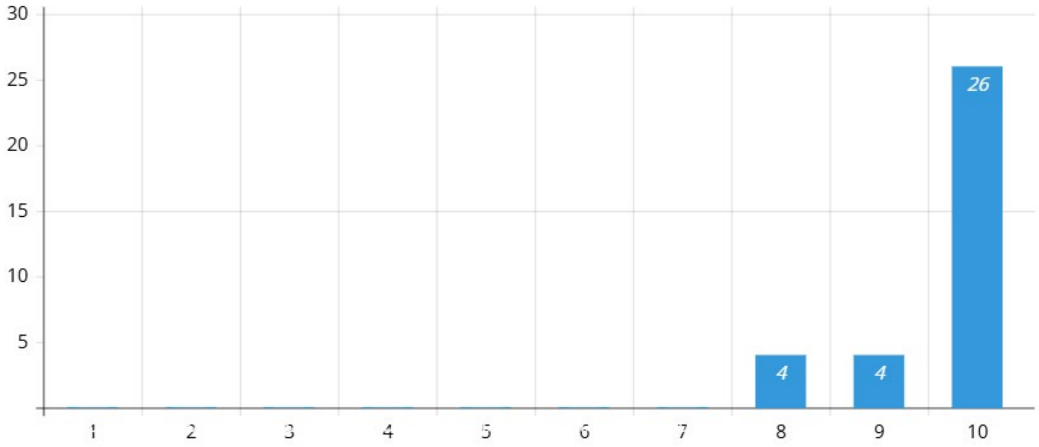

Figure 3.15. Perceived interpreters' usefulness from 1 to 10 (1=lowest level of usefulness; 10=highest level of usefulness)

To complement this set of questions that prompted respondents to form an opinion about interpreters, HCPs' level of trust in the Interpreting and Translation Service was explored (Q8.1.5, cf. Figure 3.16). Respondents were specifically asked if they trusted the interpreters' competence to translate information that might even be highly sensitive to and from English. Participants could answer "yes, completely", "no, not at all", and "sometimes." Out of 34 respondents, 33 (97.1%) answered "yes, completely". Only 1

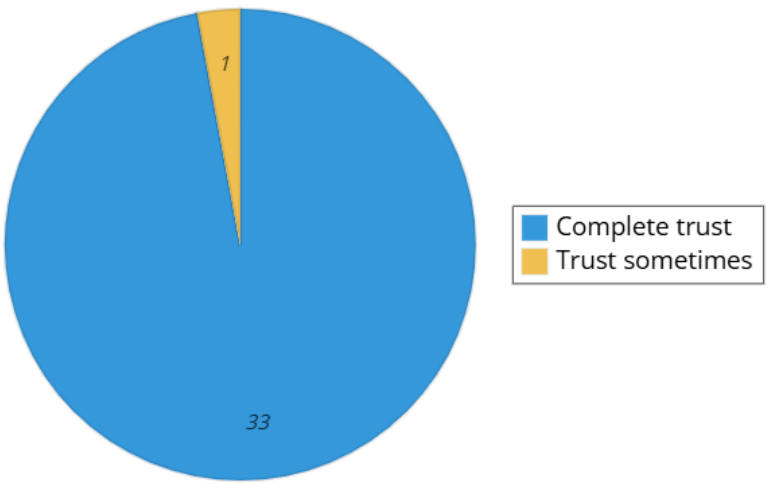

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Figure 3.16. Distribution of trust on interpreters among users of the Interpreting service

ondent (2.9%) replied that he or she trusted interpreters sometimes. No respondents indicated that they do not trust interpreters at all.

When prompted to elaborate on their answer through an open-ended question (Q8.1.6), HCPs were found to hold different beliefs and perceptions as to why the Service was to be trusted. Some commented on the interpreters, describing them as trustworthy professionals who are also accurate, competent, well prepared and observant of confidentiality. Other positive responses came from the fact that interpreters were using accurate medical terminology, while certain respondents commented on the interpreters' performance, stating that information provided from one language to another was found to be correct. This is due to the fact that some HCPs argued that they do understand English, and that allows them to double-check whether the interpreter was translating accurately or not. However, when prompted to clarify their choice by Q8.1.6, one respondent who had selected "sometimes" to Q8.1.5 claimed that "Unfortunately, English medical terminology, which I understand best, is not always correctly translated by interpreters, who know English well, but less so medical English" [1]. This verbatim statement and all those that can be found throughout this dissertation were translated from Italian.

Furthermore, through Q8.1.7 the 34 respondents were asked to rate how the following factors influenced their decision to continue to rely on the service on a scale of 1 to 5: (1) avoiding the effort to speak another language, (2) enhanced sense of security and confidence, (3) reduced consultation time resulting from language assistance, (4) difficulties with unaided English communication, (5) interpreters' competence (Q8.1.7) On this scale, 1 indicated that the factor had no influence on the

[1] Unedited orginal comment: "Purtroppo la terminologia medica inglese, che meglio capisco, non sempre è correttamente tradotta dagli interpreti, che conoscono bene l'inglese, meno l'inglese medico".

choice and 5 indicated that the factor was decisive. Respondents were given the option of selecting more than one choice. The results are illustrated in Figure 3.17.

With regards to factor (1), for most respondents (9, i.e. 26.4%), not having to make an effort when speaking another language was an irrelevant factor, while 7 (20.5%) stated that this factor moderately influenced their choice and 4 (11.7%) indicated that this factor severely influenced their choice. For 5 (14.7%), this factor was decisive.

As for factor (2), to feel safe and confident in conducting a consultation with an English-speaking patient as a result of an interpreter being present severely influenced the choice of 16 (47%) participants and was decisive for 14 respondents (41.8%). For 9 respondents (26.4%) this factor mildly influenced their choice, and for another 1 (2.9%) the influence of this factor was moderate. According to 1 respondent (2.9%), it was irrelevant.

Factor (3), i.e. reduced consultation times, was either moderately or severely influential for 58.8% of participants (29.4%+29.4%). An equal number of respondents indicated this factor as being irrelevant (5, 14.7%) or determinant (5, 14.7%). Only 2 participants (5.8%) stated that this factor mildly influenced their choice

With reference to factor (4), most respondents found that the difficulties encountered when trying to independently manage consultations with English-speaking patients had severely influenced (10 29.4%) their choice or were even decisive (9 respondents, 26.4%). For 4 respondents (11.7%), this factor mildly influenced their choice, and for 6 (17.6%), the influence of this factor was moderate. For 3 respondents (8.8%), it had an irrelevant impact on their choice to rely on interpreters.

Similarly, the majority of HCPs (16, 47%) found that factor (5), i.e. the interpreters' competence, had severely influenced their choice and for 15 respondents (44.1%) this was decisive. 6 (17.6%) stated that this factor mildly influenced their choice, 2 respondents (5.8%) was an irrelevant factor for them, while for 1 (2.9%) this factor was moderately influential.

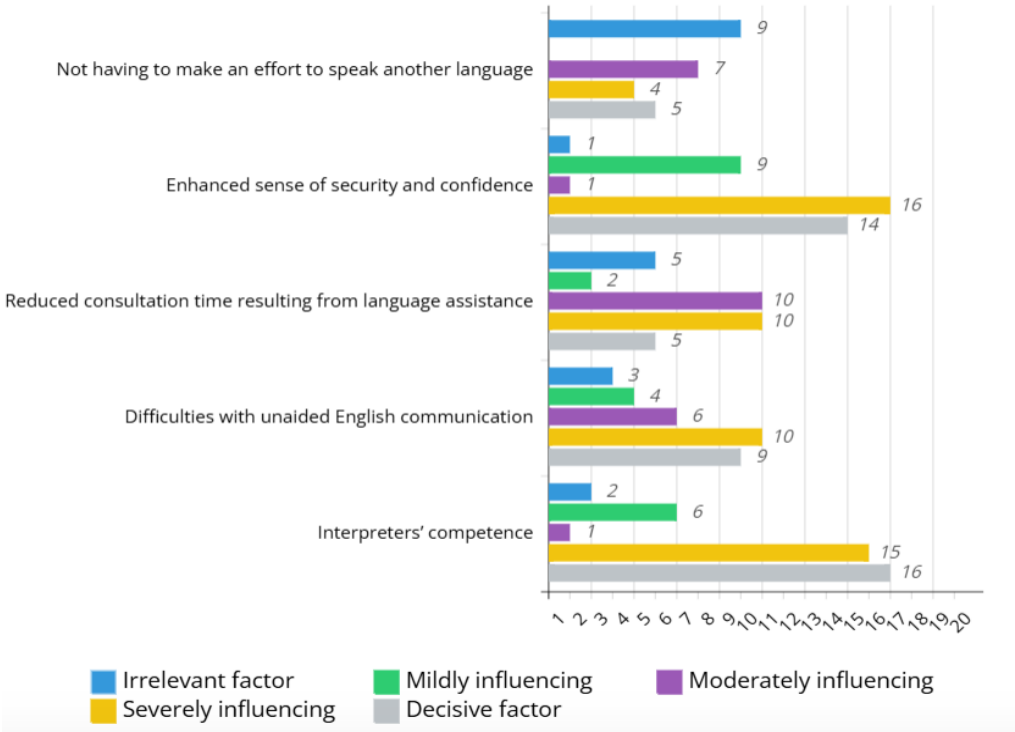

Figure 3.17. Factors influencing HCPs in using the service

In sum, interpreters' competence and the increased sense of security that comes with being assisted by an interpreter during clinical practice turned to indubitably be the most decisive factors for most respondents. Severely influencing factors are also found to be reduced consultation times due to an interpreter being present and difficulties with unaided English communication. The factor that appeared to be least influential was not having to make an effort to speak a different language.

3.3.1.1 Discussion of the data gathered from the users of the Interpreting Service

It can be stated that the recorded findings show a close relationship between the reasons for interpreter use, the factors driving 34 respondents (43.6%) out of 78 to rely on the Interpreting and Translation and Service and the degree of trust in the resident medical interpreters.

Three main reasons for interpreter use have been identified: (1) language proficiency and competence in English medical terminology self-reported as inadequate; (2) the belief that specialised communication between an English-speaking patient and a non-English-speaking clinician should be handled by a professional, and (3) the discomfort in communicating clinical and therapeutic information, including sensitive information, in a language other than Italian.

With regards to the first reason, 17 out of 34 respondents (50%) indicated that their English proficiency and command of specialized English medical terminology was not adequate enough to deliver safe medical care without an interpreter to smooth the bilingual encounter and facilitate their understanding of what was relayed by patients. This finding reflects answers on self-assessed English proficiency on a scale of 1 to 5 (Q5, Figure 3.18). Out of 34 respondents, 14 respondents (41.1%) selected 3, 7 (20.5%) selected 1, while 7 other respondents (20.5%) selected 2. With regards to higher self-declared English proficiency levels, 4 respondents (11.7%) declared that their level equalled 4, while 2 respondents (5.8%) selected the maximum level, i.e. 5.

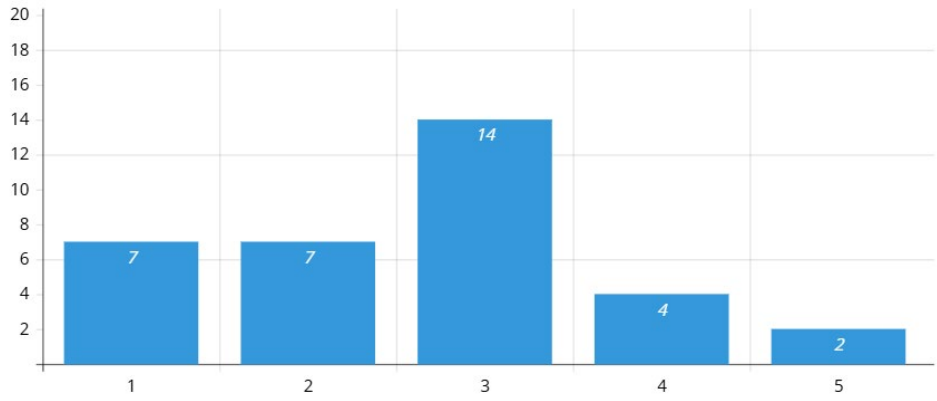

Figure 3.18 Self-reported English level among Service users on a scale from 1 to 5 (see Q5)

Therefore, it can be maintained that the majority of HCPs who opted for an interpreter exhibited an intermediate proficiency in English, with only a few self-assessing as highly confident with the language.

If language competence is mapped onto (2) the belief that specialised communication between an English-speaking patient and a non-English-speaking clinician should be handled by a professional, data show that among the 13 respondents (38.2%) who held such belief, 3 (23.8%) reported to have an intermediate-high level and 2 (15.3%) reported a high level of English command, while 6 (46.1%) claimed to have an intermediate level equal to 3, and only 2 (15.2%) self-assessed as having an intermediate-low level of English (Figure 3.19).

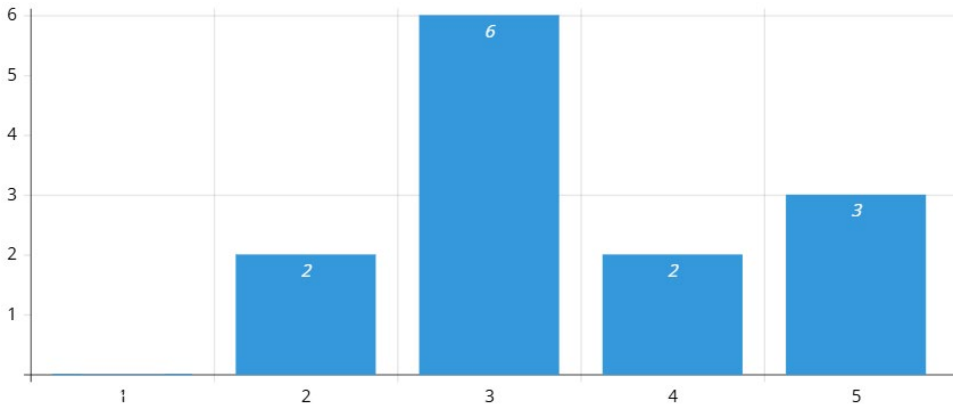

Figure 3.19 Self-reported English level on a scale from 1 to 5 (see Q5) among respondents who believed that specialized communication is best handled by professional interpreters.

Among these 13 respondents, self-reported language level is overall not necessarily low, i.e. without a predominance of levels 1 and 2. This finding would suggest self-efficacy in conducting medical encounters without language assistance, at least among the 5 respondents self-assessing as moderately and highly competent. This is why their choice to rely on professionals reflects awareness of the role of interpreters and their positive impact on care results. As mentioned in Chapter 1, several scholars discussed the notion of awareness on interpreter use in their papers (Bonacruz Kazzi & Cooper, 2003; Kale & Syed, 2010; Thompson et al., 2013; Patel et. al, 2016; Silva et al. 2021). Notably, some authors maintained that HCPs might be unclear as to when language assistance is necessary based on low awareness of their own language proficiency and positive patient outcomes associated with interpreter use (Bonacruz Kazzi & Cooper, 2003; Patel et. al, 2016). This does not seem to be the case with the current surveyed sample, at least those who resorted to this service. Such belief is most exhibited in selected responses to Q8.1.7 about the factors that most influenced each HCP's choice to continue using the Service. Indeed, it was found that the choice is only partially

influenced by factors such as the difficulty of conducting bilingual medical encounters independently or not having to make an effort to speak another language. What matters most to these HCPs and what drives them to continue requesting long-term outpatient linguistic assistance is the competence of the interpreters and enhanced sense of security and confidence when an interpreter is present. Moreover, 8 respondents (23.5%) out of 34 reported that they do understand what the interpreter is translating and are thus able to determine if the translated content is consistent with the medical information provided in Italian. This could explain why 33 HCPs (97.1%) out of 34 declared to fully trust the interpreters in their practice. Being able to testify to the competence of interpreters and, consequently, feel confident that safe and quality medical service is being delivered to U.S. patients with the help of trustworthy and qualified language professionals drove HCPs to continue relying on the Service long-term.

With regards to the third reason, (3) the feeling of discomfort in communicating clinical-therapeutic sensitive information in a language other than one's own is felt by 4 respondents (11.8%) out of 34. One possible reason behind this choice may be the field of specialisation. 2 (50%) of these 4 respondents are specialized in male and female genitourinary and reproductive system. Existing literature demonstrates that while OB/GYN and urology HCPs prefer to conduct sensitive consultations that include the display of intimate body parts with in-person interpreters, patients may prefer telephone interpreters due to concerns about privacy (Truong et al., 2023). Some patients may also have preferences regarding the gender of interpreters, especially during pelvic examinations (Truong et al., 2023). For the purpose of this study, however, telephone interpretation was not considered since the in-house Interpreting and Translation Service at hand never provides this type of assistance.

For these three main reasons, all 34 HCPs indicated that they would recommend the Service to their colleagues (Q8.1.8). The reasons provided as well as the findings recorded and illustrated in this section justify the fact that 33 respondents (97.1%) out of 34 expressed complete trust in the interpreters.

Overall, 34 respondents (34.6%) in the total responding sample, accounting for 78 individuals, maintained a positive view of interpreters. For them, interpreters are trustworthy (Q8.1.5), accountable (Q8.1.3) professionals whose role within the medical centre is useful (Q8.1.4) and highly recommended (Q8.1.8).

3.3.2 Participants who never accessed the Interpreting Service

Of the total responding sample of 78 HCPs, 44 (56.4%) chose never to use the Interpretation and Translation Service. This percentage accounts for the highest share of the responding population. The reasons behind this choice were investigated by Q8.2.1 and are four: (1) the ability to independently communicate with their U.S. patients due to a self-assessed sufficient level of English, (2) unawareness of the in-house Interpreting and Translation Service, (3) the choice not to provide medical care to patients from NATO bases and (4) too slow communication through the interpreter (cf. Figure 3.20). As in the parallel question asked to those who had used the Service, multiple options could be selected.

With regard to the first reason, 20 respondents (45.4%) expressed confidence in their English proficiency and their ability to conduct medical encounters safely without the need for an interpreter. 12 respondents (27.2%) declared that they were not aware of the existence of the in-house Interpreting and Translation Service, even though – interestingly – their answers to Q4 show that these respondents had been delivering

medical services within the clinic for at least 6 months, up to a maximum of at least 5 years. With regard to the third reason, 3 respondents (6.8%) decided not to tend to patients from NATO bases. In this case, respondents were not prompted to elaborate further to respect their privacy and choice of medical practice. Finally, one respondent (2.2%) stated that communicating through the interpreter was too slow and that for this reason he or she preferred unaided interactions.

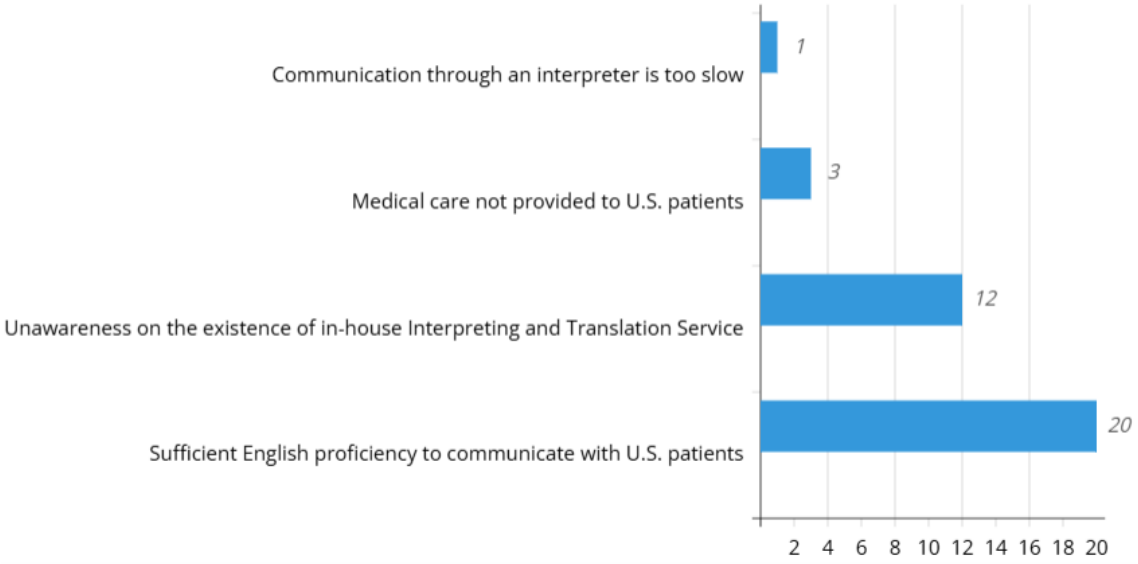

Figure 3.20. Primary reasons against interpreter use among non-users.

A low percentage (about 2.3%, i.e. N respondents) of respondents chose to expand on their reasons by selecting the answer "other". This allowed them to process in their own words what made them not opt for the Service. Some (how many) reiterated that their language level was advanced enough such as that they did not need any language assistance, while others (how many) maintained that they had never needed language assistance up to that point. At any rate, none of the 44 respondents declared that they did not trust the interpreters.

With Q8.2.2, respondents were asked to express if they thought they would rely on the Interpreting and Translation Service in the future. As shown in Figure 3.21, most (26 respondents, 59.1%) stated that they would not take this course of action while 18 (40.9%) expressed that they are likely to ask for language support in peculiar circumstances.

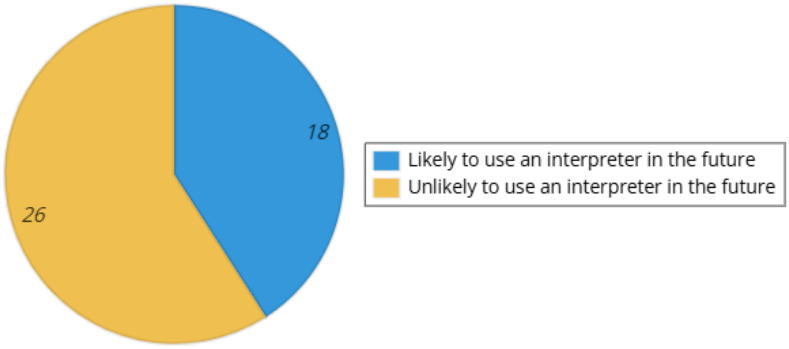

Figure 3.21. Distribution of prospects for future interpreter use by non-users.

These circumstances were explored in Q8.2.2.1. All respondents expressed that they would call for an interpreter should they find themselves in need of highly specific specialized terminology not otherwise used in ordinary clinical practice or should they need to address very complex or sensitive topics with their patients, e.g. positivity to severe conditions, invasive surgery or long-term heavy medication.

Through contingency Q8.2.3, the 44 HCPs who never used the Service were asked how often, if ever, they used other means of communication, even non-verbal, such as gestures, images, sounds, videos, machine translation, whenever they could not accurately express their thoughts in English (see Figure 3.21). Out of the total of 44 non-users, 17 (38.8%) declared occasional use, while only 3 (6.8%) reported recurrently

employing them. Most respondents (24, 54.5%) claimed they never used any of these means of communication.

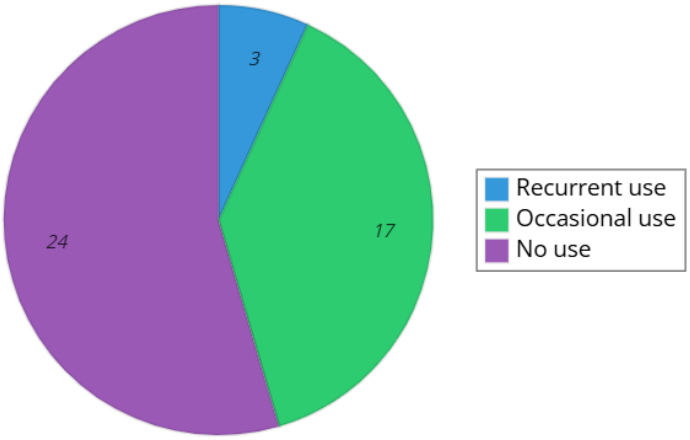

Figure 3.22 *Frequency of use, if applicable, of other means of communication among non-users.*

Respondents who declared to make occasional or recurrent use of other means of communication were prompted to specify which by Q8.2.3.1. As illustrated in Figure 3.23, 17 respondents (38.8%) declared that they used machine translation tools to help themselves during encounters with U.S. patients. Gestures and *ad hoc* interpreters, such as patients' friends or family members, were chosen as communication facilitators by 5 respondents (11.3%), while 1 respondent (2.2%) opted to help bilingual encounters with images, and another 1 respondent (2.2%) opted for practical demonstrations.

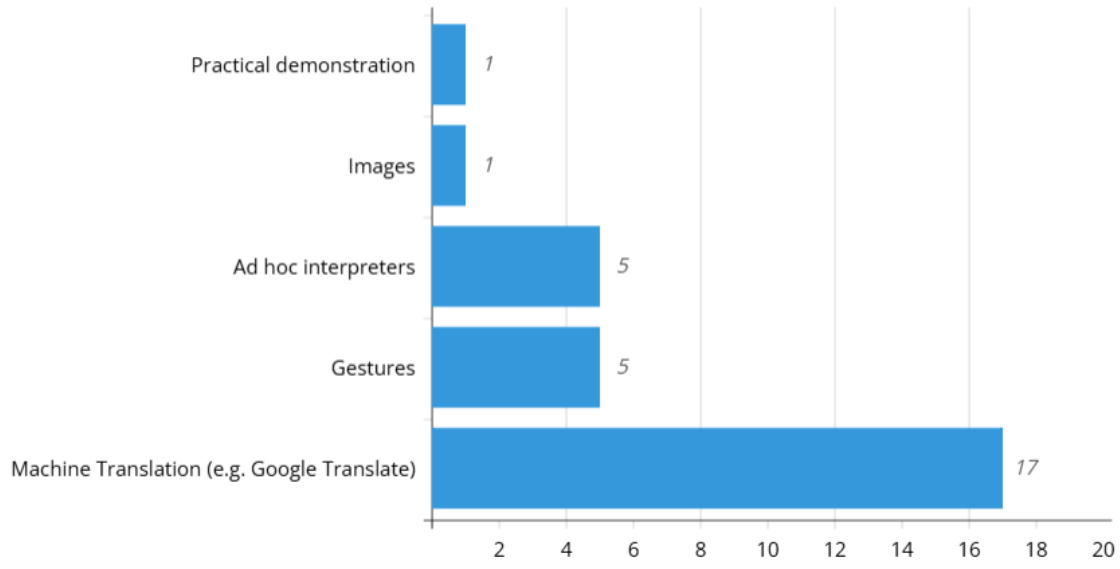

Figure 3.23. Distribution of other means of communication selected by users to contingency Q8.2.3

3.3.2.1 Discussion of the data gathered from non-users of the Interpreting Service

If the majority of the 44 non-users, i.e. 20 respondents (45.4%), declared that they were to deliver medical treatments to U.S. patients without an interpreter because of their language proficiency, their self-assessed English command should be evaluated.

When answering Q5 (see Figure 3.24), 3 of them (6.8%) selected 5, 15 (34%) selected 4, while 17 other respondents (38,6%) selected 3. With regard to lower self-declared English proficiency levels, 6 respondents (13.6%) declared that their level was equal to 2, while 2 respondents (4.5%) selected 1.

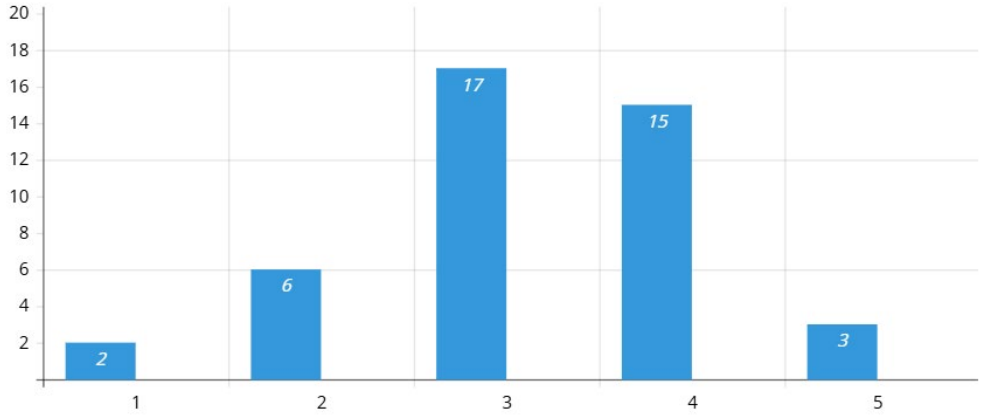

Figure 3.24. Self-reported English level on a scale from 1 to 5 (see Q5) among non-users.

Overall, this sub-sample declares to have an intermediate to high command of the English language. Compared to the sub-sample in need of language assistance, a 22.3% increase in respondents who self-reported to have an intermediate-high English level is observed (11.7% vs. 34%), i.e. 34% of the 44 respondents not in need of language assistance selected that their English level was 4 on a scale of 1 to 5.

However, there are discrepancies between the level of English declared by some respondents belonging to this group. As already mentioned in section 3.1, 4 respondents (5.1%) of the total sample stated that they had an intermediate to intermediate-high level of English, although not warranted by evidence such as attending advanced courses or significant study or professional experiences abroad. The 4 respondents identified in Section 3.1 all belong, in fact, to the sub-sample that did not require the Interpreting and Translation Service. Among these 4 respondents, 3 of them declared that they relied on alternative means to communicate with their U.S. patients, such as digital machine translation tools, ad hoc interpreters and gestures.

As mentioned in Chapter 2, the reviewed literature suggested that HCPs would use third-party digital tools to aid physician-patient communication where prompt, qualified

language assistance was not available (Bonacruz Kazzi & Cooper, 2003; Patel et. al., 2016). Despite having promptly available resident language professionals, the present study confirms this behaviour, as well as the tendency, albeit shared by a minor percentage of the total population, to sometimes resort to *ad hoc* interpreters.

As a result, two issues are noted and limited to this sample: (1) a distorted perception of their own language skills and (2) a reduced awareness regarding the risks involved in using *ad hoc* interpreters or employing media such as machine translation and gestures (Juckett & Unger, 2014). These issues are further evidenced by one respondent indicating that he or she did not need an interpreter and used gestures to communicate with patients against a self-reported low level of English, equal to 2. Nevertheless, this is a remarkably minor portion of the population.

Overall, it can be inferred that, although a relatively minor percentage of the population does not seem to be aware of the critical role of qualified interpreters in aiding clinician-patient interaction, the majority of the population who chose not to rely on language assistance still retained a positive perception of the in-house Interpreting and Translation Service.

In particular, one respondent expresses herself in these terms: “I think having a person who is fluent in English at a native-like level is a service that can give that extra something in our U.S. patients’ eyes. Although I speak English without needing interpreters, I wouldn't mind having them assist me. In addition to preventing potential miscommunications, I think it would safeguard the clinic and the clinician from any

patient who would use the language barrier as grounds for claiming damage in any capacity to both the clinic and the practitioner."[2]

3.4 Concluding remarks

This section will draw final conclusions by analysing all tendencies that emerged in the analysed sample of HCPs. Most providers (34.6%) are men over 61 who specialized in a wide range of medical fields, with the three main specialities being nursing (11.6%), physical therapy (10.3%) and orthopedy (9%).

With regards to the overall self-assessed language proficiency, most respondents, i.e 32 (41%), reported a moderate command of the English language, which is consistent with overall declared attendance to language classes of B1/B2 level, as reported by 27 (34.6%) of the total respondents (Figure 3.9). However, 57 (73.1%) out of 78 were found to have never spent more than 3 months abroad.

When asked whether or not they relied on the in-house Interpreting and Translation Service established within the medical centre, 34 participants (43.6%) answered positively, while 44 (56.4%) responded negatively (Figure 3.11). The main reasons behind the choice were identified as follows: (1) language proficiency and competence in English medical terminology self-reported as inadequate; (2) the belief that specialised communication should be handled by a professional, and (3) the discomfort in communicating clinical and therapeutic information in a language other than Italian.

[2] Unedited original comment: Penso che avere una persona che parli fluentemente l'inglese a livello madre lingua sia un servizio che possa dare quel qualcosa in più all'occhio dei pazienti americani che si appoggiano alla struttura. Sebbene parli inglese senza necessità di interpreti non mi dispiacerebbe comunque averlo presente. Ritengo inoltre che oltre ad evitare possibili incomprensioni metterebbe anche al riparo il professionista e la clinica da eventuali pazienti che potrebbero sfruttare la differenza linguistica come scusa per poter chiedere danni a qualsiasi titolo ad entrambi

The first reason was elected by 17 (50%) out of 34 respondents, the second reason was identified among 13 (PERCENTAGE) HCPs, while the third reason was found among 4 respondents (11.8%). Major factors that were elected as the most decisive in influencing such choice were interpreters' competence and an enhanced sense of safety and confidence in conducting a consultation with an English-speaking patient as a result of an interpreter being present. The first factor was rated as the most decisive by 16 HCPs (47%), while the second factor was deemed as the most influential by another 16 (47%) respondents. As the sample of 34 users was found to have an overall intermediate level of English (Figure 3.18), it appears sensible to declare that they placed high value on interpreters as competent professionals they could turn to find the necessary confidence to effectively communicate sensitive medical details to their non-Italian-speaking patients. This view reflects the findings on trust: 33 respondents (97.1%) declared to fully trust the language professionals, while only one participant stated he or she did so sometimes, as interpreters' expertise in specialized medical terminology was not considered optimal.

Non-users were 44 (56.4%) out of 78 sample respondents. None of these respondents ever mentioned that they do not trust interpreters. The reasons why they chose not to seek language assistance were the following: (1) the ability to communicate with English-speaking patients in light of self-assessed adequate levels of proficiency, (2) unawareness of the in-house Interpreting and Translation Service, (3) the choice not to provide medical care to patients from NATO bases and (4) too slow communication through the interpreter. The first reason resonates with reported higher levels of English command compared to Service users (Figure 3.24). Specifically, a 22.3% increase in intermediate-high levels is observed (11.7% vs. 34%), i.e. 34% of the 44 respondents

not in need of language assistance selected that their English level was 4 on a scale of 1 to 5. However, a small percentage of respondents, i.e. 5.1% of the 44 non-users, reported possessing an intermediate to intermediate-high level of English, although this claim lacked significant supporting evidence, such as participation in advanced classes or substantial study or work experiences overseas. This minor mismatch between self-assessed proficiency and actual command is relevant when considering that other means of communication were employed to compensate for language deficiencies among non-users, namely machine translation (38.8%), *ad hoc* interpreters (11.3%), gestures (11.3%), images (2.2%) and practical demonstrations (2.2%). Of the 44 HCPs who do not rely on the in-house Interpreting and Translation Service, 17 (38.8%) declared occasional use of such tools, 3 (6.8%) reported recurrently employing them while most respondents (24, 54.5%) claimed they never used any of these means of communication.

Given the global picture drawn on main tendencies among Service users and non-users, it can be maintained that both sub-samples of HCPs hold positive beliefs regarding interpreters. Cases of major mistrust towards language professionals were not recorded. Therefore, it can be established that the research question was answered positively.

CONCLUSIONS

The present dissertation aimed to investigate healthcare providers' perceptions of interpreters in the medical setting. Specifically, this study tried to answer the following research question: "Do healthcare providers trust interpreters?".

In order to collect valuable insights on this subject, the definition and role of the healthcare interpreter were first explored. A general overview of existing research conducted on the subject was outlined in the first chapter. Different beliefs and views were explored, and the factors eliciting positive or negative responses on interpreter use were discussed. What emerged is that although some providers, typically those who received training on interpreter use, were more favorable towards language assistance, most resorted to *ad hoc* or untrained interpreters where qualified professionals were not readily available to them. Therefore, the ground on which the present research lays is generally characterized by a significant lack of awareness on interpreter use, mostly due to substantial misinformation on the risks of malpractice, adverse patient outcomes and lawsuits which might result from the employment of unqualified individuals.

However, the study paints a rather different picture of the relationship between healthcare providers and interpreters. This stems from the fact that, unlike other medical settings explored in reviewed studies, the medical centre within which the present study was conducted has an in-house Interpreting and Translation Service that can deliver quality interpretation and is promptly available on site upon request.

The findings showed that 43.6% of the total surveyed sample, i.e. 78 providers, answered positively to the question inquiring whether or not they relied on the in-house Interpreting and Translation Service. The research question finds its answer among this

population sample, as 33 (97.1%) out of 34 respondents were found to completely trust interpreters. The one respondent who stated that he or she trusts interpreters only at times expressed doubts about interpreters' competence in specialized terminology.

These results can be explained by looking at the reasons behind their choice to continue requesting long-term outpatient linguistic assistance: the expertise of the interpreters and an increased sense of assurance when an interpreter is present. Additionally, 23.5% of the respondents confirmed that they comprehend the interpreter's translation and can ascertain whether the translated content aligns with the medical information presented in Italian.

On the other side, 56.4% of respondents declared that they never used the in-house Interpreting and Translation Service. As relevant as it is that so many providers trust and rely on the Service on a regular basis, non-users still account for the majority of the surveyed sample. While these never reported not trusting the interpreters, it is apparent that their confidence in their English proficiency and their ability to conduct medical encounters safely without the need for an interpreter prevails over the quality interpreting that they could request and that could be readily available to them.

The use of *ad hoc* interpreters and other means of communication, such as machine translation and gestures, was found also among providers with self-assessed high English proficiency. This behaviour can be interpreted as a lack of self-efficacy in assessing their own level of language command and can be associated with a general lack of awareness of the improved effectiveness of outpatient assistance that can be achieved through qualified interpreters. This lack of awareness could also stem from a lack of knowledge of the existence of such Service. Indeed, 27.2% of non-users declared that they were unaware of the in-house Interpreting and Translation Service,

even though these respondents turned out to have been delivering medical services within the clinic for at least 6 months, up to a maximum of at least 5 years. The figure indicates an oversight within the organizational framework of the medical centre, as well as a corresponding lack of understanding among physicians of the necessity to request an interpreter to support safe bilingual interactions.

In light of these considerations, it is evident that more can be done to spread awareness on the well-established and evidenced positive impacts of interpreters during medical encounters. Not only do they bridge communication and cultural gaps to ensure that patients understand medical information, but they also assist clinicians in relaying critical details about their patients' health, instructions on medications and any follow-up tests required. Extensive targeted training of providers and official recognition of interpreters via a standardized licensing system could represent two major tools that might help spread awareness about the importance of interpreter use in the medical setting.

Targeted training might educate providers on the benefits of seeking assistance when presented with individuals who speak different languages, regardless of their own language proficiency or linguistic educational background. Such training should be administered upon onboarding in the healthcare team in medical centres where major influxes of migrants are noticed, as in the case of the facility researched in the present study. Language assistance options should be clearly laid out, as well as ways to contact interpreters should the need arise.

However, there currently is no consensus on standardized regulations restricting access to the profession to those who do not meet specific criteria, such as a degree in Interpreting and Translation Studies and a reasonable number of years of experience in

the field. If a licensing system was established, interpreters could be recognized as sound and competent professionals who play a primary role in ensuring safe medical care as much as providers.

Therefore, at the present date it is unrealistic to expect every provider to place high value on interpreters as professionals. As of now, what healthcare interpreters can do to prove the validity of their role is to keep up to date with current medical terminology, participate in seminaries on specialized interpreting practices and pursue as high specialized education as available in their country.

This study has several limitations that warrant attention. First, only the insights of healthcare providers were considered. The interpreters around which this study revolves were not questioned on whether they felt trusted and valued by the clinicians they work with daily. Second, the study was conducted at a single institution with an exclusive feature, i.e. the in-house Interpreting and Translation Service, limiting its generalizability. No comparison was made between the medical centre in which the study was conducted and other facilities with similar features. Third, only 78 providers, i.e. 46.71% of the whole population, participated in the research. Due to significant time constraints, only one follow-up reminder was circulated to prompt survey completion, which resulted in a limited pool of respondents.

Further research is recommended to expand on how interpreters view themself as unlicensed professionals within medical settings and to explore their relationship with providers from their point of view.

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APPENDIX 1 – The survey

Q1 La sua età è compresa tra:

- 18-25 anni
- 26-30 anni
- 31-40 anni
- 41-50 anni

Q2 Si identifica come:

- Uomo
- Donna
- Non binario
- Preferisco non rispondere

Q3 Presso [Nome della clinica] si occupa principalmente di:

- Allergologia
- Anestesiologia
- Antalgia
- Biologia
- Cardiologia
- Chirurgia Generale
- Chirurgia Plastica ed Estetica
- Chirurgia Vascolare
- Dermatologia
- Diabetologia
- Dietologia e Scienze delll'alimentazione
- Endocrinologia
- Fisiatria
- Fisioterapia
- Gastroenterologia ed Endoscopia
- Ginecologia e Ostetricia
- Infermieristica

- Medicina dello sport
- Medicina Generale
- Nefrologia
- Neurochirurgia
- Neurologia
- Neuropsicologia
- Oculistica
- Ortopedia
- Otorinolaringoiatria
- Pneumologia
- Psichiatria
- Radiologia
- Spinometria/Baropodometria/Tecniche ortopediche
- Urologia e Andrologia
- Altro

Q4 Da quanto tempo presta servizio presso [Nome della clinica]?

- Da 1 a 6 mesi
- Da 6 mesi a 1 anno
- Da 1 a 5 anni
- Da 5 a 10 anni

Q5 Indichi il suo livello di conoscenza dell'inglese su una scala da 1 a 5.

Q6 Ha mai trascorso un periodo all'estero superiore a 3 mesi per motivi personali/professionali/di ricerca/di studio, durante il quale la lingua veicolare era l'inglese?

- Sì, per 3-6 mesi
- Sì, per 6-12 mesi
- Sì, per più di un anno
- No, mai

Q7 Ha mai seguito corsi di lingua inglese? Se si, di che livello?

- Base (A1/A2)
- Intermedio B1/B2
- Avanzato (C1/C2)
- No, mai

Q8 Ha mai fatto uso del Servizio di Interpretariato e Traduzione interno a [Nome della clinica] (interprete inglese-italiano presente in ambulatorio)?

- Sì
- No

Questions for users of the service

Q8.1.1 Con che frequenza usufruisce o ha usufruito del Servizio di Interpretariato e Traduzione?

- Solo una volta o saltuariamente (3-4 volte l'anno)
- Almeno una volta al mese
- Almeno una volta a settimana
- Più di una volta a settimana

Q8.1.2 Perché ha richiesto il servizio? Selezionare una o più opzioni.

- La mia conoscenza dell'inglese e/o della terminologia medica in inglese non è sufficiente a garantire un servizio sicuro e di qualità
- Non mi sento a mio agio nel comunicare informazioni di carattere clinico-terapeutico, anche sensibile, in una lingua altra rispetto all'italiano
- Penso che questo tipo di comunicazione specializzata debba essere curata da un/una interprete professionista
- Altro

Q8.1.3 Su una scala da 1 a 10, quanto pensa che gli interpreti di [Nome della clinica] siano professionalmente preparati ad affiancare il

medico/personale sanitario durante una visita ambulatoriale o un trattamento?

Q8.1.4. Quanto pensa che il Servizio sia utile alla comunicazione medico-paziente su una scala da 1 a 10?

Q8.1.5 Si fida della traduzione delle informazioni, anche sensibili e delicate, che gli interpreti fanno da e verso l'inglese?

- Sì
- No

Q8.1.6 Motivi brevemente la scelta precedente.

Q8.1.7 Indichi su una scala da 1 a 5 quanto i seguenti fattori influiscono sulla sua decisione di continuare ad appoggiarsi al Servizio.

- Preparazione dell'interprete
- Difficoltà nel communicare autonomamemnte in lingua inglese
- Riduzione del tempo di visita derivante dal servizio
- Maggiore sensazione di sicurezza e fiducia data dalla presenza di un/a interprete
- Non doversi sforzare di parlare un'altra lingua
- Altro

Q8.1.8 Consiglierebbe l'uso del Servizio ai suoi colleghi?

- Sì
- No

Q8.1.9 Motivi brevemente la scelta precedente.

Questions for non-users of the service

Q8.2.1 Perché non fa uso del Servizio di Interpretariato e Traduzione? Selezionare una o più opzioni.

- Non ne conoscevo l'esistenza
- Ho scelto di non prendere in carico i pazienti statunitensi/provenienti dalle basi NATO
- Ho un livello d'inglese sufficiente a comunicare con il paziente senza alcun intermediario
- Non mi fido del Servizio
- La comunicazione attraverso l'interprete è troppo lenta. Preferisco parlare direttamente con i pazienti da solo/a.

Q8.2.2 Pensa che ne chiederà l'appoggio in futuro?

- Sì
- No

Q8.2.2.1 In che occasione pensa che in futuro si appoggerà al Servizio di Affiancamento?

Q8.2.3 Le è mai capitato di avvalersi di altri mezzi di comunicazione, anche non verbale (come gesti, immagini, suoni, video, Google Translate, etc.), nel caso in cui non riuscisse ad esprimere pienamente il suo pensiero in lingua inglese?

- Sì, spesso
- Sì, a volte
- No

Q8.2.3.1 Quali tra questi? Selezionare una o più opzioni.

- Traduzione automatica (es. Google Translate)
- Gesti
- Familiari del paziente presenti in ambulatorio
- YouTube/video
- Immagini

RIASSUNTO

Nel corso degli ultimi decenni, è stato riscontrata una correlazione tra un aumento esponenziale dei movimenti di migrazione internazionale e un incremento delle barriere linguistiche presenti in ambito sanitario (Khoong & Fernandez, 2021). Infatti, sono sempre più numerosi gli individui che, a fronte di una scarsa conoscenza linguistica del Paese ospitante, si trovano ad avere un accesso limitato alle risorse sanitarie. Pertanto, risulta evidente come la presenza di una figura specializzata nel facilitare la comunicazione medico-paziente possa concorrere a garantire un accesso più equo alle cure mediche. La letteratura esistente sostiene ampiamente che l'impiego di interpreti nella pratica medica comporta risultati clinici migliori, portando il personale sanitario ad adottare un atteggiamento positivo nei confronti dell'assistenza linguistica (Michalec et al. 2015; Hsieh, 2006; Silva et al., 2021).

Tuttavia, un altrettanto ampio ventaglio di ricerche evidenzia la tendenza di alcuni operatori sanitari a sorvolare sull'uso dell'interprete a favore di altri mezzi di comunicazione per colmare il divario di natura non solo linguistica, ma anche culturale, che può intercorre tra medico e paziente (Bonacruz & Kazzi, 2003; Flores et al. 2005; Lee et al., 2006; Karliner et al., 2007; Patel et al., 2016). Le ragioni alla base di questa scelta sono varie, tra cui una scarsa disponibilità e competenza dei servizi di interpretariato (Hadziabdic et al., 2010; Juckett & Unger, 2014; Ono & Jinghua, 2024), nonché una generale mancanza di consapevolezza del ruolo critico svolto dagli interpreti nell'evitare casi di negligenza medica (Quan & Lynch, 2010; Thompson et al., 2013).

A partire dalla letteratura esistente in materia e fino ad ora brevemente introdotta, il presente lavoro di tesi mira a indagare ulteriormente le opinioni e le convinzioni degli operatori sanitari circa l'impiego di interpreti in ambito sanitario. L'obiettivo principale è quello di determinare se i medici si fidano degli interpreti, approfondendo i fattori che influenzano la decisione di alcuni di ricercare assistenza linguistica e gli argomenti presentati da altri contro questa pratica.

Le motivazioni che hanno portato all'elaborazione di questa tesi sono di natura tanto accademica, quanto personale. L'interesse per la traduzione di testi specialistici deriva dalle esperienze formative offerte dal Corso di Laurea Magistrale in Lingue Moderne per la Comunicazione e Cooperazione Internazionale (LM-38), al conseguimento del quale aspira il presente elaborato. Se da una parte l'interesse per ricerca terminologica e gli aspetti più tecnici della traduzione abbiano portato a intraprendere questo percorso accademico, è altrettanto vero che il riscontro umano dell'utilità sociale dell'interprete in contesto medico è alla base di decisioni di natura più personale. Poter assistere i pazienti durante le visite ambulatoriali per aiutarli a comprendere in maniera corretta i risultati delle valutazioni cliniche e le indicazioni terapeutiche fornite dal medico è la principale motivazione alla base della candidatura per la posizione di Interprete e Traduttrice presso un centro medico privato del territorio Veneto. Tra i servizi sanitari ambulatoriali e chirurgici erogati, la clinica collabora con programmi di assistenza sanitaria affiliati alle forze armate statunitensi, in particolare alle basi militari presenti sul territorio italiano. A fronte di un'alta affluenza di pazienti di lingua inglese e a fronte di un altrettanto elevato numero di medici residenti con una limitata conoscenza dell'inglese, introdurre un servizio di interpretariato interno al team medico è stato ritenuto essenziale per mantenere una qualità ottimale dei servizi erogati. Dopo circa tre

anni di esperienza professionale in questo contesto, è stato ritenuto ragionevole indagare se il comparto sanitario si fidi effettivamente dell'operato del Servizio di Interpretariato e Traduzione interno alla clinica. Infatti, a differenza di altri contesti esaminati in letteratura, il centro medico entro il quale è stato condotto il presente studio dispone di un servizio di interpretariato e traduzione in grado di fornire assistenza linguistica di qualità direttamente in loco. Nello specifico, questo studio ha cercato di rispondere alla domanda di ricerca che costituisce parte del titolo dell'elaborato: "Il personale sanitario si fida degli interpreti?".

Al fine di arrivare a fornire una risposta oggettiva e criticamente argomentata a questa domanda, l'elaborato è stato ripartito su tre capitoli.

Il primo capitolo delinea una panoramica generale della letteratura esistente in materia di impiego dell'interprete nella pratica medica. Un ampio corpo bibliografico è stato analizzato al fine di raccogliere diversi punti di vista, opinioni e convinzioni a supporto di posizioni a favore o contrarie all'uso degli interpreti. Ne è risultato che il terreno su cui si basa la presente ricerca è caratterizzato da una significativa mancanza di consapevolezza riguardo ai rischi di negligenza medica, con conseguenti effetti negativi sulla salute del paziente, che possono derivare dall'assunzione di persone non sufficientemente qualificate a ricoprire il ruolo di interprete. Infine, il capitolo approfondisce il tema del riconoscimento degli interpreti come professionisti a pieno titolo in Italia, con particolare attenzione alle sfide derivanti dalla mancanza di consenso nazionale su requisiti e criteri che gli interpreti dovrebbero trovarsi a soddisfare per accedere all'ambiente medico. I ruoli di mediatore linguistico e interprete vengono confrontati e discussi attraverso una breve panoramica della normativa italiana.

Il secondo capitolo illustrata la struttura del sondaggio e i metodi di somministrazione dello stesso. Il sondaggio, completamente anonimo, è stato creato con Google Form. Questa piattaforma è stata considerata il miglior strumento di ricerca ai fini di questo studio in ragione della sua popolarità, delle impostazioni di condivisione e dell'accessibilità della sua interfaccia. Il sondaggio si compone di 22 domande volte a profilare il background del personale sanitario in termini di competenza linguistica e a indagare sui fattori che più influiscono sulla loro decisione di appoggiarsi o meno al Servizio di Interpretazione e Traduzione. Il personale a cui è stato somministrato il sondaggio via e-mail si componeva di 167 individui, tra cui medici di medicina interni, chirurghi, infermieri, fisioterapisti, specialisti in sala operatoria e tecnici di radiologia. Il sondaggio è rimasto attivo nei mesi di maggio a giugno 2024.

Il capitolo si conclude con una panoramica generale dei dati demografici della popolazione interpellata, con un breve accenno alla loro lingua madre.

Il terzo capitolo presenta tutti i dati raccolti e delinea in modo critico i principali risultati. I dati sono stati analizzati dapprima in maniera aggregata e poi filtrati in base a criteri quali fascia d'età e livello di conoscenza dell'inglese.

Di 167 interpellati, i partecipanti al sondaggio sono risultati 78 (46.7%), di cui 34 (43.6%) fanno uso del Servizio in maniera più o meno regolare. Gli utenti del Servizio sono prevalentemente uomini, in media sopra i 61 anni e specializzati in una vasta gamma di ambiti di specializzazione tra cui emergono infermieristica, fisioterapia e ortopedia.

Per quanto riguarda le ragioni che spingono questa fascia di intervistati ad appoggiarsi al servizio di interpretariato, le seguenti sono state individuate: una padronanza linguistica e una competenza nella terminologia medica inglese percepite

come inadeguate, la convinzione che la comunicazione specializzata debba essere gestita da un professionista e la sensazione di disagio nel comunicare informazioni cliniche e terapeutiche in una lingua diversa dall'italiano.

I principali fattori ritenuti maggiormente decisivi nell'intraprendere questa scelta e riconfermarla sul lungo termine sono stati individuati nella competenza degli interpreti e in un maggior senso di sicurezza e fiducia derivati dalla presenza di un interprete.

Poiché il campione di utenti del Servizio ha dichiarato di avere, in media, un livello d'inglese intermedio assimilabile ad un livello B1/B2 (e pertanto non significativamente basso) sembra ragionevole dichiarare che questi partecipanti attribuiscono un alto valore alla figura dell'interprete quale professionista competente a cui rivolgersi per comunicare efficacemente e in sicurezza con i propri pazienti di madrelingua inglese. La domanda di ricerca trova la sua risposta in questo campione di intervistati, in quanto 33 (97,1%) su 34 hanno dichiarato di fidarsi completamente degli interpreti. Un solo rispondente ha dichiarato di fidarsi di loro solo a volte, esprimendo dubbi sulla loro preparazione in materia di terminologia specializzata.

Per quanto rilevante sia il fatto che così tanti medici ricerchino assistenza linguistica, sono 44 (56,4%) su 78 i partecipanti che hanno dichiarato di non aver mai utilizzato il Servizio. I motivi per cui hanno scelto di non cercare assistenza linguistica sono stati identificati nei seguenti: la propria capacità di comunicare con i pazienti di lingua inglese alla luce di livelli linguistici da loro riferiti come adeguati, la mancata conoscenza dell'esistenza del Servizio, la scelta di non fornire cure mediche ai pazienti provenienti dalle basi NATO e una percezione di rallentamento riscontrato nell'impiego dell'interprete per mediare la comunicazione interlinguistica medio-paziente.

Pur non avendo espresso sfiducia nei confronti degli interpreti e pertanto confermando la positività alla domanda di ricerca, è evidente che la conoscenza dell'inglese da loro riferita e la conseguente capacità di interfacciarsi con i pazienti senza la necessità di un intermediario prevalgono sulla possibilità di richiedere ed ottenere immediatamente un servizio d'interpretazione di qualità.

Tuttavia, una piccola percentuale tra questi intervistati, pari 4 (5,1%) su 44, ha riferito di possedere un livello medio-alto di inglese, anche se questa affermazione mancava di riscontro oggettivo, come la partecipazione a corsi di lingua avanzati o periodi significativi trascorsi all'estero per motivi di studio o lavoro.

A riprova di ciò, l'uso di interpreti *ad hoc,* come ad esempio i familiari del paziente, e di altri mezzi di comunicazione, come la traduzione automatica, i gesti, le immagini e le dimostrazioni pratiche è stato riscontrato anche tra i partecipanti che dichiaravano di possedere un'elevata competenza in inglese. Questo comportamento può essere ricondotto ad una mancanza di autoefficacia nella valutazione del proprio livello linguistico e può essere associato a una generale mancanza di consapevolezza riguardo ai maggiori risultati comunicativi che possono essere raggiunti grazie ad interpreti qualificati. Ad ogni modo, nessuno tra questi 44 rispondenti si è espresso negativamente nei confronti degli interpreti. Un mancato uso del Servizio non sembra associarsi a una mancanza di fiducia nelle competenze dell'assistenza linguistica, quanto più a una generalizzata preferenza a gestire in autonomia l'incontro bilingue medico paziente.

Pertanto, i risultati del sondaggio presentati nel terzo capitolo delineano un quadro globale in cui tutti i partecipanti sono generalmente ben disposti nei confronti della figura dell'interprete, senza particolari e importanti casi di sfiducia. Si può quindi stabilire che la domanda della ricerca ha ricevuto una risposta positiva.

Alla luce di queste considerazioni, è evidente che sia necessario raggiungere un più alto grado di consapevolezza riguardo gli effetti positivi che derivano dall'intervento degli interpreti a favore del paziente e del personale sanitario stesso.

Non solo ricoprono un ruolo essenziale nel colmare lacune linguistiche e culturali volte a garantire un accesso equo ai servizi sanitari, ma aiutano anche i medici a trasmettere correttamente dettagli critici sulla salute dei loro pazienti, istruzioni sull'assunzione di farmaci e indicazioni riguardo ai test di follow-up richiesti.

Una formazione mirata riguardo l'uso dell'interprete e il riconoscimento ufficiale di questa figura attraverso l'istituzione di un albo professionale potrebbero rappresentare due strumenti decisivi verso una comunicazione interlinguistica medico-paziente più consapevole e sicura.

Ad oggi e a livello globale, ciò a cui gli interpreti che operano in ambito sanitario possono aspirare per conferire validità al proprio ruolo è rimanere aggiornati sulla terminologia medica d'uso corrente, partecipare a seminari incentrati sulle pratiche di interpretazione specialistica e perseguire i più alti gradi di formazione disponibile nel proprio Paese.

Inoltre, è necessario espandere le ricerche sulla percezione che gli interpreti hanno della propria condizione professionale. In particolare, sarebbe interessante esplorare la relazione tra medico e interprete dal punto di vista di quest'ultimo.

In questo senso, il presente studio avrebbe beneficiato di un approfondimento riguardo la sensazione di fiducia percepita dagli interpreti del Servizio da parte del personale medico.

Inoltre, lo studio è stato condotto presso un'unica clinica, la quale presenta la caratteristica esclusiva di avere al proprio interno un servizio di assistenza linguistica

disponibile a tutto il personale. Condurre uno studio parallelo in una clinica sprovvista di tale servizio avrebbe ampliato gli orizzonti di ricerca e avrebbe delineato in modo più dettagliato la relazione tra medico e interprete in contesti eterogenei.

Infine, solo 78 fornitori (46,7%) hanno partecipato alla ricerca su 167 intervistati. A causa di notevoli vincoli di tempo, è stato inviato un solo messaggio di promemoria per il completamento del sondaggio e ciò ha comportato un numero limitato di partecipanti.