

THE INFLUENCE OF HEALTHCARE PROFESSIONALS ON THE RECOGNITION AND DEVELOPMENT OF MEDICAL INTERPRETING¹

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Resumen

Numerosos estudios demuestran que las barreras lingüísticas a las que se enfrentan los profesionales sanitarios al comunicarse con los pacientes alófonos disminuyen la calidad de la asistencia prestada. Sin embargo, en los servicios sanitarios españoles con frecuencia se infravaloran estas dificultades comunicativas y se recurre a la interpretación *ad hoc* para tratar de superarlas. El propósito principal de este artículo consiste en mostrar cómo el desconocimiento por parte de los profesionales de la salud sobre la complejidad del rol del intérprete y sobre los riesgos que conlleva el empleo de intérpretes sin formación contribuye a que se recurra a estos últimos. Asimismo, en última instancia, pretendemos resaltar la influencia que ejercen los profesionales sanitarios en el desarrollo de la interpretación médica.

Abstract

The linguistic barriers that healthcare professionals encounter when communicating with foreign language-speaking patients diminish the quality of medical care, as has been demonstrated in several studies. Nevertheless, in Spanish health services, these communicative difficulties are frequently underestimated and, in order to overcome them, *ad hoc* interpreters are used. The main objective of this article consists in showing that the use of untrained interpreters partly derives from healthcare professionals'

1. This article is the English version of “La influencia de los profesionales sanitarios en el reconocimiento y el desarrollo de la interpretación médica” by Almudena Nevado Llopis. It was not published on the print version of *MonTI* for reasons of space. The online version of *MonTI* does not suffer from these limitations, and this is our way of promoting plurilingualism.

unfamiliarity with the complexity of the interpreters' role and their lack of awareness of the risks involved in communicating through unqualified interpreters. Ultimately we expect to emphasize the influence of healthcare professionals on the development of medical interpreting.

Palabras clave: Profesionales sanitarios. Interpretación médica. Interpretación *ad hoc*. Interpretación telefónica.

Keywords: Healthcare professionals. Medical interpreting. *Ad hoc* interpreting. Telephone interpreting.

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1. Contextualization

Health is a universal human right that should be guaranteed to every citizen living in today's multicultural societies. Nevertheless, this right is violated when patients and healthcare professionals do not speak the same language and, therefore, encounter barriers that complicate or hamper their communication. Due to these barriers, access to and use of healthcare services by allophone patients are difficult and, in the end, healthcare provided to them may be of low quality. In fact, several studies demonstrate that when communication in medical settings is unsuccessful, there is the possibility of inadequate diagnosis, lack of compliance with treatments, deficient control or monitoring of patients, incomplete examinations, or unnecessary tests and hospitalizations (Leanza, 2007: 11-12).

In short, as stated by Wadensjö (1998: 51), if healthcare professionals cannot communicate with their patients, if they are unable to understand patients' explanations or to make their own explanations understood, they will hardly provide appropriate medical care.

Among the different strategies used in order to overcome the aforementioned barriers, are the linguistic services that, generally speaking, can be offered by four different types of persons (Phelan and Parkman, 1995: 555): bilingual healthcare professionals, professional interpreters, patients' relatives or friends, and volunteer or non-professional interpreters.

Putting aside bilingual healthcare professionals, who do not fall within the scope of this article, the most adequate way to facilitate communication between healthcare staff and allophone patients is undoubtedly the use of professional interpreters, because, at least theoretically, they will have the minimum competences to interpret and they will respect the ethical principles related to their profession.

The third and fourth suggested strategies can be considered as comprising the same category, in which any person who interprets without the knowledge, skills and attitudes necessary to successfully interpreting is included. This kind of exercise is usually called *ad hoc* (or natural) interpreting and, as we will see later, there are many negative consequences derived from its use.

As far as the adoption of one or the other strategies is concerned, according to Ozolins (2010), host countries receiving immigrants have given four types of responses to overcome the linguistic barriers that arise in the communication between public service providers (and, therefore, healthcare professionals) and allophone users. These responses consist basically of neglecting the need to provide interpreting services in the public sector (e.g. in some countries of Eastern Europe), the provision of *ad hoc* services (e.g. in Italy), the creation of generic linguistic services (e.g. in Canada), and the implementation of comprehensive and widespread solutions (e.g. in the United Kingdom or in Australia).

In the Spanish context, there are some local initiatives consisting of the use of professional interpreters in healthcare services. Among these initiatives, the experience of some pioneering hospitals that have implemented linguistic services to favour communication with allophone patients, such as Hospital Ramón y Cajal (Madrid) or Hospital Punta Europa (Algeciras), are worthy of note. Nevertheless, different studies² show that the most commonly used strategy in Spain is the use of *ad hoc* interpreters in hospitals and clinics. These interpreters are rarely asked to demonstrate their training and expertise. On the contrary, the only selection requirement is their personally declared knowledge of their two working languages. Obviously, their salary and their acknowledgement are similarly valued and, therefore, as poor as the criteria applied in their selection. As a consequence, trained professionals who would be able to interpret adequately often lose their interest in working in this setting and work as interpreters in other contexts. In conclusion, in the Spanish healthcare services, as pointed out by Valero-Garcés (2013: 81), there is a generalized lack of awareness of the benefits provided by professional interpreting when communicating with foreign language-speaking patients or of the possible high risks and costs when *ad hoc* solutions are used.

According to Corsellis (2010: 12-14), the advance of public service interpreting (or, in our case, healthcare interpreting) can be attributed to attitudes and behaviours shown by three interrelated groups. In the first place, the interpreters themselves should fight for the establishment of a professional framework that regulates their performance, contributing, in this way, to the acknowledgement of their training and expertise and to their deserved recognition in every sense, both social and economic. Secondly, public service

2. Examples include research carried out by FITISPoS group, regarding Spanish central zone (Madrid and surroundings), by Grupo MIRAS, concerning Cataluña, or by Grupo CRIT, in relation to Comunidad Valenciana.

interpreting professionalization depends also on governments, which are ultimately responsible for the creation of national structures and systems concerning the recruitment of interpreters. Additionally, healthcare services or, more specifically, the professionals working in them, should be aware of the linguistic barriers that they encounter when communicating with allophone patients and should try to find the most adequate solution to overcome these barriers.

It should be mentioned that the last two groups are those who exert most influence on the development of this profession that, in the words of Ozolins (2000, cited in Valero-Garcés and Martin, 2008: 4), is “institution-driven”. As a result, it is necessary to raise the awareness of these groups and to prove, through rigorous research, that if public funds were allocated to facilitate communication between healthcare professionals and foreign language-speaking patients, all parties would benefit. In this way, the interest of governments and healthcare professionals in establishing a coherent national structure that promotes the recruitment of duly qualified interpreters and determines the competences necessary for high-quality interpretation would be increased.

2. Subject under study and research methodology

As it is not possible to study the Spanish case as a whole in these pages, in the next section, by way of an illustration, we describe the strategies and solutions used over the last few years in the medical settings of a Spanish city, located in the Aragonese region, to eliminate the barriers to communication between healthcare professionals and allophone patients.

Our main objective consists of proving that factors such as neglect of or the underestimation of the significance of linguistic barriers by healthcare professionals, as well as their lack of awareness of the complexity of the interpreter's role and of the risks derived from using *ad hoc* interpreters, contribute to the use of this non-professional solution even when professional interpreting services are available. In addition, we aim to emphasize the influence exerted by healthcare professionals in relation to the development of medical interpreting.

The data presented come from a research study in which communication between healthcare professionals and non-Spanish speaking users of a women's and children's hospital in the aforementioned city was analysed. Specifically, we show part of the results obtained using, on the one hand, the document analysis technique³ and, on the other hand, information obtained

3. The analysed documents were provided mainly but not exclusively by local public administration and by the two organizations responsible for the provision of interpreting services in the hospitals and clinics in this Aragonese city.

from twenty-five semi-structured personal interviews and a discussion group in which healthcare professionals from the studied hospital participated.

Interviews were carried out between May and October 2012 and, in order to ensure the representativeness of the sample, the participants had different professional roles. Specifically, five anaesthesiologists, six nurses, seven midwives, four obstetricians and three socio-sanitary staff members (two nursing assistants with IT related tasks and a social worker) were interviewed. When data from interviews had been analysed, in June 2013, a discussion group was organised. Our purpose with this discussion group was to confirm, verify and extend information in those areas that were previously considered ambiguous, underdeveloped or inconsistent. With the combination of the data collected by means of these two techniques we aimed to provide increased reliability to the research. As in the case of the interviews, the participants in the discussion group had heterogeneous roles: the sample was formed by three obstetricians, two midwives and one nurse.

Both the interviews and the discussion group were audio recorded and later transcribed *verbatim* in order to facilitate their subsequent analysis.⁴ Questions posed in both cases followed a variable script that depended on the professional group responding to them and were subject to modifications or digressions brought about by the answers received. Items were open-ended allowing participants to share their experiences without being confined to the researcher's perspective or to the results of previous research projects. Additionally, questions were divided into different sections concerning topics such as the participants' general experience when providing healthcare to non-Spanish speaking patients, their interaction with these patients, or the social attitudes shown by healthcare professionals. The information described in this article comes from one of the important sections, which was specifically related to the linguistic barriers encountered by healthcare professionals when communicating with allophone users and the solutions adopted by the hospital under study and the professionals working in it in order to reduce or eliminate these barriers.⁵

We will divide the results analysis into different subsections that refer specifically to the following topics: on the one hand, the strategies employed in

4. Transcriptions were analysed using the qualitative data analysis software NVivo10. This software aided us to encode and classify the collected information according to the different topics (nodes) later included in our report on research results.

5. We will present the particular questions posed to healthcare professionals during the interviews and the discussion group concerning the different topics analysed in this article.

the studied hospital to reduce or eliminate the linguistic barriers encountered when communicating with allophone patients and, on the other hand, healthcare professionals' opinions and behaviour regarding the aforementioned barriers, the solutions adopted and the interpreter's role.

3. Main results of the study

As we have previously stated, in this section, we present, firstly, the main strategies used in the healthcare services of the city under study to overcome the linguistic barriers that arise when communicating with patients who do not speak Spanish. Furthermore, we briefly explain the advantages and disadvantages of these strategies. Secondly, we describe the opinions and behaviour of the healthcare professionals that participated in our research concerning the aforementioned barriers and the most frequent solutions adopted to overcome them. In the last subsection, we present healthcare professionals' understanding in relation to the interpreter's role and tasks and to the requisites necessary for adequate interpreting.

3.1. *Strategies used in the studied hospital in order to facilitate communication with allophone patients*

Several strategies have been simultaneously or alternately used in the studied context during the last few decades with the aim of improving communication between healthcare professionals and allophone patients. Among these strategies, different figures have provided interpreting services.

On the one hand, face-to-face interpreting has been provided by *ad hoc* interpreters, who were patients' family and friends or members of the Permanent Interpreting Service that was managed by a local social centre for immigrants and minority ethnic groups.

According to the collected data, the use of family and friends as interpreters is the most frequent solution adopted in the hospital studied. This strategy has some advantages, as for example, the 24 hour availability of family and friends, their previous acquaintance with the patient's health problems, and a possible lessening of the patient's anxiety when he/she is with them. Nevertheless, there are some significant risks when using family and friends as interpreters. For example, they tend to give their opinion or their own version of facts, instead of transmitting original messages sent by the speakers. They also often decide to omit some data in order to protect the patient. Besides, both they and the patient frequently may feel annoyed or embarrassed when private or delicate issues are discussed. In addition, a patient's

privacy is ultimately violated when interpreting is provided not by his/her family and friends, but by another patient's companion.

The aforementioned Permanent Interpreting Service was created in 1999, thanks to an agreement signed by the local government and the bar association of the studied city, and was suppressed in 2012. It had a limited availability (in particular, from Monday to Friday, from 9:00 am to 9:00 pm). Registered interpreters were mainly immigrants who were only required to be in possession of residence permits. They were not required to present any certificate or accreditation concerning their linguistic knowledge or their interpreting training. Moreover, these interpreters were not expected to respect any code of ethics and their performance was not quality-assessed.⁶

When the two solutions described above are employed, communication between healthcare professionals and allophone patients will very probably be non-effective, mainly due to the lack of training and expertise shown by these people who work as *ad hoc* interpreters. They not only show a lack of knowledge about language and interpreting techniques, but are also unable to confront the difficulties inherent in this occupation, especially those of a psychological nature. Additionally, they are unaware of many important aspects of their role and the ethical principles that they should respect (Wadensjö, 1998: 52).

Consequently, these *ad hoc* interpreters will surely commit the five basic errors identified by Vásquez and Javier (1991, cited in Hale 2010: 48), that consist of the omission of information (when the interpreter completely or partially eliminates the message transmitted by the speakers), the addition of information (or inclusion of information not provided by the speakers), the condensation (or tendency to simplify or synthesize messages transmitted by the speakers), the substitution of information (or tendency to replace concepts), and the role exchange (when the interpreter plays the role of one of the speakers and makes questions or offers responses instead of them).

Lack of training also probably accounts for the lack of adherence to the principles contained in nearly all the medical interpreters associations' codes of ethics.⁷ In fact, *ad hoc* interpreters often breach the faithfulness principle

6. Information presented in this paragraph was collected in an interview conducted with the interpreting service manager and the official documents provided by her.

7. Regarding codes of ethics, the following documents could be consulted: *California Standards for Healthcare Interpreters: Ethical Principles, Protocols and Guidance on Roles & Intervention* (CHIA, California Healthcare Interpreters Association, USA, 2002); *IMIA Standards of Practice* (International Medical Interpreters Association, USA, 2007);

(when omitting, adding or personally interpreting some information), the impartiality principle (due to the difficulties encountered when trying to be emotionally distanced, since they come from the same family or community as the patient), or the confidentiality principle.

In addition, when untrained people interpret in healthcare settings, they receive an important emotional impact, especially when they are minors, due to their role exchange in their family context and because they are given information that is too weighty for their maturity level.

In conclusion, since *ad hoc* interpreters present a lack of the competences required for efficient interpreting, when they are used there will probably be some negative consequences for healthcare provided, such as “reduced trust in physicians, lower patient satisfaction [...], misdiagnosis, inadequate or inaccurate treatment, and reduced quality of care” (Jacobs *et al.*, 2001: 469, cited in Angelelli, 2008: 23).

Apart from the two *ad hoc* solutions described, in June 2009 a telephone interpreting service managed by a private company was implemented in the hospitals and clinics of this city. This service has been offered sporadically to the present. In relation to its availability, the interpreting service is provided 24 hours a day all year long in medical settings. Therefore, unlike the previously analysed face-to-face interpreting service, telephone interpreting does not present any restriction in terms of days or hours of availability. Concerning the technical conditions of this service, the company provides dual-set phones, and consequently it is possible to maintain a three-way conversation (in which the two speakers can listen to their interventions and that of the interpreter at all times), and so the inconvenience of having to pass the telephone to each other is avoided.⁸

The main advantages of this service are, on the one hand, the use of professional interpreters (who have official training in translation and interpreting or, otherwise, have to pass a test that determines their ability to interpret over the phone) and, on the other hand, if compared to face-to-face interpreting, its lower costs and its immediacy.

National Standard Guide for Community Interpreting Services (Healthcare Interpretation Network, Canada, 2007); *National Standards of Practice for Interpreters in Healthcare*, (National Council on Interpreting in Healthcare, USA, 2005).

8. Information related to the telephone interpreting service presented in this article has been extracted, on the one hand, from the official documents concerning technical terms and conditions and, on the other hand, from the data offered by the company providing the service.

Concerning its disadvantages, the physical distance between the interpreter and the speakers, and the consequent lack of a common frame of reference and the inability to see the non-verbal language, can cause omissions or misunderstandings. As stated by Wadensjö (1999: 254), telephone interpreters, if compared with face-to-face interpreters, are not able to catch information provided by a speaker's gestures, posture, mime or other non-verbal elements, which play an essential role in communication and, therefore, are very important for a correct interpretation.

However, the physical distance of the interpreter can also be considered as a positive factor, since it ensures confidentiality in certain situations (as, for example, when examinations are done in medical consultations). In addition, it can mitigate the preference for male or female interpreters expressed by some patients (Mikkelsen, 2003: 260).

Finally, the main disadvantage of the telephone interpreting service in the this context is, undoubtedly and as we will see in the following subsections, its under-use, which is caused partly by healthcare professionals' lack of awareness of its existence and partly by their behaviour regarding linguistic barriers encountered when communicating with allophone patients and their misconceptions about the interpreter's role and the competences required to interpret adequately.

3.2. *Healthcare professionals' opinion and behaviour*

As its title indicates, this subsection is dedicated to the opinion and behaviour shown by healthcare professionals working in the hospital studied in relation to the linguistic barriers that they encounter when communicating with allophone patients and with the strategies that they use in order to overcome them. With the purpose of illustrating our results, we include some *verbatim* pieces extracted from the interviews and the discussion group,⁹ and so we give voice to the participants in our research.

9. These pieces are presented in their original language (Spanish) and then translated into English in footnotes. In order to ensure participants' anonymity, they are identified, as far as the interviews are concerned, with their professional role and a number that indicates the chronological order in which interviews were carried out. Regarding the discussion group, participants' identifying tag starts with the acronym GD (*grupo de discusión* – discussion group) followed by their professional role and the number that indicates the order in which their personal details were noted down. Additionally, it should be pointed out that participation was voluntary and that all the participants signed an informed consent form attesting to their willingness to cooperate in the research.

3.2.1. What do healthcare professionals think about linguistic barriers?

When asked during the interviews and the discussion group about the obstacles they encounter when relating to foreign patients, healthcare professionals point out linguistic barriers as the main cause of the difficulties that arise when providing healthcare to these patients. In fact, they were the first barriers mentioned when one of the first questions of the interviews was posed, which was exactly as follows: “If you consider that problems encountered with foreign patients are different or greater than those encountered with Spanish patients, what are the main causes of these problems according to you?”. Besides, linguistic barriers were also indicated by participants in the discussion group when they were asked: “In your opinion, what are the main causes of the difficulties that arise when providing healthcare to foreign patients?”.

On the contrary, despite the importance attributed to linguistic barriers, participants in our research show two opposing attitudes when they are asked “What type of linguistic problems do foreign users normally present?” during the interviews, or “Do you encounter linguistic barriers when communicating with foreign patients?” during the discussion group.

On the one hand, some healthcare professionals downplay the communication problems derived from the lack of a common language. In their opinion, there are currently few patients who do not speak any Spanish at all and they have always succeeded in communicating with them in one way or another.

- “De todos modos, la verdad es que encontrarte con una paciente que no sepa nada, nada, nada de español es difícil. Todas saben alguna palabra.” [Anaesthesiologist 5]¹⁰
- “Vamos, para simplemente entenderte, yo creo que te puedes entender con cuatro palabras, que son las que te sirven para saber si hay alguna patología o si todo entra dentro de la normalidad.” [Midwife 2]¹¹
- “Yo diría que siempre de algún modo esa barrera la hemos conseguido superar. Y, fíjate, que hemos tenido gente de todas partes, y nunca he tenido problema para comunicarme. Yo creo que la comunicación

10. “In any case, it is difficult to find a patient who does not speak any Spanish at all. All the patients know at least a few words.”

11. “If you are just trying to understand, you can do it with just three or four words, those you need to know whether there is any pathology or if everything is more or less within normal limits.”

depende de cada uno, si uno quiere comunicarse, por un medio o por otro lo conseguirá.” [Obstetrician 1]¹²

On the other hand, there are some healthcare professionals (the great majority of them) who describe linguistic barriers as an important obstacle, even the greatest that they encounter when providing healthcare to foreign patients. They think that the lack of knowledge of Spanish prevents these patients from expressing themselves or from understanding the explanations provided by healthcare professionals.

- “Los problemas con las usuarias inmigrantes son mayores. Sobre todo con aquellas que no entienden español y no hablan. Pero sobre todo con las que no entienden, porque no les puedes explicar nada de lo que les vas a hacer. Nosotros necesitamos que ellas colaboren y nos den una serie de datos y poder explicarles un poco en qué consiste lo que les vamos a hacer. Y si no hablan español, esto es imposible.” [Anaesthesiologist 2]¹³
- “El desconocimiento de la lengua creo que es, al menos para mí, una cosa fundamental. El prestar una atención correcta a una persona que no sabes con qué te puedes enfrentar, esto es como irte... yo que sé... como irte a la sabana y decir «Vamos a ver si tengo a los lobos ahí esperándome».” [Anaesthesiologist 3]¹⁴

According to some healthcare professionals, their inability to communicate with allophone patients will probably result in important medical or legal consequences, especially in relation with the use of the epidural anaesthesia in the context of our study.

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12. “I would say that we have always succeeded in overcoming this barrier one way or another. Listen to this... We have had patients from all over the world and I have never had a problem when communicating with them. I think that communication depends on oneself, that is, if you want to communicate, one way or another you will succeed in communicating.”
 13. “Problems with foreign patients are greater than those encountered with Spanish patients. In particular, with those who do not understand or speak Spanish. But especially with those who do not understand, because we cannot explain to them what we are going to do. We need their collaboration, we need them to give us some details and we need to explain somehow to them what we are going to do. If they do not speak Spanish, this is impossible.”
 14. “The lack of knowledge of Spanish is, at least in my opinion, an essential issue. Providing adequate healthcare when you do not know what you are up against... I do not know... it is like going to the jungle and saying «Let’s see if there are any wolves waiting for me».”

- “Para mí la mayor barrera es la lingüística. [...] es que en una anestesia epidural, con el volumen de anestésico que yo estoy poniendo, si lo pongo en el sitio erróneo, es que te cargas a una persona, es que te la cargas, así de sencillo, ¿vale? Entonces, tienes que tener unos métodos para intentar comprobar que tú lo estás haciendo bien, y los métodos son no solo farmacológicos, sino que yo tengo que preguntar a la gente cómo se siente, qué es lo que nota, si se le duermen las piernas, si está todo bien... Y si yo no tengo una comunicación que sea fluida, pues...” [Anaesthesiologist 3]¹⁵
- “En teoría según la legislación que existe en nuestro país, la paciente tiene que entenderlo y tenemos además que contarle todas las opciones que hay, cómo funcionan y lo que puede pasar con cada una de ellas. Y ella es libre de decir si quiere, cuándo quiere... pero con las que no hablan tu idioma a veces esto es muy difícil hacerlo.” [Anaesthesiologist 4]¹⁶
- “A ver, hay un problema legal. Realmente, en otros hospitales donde he trabajado, si tú no te entiendes con el paciente, no deberías hacer ninguna técnica... vital, o sea, perdón, no vital. Por ejemplo, la epidural es no vital, puedes parir con o sin epidural. Si nos ponemos estrictos, si tú no puedes mantener una conversación normal con la paciente, no deberías aplicarle técnicas que ella puede no entender.” [Anaesthesiologist 5]¹⁷

Finally, it should be pointed out that, when talking about linguistic barriers, healthcare professionals sometimes distinguish between different patients

15. “In my opinion, the main obstacle is the linguistic barrier. [...] we are talking about an epidural anaesthesia, with a very high dosage of anaesthetic, and if I administer it in the wrong place, I can take down the patient, it’s as simple as that! And so, I should use some techniques in order to know that I am doing it right, and these techniques are not pharmacological. On the contrary, I should ask the patient how he/she is feeling, if his/her legs have gone numb, if everything is ok. And if the communication is not fluent, then...”

16. “Theoretically, according to Spanish legislation, patients should understand and we should explain to them all the different options that they have, how these options work and what consequences they may have. And patients are free to decide if they want to, when they want to... but it is very difficult when patients do not speak Spanish.”

17. “Let’s see... there is a legal problem. In other hospitals where I worked I was told that if you cannot understand the patient, you must not use any vital... no, sorry, I mean non-vital technique. For example, epidural anaesthesia is non-vital. You can give birth with or without epidural anaesthesia. Strictly speaking, if we are not able to maintain a normal conversation with the patient, we should not use any technique that she is not able to understand.”

depending on their country of origin. As we will see in the interview excerpts presented in a later section, healthcare professionals think that communication is fluent when they are speaking with patients coming from Latin America or from Eastern Europe. On the contrary, in their opinion, communication with patients coming from Asia, Sub-Saharan Africa or Maghreb is usually difficult. These data could be seen as an indicator in order to undertake new research related to the specific needs of the context under study and to be able to provide an adequate response to these needs.

- “Y también según... digamos la... no sé cómo decirlo, según la raza, ¿sabes?, o el origen, pues es mucho más difícil la comunicación, por ejemplo a la hora de preguntar por las alergias y tal. Los chinos sí que siempre traen un acompañante, normalmente nunca están solas. Las rumanas y tal sí que se desenvuelven muy bien en español. Así que normalmente este tipo de problemas pues son más con árabes y con gente de color.” [Nurse 1]¹⁸
- “A ver, por ejemplo, los del este sí que la mayoría son muy espabilados y saben más que... más que nosotros. Con los sudamericanos evidentemente no hay barrera lingüística. Ahí, estupendamente. Y las marroquíes, las argelinas... vienen algunas que no entienden absolutamente nada, sobre todo las que han pasado allí el embarazo y vienen a parir aquí.” [Midwife 5]¹⁹
- “Barreras lingüísticas, con las rumanas, por ejemplo, no, porque las rumanas entienden bastante, se desenvuelven muy bien. El problema es sobre todo con las chinas y las marroquíes, principalmente. Las marroquíes te das cuenta que igual llevan aquí diez años y no hablan (español), igual que algunas chinas.” [Obstetrician 3]²⁰

18. “And also depending on... how can I say it? ... according to their race, you know?, or their origin, communication is really hard, for example when we are trying to ask about allergies and all that stuff. Chinese patients do always come with a companion, they are not normally alone. Rumanian and similar patients are fluent in Spanish. And so, this kind of problem usually arises with Arabs and black people.”

19. “Let’s see... For example, people from Eastern Europe are usually bright and they know more than... more than us. When we communicate with patients from South America, obviously there is no linguistic barrier. In that case, everything flows. Patients coming from Morocco or from Algeria... some of them do not understand a single word in Spanish, especially those who have been in their countries during pregnancy and come to Spain to give birth.”

20. “We do not encounter linguistic barriers with, for example, Rumanian patients, since they understand Spanish, they get on very well. The problem arises in particular with Chinese and Moroccan patients. There are cases of Moroccan patients who have been

3.2.2. What strategies do healthcare professionals use in order to reduce or eliminate the linguistic barriers?

Both with the interviews and the discussion group we try to analyse the strategies used by healthcare professionals in order to overcome linguistic barriers. In particular, the following questions were posed during the interviews:

- “How do you usually solve linguistic problems?”
- “Are there interpreters in the hospital? Are they officially appointed or volunteers? Do the patients come with someone who translates for them?”
- “Is there any service provided by the public health system where you can ask for face-to-face interpreters or over-the-phone interpreters? In that case, do you use this service?”

Regarding the discussion group, the questions posed were the following:

- “How do you eliminate linguistic barriers?”
- “What are the results obtained from the techniques that you use?”
- “Does any other strategy to eliminate these barriers come to your mind?”

According to the information provided by healthcare professionals participating in our research, the use of allophone patients’ family and friends as interpreters is the most frequent technique used in this hospital in order to communicate with these patients.

- “Son los pacientes los que generalmente traen a alguien que les traduzca. Suele ser alguien de la comunidad o un familiar que lleva más años en el país y un poco controla el idioma.” [Anaesthesiologist 1]²¹
- “Suelen venir con familiares, amigos... que saben más o menos hablar español, y entonces con la gran mayoría no tenemos ningún problema en que pasen, y les expliquen las cosas y estén con ellas.” [Midwife 4]²²

living in Spain for ten years and do not speak Spanish. The same happens with Chinese patients.”

21. “The patients usually come with someone who translates for them. This person is usually someone from their community or a relative who has been living in Spain for longer than them and more or less understands Spanish.”

22. “They usually come with their family and friends... who speak Spanish more or less. And so, most times we do not have any problem in letting them come in and explain everything to the patients and accompany them.”

According to the information provided by the participants in our study, we get to know that these *ad hoc* interpreters are not always patient's direct relatives or friends. On the contrary, other patients or their companions have been sometimes used or even children and other people who are contacted by phone.

- “Sí, sí hemos utilizado a menores para hacer de traductor. Y, a veces, incluso he utilizado el teléfono móvil para hablar con familiares y explicarles a ellos las cosas. Pues el sobrino sabe español y chino, y traduce a su tío español y chino.” [Anaesthesiologist 5]²³
- “Según qué personas hay, las uso de intérpretes yo. Les digo «¿Tú eres rumana y hablas rumano y español? Pues, vente conmigo que me vas a ayudar a preguntarle a esta paciente». Vamos, hago como conjuntos. Con los árabes, también. Y ellos colaboran muy bien.” [Nurse 5]²⁴
- “Yo, cuando ha hecho mucha falta, incluso he buscado, por ejemplo... necesito una persona que habla un dialecto africano, pues me he recorrido las plantas buscando a algún negro que sea capaz de traducir.” [Socio-sanitary staff 1]²⁵
- “Se recurre muchas veces a parientes, amigos, o incluso compatriotas que se encuentran en el hospital. ¿Y niños? ¿Para interpretar a sus padres? Sí, los hemos utilizado muchas veces. Los críos son más hábiles aprendiendo los idiomas y hay fundamentalmente mujeres que no hay forma de que lo aprendan y sus hijos les traducen.” [Socio-sanitary staff 1]²⁶

23. “Yes, we have used minors as translators. And, sometimes, I have even used my mobile phone to speak to the patient's relatives and explain everything to them. If, for example, patient's nephew speaks Spanish and Chinese, he/she translates for his uncle in Spanish and Chinese.”

24. “Depending on the people available, I use them as interpreters. I say: «Are you from Rumania and do you speak Spanish and Rumanian. Then, come with me because you are going to help me to ask a question to this patient». You know, I pair them up. I do the same thing with Arabs. And their collaboration is usually very good.”

25. “When it was really necessary, I have even searched for, for example... If I need someone who speaks an African dialect, I go from one floor to the other searching for a black person who is able to translate.”

26. “We have very often used relatives, friends or even people coming from the same country that are in the hospital. And what about children? Do you mean (children) interpreting for their parents? Yes, we have used them many times. Kids are good at learning languages, and in the case of those women who just can't learn Spanish, their children translate for them.”

Many healthcare professionals think that the use of patients' families and friends as interpreters has some advantages, as for example their availability or their proximity to the patient. As stated in previous studies (Diamond *et al.*, 2009: 258-259; Bischoff & Hudelson, 2010a: 2842; Bischoff & Hudelson, 2010b: 17), these factors (along with others, such as the reduced costs or the availability of bilingual healthcare professionals) could be decisive in those cases where *ad hoc* interpreters, instead of professional interpreters, are used.

- “[...] con las que no hablan nada, nada, nada, desde luego el acompañante sirve de traductor. Y la experiencia con el acompañante que hace de traductor es útil, yo creo que sirve, sí.” [Anaesthesiologist 5]²⁷
- “Pues, a ver, lo que yo veo es que si la persona (el acompañante que hace de intérprete) está aquí, siempre en algún momento, cuando tengas una duda, pues siempre puedes recurrir a ella. Y, aunque la comunicación no sea muy fluida, siempre está ahí, ¿sabes?” [Nurse 1]²⁸
- “Cuando el marido o un familiar hacen de intérprete, generalmente, sí que se solucionan los problemas de comunicación. Porque él les explica y así...” [Midwife 7]²⁹
- “Muchas veces sí que hemos utilizado como intérprete a algún familiar o amigo que hablara español y la lengua de la paciente. Si vemos que entre ellos hay una buena relación, casi es preferible, porque si es un familiar íntimo, que a la paciente no le importe que se entere de cosas, entonces, pues casi es mejor...” [Obstetrician 1]³⁰

Additionally, some healthcare professionals even think that it is the patient's responsibility to come to the hospital accompanied by someone who can help them to communicate in the case that they do not speak Spanish.

27. “[...] in the case of those patients who speak no Spanish at all, their companion serves as a translator. My experience with companions as translators has been useful, I think that they really serve for this purpose.”

28. “Let's see... I think that if this person (the companion working as an interpreter) is here, at every moment, when we have a doubt, we can always use him/her. Even when the communication is not so fluent, he/she is always there, do you know what I mean?”

29. “When we use the patient's husband or a relative as an interpreter, problems of communication are generally solved. Because he explains everything to the patient and so...”

30. “We have used relatives or friends who speak Spanish and the patient's mother tongue as interpreters many times. If we see that there is a good relationship between them, it is almost preferable to use them, because if this relative is close to the patient, if the patient does not mind sharing information with him/her, then it is better...”

- “En general (las usuarias) no vienen con alguien que les traduzca, no vienen preparadas, lo que pasa es que aquí se les dice que, hombre, sería mejor, ¿no? Pero yo no creo que tengan la concepción de que tengan que buscar a alguien que les traduzca y eso, simplemente vienen, y vienen, sin preocuparse de si les entienden o no.” [Anaesthesiologist 2]³¹
- “Bueno, claro, hay muchas señoras, muchas mujeres, que cuando llegan aquí no tienen ni idea de nuestro idioma, y entonces les aconsejamos siempre que se busquen a alguien que les haga de intérprete.” [Obstetrician 1]³²
- “Yo también me hice un cartel que pone «Por favor, vengan acompañados de alguien que hable nuestra lengua», porque acudían a las consultas sin decir ni media palabra, ni acompañante, ni habiéndolo solicitado previamente, con lo cual no daba tiempo de solicitarlo y tal...” [Socio-sanitary staff 1]³³

Nevertheless, other healthcare professionals are aware of the problems that may arise owing to the lack of training and expertise in interpreting of patients' family and friends. In this regard, some healthcare professionals point out the lack of general knowledge of Spanish or of medical terminology and of the main concepts related to healthcare services.

- “Normalmente te traduce el marido, [...] que tampoco es gente que tenga unos conocimientos... o sea, que tiene que ser todo como muy casero, vamos, tenemos que explicárselo a él para que se lo pueda explicar.” [Anaesthesiologist 2]³⁴

31. “In general, they (patients) do not come with someone who translates for them, they don't come prepared. We tell them that it would be better, but I do not think that they are aware of having to look for someone to translate for them, and so they simply come, without worrying about being understood or not.”

32. “Well, undoubtedly there are many ladies, many women, who arrive here and do not speak Spanish at all, and in those cases we advise them to look for someone who can interpret for them.”

33. “I also wrote a sign saying «Please, come with someone who speaks Spanish», because they came to our consultations without speaking any Spanish, without a companion, and without having previously asked for an interpreter, and so it was too late to ask for one, and so on...”

34. “As a general rule, it is the patient's husband who translates, [...] and he is not usually someone who has deep knowledge of... in other words, everything has to be very rudimentary, you know, we have to explain everything to him and so he is able to explain it to the patient.”

- “Y es que la comunicación no es la misma. Porque tú estás con una persona que le está contando bien, se supone, lo que tú quieres decir, pero es que hay muchas ocasiones en las que, hablando con esa persona, te das cuenta de que tampoco te entiende al cien por cien lo que tú le estás diciendo. Entonces dices, muchas veces dices «¿Le estará diciendo lo que yo quiero que le diga?»” [Anaesthesiologist 3]³⁵
- “[...] porque si el intérprete es un familiar, a lo mejor, según qué palabras ya más especializadas, pues a lo mejor, no sabe explicárselas o decírselas en su idioma. Me refiero a términos médicos y cosas de esas...” [Obstetrician 2]³⁶

Besides, some healthcare professionals seem to be worried about the possible breach of faithfulness and impartiality principles. They are suspicious of omissions, additions, condensations or role exchanges when *ad hoc* interpreters are used, since, as proved by previous studies (as, for example, Flores *et al.*, 2012), these are the common errors that untrained interpreters usually make.

- “Muchas veces tienes que insistir «No, pero pregúntale si...». Porque también a veces pasa que, si quien traduce es la pareja o el acompañante, que se supone que es el marido, te contesta él sin hablar con ella.” [Anaesthesiologist 2]³⁷
- “Si un familiar o conocido hace de intérprete, pues ayudar sí que te ayuda, pero claro, siempre te queda la duda de... de lo que realmente le está transmitiendo, si realmente le está diciendo toda la información que tú quieres o cómo la está transmitiendo.” [Nurse 3]³⁸

35. “Communication is different in those cases. Because you are with someone who is presumably transmitting what you want to say adequately. But often you are talking to this person and you realise that he/she does not completely understand what you are saying. And then you are always wondering «¿Is he/she saying what I want him/her to say?».”

36. “[...] because when the interpreter is a relative, it is possible that... if we use some specialised words, it is possible that he/she will not be able to explain them to the patient or translate them in their language. I am talking about medical terms and that sort of thing...”

37. “Often we have to insist and say «But, ask her whether...». Because when the person who translates is her husband or her partner, he sometimes answers without consulting her first.”

38. “If a relative or an acquaintance of the patient is interpreting, he/she is undoubtedly of help, but, there is still the doubt of... we wonder about what he/she is really saying, or we do not know if he/she is really transmitting all the information or how he/she is transmitting it.”

- “Cuando el marido o un familiar hacen de intérpretes a veces sí que puedes tener el problema de que no sabes si lo que le estás diciendo se lo está traduciendo tal cual o le está cambiando la versión.” [Midwife 2]³⁹

Furthermore, some healthcare professionals think that, when a patient’s family and friends are used as interpreters, they will probably breach confidentiality or privacy, issues which are so important in the medical context, as has been demonstrated in previous studies (as, for example, Leanza, 2007: 12 or Bischoff & Hudelson, 2010a: 2839).

- “[...] o te los pasan por teléfono y te explican que es el primo de... que realmente te preguntas hasta qué punto se respeta la protección de datos o de la intimidad del paciente.” [Nurse 1]⁴⁰
- “[...] también depende un poco de la relación que tenga esa mujer con el intérprete, porque estás en un momento muy importante, ¿no?, muy significativo y muy íntimo. Y, a lo mejor, estar con una persona que es la primera vez que la ves o que es algún amigo de la familia, pero que... Y, entonces, a lo mejor hay cosas que la mujer no expresa porque no se las va a decir a él para que te las diga... O puede haber situaciones que te resultan un poco... un poco violentas. Vamos, que depende de la relación que tengan.” [Midwife 4]⁴¹

The same concern about the quality of interpretation when family and friends are used as interpreters arises during the discussion group, as can be observed in the piece included below.⁴²

39. “When the patient’s husband or relative is interpreting, you sometimes do not know whether what you are saying is being translated faithfully or the interpreter is changing the message.”

40. “[...] and sometimes they pass you their telephone and they explain that the person on the other side is a cousin of... And you really wonder how data protection or the patient’s privacy are respected.”

41. “[...] it also depends somehow on the relationship between the patient and the interpreter. Because she (the patient) is going through a very important moment, isn’t she? It is a very significant and private moment. And maybe if the patient is with someone she has never seen before or someone who is a friend of the family but... In these cases, there will probably be some things that the patient does not want to say to this person... And some situations can be a bit upsetting. In short, it depends on their relationship.”

42. Pieces extracted from the discussion group will be translated all together in the same footnote, in order to maintain the normal flow of conversation that they represent. The different interventions will be separated by a slash (/). Interventions made by the researcher, will be included between brackets (...).

- “Y, normalmente, les pides si pueden entrar con alguien que entienda o que hable español más que ellas. Lo que pasa es que a veces, yo que sé...” [GD – Midwife 2]
- (Les pregunto si, cuando han usado como intérpretes a parientes o amigos, la comunicación ha resultado eficaz.)
- “A veces te encuentras con que el intérprete sabe menos que ellas.” [GD – Obstetrician 2]
- “Exacto, que el intérprete sabe menos, o no estás realmente convencida de todo lo que se está traduciendo, ¿no? O que no sabes lo que le está llegando, porque, claro, como tú no tienes ni idea, ni tienes mucha confianza...” [GD – Midwife 2]
- “A veces, es verdad, que no te quedas del todo convencido. Y, luego, también depende de qué grado de familiaridad o de relación tiene con la paciente. Porque si es la madre y, como pasa a veces con las españolas, que es la madre la que sabe y la que te contesta cuándo tiene su hija la regla y no sé cuántos, pues... Te la lía, esa sí que te la lía, porque ahí sí que intuyes que la mujer se ve apurada y no está entendiendo qué...” [GD – Obstetrician 2]⁴³

Regarding interpreting services provided by an external company or center that we have presented in the previous subsection, the lack of knowledge about their existence and their under-use are the first aspects that should be highlighted.

- “No lo sé. La verdad es que los intérpretes que hay no sé de quién dependen, si es un servicio oficial o si es algo voluntario. El centro, propiamente, yo creo que no cuenta con intérpretes. Hay intérpretes

43. “Generally, you ask the patients to come with someone who understands and speaks Spanish better than them. But sometimes, I do not know whether...” / (Participants are asked about the effectiveness of communication when relatives and friends have been used as interpreters.) / “Sometimes the interpreter knows less Spanish than the patient.” / “That’s right. The interpreter has less Spanish, or we are not convinced about what he is translating. Or we do not know what the patient is understanding, because we do not have a clue, and we are not very confident...” / “It is true. Sometimes we are not fully convinced. And it also depends on the familiarity or the relationship between the patient and the interpreter. Because, for example, if the patient’s mother is interpreting and, as Spanish mothers usually do, she is the one who knows everything and she answers when her daughter’s last period was... You know, she makes a complete mess, because we see that the patient is embarrassed and she does not understand what is going on...”

- que creo que si se les llama, vienen. Pero que trabajen aquí y eso, no.” [Anaesthesiologist 2]⁴⁴
- “No, no, el centro no cuenta con intérpretes.” [Anaesthesiologist 3]⁴⁵
 - “Sé que hay forma de resolver los problemas lingüísticos, parece ser que con teléfonos y tal, pero yo no lo he utilizado, no, no lo he utilizado.” [Anaesthesiologist 5]⁴⁶
 - “No, no conozco ese servicio de interpretación telefónica del que me hablas y, por supuesto, no lo he empleado nunca. [...] Pero traductores presenciales, creo que sí que hay.” [Midwife2]⁴⁷
 - “Hasta ahora existía un servicio de... guía telefónica, que podías hablar, les llamabas y decías «Oye, este es ruso, o es senegalés»... Pero creo que llevamos ya varios meses que ya no existe ese móvil con el que te ponías en contacto con los traductores.” [Socio-sanitary staff 3]⁴⁸

Some healthcare professionals do not consider that using these services is useful and they say that they are able to communicate with allophone patients by adopting other solutions, mainly using family and friends, as we have previously explained. They do not take into account that, as proved by previous studies (Flores, 2005; Flores *et al.*, 2012), these untrained interpreters very likely will commit some errors with serious consequences. In addition, it seems that they downplay the fact that, as shown in different studies (as, for example, Diamond *et al.*, 2009: 256 or Nápoles *et al.*, 2010: 302), the use of professional interpreters guarantees effective communication with allophone patients and, consequently, these patients' satisfaction is high, the inequalities when accessing and using healthcare services are reduced and medical care provided is improved.

44. “I do not know. To tell the truth, I do not know whether interpreters working here are employed by an official service or if they are volunteers. The hospital, as far as I know, does not hire interpreters. I think that there are some interpreters who come if we call them. But they do not work as part of our staff.”

45. “No, no, there are no interpreters hired by the hospital.”

46. “I know that linguistic problems can be solved somehow, I think there is a phone that we can use, but I have never used it. No, no, I have never used it.”

47. “No, I do not know the telephone interpreting service you are talking about and, of course, I have never used it. [...] But I think that there are maybe some face-to-face translators.”

48. “Until recently there was a service of... like a telephone guide we could use, we called them and said «Hey, this patient comes from Russia, or from Senegal»... But I think that since a few months ago, this mobile phone to contact translators is not available anymore.”

- “Pues no sabía que había un servicio de interpretación telefónica, pero si no lo usan, será porque siempre hay alguien de la familia o del entorno de la paciente que les puede ayudar.” [Anaesthesiologist 2]⁴⁹
- “Claro, es que yo creo que recurre a ello cuando ya... cuando la comunicación es nula, pero si te vas apañando con lo poco que puedan saber ellas, con lo que te cuenta el marido, o con lo que sea, pues por eso igual no se utiliza...” [Midwife 3]⁵⁰
- “Sé que existe un servicio de interpretación telefónica, pero no lo he usado nunca. Porque como siempre ha habido alguien que ha solucionado el problema de la comunicación, no ha hecho falta. [...] Pero aquí no contamos con ningún intérprete oficial. Lo que sí que se hace, como te decía antes, es recurrir a algún familiar o a un amigo que hable español.” [Midwife 6]⁵¹

When asked about the face-to-face interpreting service managed by a local centre until March 2012, some healthcare professionals see the limited availability of its interpreters as a disadvantage. Additionally, they value as a negative fact the need to contact the interpreter in advance and the impossibility of counting on him/her immediately. The lack of immediacy, as proved in previous studies that have been mentioned before (Diamond *et al.*, 2009; Bischoff & Hudelson, 2010b; Flores *et al.*, 2012), is probably one of the causes that increases the use of family and friends as interpreters.

- “Pues creo que sí que hay intérpretes, pero, claro, no están las veinticuatro horas.” [Midwife 4]⁵²
- “El problema de los intérpretes profesionales es su horario limitado. Por ejemplo, en urgencias, cuando los necesitas, a veces no coincide con el horario del intérprete.” [Obstetrician 3]⁵³

49. “I did not know that there was a telephone interpreting service, but we probably do not use it because there is always a relative or someone close to the patient who can help us.”

50. “Obviously, I think that we use it when... when there is no communication at all. But it is probably not used because we can manage all right with the patient’s minimal Spanish, their husbands’ explanations, or in any other way...”

51. “I know that there is a telephone interpreting service, but I have never used it. It is not useful, because there has always been someone who has solved the communication problem. [...] But here there is no official interpreter. What we do, as I have said before, is use a relative or friend who speaks Spanish.”

52. “Well, I think that there are interpreters, but, obviously they are not here twenty-four hours a day.”

53. “Interpreters’ limited working hours are the main problem. For example, in the emergency room, when we need them, sometimes it is outside their working hours.”

- “Antes, cuando trabajábamos con el centro municipal, se solicitaba el servicio de traducción previamente, tenían que avisar de que iban a venir, y entonces lo pedíamos. Pero, inmediatamente, era imposible, porque ellos tenían que contactar con el traductor y que viniera.” [Socio-sanitary staff 1]⁵⁴

In relation to the telephone interpreting service, there are very few participants in our study who have used it. Despite the fact that we know for sure that several informative campaigns have been organized in the hospital, healthcare professionals point out that its under-use is caused by their lack of knowledge about the service. They adduce other reasons, as for example the complexity of its use, its inconvenience, the loss of proximity with the patient, or the amount of time required to use it, when time is something very scarce in their working routine.

- “En el hospital no contamos con ningún traductor, y el servicio de traducciones telefónicas ni nos dicen muy bien cómo funciona, ni sabes a qué horas está disponible, ni dónde está.... Vamos, que a mí nadie me ha dicho dónde tengo que llamar, ni cómo tengo que hacerlo, ni a qué hora, ni a qué empresa, ni si esas conversaciones quedan grabadas o no quedan grabadas, no sé si lo que se está diciendo... sí, sé que me tengo que fiar porque es un traductor, pero lo que no sé es cómo funciona eso...” [Anaesthesiologist 4]⁵⁵
- “Yo sé que había por ahí un papel circulando que decía que se puede llamar a un intérprete que te ayuda por teléfono. Pero, chica, a mí eso no me ha llegado, ni sé cómo funciona, ni... Yo sé que las compañeras de admisión lo leyeron en la revista, que lo iban a poner y tal, pero ni siquiera sé si finalmente lo han puesto o...” [Socio-sanitary staff 2]⁵⁶

54. “Some time ago, when we worked with the local centre, we needed to ask for the translating service in advance, patients had to confirm their attendance, and then we asked for the service. But it was impossible to ask for the service immediately, because the translator had to be contacted and then he/she came.”

55. “There is no translator in the hospital, and we are not well informed about how the telephone interpreting service works, its availability, where we can use it... You know, nobody has told me who I should call, how I can do it, which company is in charge, if the conversations are recorded... I do not know if what it is being said... Yes, I know that I should trust it because there is a translator, but what I really do not know is how this service works...”

56. “I know that there was a document going around that said that we could call an interpret who would help us by phone. But I have not received this document, I do not know how it works... I know that my colleagues who work in the admissions department

- “Con ese servicio se pierde mucho tiempo, si estás al teléfono yo creo que en consulta lo que son 15 minutos te cuesta una hora y pico, y eso es inviable... Así que el acompañante hace de traductor y ya está.” [Anaesthesiologist 4]⁵⁷
- “Sé que hay un servicio de interpretación telefónica, pero yo nunca lo he utilizado. A veces... yo creo que es complicado y, además, hacerlo... no sé, a través del teléfono yo creo que también se pierde un poquito de... de intimidad, de cercanía con la mujer, con lo que te está diciendo a través del teléfono la otra persona...” [Nurse 3]⁵⁸
- “Y si no te entiendes nada, nada, nada, pues hay un teléfono en urgencias con el que te puedes poner en contacto con algún traductor. Pero, claro, no es tan fácil tampoco a veces... Digamos que lo del teléfono para ponerse en contacto con un traductor yo lo uso ya como último recurso. Yo creo que es un poco por el tiempo. Pensamos que con el teléfono vamos a perder más tiempo o... Como que te intentas apañar, y no sé si no lo usamos por tiempo o por intentar solucionar tú mismo la cosa.” [Obstetrician 2]⁵⁹

Both the lack of use of the telephone interpreting service and the lack of knowledge of its existence and functioning shown by healthcare professionals are confirmed in the discussion group. Only one of its participants has used the service, as can be observed in the piece included below.

- “Si no, recurrimos al traductor del hospital.” [GD – Obstetrician 3]
- “Ya, pero depende de cómo te pille... Porque yo reconozco que si me pilla en el ambulatorio, con un montón de mujeres esperando y tal, pues...” [GD – Obstetrician 1]

read it, and someone said that they were going to set it up, but I do not even know whether it has been set up or...”

57. “You waste a lot of time with this service. If we are on the phone, the consultation will probably last an hour and a half, which, if compared with a normal consultation, that lasts fifteen minutes, is unfeasible... so we use the patient’s companion as a translator, and that’s that!”
58. “I know that there is a telephone interpreting service, but I have never used it. Sometimes ... I think it is complicated and, besides, using it... I do not know, by phone, in my opinion there is a lack of ... privacy, of proximity with the patient, with what is being said to you by another person on the phone...”
59. “And if we cannot understand anything at all, there is a phone in the emergency department that we can use to get in contact with a translator. But, obviously, sometimes it is not so easy to... Let’s say that using the phone in order to contact a translator is my last resort. I think that the problem is probably time ... We suppose that if we use the phone, we are going to waste more time or... We try to get by, and I do not know whether we do not use it to save time or to try to find a solution by ourselves.”

- (Le pregunto a GD – Obstetra 3 si, cuando ha hablado del traductor del hospital, se refería a un servicio de traducción/interpretación en concreto.)
- “Me refiero al de urgencias. Ese es el que yo he utilizado. El servicio de interpretación por teléfono.” [GD – Obstetrician 3]
- (Le solicito, visto que tiene experiencia empleando el servicio de interpretación telefónica, cómo le ha resultado, si lo ve complicado o sencillo.)
- “No, bien. Bueno, yo lo he usado dos o tres veces y... siempre me ha ido bien. Lo he usado siempre por el día, ¿eh? (Le comento que el servicio está disponible veinticuatro horas al día.) Ah, ¿está veinticuatro horas? No lo sabía... Pues, bueno, por el día, bien, a mí me ha funcionado bien. Ahora sí, hay que tener tiempo para usarlo, porque, por ejemplo, hay que poner muchos códigos y...⁶⁰ Pero sé que se usa poco, e incluso hay profesionales que no saben ni que existe, o que no saben cómo se usa...” [GD – Obstetrician 3]
- “Por ejemplo, yo no sé cómo se usa.” [GD – Obstetrician 1]
- (Pregunto al resto de participantes si algún otro ha usado este servicio y todos niegan, verbalmente o mediante un movimiento de cabeza, haberlo empleado.)
- “No, normalmente se recurre a algún pariente o amigo de la paciente y...” [GD – Obstetrician 2]
- (Les pregunto qué inconvenientes ven a la interpretación telefónica y por qué creen que no se usa.)
- “Hombre, es que es muy impersonal, ¿no? Estás ahí a través del teléfono... Vamos, a mí no me gusta. [...] la verdad, es que a lo que más recurrimos es al intérprete que es pariente y amigo. Porque, a mí, cuando me vienen con un teléfono y le tienes que contar a un tercero al que no estás viendo...” [GD – Obstetrician 2]⁶¹

60. It is important to highlight that the number of codes that should be typed before getting in touch with the interpreter is one of the issues that, according to the member of the Aragonese Government who is in charge of the interpreting service, will be improved in its next awarding period, since they are conscious of the loss of time derived from this fact.

61. “In exceptional cases we use the hospital’s translator” / “Yes, but it depends on what you are doing at the time... Because I admit that if I am in the outpatients department, with loads of women waiting outside, then...” / (I ask GD – Obstetrician 3 if, when he referred to the hospital’s translator, he meant a particular translating/interpreting service) / “I mean the translator in the emergency room. That is what I have used. I mean the telephone interpreting service.” / (As he has experience in using the telephone

Providing professional interpreting services is not enough, as is shown by the fact that even when these services are available, they are not used. Therefore, there is a need for professionalization and an increased awareness of the interpreters' role by healthcare professionals and the institutions in which they work (Bischoff & Hudelson, 2010b: 19; Brisett *et al.*, 2013: 139).

3.2.3. What are the role and the competences that, according to healthcare professionals, interpreters should have?

Regarding healthcare professionals' opinion about the role and the tasks of the interpreter, the following questions were posed during the interviews: "What is your general experience with a third person working as an interpreter like?" and "According to your experience, do you think that any person with linguistic knowledge of two languages can work as an interpreter?".

As far as this issue is concerned, in the first place, it should be noted that there is a lack of knowledge and misconceptions about the proper terminology that should be used to refer to interpreters and their work. It has been shown in some pieces extracted from the interviews and the discussion group that we have previously included, in which participants interchangeably use the following terms: "translator", "telephone translator", "telephone translation (service)", or even "telephone guide".

In relation to interpreters' role, the majority of healthcare professionals think that their only task consists of literally translating what is being said by the speakers. We can infer from this that they consider interpreters as external agents who restrict themselves to the automatic reproduction of a message from one language to another. The same idea about the interpreter as "translation machine" has been pointed out in previous studies, as for example that

interpreting service, I ask him how it was, if he thinks that it is simple or difficult.) / "No, well... I have used it two or three times and... it has always worked well. But I have always used it during the daytime." / (I tell him that the service is available twenty-four hours a day) / "Oh, yes? Is it available twenty-four hours? I did not know that. So, well, during the daytime, it has worked well. Anyway, you have to have time to use it, because, for example, you have to type in a lot of codes and... I know that it is underused, and there are even some healthcare professionals who do not know about its existence or how to use it..." / (I ask the rest of participants if they have also used the service and all of them, verbally or shaking their heads, deny having used it) / "No, we usually use patients' family or friends and..." / (I ask them their opinion about the disadvantages of telephone interpreting and why they think that it is not used) / "It is very impersonal, isn't it? You are there on the phone... In short, I do not like it [...] actually, the most common solution is the use of relatives or friends as interpreters. Because, in my opinion, when there is a phone and you have to tell something to a third person that you cannot see..."

made by Leanza (2005: 177), which indicates that “reproducing or rendering speech actions of others is a fairly creative activity” is not taken into account (Wadensjö, 1998: 69).

- “No hay que interpretar, porque hacer de intérprete no significa interpretar lo que el otro quiere decir, sino que si el otro dice «Pipí, sí», el intérprete dice «Ha dicho: Pipí, sí». Como un notario.” [Obstetrician 1]⁶²

Additionally, some healthcare professionals do not see big differences between the use of family and friends as *ad hoc* interpreters and the use of professional interpreters. They simply point out that professional interpreting offers more guarantees on faithfulness to messages transmitted by the speakers, and they confuse “faithfulness” with “literal rendition”, as can be observed in the following pieces.

Nevertheless, they do not mention other principles that professional interpreters should respect such as impartiality or confidentiality, nor their training to work as interpreters, which are distinguishing factors between professional interpreters and natural ones (Flores *et al.*, 2012: 548-550).

- “Y, luego, también pasa que con el intérprete (profesional) sabes que se lo va a traducir todo tal cual, y el familiar también se lo puede contar un poco como él quiera. Eso lo he pensado muchas veces, sí.” [Obstetrician 2]⁶³
- “No veo diferencias entre recurrir a un intérprete profesional o a una persona que simplemente conoce las dos lenguas. No, porque vamos, normalmente la gente pone interés en traducir. Lo único es que con uno profesional te queda la tranquilidad de que está haciendo la transcripción literal de lo que tú estás diciendo, que no interpreta ni pone nada de su cosecha. Es la única diferencia, porque con la otra forma te queda la duda de...” [Socio-sanitary staff 1]⁶⁴

62. “Interpreters should not interpret, because working as an interpreter does not mean interpreting what the other person is saying. Instead, if the other person says “Peepee, yes”, the interpreter says «He has said: Peepee, yes». Like a public notary.”

63. “And it also happens that when we are working with (professional) interpreters, we know that they are going to translate everything as it has been said, and, on the contrary, patient’s relatives will probably say what they want. Indeed, I have thought about this many times.”

64. “I do not see any difference between using a professional interpreter and using someone who simply knows both languages. Because, you know, people usually make an effort when translating. The only difference could be that when we are working with a

One of the healthcare professionals interviewed, who is unaware of the impartiality principle that professionals interpreters should respect, mentions another difference between professional interpreters and family or friends working as interpreters. In his opinion, the former are like allies whereas the latter seem to be on the patient's side. The same idea of the pressure that healthcare professionals occasionally exert on the interpreter, and how they may in some way force interpreters to waive the impartiality principle, are brought to light in the research carried out by Angelelli (2008: 150). This is also discussed in other studies, as for example that done by Leanza (2007: 20), according to which, a great number of healthcare professionals participating in the research see the interpreter as an "ally".

- “Cuando el intérprete es profesional está como de tu lado, y cuando el intérprete es un familiar del paciente, está como en el otro lado y la barrera es mayor. Cuando es un profesional, el intérprete es más como tu aliado. Esa es la única diferencia que veo.” [Obstetrician 3]⁶⁵

Concerning the requirements needed to interpret, the majority of healthcare professionals that participated in our study think that knowledge of the two working languages is enough to do interpreting tasks.

- “Sí, yo creo que con que tengan conocimientos lingüísticos es suficiente, sí.”⁶⁶ [Anaesthesiologist 2]
- “Si tiene un buen conocimiento de las dos lenguas, yo creo que sí es suficiente.” [Anaesthesiologist 3]⁶⁷
- “Yo creo que sí, ¿no? Vamos, si sabe español y el otro idioma creo que es suficiente...”⁶⁸ [Nurse 4]
- “Por supuesto, claro. Por ejemplo, si una señora viene de Marruecos y el intérprete habla árabe y español, pues ya...” [Midwife 7]⁶⁹

professional, we are sure that he/she is doing a literal rendition of what we are saying, that he/she is not interpreting nor is he/she making anything up. That's the only difference, because with the other solution you usually have some doubts about...”

65. “When we work with a professional interpreter, he is like on our side, and when patients' relatives are used as interpreters, they are on the other side and the barrier is bigger. Professional interpreters are like an ally. That is the only difference that I see.”

66. “Yes, I think that having linguistic knowledge is enough.”

67. “I think it is enough if he/she has a good knowledge of the two languages.”

68. “I think so, don't you think? If he/she knows Spanish and the other language, it is enough.”

69. “Yes, of course. For example, if a woman comes from Morocco and the interpreter speaks Arab and Spanish, then...”

- “Considero que si sabes los dos idiomas perfectamente, puedes hacer de intérprete. [...] Por eso digo, para la cosa digamos... nuestra, médica, hablando así, a mí me basta con que sepa los dos idiomas.” [Obstetrician 1]⁷⁰

Other healthcare professionals think that linguistic knowledge is not enough. In their opinion, interpreters should also have knowledge of the two cultures and medical terminology and should know how healthcare services work.

- “Tu traductor tiene que conocer muy bien la terminología médica y la técnica que vas a usar para luego saber traducir lo que les estás diciendo.” [Anaesthesiologist 4]⁷¹
- “Claro, una cosa es el conocimiento de la lengua, y otra sería el conocimiento que tenga de la... de la cultura, de las costumbres... Y, me imagino, que con ambas cosas pues sí que serviría.” [Nurse 3]⁷²
- “Hombre, a ver, lo ideal sería que el intérprete tuviera conocimientos a nivel sanitario. Porque a veces tú puedes saber un idioma, hablarlo medio decente, pero a nivel sanitario no saber decir nada. Así que, si los intérpretes pudieran tener también conocimientos a nivel sanitario, pues sería estupendo.” [Midwife 4]⁷³
- “Yo creo que habría que tener conocimientos médicos también, o al menos una noción de cómo funciona el sistema sanitario español, o sea, debería estar bien integrado en lo que es la cultura sanitaria.” [Midwife 6]⁷⁴

70. “I think that if you know both languages perfectly, you can work as an interpreter. [...] For that reason, I say that, in our case... you know, in healthcare settings, it is enough if the interpreter knows both languages.”

71. “Your translator should have a deep knowledge of medical terminology and the technique we are going to use, and so he/she will be able to translate what we are saying to patients.”

72. “Obviously, it is not the same the knowledge of one language and the knowledge of... of culture, traditions... And I suppose that if the interpreter has both types of knowledge, it will be enough.”

73. “You know, the ideal situation would be if the interpreter knew something about the healthcare field. Because even when you know a language, and you speak it more or less properly, it is possible that you cannot say anything related to healthcare. And so, it would be great if interpreters also had some knowledge about the healthcare field.”

74. “I think that interpreters should also have some medical knowledge. At least, they should have a notion of how the Spanish healthcare system works. That means that interpreters should be well integrated in the healthcare culture.”

In our opinion, healthcare professionals should have mentioned other knowledge, skills and attitudes that are needed to interpret adequately, such as for example, knowledge about interpreting techniques, analysis and active listening skills, or knowledge about ethical principles related to interpreting and how to apply them (Angelelli, 2007: 63; Del Pozo, 2009: 36-37).

By virtue of what we have previously presented, we can claim that the majority of healthcare professionals that have participated in our study are not aware of medical interpreters' working conditions, neither are they familiar with the role and tasks performed by interpreters in order to facilitate effective communication between healthcare professionals and allophone patients.

4. Conclusion

Based on data obtained from participants in the research presented in this article, we deduce that, despite the availability of professional interpreting services, *ad hoc* interpreters have been used many times in the hospital under study in order to facilitate communication with allophone patients. On those occasions, it is quite possible that, due to the reasons previously discussed, these natural interpreters have committed interpreting errors or have not respected ethical principles inherent in the profession. Consequently, fully effective communication with allophone patients has probably not been possible, compromising as a result the quality of healthcare provided.

Nevertheless, the majority of healthcare professionals that have used *ad hoc* interpreters say that they are satisfied with the results obtained, which, in their opinion, if not ideal, at least have been "acceptable". As stated by Hale (2010: 46), what is important here is not if the doctor is happy with an arrangement, but whether the patient is receiving adequate healthcare. The reason for their satisfaction with the interpretation provided by patients' family and friends is related to a large extent with their lack of knowledge not only about the consequences that adopting this solution can provoke (and about the benefits that would be derived from using professional interpreters), but also about the role of medical interpreters and the requirements they should fulfil in order to successfully interpret. In fact, a large number of healthcare professionals that have participated in the study think that linguistic knowledge is sufficient to perform quality interpretation. Additionally, they underestimate the required level of knowledge of the working languages (Mikkelsen, 1999) and they do not take into account that, as pointed out by Phelan and Martín (2010: 5), "the ability to speak two languages does not make an interpreter", but other knowledge, skills and attitudes are needed to interpret effectively.

In short, even if a significant number of participants mention linguistic barriers as one of the main problems that they encounter when providing healthcare to allophone patients, the resources that they use in order to overcome these barriers are not appropriate. This inappropriateness is mainly caused by the fact that, in general, healthcare professionals are unaware of medical interpreters' working conditions, and of the role and tasks they perform in order to facilitate communication with allophone patients. Besides, some healthcare professionals that have participated in the study do not perceive great differences between using family and friends as *ad hoc* interpreters and using professional interpreters. Actually, the great majority of them think that the only advantage of using trained and qualified interpreters consists in the fact that, if compared with *ad hoc* interpreters, they offer more guarantees of faithfulness to the message transmitted. On the contrary, they do not mention the importance of training to ensure the respect of other principles related to this profession, which, as we have pointed out in our analysis of the possible errors and omissions made by unqualified interpreters, are distinguishing factors between the services provided by professional interpreters and those provided by natural ones. This would seem to indicate a significant lack of awareness of medical interpreters' work and of the training needed for quality interpretation. Thus, as stated by Pöchhacker (2004: 166), "for a practice or occupation to be acknowledged as a profession, it must be perceived to rest on a complex body of knowledge and skills, mastery of which can only be acquired by specialized training".

In conclusion, it is worth noting that, even if this study is focused on a specific context and presents a limited dimension, we think that it contributes to demonstrating the importance of "educating" and raising the awareness of the users of interpreting services (in our case, healthcare professionals) in order to promote the use of professional interpreters. Our study reveals how, despite considering linguistic barriers as an obstacle to communication with allophone patients and, consequently, to the provision of an adequate healthcare, the solutions adopted by healthcare professionals to overcome these barriers are frequently inappropriate, because they show a lack of knowledge of the tasks and principles inherent to medical interpreting. In our opinion, healthcare professionals would not use *ad hoc* interpreters so often if they were more aware of the complexity of interpreters' role, of the negative consequences caused by the use of natural interpreters and of the benefits derived from using trained and qualified interpreters. Therefore, as explained by Bischoff, Loutan and García (2009: 283-287) training and information should be provided to healthcare professionals, to familiarize them

with the tasks corresponding to interpreters, the requirements needed to perform these tasks adequately and the most appropriate way to interact and relate with interpreters. Ultimately, in this study it is illustrated that, as stated by Corsellis (2010: 12-14), healthcare professionals are an influential group regarding the use of trained interpreters and the awareness and professional development of medical interpreting.

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BIONOTE / NOTA BIOGRÁFICA

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