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1. List of abbreviations

MSF: Médecins Sans Frontières

HIV/AIDS: Acquired Immune Deficiency Syndrome

NAATI: National Accreditation Authority for Translators and Interpreters

CHS: Core Humanitarian Standard

AUSIT: Australian Institute of Interpreters and Translators

GP: General Practitioners

TT: Target Text

ST: Source Text

TM systems: Systems of Translation Memory

CAT-tools: Computer Assisted Translation tools

IMIA: International Medical Interpreters Association

Table of Contents

1. LIST OF ABBREVIATIONS I

1. INTRODUCTION 1

1.1. RESEARCH QUESTIONS 1
1.2. SIGNIFICANCE 1

2. LITERATURE REVIEW: INTRODUCTION TO THE TOPIC OF MEDICAL TRANSLATION: VARIOUS APPROACHES 3

2.1 ETHICS IN TRANSLATION 10
2.1.2. WHAT IS VOLUNTEERISM? AN OVERVIEW 12
2.2. A BRIEF OVERVIEW OF MEDICAL VOLUNTEERISM: CONSIDERATIONS 13

2.3. THE IMPLEMENTATION OF TECHNOLOGIES TO ENHANCE VOLUNTEERING TRANSLATION AND THE MOTIVATION THAT LIES BEHIND THE CONCEPT OF VOLUNTEERING: A BRIEF OVERVIEW 15

2.3 MSF: ETHICS ACCORDING TO ONE OF THE GREATEST MEDICAL HUMANITARIAN ORGANIZATIONS 15
2.4 STRATEGIES FOR BETTER COMMUNICATION IN HEALTH CARE SETTINGS 16
2.5 CULTURE WITHIN HOSPITALS: DEVELOPING MODELS TO COPE WITH THE DIFFERENT CULTURAL BACKGROUNDS OF PATIENTS 20
2.5.1. THE IMPORTANCE OF CULTURAL MEDIATORS IN HEALTHCARE SETTINGS: AN ITALIAN SCENARIO 32

2.5.2. PSYCHOLOGICAL REQUIRMENTS AND ATTITUDE CULTURAL MEDIATORS NEED TO HAVE 34

2.5.3. THE IMPACT OF STRESS FOR HEALTHCARE INTERPRETERS AND TRANSLATORS AND HOW TO DEAL WITH IT 35

2.5.4. CULTURE IN MEDICAL TRANSLATION AND CULTURAL ADAPTATION OF MEDICAL TEXTS: SOME EXAMPLES 37

2.6 WORKING AS A HOSPITAL INTERPRETER OR TRANSLATOR: CULTURAL AND ETHICAL FACTORS 41
2.7 FURTHER TRAINING FOR TRANSLATORS: PSYCHOLOGY AS A PART OF THE TRANSLATOR'S EDUCATION 43
2.8 INTERDISCIPLINARITY IN TRANSLATION 45
2.9 QUALITY IN MEDICAL TRANSLATION 46

3. RESEARCH GAP 48

4. RESEARCH METHODOLOGY: QUALITATIVE METHODS OF RESEARCH: QUALITATIVE RESEARCH, THEORETICAL APPROACHES 49

5. DATA COLLECTION AND ANALYSIS 55

5.1. DESCRIPTION OF THE INTERVIEW QUESTIONS 55
5.2. INTERVIEW PARTNERS 56
5.3. RESULTS AND DISCUSSION: COMMENTS TO THE ANALYSIS 62

6. CONCLUSION: CLOSING REMARKS 64

BIBLIOGRAPHY 65

APPENDIX I

A. INTERVIEWEES CHART I

B. CATEGORIES CHART X

ABSTRACT (English)…….XII

ABSTRACT (German)……..XIII

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1. Introduction

Communication has always been a crucial matter since the very ancient times, as Gentzler states (2014). It is the part of people's usual life and helps them to express their emotions and themselves. Communication plays an even more important role between two individuals, who don't speak the same language. Therefore, it takes a third party i.e. an interpreter, in order to ensure proper and thorough comprehension. In the healthcare context in particular, linguistic misunderstanding can lead to severe consequences. Therefore, this MA thesis aims at analysing the linguistic challenges and the emotional charge of hospital translators working in healthcare settings.

Indeed, communication can be of different types: concerning direct interaction, it can be oral and written. The latter, especially translation, can easily lead to misunderstandings, if not performed in a proper way and by using proper terminology, according to Darrell *et al.* (2005) and Karwacka (2014). Particularly, in the healthcare setting, the terminology must be accurate as many terms come from Latin or Greek (Newmark 1988). In the literature review, the existing studies about the topic shall be concisely described.

The aim of this MA thesis is to analyse how medical translation is performed by professionals, who work as freelance translators and those who are working as volunteer translators; moreover, it shall be analysed how these professionals work within their environment, pointing out the challenging aspects of translation and, alongside with this, specific medical terms.

1.1. Research Questions

Questions that have been analysed in this paper are:

1. What kind of difficulties do translators encounter when they work at the hospital in terms of translation and emotionally striking experiences?
2. How do they manage the difficulties listed above?
3. What are the positive and negative aspects of the work of a translator within the healthcare setting?

1.2. Significance

This study aims to underline the importance of some factors regarding the profession of healthcare translators. First and foremost, this study stresses not only the crucial role that good training can provide in terms of vocabulary, but it also offers an insight into the emotional intensity of the different situations, which can be faced in this particular profession and how workers react to these problems.

A good way to offer such an insight is to interview people currently employed in this sector. Regarding this specific activity, it is important to gain the trust of the interviewees, e.g. by providing them with the full information about the research that is to be proposed, so that they may provide information about delicate and personal aspects as well.

The present paper should give a new input to academics willing to conduct research in this field, because analysing the emotional outcomes linked to the practise of a healthcare translator can help understand all the different aspects of this job. As a matter of fact, very often translators are considered “bridges of the communication”; nevertheless, the emotional aspects of this job are hardly ever described. On the contrary, the preparation and training of the translators are widely discussed. This can lead to a misunderstanding of the role of a translator, which is many times just seen as a “automatic language machine”. Thus, it is very important that all aspects of this job are taken into consideration, not only the linguistic aspects. Therefore, further research on this topic is advisable.

2. Literature Review: Introduction to the topic of medical translation: various approaches

In this chapter various translation approaches and techniques are going to be displayed as far as medical translation is concerned. Such approaches are described by researchers like Newmark (1988), Araya Fonseca (2006) and more recently Mićić (2013).

In her paper, Marisol Araya Fonseca (2006) not only shares her experience as a medical translator but she also provides practical suggestions about how to render a good translation of a medical text, by looking at the terminology and also at the medical style which is typical of such texts. First of all, she gives a brief overview of the good principles of a translation, and later she analyzes medical translation in more detail.

She claims that the role of the translation is that of fulfilling a necessity, that can be seen also in fields like politics, sociology, economics and science, so in all those fields in which there is a readership with their specific needs (Araya Fonseca 2006).

According to the author, the semantic accuracy is one of the essential features of a good translation: she defines the translator as "sculptor of the language" as the translator - thanks to his experience and accuracy - can translate into another languages the information that the readership cannot comprehend as they do not understand the source text (Araya Fonseca 2006).

Araya Fonseca (2006) claims that in order to translate a text it is necessary to grasp the meaning of words and not only: In fact, the translator has to detect and needs to evaluate when to use that given expression and in what context. Also when translating medical texts, it is important that the translator does not have to give up the creativity and sensitivity he or she possesses, as those are necessary elements to understand what kind of terminology will be needed, according also to the context of the text that is being translated. By doing so, the translator selects the terminology that is more adequate for the technical text that he or she is currently translating according also to the source text. Translating a medical text means to use properly the style and terminology according to a specific linguistic register, not to give up one's creativity. Creativity will be used according to the needs of the readership that uses that given terminology which is typical of the medical field (Araya Fonseca 2006). To translate means that the text which is being translated must be accurate and perfect and for this reason the translator should each time improve his work, taking creativity into consideration too (Araya Fonseca 2006).

Just like the actors that are acting in tv series like ER, Grey's Anatomy have to first study the characters, observe the behaviour and the attitude of physicians, so do translators when they are translating medical texts, but in the case of the translators the translation process depends much -and first of all- on the credibility of the translator before the readership (Araya Fonseca 2006). Moreover, translators while doing their task do not have a rehearsal stand-in that suggests them what do and furthermore translators do not have a

previously written script (Araya Fonseca 2006). After having provided a brief overview of what it means to translate medical texts, Araya Fonseca (2006) focuses on the various terminological aspects of medical translation.

Medicine is one of the most ancient disciplines in the history of humanity. Many of the medical terms in use today in this field have a Greek and Latin origin and they date back to the 5th century AC. This terminology is contained in the Hippocratic Collection: a collection of about 60 books (Araya Fonseca 2006).

Today some of those medical terms are still in use, for instance: carcinoma, nefritis, hysteria, outbreak, coma, spasm, polyp and these terms have become part of the medical jargon.

Medical texts belong to the category of scientific descriptive texts and have an informative function, this means that they are aimed at informing the readership, the text itself and its register is objective and impersonal and the terms used are not emotional. In fact, the main principles of a good medical translation are truthfulness, exactness and clarity (Araya Fonseca 2006).

Araya Fonseca (2006) declares that it is important for the translator to be responsible while translating the medical text, as it deals with human life and dignity and therefore responsibility is a necessary requirement. Responsibility is required in the translation process also because it is important for the translator, whenever there are unknown terms for him, to investigate them and to discuss the terminology also with other experts in the field, for instance other physicians or healthcare professionals that can suggest what is the most appropriate term that fits the text and why (Araya Fonseca 2006).

One of the most difficult tasks for a translator who works in such field is to translate the terminology, especially the terms that can acquire different nuances according to the use. To this end, Araya Fonseca provides a brief example. “Course” is a word which can have two main meanings in the context of medicine:

1. It can describe the stage of development of a given illness.

2. It can indicate a series of treatments (Araya Fonseca 2006). As stated before, medical texts are characterized by an unemotional style where verbs are in the passive form. Such examples are to be found in sentences like “Patients are prepared for surgery” or “E. Coli strains were found in ice samples collected from a fish market” (Araya Fonseca 2006). Araya Fonseca (2006) suggests that in order to translate these particular nuances in the best way possible, a good strategy that can be implemented is to maintain the appropriate linguistic register which is typical of medical texts and to avoid comprehension mistakes that will make the translation to be far from the source text. Another important suggestion she provides is that medical texts should not be translated literally. In order to deliver a good medical translation, the translator can use different strategies:

1. The translator must rely on technical/medical dictionaries, may they be monolingual or bilingual, that not only contain the meaning of the word but also a description of the given term. This will help the translator to better understand the text that is being translated. It is important to keep in mind that not all dictionaries are up-to-date and therefore a specific term can exist in one language and still not be available (yet) in another (Araya Fonseca 2006).

2. The translator needs to produce a glossary (terminology list) by using the computer so it will be accessible at any time. Dictionaries are useful tools for translators, but the translator needs also to investigate the literature, in order to go beyond the meaning of words.

3. The translator needs to keep himself/herself informed about the terminology, and the best way to do so is to constantly read medical journals or reviews from the source language to the target language and vice versa. To investigate the new terminology is the core of the translation process at it enables to find the appropriate medical linguistic register that needs to be used and the appropriate style (Araya Fonseca 2006).

4. Another strategy that can be used – rather at the end of the translation process – and if the translator is not sure or has some doubts about what he/she has been translating so far, is that of asking an expert of that specific topic for advice, who will certainly clarify the translator's doubts about the specific terminology and will therefore provide the translator with the adequate definition of the term (Araya Fonseca 2006).

Translation, may it be from the native language to another language, free translation, literal translation or of any other type, is a mental process that requires concentration, commitment, creativity, perseverance, and above all the translator needs to be very responsible (Araya Fonseca 2006).

Furthermore, the translator needs to have a deep knowledge of his/her mother tongue. Translating from a language to another without mastering one's mother tongue can lead to serious misunderstandings and furthermore this can make his/her reputation as a translator questionable (Araya Fonseca 2006).

There is a wide range of medical texts, for instance biomedical essays, clinical reports, toxicological reports, informed consent forms for patients, analysis about the production of specific medications, and given the complexity and the style of such genre of texts, the translator not only needs to translate the text, check the exactness of the linguistic register, the technical terms, the grammar, the writing and the fluency of the text, but he or she will also need to investigate the lexical and stylistic aspects by continuously reading specific texts belonging to the medical field from the source language to the target language and vice versa (Araya Fonseca 2006). In addition, it is essential that the translator finds resources and means that provide him or her with reliable information for the translation process. An intuitive attitude is essential for the translator as this enables the language expert to look for the necessary information in order to deliver a good translation (Araya Fonseca 2006).

The translator must also be ready to invest time and money in other resources that will ease and enhance his or her job and his or her efficiency. At the same time, the translator must be aware of his or her limitations and decide also to refuse an assignment if the requirements cannot be met (Araya Fonseca 2006).

Also Mićić in her paper about the different "languages of medicine" (2013) claims that medical translations must be impersonal, precise, have fixed procedures of reporting data and must be objective (Mićić 2016: 226). Mićić suggests also that some medical expressions such as in the case of the expression "the patient complains of ..."" should be analyzed attentively. In this case in fact, Mićić claims that the medical jargon acquires a particular nuance. She explains that the patient is not complaining for particular reasons, but the term itself according to the medical language means "is presented with" (Mićić 2013: 226). The translation of medical reports is therefore a particular aspect of the translation of a medical text. Medical reports contain specific standardized "medical phrases", as for instance the example given above.

Mićić declares that not abiding by these "medical phrases" means to not respect the standards of the target text and this may lead to severe consequences like endangering the medical scientific credibility and it may cause imprecisions in the medical translations (Mićić 2013: 227). Furthermore, the author underlines the main features that characterize medical texts:

- The verbs and adjectives are nominalized.
- Medical technical terms are used.
- Language which is open to considerations, for instance through the use of "might"
- Passive verbs and impersonal forms

Mićić (2013) also adds that metaphors play an important role in medical language and that there are different kinds of metaphors that are worth citing and it is important also to explain their function: Metaphors in medical texts describe medical concepts and they have an instructive function and for this reason they are defined "didactic" metaphors. In the field of medicine for instance, metaphors are widely used to describe body parts but also to emphasize the role of the physicians who in American culture are seen as the "healers" whilst the patients play always a passive role (Mićić 2013: 225f). Diseases are also often described by using metaphors, for instance, there may be types of "good" tumors and "evil" tumors. AIDS together with cancer are seen as diseases which can lead to worrying thoughts within society, even more than others, like syphilis that has a minor impact on society (Mićić 2013: 226). Also in other cultures, in Turkey for instance, diseases are perceived as evil spirits and sometimes the worsening of the health condition is seen as "God's will" (see Karadudak *et al.* Chapter 2.5).

Also Fischbach identifies different kinds of translations and suggests some practical examples for how to translate specific medical expressions from German to English. Moreover, he describes the profile that a good translator working in this field should have.

There are two types of translations that have different aims, i.e. to inform and to promote, even if the two are not always connected to each other. We can talk about translation, if the source language and the target language differ from each other (Fischbach 1962).

A good translator, as Fischbach declares, is the one who makes the translation 'invisible', i.e. the person who reads the document should not realize that he/she is actually reading a translated text (Fischbach 1962). This is the case with texts addressing the pharmaceutical industry (Fischbach 1962).

To this end, according to Fischbach there is also another important factor that translators should consider. This refers to the different connotations which medical terms have in different languages. For example, peptic ulcer is not peptic ulcer, but ulcer gastro-duodenal in French, and conversely anthrax in French is not anthrax in English, but carbuncle. The German word Halsweh can be defined as a "false friend" for English speaking people and its literary translated as a pain in the neck. However, it means sore throat (Fischbach 1962).

If necessary, the translator must change words and structures entirely and use other expressions that are useful in the target language and choose different cultural patterns to describe things. The author points out other significant differences concerning the length of the translation and the amount of words you are translating, especially, if you are translating from English to a Romanic language. He also points out the importance of searching the right source of information and to discuss it with other specialized translators (Fischbach 1962).

Newmark points out the features of technical language, which is emotionless and without connotations. A good translator must be able to rephrase sentences and use the appropriate metaphors in the target language (Newmark 1988).

Newmark offers various approaches in order to deal with technical terms belonging to medical texts and he suggests that attention should be paid especially to standardized terms. An example is given in relation to the verb "sort out", which can have two meanings, namely to examine individually or to separate (Newmark 1988).

There are also different levels of technical language that are listed in 3 categories:

- Academic: It includes Greek and Latin words that are related to academic papers.
- Professional: It is formed by formal terms and used by experts working in the fields, e.g. Parotitis.
- Popular: vocabulary that includes familiar terms, for instance, chicken pox or scarlet fever.

The author later displays various techniques and tricks which are useful to deal with technical translation:

1) Words that have a Greek and Latin connection: The translator must be careful and should not create neologisms. Words, as well as chemical suffixes, have to be checked carefully (Newmark 1988).

2) Verbs: Some verbs in some languages have a more abstract meaning and therefore must be converted in the target language in order to be better understood.
3) Puns: They may not have similar connotations in the source and target language, for example, “mesure” can be translated in English as “measure” or “measuring” (Newmark 1988).

Moreover, Newmark suggests that the target language should sound as natural as possible, for example, by using the gerund when switching to English. Translating technical texts means that you can form sentences and re-write them as needed. You use this method by translating informative texts, as the aim is to create better texts than the source text. Nevertheless, it is good to be creative, but it is better not to create terminology (Newmark 1988).

The situation is slightly different if you translate for international scientific journals that have their own standardized terms and sentences, for example, “the answer is”, “the outcome was” Newmark (1988). As a consequence, it is always useful to review databases at terminology bureaus, as translators are always bound to terminology and its changes (Newmark 1988).

According to Maurizio Viezzi (1992), technical translation is not just about terminology, but translating technical texts also means to stick to standardized expressions and conventional language (Viezzi 1992). In his paper, Viezzi (1992) compares translations made by physicians, and analyses in particular the difference between English grammar structures and Italian ones by focusing on omissions and parts of the texts added to the target language.

In his analysis, the author claims how the process of “making the sentence impersonal” tends to create even more difficulties for the reader. Therefore, the text can be easily misunderstood, all of this just for the sake of keeping a good style. But if we look at the syntax, in the target language, “impersonalisation” makes it longer and complicated Viezzi (1992). Viezzi gives several examples of how words as “disease” are translated into Italian with the word “patologia”, although in English it is a word, which is frequently used in settings that do not strictly belong to healthcare (Viezzi 1992). Other examples given are:

- Determinano l'insorgenza di patologie (to produce pathology)
- Essere sottoposti a trattamento eparinico (to receive heparin).

Viezzi underlines the fact that the two languages, English and Italian, differ greatly in their syntax. Italian sentences tend to be longer and filled with terminology. Viezzi (1992) suggests that this feature is quite surprising, as the translated text belongs to the medical setting in which the language used should be more concise (Viezzi 1992).

As discussed before, the technical translation is not all about terminology, but a good technical translation should also meet the stylistic needs of the readership (Viezzi 1992).

Recalling Viezzi’s position, Berghammer (2006) states that the translator must have an excellent knowledge of the source language as well as the target language and furthermore the

translator needs to take into consideration the message that the author wants to transmit and what the expectations of the readership are (Berghammer 2006: 43). Berghammer underlines that by acting this way, the translator first has to interpret the text and acts first as an interpreter and that every mistake, as tiny as it may be, can have serious consequences (Berghammer 2006: 43). To better explain the point, Berghammer (2006) provides some examples of mistranslations of Freud's essays, which present some translation mistakes from German to English (Berghammer 2006: 43).

Language was considered by Freud a very important element in his writings and his purpose was to make language accessible to the people so that they could read his writings and act more logically (Berghammer 2006: 43). For this reason, he chose to use plain language. To express his ideas, he used the language that children use to communicate, avoiding terms which derived from Latin or Greek whenever possible (Berghammer 2006: 43). On the contrary, Freud's translators preferred to use terms which had Latin and Greek roots and this produced several mistranslations, as the original purpose of the text and meaning completely changed. A first example of mistranslation can be seen in the title of one of Freud's work i.e. "Die Zerlegung der Psychischen Persönlichkeit". Such title was translated into English as 'The Anatomy of the Mental Personality" even though there is no reference of such technical word in Freud's original German text (Berghammer 2006: 44). Other striking examples of mistranslation in these texts refer to the terms Freud used to define the aspects of the mind: "Ich" the "Über-ich" and "Es". In the English translations, this categorization is not present and everything which was related to the conscious part of the soul was translated like "I" and for the unconscious part Latin terms were chosen, "ego" and "id" respectively (Berghammer 2006: 44). Another German term that was clearly mistranslated into English was "Fehlleistung". In German such term is made up by two terms: "Fehl" that identifies a mistake and "Leistung" that means accomplishment. This might be the case of the "slip of the tongue", i.e. when something that is not meant is being sad, also knowing that what has been said is not appropriate for that specific moment. "Fehlleistung" was translated into English as "paraphraxis", which has a Greek origin and therefore is not comprehensible for people who do not master the technical nuances of medical language (Berghammer 2006: 44).

Another interesting example of a mistranslation concerns the term "Schaulust" which literally means gaining pleasure from watching something. This term could have been translated as "pleasure in looking at something", which perfectly suits the purpose, but instead it was translated in English with the term "scophophilia" which does not match the context at all (Berghammer 2006: 44). By doing so, the original message that Freud wanted to transmit through his writing has been misunderstood and as a consequence also readers may misinterpret Freud's message.

In the USA it is believed that psychoanalysts should cure mental disorders and illnesses, but in reality Freud's message, who was also a doctor, was another; In order to have a good life, people should master their inner conflicts and to give and to receive love. On the other hand,

many believe that the main message is "to enable our 'ego' to build a more satisfying life for itself" (Berghammer 2006: 44).

In order to avoid misinterpretations of medical texts, translators should not only pay attention to the terminology, but they should also take care about conveying the right message by respecting the intention of the author. According to Berghammer, what it takes to produce an excellent translation is a strong passion for languages, a good sense for style, and a strong will to even translate the most difficult terms and deliver them correctly in the target language (Berghammer 2006: 44).

In the next chapter, another aspect of translation will be discussed, i.e. ethics in translation.

2.1. Ethics in translation

Regulations can be different in other countries, as far as ethical issues are concerned. In fact, to this end, in some countries like Australia, a regulation has been issued, as far as translation and ethics are concerned. This guide offers translators support and explains to them how to deal with ethical principles (NAATI 2016). Therefore, first of all, it is important for translators and interpreters to get to know the ethical standards, identifying them by their names, declare what the principle refers to, and explain if the ethical principle has been undermined, and how the problem could be solved (NAATI 2016).

General ethical standards are set by AUSIT (The Australian Institute of Interpreters and Translators), and are aimed at:

- Respecting the will of the customer and privacy
- Controlling any conflicts.
- Not accepting other kinds of assignments or tasks that are beyond their competence.
- Providing information to the parties in a complete and impartial way.
- Not using private given information for personal purposes.
- Acting in a professional way avoiding self-promotion.

According to NAATI (2016) the professional and paraprofessional translators who will take part in the test are provided with some sample questions and must later provide an answer suitable for that case. Translators, in order to meet ethical standards, must abide by the principles, such as impartiality and professional conduct (NAATI 2016), and control possible misunderstandings of any kind, which may arise from the situation and at the same time should be able to be true to themselves and independent (NAATI 2016).

On the other hand, Morrison *et al.* (2016) discuss the emerging technologies in healthcare settings, and their ethical impact on our lives. The conference took place in 2015 and 20 countries took part in the conference. One of the key-words of the conference is the concept of translation and how it is perceived (Morrison *et al.* 2016).

As technology enhances, translation and its scenarios are changing, for instance between patients and physicians. (Morrison *et al*. 2016). This concept applies also to the

increasing procedures of sharing medical information and by doing so, new challenges and ethical issues arise. For this reason, new solutions have been discussed in order to avoid too much data-sharing in healthcare settings. A valid alternative could be the usage of the web 2.0 technologies, like the ELSI 2.0 workspace, which offers easy coaching strategies, and easy access to resources and accreditation standards (Morrison *et al.* 2016).

Apart from technology, another crucial element is communication and interaction, as some patients declare that they also wish to receive detailed information about their health condition. This shows clearly that patients have different expectations and worries depending on their health condition. At the same time, there is a need for the creation of efficient management systems, which may take into consideration the various expectations of the people involved in healthcare settings, as well as its beneficiaries (Morrison *et al.* 2016).

Within healthcare settings, on-the-spot translation usually concerns non-technical matters, for example, short notes added to other documents or short medical instructions (National Council on Interpreting in Health Care 2009).

Another translation mode which is needed in the healthcare setting is the so-called sight translation. In this section of the document it is listed which documents are suitable for sight translation and which are not suitable. Documents providing instructions are suitable for sight translation, since in this way the patient can ask the doctor for further information and by doing so, they can get precise answers according to the questions.

For those patients who cannot read official documents issued by the institution, translators have to provide the documents in the language requested by the patient. The languages for which there is no translator available, the Navajo video recordings can be used to provide language assistance (National Council on Interpreting in Health Care 2009). Regarding the illiteracy of patients, Catherine Chung (2015) explains the situation of patients within the U.S health care system and she states that the health caregivers should pay attention and be able to translate healthcare-related language (Chung 2015).

This kind of health illiteracy depends on the person, and how much this person is able to understand correctly the information he/she is given. The level of illiteracy may also vary, depending on the health condition of the patient but also on the social status and economic situation (Chung 2015). Therefore, Chung suggests to first verify the literacy of the patients by paying attention to the tones of voices and its nuances. Furthermore, various strategies are proposed to deal with illiterate patients. For example, the patient has to read the text aloud, so the physician can verify if the patient understands what he or she is reading. Moreover, when explaining something, the physician should ration the words, so that the patients do not get overwhelmed (Chung 2015).

Chung adds that it is also important to use simple language when delivering information about the patient's health condition, and to check if the patient got it right by asking him/her to repeat aloud the whole procedure he/she has been told. By doing so, the

physician can understand, if the information intake is too fast or too slow and if there is a need to go back to some points. All of this is for the protection and care of the patient, as it is really important for the patient to first understand his/her health condition (Chung 2015).

In the next paragraph, a general overview of voluntarism will be provided by Olohan (2012) and Casiday *et al.* (2015). Both authors will briefly describe the benefits of voluntarism (but also the downsides of such practice). Olohan (2012) provides a general overview of the phenomenon, while Casiday analyzes the volunteering activity within the healthcare settings.

2.1.2 What is volunteerism? An overview

Olohan (2012) analyzed closely the motivations that lead translators to serve as volunteers. Olohan states that the phenomenon of volunteerism is studied in many disciplines from psychology to behavioural economics (Olohan 2012). The author in his study first briefly describes the origin of "voluntarism" by stating that the first hint of voluntary activities or similar date back to the economics theories of Adam Smith (1759). In his Theory of Moral Sentiments he underlines that some personality features like "sympathy and fairness" could indicate a propensity for volunteerism (Olohan 2012). However, the term altruism started to spread a century later and derives from the French "altruisme" that means "to live for others" (Olohan 2012).

Comte, a century later introduces the concept of "pure altruism" in which he declares that people do charity just to enhance the profit of that specific organization with no benefits for them as donors (Olohan 2012).

Although, in some cases the reason behind volunteering can be also related to egoism: Behind the idea of helping others there may be a sense of guilt but also the idea that the donor will get increases related to benefits or goods. To define this sense of satisfaction in "giving", the term "warm glow" has been created (Olohan 2012). It has been also observed that there are other aspects linked to volunteerism. For instance, those who help within a community may take advantage of their position to show superiority towards others (Olohan 2012). Volunteering may – if positive aspects are considered – broaden interpersonal relations and improve one's self esteem, CV and professional career (Olohan 2012).

Another paper published by Casiday *et al.* from the University of Wales Lampeter (2015) reports the benefits that volunteering can bring to volunteers and to healthcare service users. The study aims at finding out the connection between volunteering and the health of volunteers and healthcare service users (Casiday *et al.* 2015). There is a growing interest to analyze this connection and moreover, volunteers who are working in this sector, do claim that there are many benefits related to volunteerism (Casiday *et al.* 2015). Volunteering helped improve some health and psychological conditions of the volunteers and these are for instance self-esteem, psychological stress, burnout, depression and routine activities (Casiday *et al.*

2015). Some types of volunteering lead to some improvement of specific health conditions, for instance church volunteering helped improve depression more with respect to secular volunteering (Casiday *et al.* 2015).

Volunteerism can bring psychological benefits also for healthcare service users. The study reports that such improvement can be seen regarding self-esteem, mental health, cognitive functions, and physical activity (Casiday *et al.* 2015). In this study it has been underlined that context is a crucial element together with the age of the volunteers and the role that they play and also if volunteers receive training before starting the activity and if this matches the activity. All these factors contribute to positive outcomes in volunteering (Casiday *et al.* 2015).

Moreover, when volunteers decide to volunteer for direct patient care, this contributes to an improved self-esteem and such activity also makes these volunteers feel "useful". In some cases, volunteering can expose volunteers to particular situations that may cause an emotional overload and therefore there is the need for training and assistance (Casiday *et al.* 2015).

2.2. A brief overview of medical volunteerism: considerations

Geren & Olson (2016) observed that in recent years, medical trips have been increased on a voluntary basis. In 2014, it has been reported that many newly enrolled students of American Universities have taken part in medical volunteering activities (Geren & Olson 2016). Geren & Olson (2016) observed that in some areas of the world, there is a high concentration of diseases, for example, in Sub-Saharan Africa. People applying for medical volunteerism have a precise mission, which has also various implications (Geren & Olson 2016). These implications according to Geren & Olson (2016) regard for instance populations that in most cases live in poor conditions, as they are victims of natural disasters or are pertaining to a lower social status. Also, the supplies and situations which medical volunteers have to deal with are different from the ones they find in their home country. Most of the time, organizations can also be a problem, in some countries where medical volunteers are serving, the healthcare system may not be so developed, or may not present the same structure. Eventually, patients' needs must be taken into consideration, otherwise the healthcare system organization can be overwhelmed and cannot respond promptly to welfare obligations (Geren & Olson 2016).

Together with a supply-shortage, different healthcare system, beliefs, and cultural barriers can be a further obstacle to medical volunteerism in some areas of the world (Geren & Olson 2016). Good communication and understanding are crucial elements in order to provide a good treatment plan (Geren & Olson 2016).

Moreover, language- and culture-related misunderstandings can lead to problematic situations and clashes between medical volunteers and local health providers (Geren & Olson

2016). However, several organisations such as the Sphere Project have developed the Core Humanitarian Standard (CHS), and have published standards to make the services and interventions more effective. These principles include various aspects of volunteerism, such as mission, partnership, preparation, reflection, support sustainability and assessment (Geren & Olson 2016).

1. Task: This principle allows the volunteer to grow personally, and many reports have reflected a great personal enrichment. It is also related to the environment and population in which the medical volunteers have worked and perceived the benefits of such volunteerism (Geren & Olson 2016).
2. Cooperation: In such environments, a collaborative partnership is needed to enhance the services and it also takes mutual understanding and empathy towards the community which is being assisted. This partnership can be also a long-term one, as medical volunteer teams may return at different times of the year and help the population there (Geren & Olson 2016).
3. Planning: This step includes knowledge of the local healthcare system, basic health precautions, such as vaccinations, but also tools for on-the-spot situations, simulations, and exchange of views.
4. Assistance: This element is vital for such settings to maintain an open view and an open attitude). Backing medical volunteers in such situations is important, as in some of the cases, participants have been reporting to suffer from burnout or depression (10-20% of participants). Therefore, the support and assistance programs allow workers to discuss the challenges they faced in stressful situations. Unfortunately, such on-site coaching programs are not always available (Geren & Olson 2016).
5. Assessment: Very often reports displaying the outcomes of MSTs are just describing the services offered and are not monitoring the situations in a systematic way. Therefore, there is a need for institutions to show their efficiency for medical volunteerism by monitoring the situations and environment constantly (Geren & Olson 2016).

Despite all the challenges that medical volunteers may encounter through such activities, institutions try to promote the idea of a "common humanity" along with the principle "do not harm", which is crucial for people active in the healthcare setting (Geren & Olson 2016).

2.3. The implementation of technologies to enhance volunteering translation and the motivation that lies behind the concept of volunteering: a brief overview

In the previous chapter, the importance of mediators who can act in particular situations, like natural disasters by facilitating communication, has been underlined. Nevertheless, also technology can be a useful resource in volunteer translation, especially when people have to deal with calamities. Time and technology here play a crucial role. A good example of

technologies for translating purposes was first seen during the earthquake of Haiti in 2010, where locals could only communicate with the world through messages (Horváth 2016: 145).

Nevertheless, the majority of the messages sent were written in Haitian Creole, which was unknown to the crew members and so a project was started, namely "Mission 4636 Project" (Horváth 2016: 145). The volunteers who joined the project came from 49 different countries. The aim of this project was to translate the incoming messages, which were 4.000 for the 1 month. As soon as the translator received the message, he/she had 10 minutes to deliver it in the target language for the crew members. Such project was first started as a volunteer project but after a month, translators were employed workers and this also helped the local economy to recover as new job positions and employment opportunities were created (Horváth 2016: 145).

Above, the main aspects and the implementation of technologies within the volunteering translation in particular cases, i.e. calamities or natural disasters, have been analysed. Nevertheless, it is also important to provide a brief overview of the motivation that lies behind the fact of translating on a voluntary basis. Horváth provides some explanation:

> The motivation that lies behind the fact of translating on a voluntary basis has also been analyzed. Some people translate on a voluntary basis because they want to help people in need and to also better understand the tragedy that happened (Horváth 2016: 145). Professional translators claimed that many translate also to make the information more accessible to the public and besides that, voluntary translation also give them the chance to acquire new clients and become popular (Horváth 2016: 146).

2.3. MSF: Ethics according to one of the greatest medical humanitarian organizations

Sheather & Shah (2010) state that since the 70s the MSF has been active in the field of humanitarian aid helping people in need. One of the principles of MSF and its volunteer body is to "abide by the code of ethics", and volunteers must act according to it. Sheather & Shah (2010). It is known that in places where the humanitarian organization is active, volunteers can face stressful situations, because of the lack of resources, cultural and language barriers, and different healthcare systems. The scarcity of reflection can also affect the outcome of humanitarian aid activities and reflection can be useful to discuss how activities can be organized and faced. Some practical examples have been displayed in order to give the readers an overview of how the MSF's staff acts regarding ethical matters.

Dealing with HIV in some parts of the world can be very challenging, as people who suffer from this pathology do not follow a proper treatment and it is therefore impossible for these people to feel better. People suffering from such a disease can be often stigmatized or others can take their lives. As a consequence, MSF staff can struggle to inform the patient if the result of the HIV test is positive, and with how to best deal with it. The main issue here is how to discuss the problem of HIV with the seropositive people and the community, so that

the legends about the non-existence of HIV can be dispelled. Upon discovering HIV positivity, the MSF staff usually says that the donator's blood does not match, but now MSF is thinking to inform the community about the total amount of the positive HIV test and they are aware that they must inform the community (Sheather & Shah 2010).

2.4. Strategies for better communication in health care settings

In this chapter various communication strategies are going to be described starting from Darrel (2005), who describes how healthcare language misunderstandings can be minimized by enhancing a good cooperation among healthcare staff members and their roles of responsibility (see hands-off) and also by providing patients with a correct information and by doing so overcoming language barriers.

According to Darrell *et al.* (2005), research has been partly performed in considering how communication occurs within the healthcare setting. Researchers discuss hand-offs[1] and their importance. In order to better explain the phenomenon of hand-offs in the health care setting, authors bring the example of the kids' game called Telephone. In this game, a message is transmitted and is whispered to the other person, who is sitting nearby and then the second person whispers it to the third and so on till the last person receives the message. At this point, the message is repeated by the last person and compared to the original message. The outcomes are very different and sometimes distorted and this is what happens in the healthcare setting as well (Darrell *et al.* 2005).

In the same paper, the importance of having an efficient process of standardization for patients who have been hospitalized also for short periods in the hospital, is described. In this way, patients may not have to wait longer for their treatment or case to be viewed (Darrell *et al.* 2005).

According to Darrell *et al.* (2005), another important issue that leads to misunderstandings in the healthcare setting among patients and physicians is how the information is given (Darrell *et al.* 2005). In fact, the main task of the physician is to give advice and information to the patients. Some of the hospitals use computers where all the patients' data and hand-offs are registered. When it is time for hand-offs, patients and medical staff meet, but it may happen that the latter one may not come to the appointment due to lectures or other tasks, and as a result there is a lack of communication or the patient cannot express his/her doubts (Darrell *et al.* 2005).

Other problems that can arise from unclear hand-offs are connected to the physical setting, the social context, language barriers, means of communication, time, and inconvenient issues (Darrell *et al.* 2005). Taking into consideration language barriers, it is

1 Hand-offs is defined as the transfer of role and responsibility from one person to another in a physical or mental process (see Darrel 2005).

stated that ethnic minorities, who cannot speak English very well, can face communication problems, even if the translator is supporting them. It is therefore useful to make sure that the message has been delivered correctly, for example by asking or repeating the message (Darrell *et al.* 2005).

Concerning the means of communication, written communication is not immediate. This can lead to misunderstandings; Therefore, it is always recommended to clear hand-offs by communicating verbally, as the process is also facilitated by the use of body language (Darrell *et al.* 2005).

Since there is no given guideline on how to deal with hand-offs, some suggestions may help the physician and medical staff:

- First of all, lectures should be offered in order to introduce the topic of hand-offs and trainees should be asked to simulate a hand-off situation with a patient. Later, a discussion should be followed to discuss the situation, together with the physician as well (Darrell *et al.* 2005).
- The second step suggests that the physician create a hand-offs situation, which has to be shared and approved by the other physicians who are taking part in the exercise (Darrell *et al.* 2005).

Nowadays, modern medicine seems an unflawed discipline, but it is actually through the standardization of processes and improvement of communication that mistakes can be avoided.

In some other sectors, such as aviation for instance, the percentage of errors caused by human factors has decreased from 81% to 50% (Darrell *et al.* 2005). The communication process here refers to cockpit and crew members. Researchers have analysed the different speech-patterns and have found out that a “common” language is used. Furthermore, it has been observed that as long as conventional language is used, the performance is improved (Darrell *et al.* 2005).

In the context of aviation, hierarchy can influence effectiveness of communication between air traffic controllers and crew members responsible for flying an aircraft. Similarly, communication problems can be seen also in healthcare settings, especially between medical staff and trainees. In aviation, with respect to medical settings, young staff members are allowed to take commands if the supervisors are in trouble or feel unsafe about a procedure (Darrell *et al.* 2005). As a result, hospital staff should be encouraged more to learn how to work in teams and communicate with one another rather than merely learning by errors (Darrell *et al.* 2005).Linda Haffner (1992) also provides an insight about difficulties she encounters when interpreting for Mexican patients. She provides practical examples of difficult expressions to translate and the meaning such terms have in the Mexican culture. In her article, Linda Haffner (1992) describes the difficulties she encounters while interpreting for Mexican patients. She underlines the cultural issues that are a crucial element for

understanding how translators and interpreters work. In the first lines of the article, she describes one of the many cultural issues related to the so-called “raquea”. It is a colloquial term used by some of the Mexicans to describe the procedure called “spinal block” (Haffner 1992).

Another common belief is related to birth and women’s sexuality. Haffner states that Mexican women often feel embarrassed to talk about problems related to their sexual life, together with inhibition this makes the situation even more challenging (Haffner 1992). All matters of birth are strongly related to religion. A Latino woman cannot be considered a mother if she cannot give birth to a child (Haffner 1992).

Moreover, Haffner has pointed out little variations of the Spanish language, for instance “canilla”, which means just in some parts of Mexico “wrist”. So, she stresses how important it is to get to know these language nuances when interpreting in such a setting (Haffner 1992). Haffner also underlines that professional healthcare translators and interpreters must see themselves as bicultural and not monocultural as they are taking care of the communication between physician and patients, both coming from different cultures (Haffner 1992).

Other guidelines issued by the National Council on Interpreting in Health Care involve documents that have to be translated on the spot. For this reason, the National Council on Interpreting in Health Care has issued a document in which general guidelines for on-the-spot translators have been provided (National Council on Interpreting in Health Care 2009).

Fong Ha *et al.* (2010) points out that communication in healthcare settings can be fostered if the interpersonal aspects are also taken into consideration. According to Fong Ha *et al* (2010), through good communication, information, counselling and diagnosis, processes can have a better outcome (Fong Ha *et al.* 2010). Many physicians claim to lead effective communication, as Fong Ha *et al.* (2010) states that studies on doctor-patient communication have demonstrated patients’ discontent even when many doctors considered the communication adequate or even excellent. According to Fong Ha *et al.* (2010), communication in healthcare has improved since the 1960s, a time during which doctors often avoided giving bad news to patients, especially if the health condition was serious. Nowadays, communication patterns within healthcare settings have improved, focusing on patients’ needs and expectations (Fong Ha *et al.* 2010).

Fong Ha *et al.* (2010) reports that when the communication is focused on patients’ needs, many aspects of the patient’s health improve, for example mental health. Observably, these language barriers are to be seen when the mental condition of the patient is not optimal. This is due to factors such as stress, fear or because the patient has gone through episodes of abuse (Fong Ha *et al*. 2010).

A successful communication between patient and doctor makes the patient feel considered and involved in his/her health condition. This feeling of consideration and involvement felt by the patient is called "biology of self-confidence" (Fong Ha *et al.* 2010).

"Biology of self-confidence" can be undermined, if doctors show themselves unwilling to listen to the patient, as this may cause a patient's discomfort and shyness when describing their health problems (Fong Ha *et al.* 2010). Moreover, patients may feel discomforted and the communication outcome might get affected because of such negligence (Fong Ha *et al.* 2010).

Fong Ha *et al.* (2010) also underlines the importance of empathy by stating that a good strategy to improve good communication lies in empathy. Empathy is in fact considered to be one of the important elements that make empathic doctors important supporters of the patients. In this sense, empathy allows the patient to be heard and reduces his perception of loneliness (Fong Ha *et al.* 2010).

Regarding empathy, Fong Ha *et al.* (2010) adds that not all physicians are masters of communication as everyone has different talents, though this skill can be acquired through training and self-monitoring. An important aspect of such training is helping physicians to improve their statements and to change approaches according to the patients, from a rigid one to a more versatile one (Fong Ha *et al.* 2010).

Even if the position of the physician with respect to the patient is dominant, good communication remains crucial. Good communication has advantages for both, patients and physicians. It helps parties to better organize the treatment plan (Fong Ha *et al.* 2010).

2.5. Culture within hospitals: developing models to cope with the different cultural backgrounds of patients

According to Ballard (n.d.), in healthcare settings, cultural differences can often lead to misunderstandings. When dealing with patients belonging to minorities, habits and conventions are different from diet to personal hygiene. As a consequence, there is no disclosure of information and therefore the treatment turns into a disappointing procedure, and those patients are less likely to follow the instructions given and are described as "problematic patients" Ballard (n.d.: 2).

There is also inequality and a lack of knowledge among healthcare staff, as well as cultural differences when it comes to dealing with patients coming from cultural minorities. Technological innovation may also present an obstacle, raising worries in patients belonging to minorities (Ballard n.d.: 5). Ballard offers an example of how healthcare providers, nurses, and doctors can deal with the matter of personal hygiene. In order to explain such a concept to this target-group, the healthcare staff chose to simplify the terminology. The staff identifies and use, in this case, "bugs and germs", while explaining some procedures like preparing food or common-sense practices like, "to cover your mouth with the hand when coughing Ballard

(n.d.: 5). But not in all cultures there is the concept of "germs" and "bugs". Some Asian populations and minorities, such as the Sikh, describe this condition in a different way, i.e. they identify the filth with the concept of pollution. Body liquids, blood, urine, excrements, and also phlegm can be considered as "pollution", for instance, they never take a hot bath, as for them this would mean to bath in stagnant water, which is being polluted by the body (Ballard n.d.: 6).

When it comes to healthcare there are challenging situations, for example, when it comes to disinfecting dishes for feeding babies.

Ballard (n.d.) argues, that every culture has its own peculiarities and that all the parties involved in the healthcare interaction – patients and doctors - have their beliefs. But when cultural peculiarities clash, problems show up. If cultural and institutional systems keep refusing each other with their own beliefs, communication would turn out to be a difficult process (Ballard n.d.: 7).

Medical staff and doctors must pay attention not just to their technical approach, but also sensitivity and competence must be extended to all medical fields, where the cultural approach is supposed to be seen. By doing so, doctors must train students in a different way, i.e. not by explaining that there are "minorities", but rather medical practices should involve cultural aspects. This point highlights how cultural differences are not just to be seen among minority groups but also because there are cultural differences between doctor and patient. (Ballard n.d.: 8).

In order to achieve awareness of the situation, training should be offered for medical staff and doctors along with cultural competence, as well as support and assistance for patients. Many doctors however, do not consider cultural factors and therefore, there is the need to raise awareness about the acknowledgement and acceptance of the patients' habits and lifestyles, no matter how different they are from the country they are residing in. Moreover, Ballard (n.d.) states that a failure to match technical skills with the relevant degree of cultural competence can impair therapeutic effectiveness (Ballard n.d.: 8). There is also the expectation that such diversities are taken into consideration to overcome difficulties and to improve the British healthcare system (Ballard n.d.: 9).

Karabudak *et al.* (2013) offers an overview of cultural beliefs and behaviours that patients have in medical healthcare settings, for instance beliefs patients have about diseases that are seen as God's will. Karabudak *et al.* (2013) provides also transcultural models that can be used in order to deal with cultural differences. However, in Turkey there is a growing awareness, as far as cultural competence is concerned (Karadubak 2013). To this end, it is stated that nurses should be aware of the cultural properties of patients, their families, as well as their own institutions (Karabudak *et al.* 2013: 342).

Transcultural models have been developed within healthcare systems in order to deal with cultural diversity. One of them is called "Transcultural Assessment Model of Giger and

Davidhizars" that aims at analysing the perception of patients concerning health, disease, reactions and their consequences. Along with such elements, six cultural parameters have been taken into consideration: communication, space, social organizations, time, environmental control, and biological variations (Karabudak *et al.* 2013: 342ff).

The model has been used to analyse a specific case of a child suffering from kidney failure. The application of the model facilitates the understanding of the patient's beliefs and behaviours (Karabudak *et al.* 2013: 342).

Karabudak *et al.* (2013) states that communication in this case is essential, as communication makes it possible for us to relate to the world. Regarding the language, the woman does not use any dialect while communicating and acts within a personal space to communicate (Karabudak *et al*. 2013: 343).

Furthermore, the social elements play a role in Turkish families and culture. Usually, the mother takes care of the health condition of the family members and the husband takes care of the financial aspect. According to the healthcare condition of the son, the mother considers the whole situation as "God's will" and the outcomes too, whether they are positive or negative. Moreover, the Imam would not see the proposed transplant option as misconduct (Karabudak *et al.* 2013: 343f).

Time is another crucial factor of cross-cultural communication. According to Karabudak *et al.* (2013) some cultures perceive time as "social time" (Karabudak, *et. al* 2013: 344). For example in this case, the mother of the little child perceives and describes the duration of the son's illness as "God's will" and she does not have any influence on it (Karabudak, *et al*. 2013: 342). Karabudak *et al.* (2013) claims that tokens and amulets are used as a mean to control external influences (Karabudak, *et al.* 2013: 343f). The mother of the child states that she would show gratitude by offering gifts, if the child recovers from the disease (Karabudak *et al*. 2013: 344).

Diseases such as kidney failure also include impacts like genetic factors. In this case, it has been observed that in the family history, other cases of kidney failure have been reported as well (Karabudak *et al.* 2013: 344).

Karabudak's model also offers an overview for medical staff, i.e. nurses in particular, and shows how they could deal with patients coming from different backgrounds, by taking into account a cultural point of view (Karabudak *et al*. 2013: 345).

Like Karabudak, researcher Hande Dag (2017) reports examples of language barriers that are to be seen in the gynaecology ward at the Dokuz Eylul University, Turkey.

Researcher Hande Dag reports in her experience as a nurse in the gynaecology ward, that there are many women assisted, who belong to a lower social status or are refugees. She describes the situation of a Syrian refugee who gave birth to a child some days before.

In this case, she states that there is a strong cultural and language barrier, which often leads to misunderstandings, incorrect behaviour and mutual disrespect (Dag 2017: 1).

Language barriers could not be overcome. Arab patients were also asked to help in the interaction, but no great improvement was made. Programs like Google Translator were also used to try to communicate, and sometimes body language was used (Dag 2017: 1).

Bad communication leads to a wrong comprehension of medical instructions (Dag 2017: 1). Due to the miscommunication, the patient got anxious and could not accomplish and follow the instructions given (Dag 2017: 1).

Dag expresses in her paper the need for intercultural nursing lessons, and an intervention of the Turkish Ministry of Health to provide interpreters who are proficient in the Arabic language (Dag 2017: 1).

Some other issues concerning miscommunication are reported by Ahmad and Uskul (2003) in a Turkish hospital, located in the central area of Istanbul, in the gynaecology ward. They analysed what the interaction between patients and physician is like. It is reported that the interaction can vary, depending on the physician's sex. When male gynaecologists visit their patients, they address them by using straight language while welcoming the patient in the ward and usually, patients would wait for the doctors to come in soon after they got undressed (Ahmad & Uskul 2003: 210). On the other hand, female gynaecologists throughout the visit are more likely to use empathic manners and usually also refer to their past examinations in order to make the patient feel more comfortable (Ahmad & Uskul 2003: 210). Another difference in the communication process between female and male gynaecologists is the way they explain the outcomes, male physicians tend to use technical terms while commenting the outcomes, whilst female physicians are more likely to use no technical language while explaining the outcomes and patients are more encouraged to ask question whenever they are not familiar with any technical terms (Uskul & Ahmad 2003: 211).

During the examination male physicians have been found less willing to provide information about future examinations and less ready to give further instructions after the examination is over (Ahmad & Uskul 2003: 211).

According to the behaviour and perception patients have towards physicians, some women tend to be more reluctant when being examined by male gynaecologists because of religious beliefs. Male physicians treat women coming from lower social status and those highly educated in a different way. They address less educated women with direct questions. The opposite treatment is seen towards highly educated women, who are persuaded by the male gynaecologist (Ahmad & Uskul 2003: 211).

There are several differences according to the studies conducted in Western countries and Turkey regarding gynaecological encounters. Differences were firstly seen in the way gynaecologists approached patients, for example regarding the style of communication and eye contact. The social status of the patients can affect the visit, and this can cause gaps. More

medical training and empathy could help to reduce such divergences (Ahmad & Uskul 2003: 212).

It is stated that the communication is difficult among male gynaecologists and female patients and this may require more training (Ahmad & Uskul 2003: 214).

Different treatments within healthcare according to ethnicity are reported by an American study carried out by Betancourt et al. (2000). To this end, Betancourt et al. (2000) states that differences during medical visits can lead to severe consequences. As Betancourt et al. state, mistrust can be generated in many ways in cross-cultural encounters, but it often arises from the fear of prejudicial treatment based on race or ethnicity (Betancourt *et al*. 2000: 30).

According to Betancourt *et al.* (2000), an initiative called *President Initiative on Race Healthy People 2010* has been launched to diminish racial ethnical disparities in health, specifically in some of the diseases such as cancer, HIV and vascular diseases. (Betancourt *et al*. 2000: 30).

Inequalities regarding treatments in healthcare settings may also arise from poor communication, prejudices, and scepticism from patients. So how can possible solutions be found? Firstly, the patient's and the doctor's points of view of shall be clarified. Moreover, other essential elements should be respected as well, which include the patient's cultural beliefs. It is important to learn more about the patient's culture, as it may offer hints to help understand his or her illness, and it may offer an overview of other important factors, such socioeconomic components (Betancourt *et al*. 2000: 30).

A good strategy to achieve a better interaction is given by the so-called "Ethics of Caring" (Betancourt *et al*. 2000: 30). This approach intends to refocus on the doctor's response to the individual patient, away from the less empathic, principle-based method focused solely on fairness and equity.

> We may stray from the ethics of caring and assume the more distant postures that stress principles over empathy. An orientation of care incorporates the attributes of attentiveness, honesty, patience, respect, compassion, trustworthiness and sensitivity into all acts of behaviour. (Betancourt *et al.* 2000: 31).

Marcia Carteret (2012) in her book "Dimension of culture: Cross-cultural communication for healthcare profession" provides good strategies to make medical care more patient-friendly and accessible for people who have a different cultural background. First of all, she provides a brief overview of how cultural minorities and their health beliefs are perceived by American physicians. She provides also effective strategies that can be implemented to improve the communication and welcome these minorities within the American healthcare system. Later on, she focuses on the Mexican cultural minorities who are present in the USA and will briefly explain their health beliefs, how the concept of illness is perceived by these cultural minorities and

later she provides some examples of popular illness and how these can be explained, defined and understood to ease the access to the healthcare system for these minorities and to build a friendlier environment for them within American hospitals. In fact, in her book Carteret claims that in the USA doctors are highly prepared to study the different branches of medicine, like for instance anatomy or biology, but less attention is paid to the cultural differences and to the backgrounds of the patients coming from a different cultural environment. The main challenges of cross-cultural communication in healthcare derive from the fact that health care professionals do have other beliefs, rituals and concepts, just like their patients and that is because both parties act according to the culture they come from (Carteret 2012). In order to provide a good response to cross-cultural communication, physicians need to be aware of such mechanism. Indeed, if such mechanism is not understood properly it could affect also the outcomes of a treatment. That is why it is important that in American medicine school patients' beliefs and cultures need to be a subject of study (Carteret 2012).

The first step for improving the mechanism of cross-cultural communication- according to Carteret- is to understand that both, healthcare provider and patient, do come from different cultures and cultural backgrounds. Secondly, it is important to understand how this cultural difference influences the patient-physician interaction (Carteret 2012).

The author provides practical suggestions for cultural healthcare providers about how to develop an effective cultural approach:

- Identify the implicit aspects of culture: understand the behaviour and beliefs of the patients, those related to illness as well and how illness is perceived in their culture.
- Master the thoughts: do not assume that one culture is dominant over another. Every culture is different and it is important to understand its mechanism.
- Have a "cultural-humble" approach: In order to achieve this, it is essential to understand one's culture first. Only later it will be possible to distinguish effectively cultures and their features.
- Have a flexible attitude: by doing so there will be the chance to achieve better outcomes when dealing with patients coming from different cultural background.

Moreover, the author claims that physicians need to focus on the behaviours, beliefs and prejudices that could present an obstacle for the interaction with patients (Carteret 2012).

In addition, Carteret provides an overview of how the concept of illness is perceived by cultural groups. The impact they may have can delay medical treatment. The main concepts that identify an illness are three: "personalistic", "naturalistic", "biomedical".

According to the personalistic concept, an illness can be caused by a supernatural entity which for instance can be identified with an ancestor who passed away, whilst it is believed that evil influences can undermine the spirit (Carteret 2012).

According to the naturalistic belief, illness has a strong connection with nature, i.e. when the harmonisation between nature and human being is not strong, illness shows its signs. Such deficit can be cured – according to the people believing in such approaches - through ayurvedic treatments (Carteret 2012).

The biomedical concept of illness states that the treatment and diagnosis should be given according to scientific information (Carteret 2012).

As said before, it is crucial to understand the culture of patients coming from different cultural backgrounds as it enhances cooperation between healthcare provider and patient, together with the enhancement of a mutual understanding. In order to do so, physicians need to understand that - also as far as cultural subgroups are concerned - there are differences. Other factors that should be kept in mind are the socio-cultural background, economical-background and the level of English proficiency (Carteret 2012).

- Carteret displays some cultural and behavioural differences, features and beliefs that are typical of Latino[2] communities in the USA. For instance, for Latinos personal relationships are more important than time efficiency. That is why they wish that physicians take such aspects into consideration. If a physician shows detachment towards them, they could perceive it as unfriendliness and as a consequence, they may be not so cooperative with the physician. Carteret suggests in this case that the physician should talk at a slower pace, be respectful towards them and try to speak some Spanish too. As far as non-verbal communication is concerned, handshaking is appreciated by the Latino community and also a light shoulder-tapping, as it is a sign of cordiality (Carteret 2012). Before, it has been briefly described what is believed to cause illnesses and the various ideas around the concept of "illness". Now a short description of popular illnesses of the Latino culture will be displayed, together with their meaning and cultural translation into English: "Empacho": It indicates a temporary condition of indisposition of the stomach or of the intestine which is caused by not properly digested food or because the food has not been chewed properly or it is due to wrong eating habits, i.e. chewing/eating too fast.
- "Susto": It indicates a temporary emotional shock experienced after a scary experience.
- "Mal de Ojo": It is translated into English as "evil eye". Such condition is believed to be caused by other people who have a strong appreciation towards another person, usually children. It is believed that such a person casts a spell on the child by looking at him or her and as a consequence the illness results.
- "Moliera Caida": Such a condition is believed to be the result of pulling away a baby too soon after breastfeeding or after drinking from the bottle (Carteret 2012).

[2] The term Latino refers to all those people living in the USA who have a Spanish origin (Latin American, the Carribean, Mexico, Central America and South America (Carteret 2012).

As we have seen, these populations have different beliefs concerning illness and healing methods. For this reason, many US physicians see such attitudes as a cultural obstacle. People coming from these different cultural groups rely on their traditional healer and may go to the hospital later, when health complications arise (Carteret 2012).

Sometimes people who belong to these other cultural groups may refuse to accept the medicines and the treatments they are offered from the healthcare system. For instance, a case of a Latino young girl is presented. The girl was diagnosed with a strong form of diabetes, known as mellitus 2 and the mother was given the treatment instructions in which insulin shots were prescribed. Initially the mother seemed to agree with the treatment, but later the physician who was in charge of following the treatment found out that the mother of the girl refused to start the insulin treatment because the grandmother believed that the insulin could cause addiction and therefore had banned the insulin shots (Carteret 2012).

That is why it is important to find a way to communicate with the patients and to get rid of all these misconceptions about Western concepts of illness and related treatments (Carteret 2012).

Carteret (2012) suggests some techniques that can be taken into consideration to improve communication and mutual understanding between patient and physician:

1. Before discussing treatment and health issues, take some more time to create harmony.

2. Physicians should make the patient understand that they are aware of the culture-based mechanisms.

3. Be aware of how the professional profile of the physician is seen by other cultures.

4. Show empathy and welcome questions coming from the patient. Respect the moment of silence, as the patient may be trying to find the right words to explain the situation.

5. Show awareness about traditional medical treatments that may be typical of specific cultural groups, without expressing offensive opinions about such treatments.

Furthermore, during a visit it is advisable for a physician to:

1. Show friendliness at the start of the visit. Take notes about the patient's case history. If the family is planning to go back to the country of origin for a short time, ask them later about the trip. Families are pleased to see that their physician remembers.

2. Ask questions about the well-being of the family. This is also much appreciated.

3. Handshaking is also good in these situations. Mind that if the patient does not stretch out their hand, it does not mean that it is a sign of impoliteness, as there may be cultural factors that hold back the patient.

4. Eye-contact with the patient is essential (Carteret 2012). In the last years in the US, new models of interaction with patients have been implemented. An important factor to better

achieve all this is to try to start a dialogue, i.e. interaction with the patient, where the patient is at the centre of the interaction (Carteret 2012).

In this chapter different strategies and models have been displayed for a better understanding of the phenomenon of cross-cultural communication within healthcare settings. Practical examples were given, especially as far as Turkey and the Latino community in the USA are concerned. Strategies to better the cross-cultural communication have been implemented in Europe as well. In particular, a EU project called “Migrant friendly hospitals” has been introduced in some European countries and in Italy too. Chiarenza (2005) explains how it works. The author first briefly describes what the migration phenomena is by doing a short historical excursus. Later on, he particularly focuses on the Italian situation of cross-cultural communication within healthcare settings and he will describe how this European project was implemented in some of the Italian hospitals in Reggio Emilia and what its aims are. In Europe nowadays, migration is also an important topic. Currently hospitals in Europe are trying to find a way to facilitate the access to services for migrants. According to the IOM World migration 2003, today one person out of 35 is a migrant. Migrants are defined as people who live outside of their country of origin and this number would increase even more if also second and third generations were included in the report. Among this group of people there are asylum seekers, or people who were forced to flee because of wars or because of dictatorships while others escape for economics-related reasons (Chiarenza 2005).

Anyway, the migration flows increased drastically at the end of the 70´s and spread across Italy and other East European countries. Given the increase of the migration flows, these countries in order to be productive had and still have to rely also on foreign workforce (Chiarenza 2005).

Indeed, migration flows are going to increase in the following years as well. (Chiarenza 2005).

The situation and these perceptions vary from country to country: In Italy, governmental authorities did not really know how to deal with the matter and it was unexpected for Italy to have such heavy migration flows. As a consequence, there is a huge gap in Italian welcoming and integration policies that has not been restored yet (Chiarenza 2005).

This situation fueled illegal immigration flows and as a consequence many illegal migrants were present on the Italian territory. This furthermore lead to a social miscontent and refusal towards immigrants (Chiarenza 2005).

Today in Italy there are different foreign citizens who hold a different juridical status: regular working citizens, foreign citizens residing in Italy and waiting for the residence permit approval, asylum seekers, and people whose right of political asylum has been recognized (Chiarenza 2005).

Such migration flows have completely changed the geographical scenario of Europe; Today, the modern society is a multicultural society where there are groups of people sharing some ideas that clash with other ideas of the people that are not part of these groups. This causes anxiety within the local community, but today the matter is not the acceptance or the refusal of this migration phenomenon itself, but how to organize such a multicultural society (Chiarenza 2005).

A good strategy to organize this society would be the implementation of a so-called "cultural democracy" which aims at banning concepts like "purity of culture". Cultural democracy must foster the concept of equality and equal rights for everyone, no matter which religious beliefs people have, or to what cultural group they belong. Furthermore, new strategies have to be developed, in order to fight every kind of discrimination and offer new chances for everyone. In order to do so, it is necessary that the host countries implement projects and strategies that involve public institutions at various levels, above all social and healthcare services (Chiarenza 2005).

Therefore, healthcare services need to change their approach when dealing with patients coming from different cultural backgrounds. In particular, changes need to be made in the way they communicate, the way they provide information and the way they treat patients in order to meet the requirements and the needs of a multi-cultural society (Chiarenza 2005).

Chiarenza (2005) states that there is a connection between physical and mental well-being and immigration. Health risks for migrants are connected to the poor living condition they had in their country of origin, to the experiences they had to cope with during their journey and later to the difficulties they had to face upon their arrival in the host country and eventually to the isolation and marginalisation they had to experience when they settled in the host country (Chiarenza 2005).

Stress factors and marginalisation, as well as working and social conditions undermine the well-being of immigrants. It is obvious that to live in such conditions can cause emotional instability, anxiety and frustration. Many people on the contrary think that immigrants do carry with themselves exotic illnesses, but in reality the well-being of immigrants is undermined by other factors, i.e. a lack of a basic healthcare assistance and the strong limitations that restrict their access to healthcare services and assistance. This is due to poor language knowledge and a poor knowledge of the healthcare system of the host country. Also, the lack of communication strategies of the healthcare professionals of the host country can complicate the situation even more. These inequalities concerning the access to healthcare services can be overcome through the creation of systems that welcome cultural diversity and tear down those barriers that could be a further obstacle for the detection of illnesses and the related treatments (Chiarenza 2005).

To this end, the EU from 2002 to 2005 started a project called "Migrant-friendly Hospitals that was part of the European Project of Public Health and this project was aiming at:

1. Improving the quality of healthcare treatments, the quality of the assistance to patients, and the quality of information and guidance of patients.

2. Improving the access to healthcare services and the appropriate usage of such services.

3. Improving an effective cooperation between patients and healthcare professionals

4. Raising the communities' awareness to adopt healthy lifestyles, by using the resources that the host country assigns, and combining them with the cultural models of the ethnic minorities.

In addition, the project aims specifically at:

1. Activating and assessing the organizational development by creating structures, services and processes that meet the different cultural needs

2. Specifically focusing on the needs and priorities

3. Creating and evaluating the models of good practices that focus on the particular healthcare needs of the immigrants

4. Presenting recommendations to the EU and releasing the outcomes

The hospitals that decided to join the project improved their cultural competence and at the same time new cultural diversity policies were implemented. That lead to a complete re-organization of the hospital in terms of services and infrastructures and management commissions (technical commissions, interdisciplinary commission, social networks) were created. These management commissions are responsible for the organization and management of the structure of the hospital and its good functioning, as these responsibilities and choices clearly have an impact on the migrants and on the ethnic minorities. Several interventions were adopted:

- Enhancement of the access to healthcare services by issuing multilingual informative leaflets
- Development of good strategies regarding hospital admission and hospitalization
- Provision of an intercultural mediation service to overcome language barriers
- Enhancement of the welcoming procedures within the hospitals by providing tailor-made menus and to offer support concerning the different religious needs and beliefs
- Provide the patient with adequate assistance during the discharge by providing the patient with information about the hospital networks in the territory and by providing

the patient with information concerning the treatment of illnesses and how to adopt an adequate lifestyle

- Integrate the "cultural competences" with the professional and organizational competences
- Assessing the services provided and the adequacy of such services

Moreover, several little projects were also implemented. The objective of such project was to enhance the cultural and organizational improvement of the hospitals, in many cities 3 further little projects were started. These projects focus on the following areas: intercultural mediation, education and information of the patients and the education of healthcare professionals. Within the Italian hospital "Guastalla AUSL Reggio Emilia" which was joining the project, these little projects were started simultaneously in different wards: gynaecology, paediatric, and Emergency. In particular, 2 of these little projects will be displayed in this paper as they particularly focus on the improvement of communication strategies within healthcare settings:

Project A: creation of a cultural mediation service:

The aim of this project was to improve the quality of the cultural mediation services offered in the hospitals that joined the project all over Europe. It was necessary to implement different forms of intercultural mediation. The service was performed and provided by qualified personnel, i.e. interpreters and cultural mediators. The telephone interpreting service was also activated and the translation of informative material was also provided by qualified translators and cultural mediators.

Such project aimed at creating the following services:

- Evaluation of the needs of the patient when he or she enters the hospital (search for information, access to basic and specific healthcare services)
- Combination of the cultural mediation service with the organization of the service activities
- Enhance the cooperation between cultural mediators and healthcare professionals
- Ease the access to the language services provided in case of emergencies or unscheduled examinations

Project C: The aim of the project was to develop cultural competences that helped to enhance awareness and knowledge of the healthcare professionals. Specific education programs have been offered. These programs aimed at improving the healthcare assistance services by creating a culture-based approach. The objective was so raise awareness among healthcare professionals towards other cultures and to overcome prejudices and to integrate different health beliefs and healing beliefs in effective treatments procedures. The target group were

healthcare professionals (physicians, nurses, obstetricians, physiotherapists and personnel working at the information desk).

The courses were held by qualified professors who could combine specific knowledge of the healthcare system procedure and fieldwork. Moreover, the courses were also attended by other experts as cultural mediators who belonged to the predominant ethnic groups within the local territory.

The organization of the courses was based on an active participation and typical work situations were re-created.

Nowadays, patients in hospitals belong to different ethnic groups and cultures. Given the situation it is important to welcome the challenges and opportunities this multicultural society brings. Such initiatives focused on migrants as patients and were part of the integration policies and improvement policies as far as healthcare systems were concerned.

To provide healthcare services that are "culturally adequate" i.e. that meet the needs of the different ethnic groups, means – first of all – to improve the quality and safety of health treatments, improve the patient's satisfaction and improve the health treatments' outcomes.

To this end, this EU project which was started can be a good example for the implementation of similar projects in the future (Chiarenza 2005). The strategy that should be implemented should be aimed at evaluating and monitoring the overall provision of healthcare services and also at understanding the priorities and to take specific actions to develop them (Chiarenza 2005).

The EU project "Migrant Friendly Hospitals" indicated areas where interventions are needed, i.e. communication, cultural competence and patients' education regarding the healthcare system. When there is a miscommunication between patients and healthcare professionals, the quality of healthcare treatments will be inevitably affected by this and therefore it is important to overcome the cultural disparities. Furthermore, it is essential to provide equal access to healthcare assistance, so that inequalities concerning the health conditions of people are eliminated (Chiarenza 2005).

In the next chapter, the professional profile of cultural mediators in Italy will be briefly portrayed.

2.5.1. The importance of cultural mediators in healthcare settings: an Italian scenario

In this chapter, the professional profile of cultural mediators will be displayed. In the previous chapter the importance of adopting models and strategies in order to establish a cross-cultural approach in healthcare settings was observed. Several examples of cross-cultural models were provided and strategies were provided, as far as Turkey, the USA and Italy are concerned. Italy adopts also cross-cultural approaches in order to assist migrants. To this end, in Italy there is a specific professional figure called "mediatore culturale". The author Elena Tomassini offers a brief overview of the role of such mediator within healthcare settings.

The Italian Emilia-Romagna region was the first to adopt such a cross-cultural approach within hospitals, as over the years there have been several miscommunication issues with immigrants (Tomassini 2012: 42).

In Italy, cultural mediators' skills and knowledge should include: awareness of the migration process dynamics, knowledge of the foreign language of origin (written and spoken), knowledge of the Italian language (spoken and written), healthcare setting's mechanisms in the country of origin and in Italy, terminology that belongs to the specific setting, EU regulations about immigration and the rights immigrants have, interaction techniques (interpreting techniques and also basic knowledge of intercultural dynamics, migration psychology and cultural anthropology (Tomassini 2012: 42).

The role that cultural mediators play is essential as it serves as a bridge between cultures.

In fact, the cultural mediator serves as facilitator for both cultures: When immigrants arrive, they have to face another reality and in the new country they have to give life to new relationships but they are anyway - to some extent - still grounded in the culture of the country of origin and thus the rule of cultural mediators is crucial as it eases the interaction between immigrants and Italian institutions, healthcare settings included (Tomassini 2012: 44).

In Italy the cultural mediators working within medical settings do not have any knowledge of exotic languages, for instance Farsi, Filipino or Urdu. (Tomassini 2012: 46). Within Italian Interpreting and Translation universities it is very hard to find specific curricula offering such languages. Usually translators and interpreters who currently work in healthcare settings and who have a knowledge of such languages have attended courses offered by the local authorities of the city. For this reason, a cooperation between universities and institutions (healthcare institutions as well) is essential. A way to achieve this would be to offer specialisation courses or to offer in-training courses for those mediators who have no formal qualification and would like to earn translating and interpreting skills (Tomassini 2012: 46f.).

Examples of cultural mediation with exotic languages can be found for instance in Ancona. Specifically, cultural mediators are asked to ease the interaction between patient and physician. Their main tasks are:

- Provide information about treatments
- Translation of brochures and other medical documents

  Welcome migrants and explain to them what the healthcare procedures are and facilitate their access to them

The following languages are offered at the hospital: English, French, Arabic, Russian, Ukranian, Polish, Turkish, Romanian, Serbian, Croatian, Bosnian, Albanian, Filipino, Urdu, Hindi, Chinese, Greek, Macedonian, German, Bulgarian, Farsi/Dari, Fanti/Ashanti (Tomassini 2012: 50).

It has been observed how important a cooperation between local Italian institutions and universities may be in order to improve intercultural communication within healthcare settings by offering specific training courses and university programs (Delli Ponti & Forlivesi 2005).

However, the more specific aspects and features of the profession will be learnt while working on the spot. Certainly, a necessary requirement for intercultural mediators in such a setting is the excellent linguistic knowledge and also an excellent knowledge of the medical terminology and knowledge of colloquial linguistic registers. That is because sometimes patients are not familiar with the medical jargon (in their mother tongue too) and therefore the mediator must be ready to explain these terms by simplifying them (Delli Ponti & Forlivesi 2005).

In other situations, patients who have a good knowledge of the English language do not know how to deal with the medical jargon. Sometimes in the mother language of such people specific medical terms cannot be understood, as for instance for the word “tetano” (tetanus). This may cause problems, especially if patients are expected to sign for an informed consent before undergoing short tests or surgical operations (Delli Ponti & Forlivesi 2005).

In some extreme situations, when a verbal interaction with the patient is nearly impossible, body language can also be used - knowing that body language differs from one culture to another (Delli Ponti & Forlivesi 2005).

In this chapter, the role of the cultural mediator in Italy has been briefly portrayed, as well as the intercultural requirements and the linguistic knowledge needed to do this job. Moreover, the importance of a close collaboration between universities and healthcare institutions to promote and enhance intercultural dialogue has been discussed. In the next chapter, a brief overview will be given of the psychological requirements and attitudes that cultural mediators need to have in order to effectively work within healthcare settings.

2.5.2. Psychological requirements and attitudes cultural mediators need to have

People who work in such settings may deal with different situations which may be physically and emotionally stressful. Essential requirements that are needed to work in such settings are openness towards the patient and availability and to be adaptable and ready to face any kind of situation.

Moreover, it is important to have an empathic or helpful attitude towards the patient and to understand the socio-cultural dynamics that lie behind the patient's need of help. While doing this, it is important that the interpreter or translator does not get too emotionally involved, as this may cause a psychic stress that would be unbearable (Delli Ponti & Forlivesi 2005).

In some cases, the cultural mediator is seen not as just the person that reports to the physician what the patient says, but the role that he/she plays is that of easing the communication, so that it can be as fruitful as possible (Delli Ponti & Forlivesi 2005)

Because of the particular emotional involvement that can derive from such a profession, it is advisable for people who can be easily impressed by events or striking situations not to choose this profession. Such personality feature can however be improved with experience and time. A good strategy to relieve the stress that derives from these situations is to talk to other colleagues (Delli Ponti & Forlivesi 2005).

Also, psychologists claim that there is a correlation between medical translators and interpreters and the ability to work in healthcare settings. In fact, researcher Hubscher-Davidson states that:

> Being able to appraise and communicate one's own and other people's emotions is a key aspect of intercultural communication, and therefore a key skill for translators and interpreters. Along with being a competent linguist, a translator arguably needs to mediate effectively between cultures, to understand a target reader's needs, expectations, and how to communicate a source author's message in a successful way to target readers, or to a target audience in an interpreter's case. (Hubscher-Davidson 2013: 332f.)

Being able to recognize the needs of a reader or of a costumer and find a good solution to fulfil those requirements, that later will determine the success of the translation or interpreting performance, is called by psychologists "emotional intelligence" (Hubscher-Davidson 2013: 333).

Hubscher-Davidson also stresses the importance and the role of interpreters and translators as culture bridges, in a world that nowadays is becoming increasingly globalized. The role of a translator is to transfer specific information from one culture to another, to be exact in transferring the information of the source text and to be ready to deal with any kind of situation. These are essential abilities of translators and interpreters. To this end it will also be argued that the emotional condition i.e. the ability to process and react to life's happenings is a key element to assess the interpreter's abilities (Hubscher-Davidson 2013: 335).

2.5.3. The impact of stress for healthcare interpreters and translators and how to deal with it

In chapter 2.5.2. the fact was stressed that interpreters and translators working in healthcare settings could come across stressful situation, and as a consequence experience a severe psychological stress. To this end, Crezee *et al.* (2015) have developed a "self-care" kit for interpreters to deal with stressful situations. Such strategies will help them to cope with traumatic events.

The main causes of stressor will be identified and briefly reported: Stressors affect the job of an interpreter and interpreters themselves claim that they feel stressed because of their job, but in most of the cases they are afraid of telling this, as they do not want to be seen as emotionally fragile (Crezee *et al.* 2015: 75).

Crezee *et al.* (2015) have observed that the main causes for stress can derive from the fact that interpreters are asked to linguistically assist people, like refugees, who had to deal with episodes of violence and torture (Crezee *et al.* 2015: 76). It has been observed that particularly people working with refugees in hospital may experience traumatic moments but traumatic moments may be reactivated also when interpreters deal with other traumatic situations. To this end a survey in New Zealand was carried out and it focused on interpreters working within hospitals with refugees and the outcomes state that seventy-six percent of interpreters had been negatively affected by the experience. One of the interpreters who was interviewed added:

> Each of our hospitals has the same core list with a few minor variations […] as some who have a refugee background choose not to cover the mental health areas, and not wanting to relive some of their own traumas in the process: the latter was more applicable to the African refugees (Somalia, Ethiopia) in the earlier days of their coming to NZ. (Creeze *et al.* 2015: 76)

In addition, Creeze *et al.* 2015 identify other stressor features that are:

- Personal financial situation or relationships
- Life events and current psychological situation
- Resilience level
- Interpreter's psychological abilities
- The type of assignment the interpreter has to deal with and if it recalls unpleasant memories
- The mental and physical condition of the interpreter and wellness (Creeze *et al.* 2015: 76)

To help interpreters deal with such a situation and with not being overwhelmed by stress, it shall be underlined that the interpreter should view things in a more detached way and avoid

empathizing too much with the patient. For interpreters who deal for the first time with such demanding situations within healthcare settings, it is advisable that they start a process of "self-care" and maybe later on look for external help provided by professionals (Crezee *et al.* 2015: 77).

The "self-care" approach is explained as follows:

1. Be conscious of the fact that the assignments have a negative impact on the personality and decide if there is the need to do something about it or not

2. Decide the step to take in order to take care of the situation

3. Cope with the negative consequences the assignment has had on the interpreters or admit the lack of awareness about the topic or not deciding to do anything for the different stages of being negatively affected (Crezee *et al.* 2015: 77).

Moreover, it is important for interpreters to manage their working hours and organize themselves. Language professionals working in healthcare settings might have schedules filled with more assignments with respect to other language professionals working in the legal field for instance. Furthermore, interpreters may ask to be given less assignments, so that they can reduce the stress and by doing so prevent burnout when they understand that it is approaching.

Another useful practice for language experts working in such sector is to practice mindfulness. Mindfulness is a principle from the Buddhist culture and aims at focusing on the needs of the client, and thus to do their best to fulfil them, so that they can "distract" themselves from their own emotions and thoughts (Crezee *et al.* 2015: 78).

Another important suggestion to deal with stress could be offered by supervision. Meetings with other fellow professionals may be also a useful tool to prevent distress and it is a good opportunity to exchange opinions about the matter (Crezee *et al.* 2015: 79).

In addition, it is important that language experts are aware of the possible negative aspects of the profession and therefore professionals must learn to recognize stress factors and:

1. Be aware of their own emotional fragilities or gaps.

2. The mechanism they use to deal with stressful situations and limitations

3. The symptoms they feel with respect to when they actively work

4. The institution where the assignment is taking place (Crezee *et al.* 2015: 79)

These techniques are primarily designed to offer the linguistic professionals a way to cope with severe stress related to the tasks, i.e. assignments they are performing. Anyway, in some cases they might want to seek for external assistance, i.e. from psychologists. These models are a first response to try to help interpreters deal with the stress and find a right balance and by doing so to maintain their physical and mental health and also to help them recognize the pleasant aspects of their job and to improve them (Crezee *et al.* 2015: 80).

In the next chapter some translation problems of specific cultural features that are found in medical texts are going to be displayed. The translation of such medical documents is from English to Swedish and also some examples from Holland will be provided.

2.5.4. Culture in medical translation and cultural adaptation of medical texts: some examples

In this chapter, particular attention is going to be paid to the very translation process and how cultural features can be translated to better understand the needs of the patients.

In her paper, Rask (2008) analyzes the issues of translating medical texts from English to Swedish. Such texts were dealing with dementia in elderly people (Rask 2008).

Before translating the text, the researcher evaluated the source text, to better understand what the needs of the target readership could be. The features of the text and its aim were also taken into consideration (Rask 2008). The second step was the translation from English to Swedish, which was accomplished thanks to the personal knowledge and know-how of the researcher and support provided by other colleagues (Rask 2008). The challenging part for Rask was to deal with the cultural differences and the terminology. Rask suggests that translators when translating medical texts should be exact and they should also bear in mind the formal equivalence principle, i.e. maintaining the aesthetical feature of a text. Another important step a translator should follow when translating a text is to look for parallel texts that belong to the field of the text that is being translated, as that could ease the translation process (Rask 2008).

Rask (2008) also described the medical terminology she had to deal with while translating the text:

-scientific medical terminology is generally used among medical staff

-general medical terminology used by medical staff to communicate with patients

-medical jargon (Rask 2008).

What a translator should not underestimate during the translation of a medical text, is that cultural terms differ from a language to another. Therefore, the translator should think of how to solve the problem (Rask 2008) and thus cultural adaptation may be useful. This might be the case of elements that are found in the source text but that are not present in the target culture, for example national institutions or organizations (Rask 2008). To this end, Rask provides an example related to the translation of a culturally adapted term, namely the English “residential care” and “residential home”. The author points out that the institution “residential home” does not exist in Sweden, because people in Sweden are assisted at home. But as far as the translation of such term is concerned, the English word has been maintained in the text and a short explanation has been provided at the end by adding a footnote (Rask 2008).

Another example of cultural adaptation provided by the author refers to the English word "tea" (Rask 2008). In Swedish such term has been replaced with "coffee-drinking", as in Sweden it is more common to drink coffee.

As said before, the terms which deal with national institutions in Sweden are totally different from the English ones, so it is advisable for the translator to follow the principle of the cultural adaptation. The term is the English "care" that in Swedish is translated with 'vård', 'omsorg'(Rask 2008).

Rask claims that in Sweden there is a clear distinction among these terms: Rask in fact explains that the term "omsorg" refers to services addressed to older and disabled people as for instance cleaning and washing services, while the term "omvårdnad" identifies the daily activities, such as eating and get dressed. The author decides to translate the concept of "care" by using the term "omvårdnad" as it partly matches the concept of medical care (Rask 2008).

Another interesting term that was replaced in Swedish with an equivalent term in the target language was "nursing home". In Great Britain this institution offers assistance to those people who need to be constantly helped (Rask 2008). In Sweden there is a term which is used to identify the institution even if in Sweden it offers assistance just to elderly people and it can be translated with "'servicehus "and "gruppboend" which are both hyponyms. But for this specific case, a hyperonym had to be used and there was the need to neutralize the term in this case to make the translation equivalent in Swedish. Such hyperonym is "särskilt boende" (Rask 2008).

Another term whose equivalence was hard to deliver in Swedish refers to the term "relative". In Swedish such term can be translated with "närstående and this is because according to the Swedish Law that regulates the role of caregivers it is stated that people who assist an older person can be also a close friend and not necessarily a family member (Rask 2008). In this case the term has been made equivalent according to the Swedish legislation on the matter. In this case, is important for the translator to keep himself/herself informed about the current legislation procedures in the specific country he is translating for (Rask 2008).

Rask (2008) argues that translation implies the ability to deal with many factors. As far as the cultural factors are concerned, the main issue was represented not by the term itself and how to make it look equivalent, but rather by how to correctly insert the term in the target text and in order to avoid taking up too much space in the text, the preferred solution was to add footnotes at the end of the page (Rask 2008).

Other important aspects concerned the accuracy of the translated terms. As far as national institutions are concerned, in order to transfer terms and their role in the target text, the translator should always be informed about the ruling legislation of the target country (Rask 2008). There is also the need to have deep knowledge of the customs that are typical of the target country and above all translators have to be ready to face the new challenges the profession poses (Rask 2008).

Another interesting study regarding cultural adaptation was carried out by van Widenfelt *et al.* (2005). Such paper focuses on the translation and cultural adaptation of the assessment tools used in the field of family and child psychology. Many of these assessment tools are translated into English, but it is also important to provide an alternative for non-English speaking cultural groups (van Widenfelt *et al.* 2005). In fact, in her paper it is stated that (…) "Psychopathology might be viewed as universal, but culture may play a role in variations of expression. In this view, it is assumed that instruments used in another country will likely need to go through some culture-specific adaptation" (van Widenfelt *et al.* 2005).

The aim of producing a good translation is that of maintaining the equivalence between terms in the source and target language, nevertheless there is the need to make the concepts (and their meanings) equivalent too and for this reason a cultural adaptation may be the right choice (van Widenfelt *et al.* 2005).

In the translation process when dealing with cultural adaptation it has been observed that there are some terms that are easier to translate in the target culture. This is the case of a symptom assessment tool which was translated into Chinese and it was linked to the concept of "self-esteem". However, it has been observed that in the Chinese culture the concept of self-esteem does not exist. The concept of self in the Chinese culture only exists if relationships are taken into consideration and such element cannot be evaluated individually, as the child itself ascribes his/her goals to the help of others (van Wildenfelt *et al.* 2005).

- Besides the importance of adapting a text to the target culture, the researchers identify which problems may occur in the translation process in such field: Literal translation: sometimes elements in the sentence may sound not correct as they were translated too literally. As a result, the meaning will be distorted, as in the case of the sentence "I am a winner" was translated in Belgian with "ik ben een winnaar.". Later on, children were interviewed and it was found out that such a translation could never sound like an appropriate cultural translation, as in the target culture it would not be appropriate to translate the sentence like that. So, after some brief brainstorming the translation team decided to deliver the sentence as "I will succeed in everything I do/I can do anything".
- Incorrect translation: Sometimes the texts can be mistranslated because the text was written by a foreign author. This is the case for example of the SCL-90[3]. In the Dutch version of the scale, the item 51 has been translated like "een gevoel van leegte" which in English would mean "an empty feeling" or "feeling empty". As a result, such translation is wrong as in the English original text the item 51 is part of another category, i.e. Obsessive-Compulsive subscale and on the other hand the translated element belonging to the Dutch version of the SCL-90 refers to Depression subscale.

[3] The SCL-90 is an assessment method in the field of psychology and it is also used to measure the outcomes of phycological treatments (Giunti)

- Altering some items: In some cases it was necessary to alter some terms, as in the target culture there is no equivalent word for them. This might be the case of the English word "bully". Namely, the translation team decided to provide a short explanation for this term, as it is shown here: "a bully is someone who "plays the boss and teases". Moreover, the author points out that the verb "to tease" in Dutch includes a wide range of behaviours as "harassment" and "intimidation" (van Wildenfelt *et al.* 2005).

As ultimate step of the translation process there is the need to check the translation by using the back-translation method. Such method is useful in order to identify possible problems in the translation process and if necessary it may be useful to discuss further cultural adaptation regarding specific terms, if those translated are not clear. However, there are also other opinions that define back-translation as not appropriate for the revision of a translation as through this method may not exactly deliver the cultural equivalence in the target text and its culture. Through back-translation it can rather be observed if the translation was a literal one, but through such a translation is it very unlikely to reach an equivalence of the source text and target text (van Wildenfelt *et al.* 2005).

van Wildenfelt *et al.* (2005) conclude that gathering cross-cultural information is an essential element in these kinds of research, as it helps to understand the psychological profile and features of the human behaviour. To this end, it is important to deliver an excellent translation, as translation mistakes could affect the results of the researchers concerning assessing tools in the field of psychology. For this reason, van Wildenfelt *et al.* (2005) summarize the main points that were taken into consideration in order to translate the material:

- The translation team should be made up of different experts and cultural adaptation of the target text should be a priority.
- Back-translation methods are used to check the content and aim of the text. Although it is not recommended to rely on such translation methods to check the equivalence between source text and target text (van Wildenfelt *et al.* 2005).

Regarding translation methods, IMIA also provides a guideline about how to deliver an excellent medical translation; What are its main feature and what should be taken into consideration, stressing as well the important role cultural adaptation plays.

First of all, it is essential to understand if the source text is a reliable one, because if the source text presents some deficits, it may affect the outcome of the translation as well (Txabarriaga 2009: 6).

Furthermore, there is the necessity for such text to be correct as far as language is concerned and to deliver the correct information in terms of content (Txabarriaga 2009: 6).

Furthermore, the text must be free of any metaphors or abstract language. This applies mainly to documents containing instructions or guidelines (Txabarriaga 2009: 6).

According to the author, a medical text (i.e. guidelines) should not present any cultural adaptation unless the text is addressed at a specific target group, campaigns or is being translated for specific social marketing activities (Txabarriaga 2009:6). In addition, the text should be translated by taking into consideration the linguistic register. The text may be culturally adapted, but only if it is necessary to do so due to the target group the text is addressed to. Thus, it is also crucial that, if the source text is informative, for instance guidelines, some source information should be delivered in the target text as well, as for instance language assistance in other languages, all the information should be delivered in those given languages in the target language as well, in conformity with the principle of cultural adaptation of texts (Txabarriaga 2009: 6).

In this chapter, examples of cultural adaptations and related translation strategies have been displayed. In the following chapter attention will be paid to the cultural and ethical factors interpreters and translators should be aware of while working in healthcare settings.

2.6. Working as a hospital interpreter or translator: cultural and ethical factors

According to the U.S. Department of Health and Human Services (2003), supervision should also take into consideration different elements such as cultural competence, which is also required in this working environment (Powell *et al*. 2009: 11). Cultural competence refers to the ability to honour and respect the beliefs, language, interpersonal styles, and behaviours of individuals and families receiving services, as well as staff who are providing such services. It is a dynamic, ongoing, developmental process that requires commitment and is achieved over time (U.S. Department of Health and Human Services 2003: 12).

There are three important sectors identified in which culture cannot be excluded within supervision settings, i.e. in building the supervisory relationship or working alliance, in addressing the specific needs of the clients, and in building supervisee competence and ability (Powell *et al*. 2009: 22).

Becoming culturally competent means to analyse the cultural gaps that supervision participants may present, and to help them discuss topics concerning sexual orientation or gender. Discussing such topics during the supervisions can help to avoid misinterpretations and participants can acquire a level of trust in the supervisors (Powell *et al*. 2009: 22).

During the supervision, it is important to identify the different cultural backgrounds of the supervision group. For example, factors, such as sexual orientation, if the supervisee is related to a minority or not, must be taken into consideration, thus these topics should also be discussed (Powell *et al.* 2009: 22).

The most complex ethical issues arise in the context of two ethical behaviours, for instance, when a counsellor wants to respect the privacy and confidentiality of a client, to

respect the clients will and not to disclose anything. Or if the counsellor and the client know each other, then the counsellor should provide the client with another counsellor's name. Also, supervisors who lead the supervision sessions are human beings and can make mistakes. Sometimes the answers to ethical and legal questions are vague. Ask a dozen people, and probably get twelve different points of views. (Powell *et al.* 2009: 13).

The code of ethics regarding clinical supervisions also deals with the matter of a dual relationship that can occur among supervisor and supervision groups or between clients and counsellors. It may involve the two parts in a non-professional relationship that can be of different nature. Therefore, interpersonal relationships should be avoided. Moreover, problematic issues can also be of sexual nature, like harassment, consensual or hidden sexual relationships. Another kind of issues involve asking for favours from clients, employing emotional abuse to acquire power (Powell *et al.* 2009: 14). Thus, it is essential that all parties clearly understand these kinds of issues and avoid getting involved. Such issues are not only considered a violation of the ethical code, but also a legal infringement (Powell *et al.* 2009: 14).

In supervision sessions, aspects like informed consent and confidentiality have to be discussed. The supervisor has to inform all the supervision participants about the aspects concerning the supervision itself, such as feedback and assessment and also in the contract these clauses need to be present (Powell *et al.* 2009: 15).

With regard to confidentiality, it is said that confidentiality is of three levels, i.e. the client's consent for treatment, the client's consent for supervision of the case, and the supervisee's consent for supervision (Powell *et al*. 2009: 15).

Moreover, supervision responsibilities must abide by the ethical and legal standards. Through confidentiality, personal information is not disclosed and such standards should be defined by the state and its legal system. Supervisors should be also informed about difficult cases and should be offered a way to deal with such cases, always according to the ethical standards (Powell *et al*. 2009: 15).

Confidentiality standards within supervision groups are described in the previous discussion, but the ethical standards which the supervisors have to respect are discussed below:

> Uphold the highest professional standards of the field. Seek professional help (outside the work setting), when personal issues interfere with their clinical and/or supervisory functioning. Conduct themselves in a manner that sets an example for agency mission, vision, philosophy, wellness, recovery, and consumer satisfaction. Reinforce zero tolerance for interactions that are not professional, courteous, and compassionate. Treat supervisees, colleagues, peers, and clients with dignity, respect, and honesty. Adhere to the standards and regulations of confidentiality as dictated by the field. This applies to the supervisory as well as the counselling relationship. (Powell *et al.* 2009: 17)

It is important that supervisors stick to the principles while exercising the profession, and that the supervisees can assess the session and the work of the supervisor. If needed, the supervisor can create a personal plan for each participant so that personal goals can be reached (Powell *et al.* 2009: 17). During the assessment activity, it is essential to bear in mind the so-called "gatekeeping" role of the supervisors. The responsibility of the gatekeeper is that of respecting the achievements and aspirations of the clients, and always respecting the ethical standards. Besides academic education, personality traits like empathy and sincerity can also influence the supervision session (Powell *et al.* 2009: 17).

In the next paragraphs the essential elements in translation studies, and interdisciplinary aspects in translation are discussed.

2.7.. Further training for translators: Psychology as a part of the translator's education

Cozma & Dejica-Cartis (2013) claims that translation is a field that requires both practical and theoretical skills and translators must be accomplished in many fields. This leads translation students to look for broader education possibilities which may help them to meet the translation requirements of the real life (Cozma & Dejica-Cartis 2013: 895).

In this sense, it is not only important for translators to improve their skills and to fulfil their expectations, but also to create a good psychological environment that can improve their education and future working experience in a positive way (Cozma & Dejica-Cartis 2013: 896).

To this end, Cozma & Dejica-Cartis (2013) interviewed some students of the MA Translation Studies of the University of Timisoara. Interviewees were asked about their fears and expectation about their future careers, they were also asked which contents could be provided in the university courses, so that they could feel psychologically secure and ready for their careers and how the translation teaching stuff could be more helpful (Cozma & Dejica-Cartis 2013: 896). The students pointed out that they feel unsure about many fields. They are afraid of not finding the proper term and they also fear that dictionaries sometimes may not be helpful (Cozma & Dejica-Cartis 2013: 896). Another concern students have pointed out is that of not being able to render the translation spontaneously (Cozma & Dejica-Cartis 2013: 896).

Nevertheless, students have expressed the desire for their teacher to deal with other aspects of the translation, such as practice in various fields of translation, managing deadlines and learning other useful professional strategies (Cozma & Dejica-Cartis 2013: 896).

In order to achieve this goal, it is important for translation students to work in a good training atmosphere. Therefore, the teacher needs to be supportive and optimistic. Trainers should be present in every class for the students to understand the process of translation, also the emotional part should not be underrated in the translators' training procedure (Cozma & Dejica-Cartis 2013: 897). In order to improve the students' education, translation trainers

should help them to identify the linguistic aspects and different language features present in the text and how to deliver them in the target language (Cozma & Dejica-Cartis 2013: 897). Cozma & Dejica-Cartis (2013) declare that students must be taught to understand which specific field the source text belongs to and the readership for which it has been written. Furthermore, the translator should assess the texts also by comparing them with the target culture, bearing in mind which cultural differences might be present, as later they may decide which part they should leave out or which part they should keep (Cozma & Dejica-Cartis 2013: 898). In order to achieve this, it is important that students translate the texts by using their expertise and by doing so it is possible for them to understand if they feel ready to translate the text or whether more research can be useful (Cozma & Dejica-Cartis 2013: 898). These stages are described as follows:

- Research: In this stage, students must search for problematic parts of the translation, as for example grammar, language structure or culture-related research. The analysis is carried out in many ways, with the support of the internet, online glossaries, making comparisons between texts and a talk with experts in that specific field. This helps a translator to find the sources for the translation.
- Target text: In this part, students are making several decisions while bearing in mind which cultural elements could be relevant for the target culture. Another important element is the terminology. The purpose is that the translators can find identical words, but if there is no word equivalence in the target language, translators must provide an explanation in order to make the text clear in the target language (Cozma & Dejica-Cartis 2013: 898).
- Revision of the translation: The part of the revision is important because it is aimed at checking if all the information in the source text is also present in the target text. For instance, translators might seek help from another translator, may it be a native speaker or a colleague, to check the text, since a person who has not read the source text may act in a more objective way. With regard to this phase, Cozma & Dejica-Cartis (2013) report that in a professional context, evidence of the lack of revision is not acceptable and a final text has to be read as it has been originally written in the target language (Cozma & Dejica-Cartis 2013: 899).

To conclude, Cozma & Dejica-Cartis (2013) suggests that translation trainers should provide students with the right skills so that they can face the future translation challenges. In order to achieve this, it is important to maintain a supportive atmosphere in class (Cozma & Dejica-Cartis 2013: 899).

Like Cozma & Dejica-Cartis who describe the various approaches to translation classes, also Jones (2010) states that it is important to adopt an interdisciplinary approach within the education system and in the teaching methods, as it enriches the student's

knowledge and enables a student to adopt new strategies while dealing with problems. It also helps students to develop their personality Jones (2010: 78).

According to Lee-Jahnke (2011), it is important to highlight which organization strategies translators may adopt, for example, "to highlight passages, to summarize articles, and to take notes while reading or listening" (Lee-Jahnke 2011: 8). This new knowledge should be later integrated with the old one, and it has been found that in order to integrate the new knowledge, students need to be stimulated to develop new strategies and to re-elaborate information (Lee-Jahnke 2011: 8).

2.8.. Interdisciplinarity in translation

Fiola (2012) declares that translators must act as people who build bridges between cultures and as "communication engineers" (Fiola 2012). Fiola states that in the education of translators, theory should also be taken into consideration. In Canada, many institutions, for example the Government of Canada's Translation Bureau, are thinking about the importance of translation competences to evaluate the quality of translation. To this end, an approach has been suggested which is called "Para-translators" (Fiola 2012). The main aim of this model is based on ensuring and analysing the quality of a translation and the importance is given to the purpose of the translated text rather than the linguistic aspects. In Canada, translators are trained at an undergraduate level and many researchers and experts ask themselves how much theory should be taught (Fiola 2012).

Fiola (2012) states that translators are professional communicators and communication problem solvers. This kind of problem solving can be learned thanks to an interdisciplinary education (Fiola 2012).

According to education and the various approaches, Duerr (2008) also suggests a model that can be used in all educational areas and at all levels:

- Evaluate the needs of the learners taking into consideration the objectives of the curriculum.
- Think of further thinking skills that can be taught or pick them from other existing lists.
- Think of a long-term plan for sequencing thinking-skills instructions.
- Name each skill.
- Describe all the steps that are necessary in order to apply each skill.
- Apply such skills to the education program.
- Verify if the skills have been acquired. (Duerr 2008)

Interdisciplinarity in translation does not mean that the subject is related to others, but it has its own "thread" and its own graduation programmes. Therefore, it is important to point out the importance of translation schools and the way they shape future translators. However, it is

often said that the translators lack a practical approach, but translation schools have already tried to simulate real-life situations, which perfectly emulate the real life. On the other hand, the job market should welcome and understand the idea that translators are professionals who have gained specific knowledge in the inter-linguistic and intercultural field (Fiola 2012).

2.9. Quality in medical translation

Karwacka (2014) states that misunderstandings can be a very dangerous matter, especially in healthcare settings. For this reason, it is important to check the quality of translations delivered in such settings. (Karwacka 2014: 20).

Medical translation is a complicated process that involves different aspects, such as acceptance in the community and finding mistakes. As an example, mistranslations concerning surgical prostheses are reported, looking at a series of surgical operations, more specifically knee replacement surgeries which were carried out in Germany between 2006-2007. The consequence of incorrect translations was that 47 people were injured. Two different kinds of prostheses were used for these surgical operations; one with cement and another one without cement. On the label of the prosthesis package the instruction for the femoral part clearly indicated that it was "non-modular cemented", which was incorrectly translated as “without cement”, and as a consequence the prosthesis had not be inserted in the right way and the medical personnel who operated on the patients was completely unaware of this. Thus, the patients have suffered the severe consequences of implantations (Karwacka 2014: 22).

Furthermore, it is important for translators to be trained and to show particular professional certificates, since there can be different opinions regarding a medical translator’s experience. Above all, medical translation also requires definite abilities, for example, terminology research with the help of specific dictionaries (Karwacka 2014: 23).

If medical certifications are not required, translators or linguists have to assess themselves whether they are able to translate medical texts in the way it is required; they should ascertain to have acquired medical knowledge and experience in the required field. There is an ideal example of cooperation among medical professionals and linguists. Linguists can proofread texts written by medical professionals and medical professionals can proofread texts translated by linguists (Karwacka 2014: 24).

Another useful method of assuring translation quality is that of the back translation. Back-translation should be provided ideally by a translator who did not translate the text himself, so it can be neutral. The aim of the back translation is that of detecting the subtleties of the target language (Karwacka 2014: 26).

The technique of the back translation is also used by organisations in several countries. A model of back translation is introduced by the International Society of Pharmacoeconomics and Outcomes Research (ISPOR). The system works in a way that the two given translations

are compared and rearranged. The following step concerns a homogenisation of the text which is carried out by a third person. Another organisation created a similar system, which aims at checking the quality of a translation. It is called FACIT and the back translation in this case is carried out by 3-4 experts, who will edit and proofread the text and conduct the tests with the patients. In this process, several experts with different skills are involved, such as linguists and medical specialists (Karwacka 2014: 27).

Quality in medical translation, like all service provision between businesses and professionals, means to meet client's expectations. Translations performed within the medical healthcare settings need to be more accurate than any other kind of communication service, as they may affect healthcare decision making and settings (Karwacka 2014: 29).

However, it is important to bear in mind that the language into which texts are translated has to be accurate, grammatically correct, and meet the needs and aims of the original text, i.e. the source text (Karwacka 2014: 29).

Karwacka suggests a model for quality translation assurance that can be summarized as follows:

> After the TT is produced by a translator, it should be proofread for its compliance with the purpose, readers' needs, client's instructions, accuracy, information transfer and linguistic quality. A proofreader's suggested revisions and reasons for them should always be consulted with the translator. If the patients cannot read the medical texts, the concepts in the source text should be translated in a way which can be understood. Moreover, the process should be concluded with feedback provided to the translators and proofreaders in order to secure improvement in medical translation quality. Translation memory and terminology bases should be updated to provide accurate and consistent support in subsequent projects. (Karwacka 2014: 30)

Communication can be enhanced by providing translation from professionally trained translators, although medical inaccuracies are still present in papers and documents. This shows that there is still a need for improvement and further training. It is still debated whether professional linguists or medical professionals should be hired in order to translate medical texts, but a widely discussed option would be that of introducing a dedicated system of agreements and teamwork, which may maintain the quality and assurance of the translation. The text should be translated by an experienced translator, and then checked and verified by a specialist and proofread by a third person (Karwacka 2014: 31). By doing so, the translator would not be the only one who is responsible for the translation, but he would be part of a team. By introducing this model, the translation quality within healthcare settings can be improved (Karwacka 2014: 31).

It is true that medical science is a field that is expanding its horizons even more and so does medical translation. IMIA (International Medical Interpreters Association) claims that medical text should be translated by people who have a native or a near-native level of

language proficiency, analytical capabilities, and deep cultural knowledge in the source and target language (Karwacka 2015: 288).

The other requirement for a translator is the command of CAT-tools, an academic qualification and certain psychological characteristics, such as decision-making capabilities, thoroughness, and allegiance (Karwacka 2015: 288).

As previously discussed, back translation is one of the methods to ensure the quality of the translation. Another possible method is called "parallel forward translation", along with harmonisation. In such cases, two parallel translations are carried out and then they are compared and arranged. In the case of the parallel translation, the budget influences the translation project, but the further cost has a much more positive effect, as far as the final result of the translation is concerned. However, it is different when it concerns back-translation (Karwacka 2015: 291).

A possible method that allows assessment of a good translation is the so-called Cognitive Debriefing. Such a method is used especially, when it comes to questionnaires or scales (Karwacka 2015: 291). Through this method, it will be verified, if the terminology is appropriate for a readership who is not proficient in healthcare matters and settings. The patients are then asked to provide an opinion and this serves as a litmus test about how patients perceived the words given in the questionnaire, and it may help to understand if the words used are "lay-friendly" (Karwacka 2015: 291). This is seen also as a multidisciplinary method which may help to improve the medical translation research within medical settings (Karwacka 2015: 291).

In the next paragraph the research gap will be presented.

3. Research Gap

In the literature review, the emphasis has been on the importance of the quality of the translation and also on the importance of interdisciplinary aspects in translation, as well as on how students should be taught. But this paper investigates how on-the-spot translators react while they are working. The aim of this research is to analyse not only the translator within the hospital and how he/she carries out his/her performance according to his/her education, but also to analyse whether attention is paid to other aspects, i.e. first of all personal impressions are analysed and this impression analysis covered all aspects that can be a part of the profession, such as the translation challenges and the feelings about it, the emotional difficulties, both the volunteer translators and the non-volunteer ones. Another aspect regarding emotional aspects of this occupation is the psychological features. In the literature review, it has been widely reported that third-party supervision is an important aspect of all healthcare professions and can be useful for interpreters or translators as well after they have experienced particular situations, like the loss of human life.

The interviewees have responded to the questions regarding emotionality in a reasonable manner, by providing details without feeling ashamed about what they felt. In this sense, the research tries to provide a full overview of all the aspects, i.e. to be as interdisciplinary as possible.

4. **Research Methodology: qualitative methods of research: qualitative research, theoretical approaches**

In previous sections of this paper, it has been highlighted that the translation is a very important element when it comes to improving the communication within a healthcare setting. It has also been discussed that the translation can have different forms of interpretation (see Chapter 0, Literature review).

In this chapter, qualitative methods of research are discussed. Furthermore, it is explained how these methods are used to analyse interviews and to display the results of present research.

The qualitative research method was first developed in the USA. The aim of such a research method was to analyse war propaganda in mass media (Ramsenthaler, 2013: 23).

The objective of this qualitative method is to display different methodologies about the analysis of the text and it refers to a question posed at the beginning of the research. This method evaluates the main research question (Ramsenthaler 2013: 23).

Depending on the analysis of the material, different categories are created and each category belongs to a system of categories, subcategories, and examples. This gives the chance to later interpret the results, which are the core of the analysis (Ramsenthaler 2013: 23).

The main phases of the qualitative research method are the following:

- Create a model of communication: This model of communication contains what is expressed by the interviewed people, may it be emotions, experiences or points of view. This model of communication includes also a description of the samples and other information that can be provided by books concerning the qualitative research methods (Ramsenthaler 2013: 24).

- The core of the qualitative research method is that of creating categories for the analysed material. The material is divided into parts that can be analysed. This distinction within categories enables the researcher to keep track of the structure of the material to evaluate it (Ramsenthaler 2013: 24).
- The categories can be modified many times during the qualitative analysis. The categories can include deductive or inductive clues. The clues of the categories are inductive if they are obtained from the material itself. Deductive clues are information that is obtained from other fields of studies or theory (Vogt & Werner 2014: 54).
- Criteria for qualitative research: there are 3 main criteria for qualitative research, namely comprehension, triangulation, and concordance. It means that the elements in the text are comprehensible, as they are analysed according to the guidelines of the qualitative research method, and from there, conclusions can be drawn according to the question that is posed at the beginning. Triangulation means that the outcomes of the evaluation process can be compared to the outcomes coming from other studies. Concordance, i.e. homogeneity between the categories, is another important criterion (Ramsenthaler 2013: 25).
- Decide what material should be analysed. It is important to analyse those parts of the text that are close to our research question (Ramsenthaler 2013: 27).
- Analysing the situation: How is this material collected? And what are the emotions, the social status of the interviewed people? (Ramsenthaler 2013: 27).
- Paying attention to the features of the collected material: What kind of material is the one collected? Generally, for this kind of analysis, a transcription of the information is needed. If it is necessary, notes can be inserted, just next to the collected material that is useful for the research (Ramsenthaler 2013: 27).

Consequently, the material needs to be analysed according to the questions and interpretations:

- Understand where the core of the interpretation is. For instance, the focus of our data interpretation can be related to the emotions or the intentions of the interviewed people (Ramsenthaler 2013: 27).
- It is important to understand the research question thoroughly so that the material can be analysed (Ramsenthaler 2013: 28).

The most important part of the process is to build a model of the analysis of the contents and the data:

- Find a proper technique. To analyse the data, one of these three methods can be chosen: summary, description, or structuring (Ramsenthaler 2013: 28).
- Build a “structure model”, for instance, an organisation map of how the analysis is conducted, as this will later enable the researcher to create the analysis unit. Through the creation of a structure model, the analyses of contents are comprehensible, and it

must be created by taking into consideration the collected material, as well as the research question. Moreover, such structure model should contain the criteria for choosing the category that sums up the parts of the text, which must be analysed (Ramsenthaler 2013: 28).

- Categories can be for instance, of two types: inductive or deductive (Ramsenthaler 2013: 29).
- It is necessary to create categories. By creating different categories, the interview can be better analysed through categories like "observation lenses", which can help to filter the most important information. Through these "observation lenses", it can be easily understood which information is useful to our research question. Categories can be divided into main category, sub-category, upper-category, even though it is not mandatory to have all of these different categories, i.e. the main categories can be identified only. Nevertheless, identifying one main category could not be sufficient for the research question, so it is advisable to provide a definition for each category and examples from the source text (citations). A good category system contains the following features:

- For each category, it is very important to describe what it includes.
- Examples from the source texts (citations).
- Create code units: It is a very helpful tool to understand which features are contained in a passage and why this passage is included in a specific category. Moreover, through code units, categories can be identified. Code units classify specific passages into a specific category, for instance:

> Wenn Sie beschließen, dass Zeile 45 bis 51 aus Interview 4 zu Kategorie A gehört und Zeile 52 bis 60 zu Kategorie C. (Vogt & Werner 2014: 51)

When all categories as well as code units (if there are any) are created, we have to evaluate these categories and the results that may be produced. The different categories can be compared to one another and some peculiarities can be identified. Also, some passages can be interpreted and explained (Vogt & Werner 2014: 65).

Clearly, all the categories can be modified. Under-categories can be modified and sub-categories as well. After modifying the categories, it is advisable to revise the material. The categorisation is never a definitive process. While categorizing, the declaration of the interviewees should be kept in mind, for instance, a category can be first named as "Nervenpflichtungen" but later the name can be modified into "Belastungen im Studium" Vogt & Werner (2014: 57).

If no more categorises can be found, then the research analysis is concluded. In order to interpret these categories, it is useful to make an outline of the outcomes, so that the

connection between the categories (if there is any) can be identified (Vogt & Werner 2014: 67).

The last part of the analysis of the qualitative data is the interpretation of the final outcomes. In this phase, anonymity for the people that are being interviewed should be respected, so that the readership may not recognise them (Vogt & Werner 2014: 67). Moreover, stereotypes are also a major problem; therefore, the question must be asked in such a way that is not discriminatory and should be connected to the research question posed at the beginning. In this way, a correct interpretation of the data can be provided in the final part of the analysis (Vogt & Werner 2014: 67).

In addition, it must be noticed that the qualitative research method does not take into consideration the quantities. It rather focuses on the quality of the assumptions given, i.e. what has been declared by the interviewees. Through qualitative research, phenomena can be described and displayed (Vogt & Werner 2014: 67).

If at the end of the analysis there are still unanswered questions or doubts, then it does not mean that the analysis is carried out in a wrong way. Rather, this could give a new way to the research questions or to a new research field (Vogt & Werner 2014: 68).

It is not always possible to reproduce the whole analysis. Therefore, it is important to select the main parts which are useful for the argumentation to be developed. Also, the hypotheses can be revised. Moreover, the analysis of the material can contain sub-categories as well Saldanha & O' Brien (2013).

In the qualitative research method, it is important to comment on the collected material in a way that is not excessive, but also without omitting crucial information. While analysing data and after its codification, it is very common to deal just with the "labels", which are the result of a codification process. That is why it is very important to report quotations as well, in order to show the depth of expression of the interviewees. The interviewer should let the participants express themselves and the important information should be selected, according to his/her research question. Moreover, it is very important not to disclose anything about the identity of the interviewees or about the organisation where they are employed. The summarisation is another important step of the qualitative research, as there are important statements that can be highlighted. If dates or figures need to be summarised, it is suggested to put them in a chart or with bullet points Saldanha & O' Brien (2013).

Questionnaires and interviews can also be done by e-mail. It could be useful to find groups which are not easy to interview, the so called "hidden population". Online questionnaires can also be a useful tool because they can be forwarded to forums and groups belonging to the analysis-target group. Online questionnaires clearly have disadvantages, as the informed consent cannot be easily guaranteed Saldanha & O' Brien (2013).

Interviews are an important tool for research in translation studies and are very much used in community interpreting settings. Nevertheless, interviews are becoming a popular tool

for translation studies as well, for instance, as far as the analysis of the sociological implications in translation are concerned Saldanha & O' Brien (2013).

Organizing an interview can be a time-consuming activity for the interviewees and interviewers as well, as interviews must be transcribed and analysed. A research target is usually a group of people not large enough to represent the whole population. Interviews enable interviewers to listen to the voice of the interviewees and their thoughts. It is important for the interviewer to act as neutral as possible and let the interviewee express themselves. The interaction is a key element in interviews. According to discourse analysis, discourse is the core of the interaction itself, and therefore it must be taken into consideration. It is important that through language analysis the social context emerges, and it is useful to understand the effect that language has in that specific context. From this perspective, the opinions of the interviewees must be reconstructed and not only "stored". By doing so, the interviewees have also a chance to give their opinion, which could be useful to better understand the social phenomena Saldanha & O' Brien (2013).

It is essential to keep in mind the ethical considerations. Especially if the interviewee works with other institutions, an authorisation may be required. If online surveys are used as an interview tool, it is important to assure the interviewees that the data is collected just for that specific purpose (Saldanha *et al.* 2013). Anonymity plays also a crucial role because translators are disclosing personal experiences and therefore, it is advisable not to deal with too sensitive topics Saldanha & O' Brien (2013).

The present data analysis is collected and is analysed by using the inductive categorisation. The inductive categorisation method draws conclusions from the material analysed so far. Chesterman & Williams (2014) claims that the comparative studies are certainly quite frequent in Translation Studies research, and it is common to make comparisons between target texts, source texts, and its features according to MT systems. All comparative research methods in qualitative research have some features in common, such as comparisons between similar elements and its features. Also, a suitable measuring tool must be used in all cases where it is necessary Chesterman & Williams (2014: 27).

After analysing the material, the categories should be created and then conclusions need to be drawn. This way of writing is useful both to understand and remember what has been analysed, so the best way to deal with it is to summarise the ideas in a way that suits the researcher's personality. By doing so, the report would be like a dialogue Chesterman & Williams (2014: 3).

After discussing how to structure the thoughts and having an idea of how to write them down, it is appropriate to think also about the readership. The report is not just about information, but it is a tool of communication. At this stage, it is necessary to think about the topic that has been analysed and it is also important to take into consideration the readership, whether they already know something about the topic and how to keep their interest alive.

Other related questions might be about the purpose of the report and its function, for instance, if its function should be merely informative about the facts and trends of that specific topic. It is crucial to keep in mind that the analysis which is carried out is not just a chronological list of facts, but the researcher is the author of this journey, which needs to be explained to the readership in order to persuade them Chesterman & Williams (2014: 13).

5. Data collection and analysis

The research methods used to analyse the present research question are written interviews posed to translators who have been working or are still working within healthcare settings. The questions are sent via e-mail to the interviewees, as they are in Italy and Austria.

The interviewees are asked to describe their experience, for instance, how they applied, the difficulties they have gone through, the types of texts they have to translate and their emotions and feelings as human beings.

Some of the interviewees (translators) are working in hospitals and others for a non-profit organization.

In the present research, four people have been interviewed. They have different language combinations and different experiences, but they all have been working in healthcare settings. It can be highlighted that almost all the interviewed people have gone through a selection procedure before applying for their current job (interviews 1 and 4). The eight questions the interviewee is asked to answer focus on the aspect of translation at the work place. Though, some of the interviewed people also mention their interpreting activity and other activities they have to accomplish during the working period, for instance, debt collection procedures. Even though the interviews are carried out by e-mail, all participants seem to be keen and enthusiastic about their job as hospital translators, as most of them underline their interest in other cultures. In all four interviews, it is stated, how translators need to understand the source text. In some cases, translators stated that they have difficulties to understand the source language even more if the source language spoken by the patient is neither German nor English. Furthermore, they stated that they all have a long working day and schedule, except for one of them, who also has the chance to work from home without always going to the office.

5.1. Description of the interview questions

The interviews have been collected in a chart. All the interviews have related categories to better understand and analyse the statements. Five main inductive categories have been created:

1- Job application.
2- Aspects of the job.
3- Difficult situations.

4- Technical issues of translation.

5- Policies and restrictions to be respected.

Next to the fifth category, an under-category is created and it is called “typical day”. A description is provided for every category (second section of the chart) in order to briefly describe it. The third section of the chart includes speeches and it enables the readership to see the direct reactions of the interviewees. For each of the five categories, an example is provided, even if it was not always possible.

In the last part of the charts, code units are listed. The function of code units is to disclose further details belonging to that specific category. In the charts, code units are found in the interview 1 and 2.

5.2. Interview partners

Data chart for the interview partners is contained in Table 1.

	Sex	**Spoken Languages**	**Professional Experience**
Interviewee 1	Female	Italian, English, German	Translator and interpreter at an Italian hospital during the summertime.
Interviewee 2	Female	Italian, French, German	Translator and interpreter at a General Practitioner’s clinic in a holiday site during the summertime.
Interviewee 3	Female	German, English, French	Translator and interpreter, working as a volunteer translator for MSF.
Interviewee 4	Female	Italian, English, German and Spanish	Interpreter and translator at an Italian hospital during the summertime.

Table 1 - Data Chart

In the previous chapter questions posed to the interviewees were described. In this chapter a brief overview of the answers will be given. The interview questions were asked in English but some of the interviewees preferred to answer in Italian, as they found it easier to express their thoughts in their mother tongue. The answers will be reported as follows:

It is interesting to see how the interviewees answered the fourth question. The majority stated that while dealing with difficult moments, they asked for an advice when they felt insecure about the topic or they asked the patient to repeat the sentence so that the message could be delivered in a better way.

Also, while translating, all the interviewees have said that the words of the physician must be reported, and also no information should be added or omitted. Furthermore, in two of the cases, interviewees (interview 3 and 4) have stated that as far as regulations are concerned, they had to sign an NDA (non-disclosure agreement). References to NDA or similar agreements are mentioned in the literature review (see chapter 0). In interview 1 and 2, the regulations implied for the translators were just to wear a white coat and to exactly report what had been said by the physician. When interviewees were asked to describe their jobs (in interview 3 and 4), it is stated that they have signed a job contract of three months. Whereas, in the first interview, it is stated that the night shifts are also required. Moreover, as it is reported, the translation job required flexibility in all the cases.

Affinities are also to be found regarding question 7, in which translators are asked about the kind of job, i.e. whether it is a job "on call" or not and the answer has been homogeneous:

> (…) in my 9 different periods as a translator, I used to be hired for my shift, I had colleagues of course but night time was not considered apart from the last 3 periods, when we were given, on a rotary base, a mobile phone to answer calls coming from the different wards, or different points of casualties in the area managed by the Administration during nightshifts. I'd better say that in Italy the Health Administration is a public state service divided into many small districts, which cover an area geographically quite large. (interview 1)

> "I had a fixed-term employment contract (approx. 3 months) and it was a shiftwork". [4] (interview 2).
> "No, I am not always available. Usually, we agree upon the next time, I come to the office to continue working on the translation. If I cannot come to the office, I work from home and send the progress to my supervisor". (interview 3)

> In my case, the job was a 3-month-job, so I was all the time available except for Saturdays and Sundays. During the day, I received a lot of calls from different wards and at the same time! So I had to be there as soon as possible and sometimes when I was needed in a short time, I also called for help and contacted my colleagues, who were working as the telephone interpreters (interview 4).

Similarities can be found also with regard to question number 8. All interviewees had a typical day, starting in the morning and finishing usually in the evening, with shifts in evenings and in the night. Examples are given as follows:

- "(…) translators used to work on different shifts, which were 8-2 or else 2-8, every day with a day off" (interview 1)

[4] Avevo un contratto di lavoro a tempo determinato (circa 3 mesi) e si trattava di un lavoro su turni

- "(…) in smaller places called First Aid, there was sometimes just one figure, working 10-16, with one day off". (interview 1)

> (...)I worked approx. 70 hours/month (also on Saturdays, Sundays and on public holidays according to the shifts). There were three shifts: one in the morning (8.30-13.30) another shift in the evening (18.30-23) and one shift (about two hours) in the afternoon in other headquarters.[5] (interview 2).

Other examples from other interviews:

- "(…) we agreed on 2 hours per week. However, this is not a fixed agreement. If there is no work for me, I don't come to the office" (interview 3).
- "(…) my typical day looked like a pretty busy one. At 8 o' clock I had already to be in my office and the first thing I had to do was go to the Emergency and pick up all the medical reports of the day/night, as I needed them for my debit recovery activity".
- "I used to finish work usually at 19.00, but I sometimes stayed longer, if I had other translations to do. I always have considered my job as much fun, rather than tragedy, and I was happy to stay longer at work" (interview 4).

With regard to difficulties in the translator's workplace, there might be some challenges that are not related directly to the language, but can arise from the working environment, such as the fact of dealing with sensible situations, i.e. the loss of a family member and the interpreter/translator translating for them on the spot. Clearly, in such situations, the translator is not just seen simply as a "mediator" within the situation. The "mediator" in this case is a mouthpiece responding to the stimulus around him or her. The mediator in this sense conveys all strong emotions and feelings, and as a consequence, he/she must find a "relief valve", it can be other workmates, friends or people with whom they can share their experiences and doubts. As it has been stated by one of the interviewees, the hospital where she served offered a counselling or supervision in order to help the whole team to express their emotions with regard to that particular situation.

Interviewee 4 stated that supervision can play an important role, especially group supervision:

> Difficult situations are to be seen everywhere, not particularly while translating, but sometimes, I also had to interpret in a very hard situation, where a family had lost a member. The medical staff was later offered some session of supervision with expert psychologists in order to discuss the topic. Supervision was offered twice or thrice in a month and lasted 45 minutes. We were offered a group supervision and everyone had the chance to "spit out" one´s emotions and also to cry if necessary, which was really useful and relieving. I did not cry, but some workmates did, especially those who had kids. (Interview 4)

It underlines the importance of crying as a relief-method. Also, it is stated that those who cried were generally caregivers, who were having kids in their families. Interviewee 4 also

[5] Lavoravo circa 70 ore al mese (anche sabato, domenica e festività in base ai turni). Era previsto un turno la mattina (8.30-13.30), uno la sera (18.30-23) e uno il pomeriggio di circa due ore in altre sedi

adds a positive point, describing a supervisor, who never made them feel ridiculous, embarrassed or out of place:

> The supervisor gave us the chance to express ourselves in a totally free way, without constraints and the atmosphere was really relaxed. The supervisor encouraged us to talk about our emotions and fears without making us feel embarrassed or making us feel ridiculous. (interviewee 4)

In the previous discussions, what should be the role of the gatekeeper (a supervisor) has been discussed (see Chapter 2).

Another interviewee speaks also about "difficulties" related to the emotional aspect. Interviewee 1 particularly speaks about many difficult situations, which may arise from working in such an environment. And through question 3 interviewees are asked to point out particular difficult situations and that's how she replied:

> The most diverse ones, from light injuries and mild constipation or allergies and sunburns, to real critical situations where life is in danger, not to mention the support in the operation theatre during the operation if the patient was merely partly sedated. As a matter of fact, most of the people applying for these summer jobs were tourists, are oversensitive and fussy, had no knowledge about the therapies, clinical problems, diseases and certainly do not like facing the idea of being expected to communicate, somehow with a poor soul on his death-bed, just brought in by the rescuers after taking him/her out of a crashed car, or the idea of being expected to translate the doctor's terrible statement of death to the family of a patient. You also have to deal with psychiatric patients or rogues accompanied by policemen, who also need you, of course. In this case, you might get injured or at least verbally assaulted. This happens! One needs to be able, and willing to face all these situations professionally, and with care. Being able to speak the language, I mean the medical micro language, of course, is the least you are required. (Interviewee 1)

Interviewee 1 describes what kind of different situation there might be within a healthcare setting and claims that most of the people, who are applying for this job for the summer period have no idea of what they might expect. Situations can vary from the less serious to the most serious ones, where you can get injured or verbally assaulted, and you must be able to face such situations professionally.

In the literature review section, many examples of translators training by Karwacka (2014) are discussed.

A translator who works in such settings should also be able to work with different linguistic registers, and translators working with medical texts should also have a previous knowledge, as far as medical terminology is concerned (Karwacka, 2014: 23).

Another aspect related to the difficulties that might be present in such a context is that the personnel (translators) could be injured or verbally assaulted while dealing with the serious cases. To this end, the interviewee also added other emotional information by stating that she

was surprised about how she could quickly react to difficult situations, by claiming that it was the professional context that required the person to react in a fast way.

As far as difficulties in translation, i.e. technical issues in translation, are concerned (question 5), it can be stated that many of the interviewees talk about a "micro-language" that can be challenging, for instance, in the first interview:

"There is a micro-language in any sort of job. People working in this field must logically have":

1. At least some basic medical knowledge.
2. A good pile of books and medical dictionaries.
3. The willingness to get informed and upgrade oneself. The humbleness to ask the medical staff for an explanation, as they might often use difficult terms. Each document must be translated according to the style and linguistic register, for instance, a dismissal letter that is addressed to another doctor requires the use of medical terms. But the technical expressions should be explained if it is addressed to a nonmedical expert. "Let me give you an example, the verb to hydrate oneself is not that common, someone might even think to be supposed to use an ointment or a lotion on his body, but what the doctors mean here is merely to drink more liquids. So it's pointless and wrong to use the parallel verb, which may easily mislead someone, who is not working in the medical field" (Interview 1). Again, a reference to micro-language in medical translation is given by Karwacka, in the literature review (see Chapter 0).

Other translators state similarly that when they have to translate medical documents, they prefer to use database terminology and online dictionaries:

"I mainly work with online dictionaries and ask my supervisor, when there are questions about the context" (Interview 3).

"I usually worked by using technical dictionaries or terminology databases" (Interview 4).

According to the collected data, there is also positivity in many interviews. Many times it is stated that for many people this is also a very positive experience, where boundaries of respect and mutual respect, trust and friendship have been experienced. These friendship relations can last also over time, as stated in one of the interviews:

> (…) so you have the chance sometimes to create a sort of relationship with him/her and his/her family members. It happens you are rewarded with lovely cards, or even with something else like chocolates or flowers. A patient made a video of his trauma, he sent me the video, with lovely words indeed, we had kept in touch for a while via mail and when this man came back to Italy, two years later the trauma he had, he wanted to meet me for dinner with his family at the hotel, where he was staying. (Interviewee 1)

Also, professional translators working as volunteers pointed out the positive aspect of this experience, by underlining the importance of the idea of helping others is something that they really appreciated:

> "I always thought about working as a volunteer, as I really like the concept of helping others" (Interview 3).

Another important point and a particular aspect of the profession is how some interviewees, talking about coping with different situations, describe the importance of finding strategies to manage the variety of situation that people may find while working in such an environment. The essential aspect of resilience is underlined in this case, by interviewee 4:

> Moreover, it was interesting to see how while working in such a complex environment, you had to constantly find strategies to cope with difficult situations, to interiorise them and work on them, and you just know that, if you accept to put yourself in such situations, and that is what I call resilience. (interview 4)

The importance of developing strategies to respond to diverse kinds of situations and stimulus is discussed in the literature review, particularly Betancourt stresses the importance of the "ethics of caring" by reporting that:

> "Refocus on the doctor's response to the individual patient away from the less empathic, principle-based method focused solely on fairness and equity".

> We may stray from the ethics of caring and assume the more distant postures that stress principles over empathy. An orientation to caring incorporates attributes of attentiveness, honesty, patience, respect, compassion, trustworthiness and sensitivity into all acts of behaviour. (Beancourt *et al*. 2000: 30)

Karwacka underlines other characteristics that a good translator should have:

> "Decision making, thoroughness, honesty" (Karwacka 2015: 289).

In the interviews also some participants reported the importance of being empathic towards patients, besides knowing the given medical terminology:

> (…) "One needs to be able and willing to face all these situations professionally and also with care and heart. Being able to speak the language, I mean the medical micro-language of course, is the least you are required". (Interview 1)

5.3. Results and Discussion: Comments to the analysis

By using the interview data collection, translators are given a chance to express their opinion, not solely by answering the questions, rather questions themselves are posed in a way, so that the interviewees are facilitated and encouraged to express their emotions and feelings about the jobs, and not just the linguistic challenges or language-related challenges and positive aspects of their job experience. In the interviews, the impression and feelings of non-volunteer translators are also reported, in order to have a broader overview. Similarities and of course also differences have been found out. Through the analysis of the interviews, different aspects could be displayed. The interviewees began a sort of "dialogue" and felt free and comfortable describing their experiences with which a relationship of mutual respect could be established. In order to report experiences at the work place, one needs to establish "trust", so that the interviewee can open up. One can think that by sending interviews per mail, this kind of "trust" is hard to achieve but collecting data by using emails is seen as a moderate way of getting in touch with the person, and it enables people also to keep a "distance".

Similarities have been found according to the topic of difficulties in translation, particularly in some cases, i.e. by translating technical terms. Translators often have to ask a supervisor or an expert in that specific field for advice. Others have claimed the importance of relying also on glossaries or websites for specific terminology or they stated that they create themselves their glossaries or terminology. Other translation-related issues are also reported when people could not speak the local language, in this case, establishing a "communication bridge" is not simple. Some of the interviewees claimed to have relied on the help of other colleagues that were offering the "telephone translation" service. It is also stated that the translations were delivered in a short time, so that the patient would understand the core of the message. In addition, a permanent feature that has been observed in all the interviewees' answers is that they suggested to report exactly what the doctor says.

According to the regulations, there are some similarities, as far as non-disclosure regulations are concerned. For instance, in interview 3, it is also reported that she had to sign a non-disclosure agreement and so did interviewee number 4. Indeed, ethical regulations and non-disclosure agreements play a crucial role in such a setting, as well as translators testing and further trainings.

Similarities are also found regarding the typical day of work of the interviewees. The typical day is regulated by a precise timetable and duration (months). Similar cases have also been found in the literature review by Hoffmann who also underlines the importance and ability to be always available, in a short time in different wards. Interviewee 1 also states this last point. It is also stated by interviewee 4 that they had to accomplish other tasks, so-called debit collection procedures, and they both talk about the job as a job that requires "shifts".

An important aspect of the job is the emotional feature. Many interviewees have underlined in their interviews that emotions are a feature which is present in our lives and

almost in every job situation, but in the healthcare department emotions are intensified, especially, when people are supposed to translate in situations like a loss of life or serious injury. During the interview, interviewees express their surprise, how they react positively to difficult situations. To this end, it is reported in the literature review, how during the years counselling services are available for healthcare staff.

Translators and interpreters are also needed in these kinds of settings, and clearly, they find themselves involved in situations, where they assimilate information and deliver it. In this process of assimilating, hard impressions and deep emotions are kept inside, so that it becomes hard for them to "set their emotions free" in such settings. As it is observed in the literature review, the counselling activities are ethical rules psychologists have to abide by, and they have to respect the dignity of the individual and give them a chance to express their feelings. One of the interviewees shared her experience that after facing a difficult situation, she was offered a supervision session. Such sessions are organized in groups, where everyone can express his/her own feelings without feeling ashamed.

Another important positive aspect of the job is that of the cultural encounter. Translators and interpreters are seen in this setting as a cultural bridge between patients and physicians. This kind of job enables the interpreters and translators to develop a certain cultural sensitivity. Along with developing cultural sensitivity, they develop competence and a long-lasting friendship, in most of the cases.

It is stated that many times the translator serves as an advocate and trust is being developed between a patient and the translator. This trust is developed also because the patient realises that the translator or the interpreter is the only person who understands his words.

Clearly, there are also difficult moments when it comes to cultural encounters, sometimes translators have to hurry because there is not much time and the message must be delivered in a short time; therefore, only the main points are to be displayed. In order to face cultural bridges, the telephone interpreting or translation services can be used, when on-the-spot translators do not know the language of the patient, they can rely on their colleagues for further help.

The function of bridging the gap is a crucial function played also by the volunteer translators. In the literature review, it has been portrayed, how volunteers help in difficult situations, and how it can be challenging sometimes to explain to the rural population diseases and phenomena like HIV. In order to bridge this gap, MSF has to abide by some principles and regulations. This mission enables volunteers to benefit from a personal growth and enrichment. In one of the interviews, it is also observed that the interviewee working as a volunteer for the MSF also underlines the concept of helping others, by saying that she has always liked this idea, and that is the reason why she decided to join the MSF as a translator.

6. Conclusion: Closing remarks

Present research highlights which difficulties translators encounter while working in the healthcare environment. Not just translation related issues and difficulties are analysed, but also emotional aspects. To this end, people have been asked how they reacted. Questions have been posed so that the interviewees would add other details to their own experience and by doing so, the interview could flow like a "dialogue" enabling the interviewees to add their stories, anecdotes and particular moments that are worth sharing, according to them.

Questions are posed in a way that the identity of the interviewee could not be tracked or identified. In addition, questions are just an initial support for a later openness, where interviewees would talk freely about their experiences and emotions.

Many similarities have been found among translators who worked in the healthcare setting as employers for a limited period of time and those who worked as volunteers. Regarding the translation difficulties, it is stated that they used to rely on glossaries or talk to experts of the field while translating medical texts.

The interviewees have also stressed the importance of the cultural aspect and the opportunity of helping people coming from other countries. Emotions which have been underlined and stressed have to do with a strong relationship, between patients and translators or interpreters, which may develop with time and last for many years. This may be possible also because the language expert is the only reference the patient has while staying in that specific country. Other emotions and feelings mentioned in this research are those related to clinical supervision. Clinical supervision is offered in a particular situation, generally difficult ones, where also the help of the language experts is required. Emotions are in the case of sensitive situations important tools for people to relieve their sorrow and to take conscience of the situation. Here it is very important that the feelings flow freely without shame or fear.

With the interviewees, a productive conversation has been developed and the aim of showing the challenges of the healthcare translators has been reached. Moreover, positive aspects have also been underlined.

These professional profiles are gaining importance in today's world, especially in the healthcare settings, where efficient communication plays an essential role for the welfare and for an improvement of the quality of life.

In order to have an efficient communication within the healthcare department, translators should be trained in an interdisciplinary way that combines various approaches, such as psychology and physiology. Translation trainers, in order to improve their students' education, should help them to see the linguistic aspects and different language features present in the text and how to make them understandable in the target language (Cozma *et al.* 2013: 897).

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Appendix 1

A. Interviewees chart

Question 1 *Where did you get the idea of working as a volunteer translator for this organisation?*	
Interviewee 1	«The very first time I had the chance of working as an interpreter (casualties/different wards of the Hospital -Lido di Jesolo Venice) was back in 1998 and there was a public Call for a selection based on your titles . It was a temporary summer-job from May to end of September and you got paid by the State, so to say. I believe at that time there was no oral test to prove your knowledge of German and English and of a third language. This came up later, in the following years (summers)».
Interviewee 2	«Due mie ex compagne di studi che avevano già svolto il lavoro l'estate precedente mi hanno chiesto se sarei stata interessata a collaborare. Mi hanno spiegato in cosa consisteva il lavoro e ho deciso di accettare».
Interviewee 3	«I always thought about working as a volunteer, as I really like the concept of helping others. I started working as a freelance translator and interpreter last summer and after a couple of months I realized that I still had some extra capabilities so I started looking for volunteer work in my field. It didn't take long to find the organisation „Doctors without Borders". You can fill out a form on their website, indicating your field, and just apply – and that's what I did. I stated that I was a freelancer and that I offer language services. Just a couple of weeks later I was contacted and they asked me, whether I was interested in working for them. As German in not really needed in this organization, I was asked to translate from French into English (from my C-language into my B-language)».
Interviewee 4	«The very first time I got this wonderful opportunity was in May 2013 when I was hired by the ULSS 4 after having passed several exams (oral and written ones). My working languages were English, German and Italian. Besides the translation activity, I also had to interpret and assist to visit in different hospital wards and I also had to take care of debit collection procedures».

Table 2 - Interviewees' answers to Question 1

Question 2 *What are/is the most interesting aspect in the translation and what is the less interesting?*	
Interviewee 1	« The translation is immediate, the interpreters are expected to translate exactly what the doctors or nurses tell the patient (including as far as documents, insurance, fees to pay etc) and also with the same tone of voice. In my case the most interesting aspect has always been the real, serious emergency, you really have the perception, there, you are of help, above all to the patient as he/she cannot understand Italian, cannot communicate his/her anguish to the others, he's (she's) in pain and also feels also displaced and frantic sometimes. Another interesting aspect regards the in-patients, hospitalised for days in the ward. In this case you may get to know the patient a bit better , so you have the chance sometimes to create a sort of relationship with him/her and his/her family members. It happens you are rewarded with lovely cards, to follow, or even with something else (chocolate. flowers). A patient made a video out of his trauma, he sent me this video.. with lovely words indeed, we had kept in touch for a while via mail and when this man came back to Italy, two years later the trauma he had, he wanted to meet me for dinner with his family at the hotel where he was staying.».
Interviewee 2	« Tra gli aspetti più interessanti del lavoro citerei sicuramente l'opportunità di lavorare come interprete in un settore specifico (la medicina) e di apprenderne e approfondirne di conseguenza il lessico specialistico. Questo aspetto ha arricchito molto il mio bagaglio di conoscenze personale e professionale. E' stato inoltre molto interessante sperimentare "sul campo" situazioni o aspetti che nel percorso di studi universitario di un'interprete vengono trattati solo a livello teorico o a scopo di esercizio. Infine la soddisfazione del cliente finale, il suo riconoscere e apprezzare la figura dell'interprete e dunque la mia consapevolezza di aver reso possibile la comunicazione e la comprensione reciproca tra le parti sono stati ugualmente fonte di arricchimento personale. Tra gli aspetti meno interessanti citerei forse il ricorrere di determinate patologie tra i pazienti e quindi l'utilizzo a volte di espressioni ripetitive.».

Question 2 *What are/is the most interesting aspect in the translation and what is the less interesting?*	
Interviewee 3	« At the moment I cannot really think of any particularly difficult situation. What is quite challenging, however, is the linguistic approach. In the project I am currently working on I deal with interviews. Some of these interviews weren't taken in French, but an African language, and at a later moment in time translated into French (by doctors or other medical staff). I now have to translate these interviews into English, so that they can be used in the report. The difficult part for me is trying to understand the "source text", which in most cases already is a translation, and translating it into English. I sometimes don't understand the meaning of the source text, as the translation contains either spelling/grammar mistakes, or is a very vague in general. As I also don't translate the entire interview, just a few sentences, sometimes I am lacking the context of the interview and therefore am not sure, what is meant exactly.).».
Interviewee 4	«The most interesting thing of the Profession was the fact that some Latin terms Were not clear and I had to ask for further explanation. In some Austrian documents I had to deal with some Austrian terms. I cannot say that there were less interesting moments while translating. Further interesting aspects of the profession were that of getting to know people from different cultures. Moreover, it was interesting to see how - while working in such a complex environment, you had to constantly find strategies to cope with difficult situations, to interiorize then and work on them, and you just know that if you accept to put yourself in such situations and that is what I call resilience».

Table 3 - Interviewees' answers to Question 2

Question 3 *I do think that in your job you will have to deal with difficult situation sometimes. What kind of difficult situations do you have to face?*	
Interviewee 1	«The most diverse ones, from light injures and mild constipations or allergies and sunburns, to real critical situations where life is in danger, not to mention the support in the operation theatre during the operation if the patient was merely partly sedated. As a matter of fact, the most of people applying for this summer jobs with tourists are oversensitive and fussy , have no knowledge whatsoever of therapies, clinical problems, diseases and certainly do not like facing the idea of been expected to communicate somehow with a poor soul on his death-bed , just brought in by the rescuers after taking him/her out of a crashed car, or the idea of being expected to translate the doctor's terrible statement of death to the family of a patient . You also have to deal with psychiatric patients or rogues accompanied by policemen , who also need you, of course . In this case you might get injured or- at the least - verbally assaulted . This happens! One needs to be able and willing to face all these situations with professionality and also care.. and heart. Being able to speak the language, I mean the medical microlanguage -of course-, is the least you are required».
Interviewee 2	«I contributi dei medici si rivelavano, seppur rare volte, lunghi e densi di informazioni e cifre da ricordare. Non avendo la possibilità di prendere appunti in quanto i colloqui si svolgevano in modo molto spontaneo e diretto, tutto ciò appesantiva la mia memoria. Alcuni pazienti provenienti soprattutto da paesi est europei trovavano difficoltà ad esprimersi nella lingua veicolare utilizzata nel loro caso per dialogare con il medico, l'inglese, ed era dunque difficile in quei casi garantire la piena comprensione reciproca».
Interviewee 3	« At the moment I cannot really think of any particularly difficult situation. What is quite challenging, however, is the linguistic approach. In the project I am currently working on I deal with interviews. Some of these interviews weren't taken in French, but an African language, and at a later moment in time translated into French (by doctors or other medical staff). I now have to translate these interviews into English, so that they can be used in the report. The difficult part for me is trying to understand the "source text", which in most cases already is a translation, and translating it into English. I sometimes don't understand the meaning of the source text, as the translation contains either spelling/grammar mistakes, or is a very vague in general. As I also don't translate the entire interview, just a few sentences, sometimes I am lacking the context of the interview and therefore am not sure, what is meant exactly».

Question 3 *I do think that in your job you will have to deal with difficult situation sometimes. What kind of difficult situations do you have to face?*	
Interviewee 4	«Difficult situations are to be seen everywhere, not particularly while translating, but sometimes I also had to interpret in a very hard situation, where a family had lost a member. The medical staff was later offered some session of supervision with expert psychologists in order to discuss about the topic. Supervision was offered twice or three times in a month and lasted 45 minutes. We were offered a group supervision and everyone had the chance to "spit out" one´s emotions and also to cry, if necessary which was really useful and relieving. I did not cry, but some workmates did, especially those who had kids. The supervisor gave us the chance to express ourselves in a totally free way, without constraints and the atmosphere was really relaxed. The supervisor encouraged us to talk about our emotions and fears without making us feel embarrassed or making us feel ridiculous».

Table 4 - Interviewees' answers to Question 3

Question 4 *How do you deal with difficult situations?*	
Interviewee 1	«Personally i was really surprised to see that i am at my best at it. I couldnt say why as i am a tender soul normally... i cry when i watch a movie... but being there and having to react in a professional, balanced and quick way i guess takes out a balance which surprised me. i must say i really liked this job, it really overwhelmed me and engaged me , if i had a magic wand i'd go back to those times for sure».
Interviewee 2	« Nel primo caso chiedevo al medico o al paziente di ripetere una seconda volta un concetto, un dettaglio o una cifra che non ricordavo nel momento dell'interpretazione ».
Interviewee 3	« Try to cope with these difficulties by working closely with my "supervisor", who was on site when the interviews were taken. She's familiar with the bigger picture and can explain to me what exactly this person is trying to tell us. I then try to work this into the translation. ».

Question 4 *How do you deal with difficult situations?*	
Interviewee 4	« When dealing with difficult translation and terms I try to look up in specific medical dictionaries or term search and if I couldn't properly find the translation I would ask to experts in that field for further advice. When I had to interpret I also asked the physician to previously explain me the situation, so that I could better deliver the message».

Table 5 - Interviewees' answers to Question 4

Question 5 *How do you translate the documents?*	
Interviewee 1	«There is a microlanguage in any sort of jobs. people working in this field must logically have : 1 at least some basic medical knowledge at the least, 2-a good pile of books and medical dictionaries ,3 the willingness to get informed and upgrade oneself, 4 the humbleness to ask the medical staff for an explanation , giving the fact they often use difficult terms . Of course you need to translate according to the case: a dismissal letter goes to another doctor so you can use medical terms, another kind of practical document should be explained . let me give you an example: the verb to hydrate oneself is not that common, someone might even think to be supposed to use an ointment or a lotion on his body .. but what the doctors mean here ismerely to drink more liquids !!! so it's pointless -and wrong- to use the parallel verb which may easily mislead someone who is not working in the medical field».
Interviewee 2	«Mi è capitato solo poche volte di dover tradurre e in ogni caso non si trattava di veri e propri documenti, bensì di brevi diagnosi mediche ad esempio, in modo tale che fossero comprensibili nel paese di provenienza del paziente per scopi assicurativi. Non avendo il tempo materiale di consultare testi paralleli, di fare ricerche e dunque di fornire una traduzione di qualità, le mie traduzioni erano spesso un po' approssimative».
Interviewee 3	«I mainly work with online dictionaries and ask my supervisor when there are questions about the context. The quotes will be used in a report at a later stage, but I don't like to translate them directly in the document. I therefore created a word file with a table with two columns and copied and pasted the quotes into them. I prefer this way of translating, as I always see the source text and the translation».

Question 5 *How do you translate the documents?*	
Interviewee 4	«I usually worked by using technical dictionaries or terminology databases».

Table 6 - Interviewees' answers to Question 5

Question 6 *What regulations do you have to abide to, as translators?*	
Interviewee 1	«Being really quick to get there once you are summoned in the ward, understanding what the doctors say , and translating words exactly in the way they are saying them, I am afraid sometimes it is really embarassing, i had to tell someone to go to Hell, the doctor wanted me to tell the patient this.. and of course i had to.. and so i did.Basically: No adding -whatsoever - , no lessening , no summing up . it should be exactly what the doctors or medical staff say».
Interviewee 2	«Non erano previste norme specifiche, se non quella di indossare il camice».
Interviewee 3	«I signed a NDA (non-disclosure agreement), which is basically a privacy statement. Other than that there are no regulations I have to abide to. There is no stlye sheet or anything, I have all the liberties as a translator!».
Interviewee 4	« As regulation there was NDA, which was included in the initial agreement I had to sign before start the job there».

Table 7 - Interviewees' answers to Question 6

Question 7 *Is it a job on call or are translators always available?*

Question 7 *Is it a job on call or are translators always available?*	
Interviewee 1	«In my 9 different periods as a translator i used to be hired for my shift, i had colleagues of course but night time was not considered apart from the last 3 periods when we were given -on a rotary base- a mobile phone to answer calls coming from the different wards or different points of Casuaties in the area managed by the Administration during nightshifts . i'd better say that in Italy the Health Administration is a Public State service divided into many small districts which cover an area geographically quite large».
Interviewee 2	«Avevo un contratto di lavoro a tempo determinato (circa 3 mesi) e si trattava di un lavoro su turni».
Interviewee 3	«No, I am not always available. Usually we agree upon the next time I come to the office to continue working on the translation. If I cannot come to the office, I work from home and send the progress to my supervisor».
Interviewee 4	«In my case the job was a 3-month-job, so I was all the time available except for Saturdays and Sundays. During the day I received a lot of calls from different wards and at the same time! So I had to be there as soon as possible and sometimes when I was needed in a short time I also called for help and contacted my colleagues who were working as telephone interpreters».

Table 8 - Interviewees' answers to Question 7

Question 8 *If yes, how does the schedule of a translator look like?*	
Interviewee 1	«In my area (san donà di piave- jesolo -caorle- bibione-...near Venice Azienda sanitaria Veneto orientale, now number 4) it is a job dealing to the presence of many tourists on the sea-side resorts . Therefore it is only a summer job starting May 1 till the end of September. When i used to work there , my last experience was 12 years ago , the interpreters used to work in different shifts which were 8-2 or else 2-8, every day with a day off. In smaller places called First Aid there was sometimes justone figure, working 10-16 , with one day off. Main tasks range from 1-sorting out the documents of the patients at the first aid department of the previous day, checking on insurances of any in-patients in the wards or if citizens of the European Union on the TEAM (european medical insurance card) , be on call (all the time during the shift via a dedicated day mobile phone), calculating bills and printing receipts, getting in touch with members of the families or insurances or tour representative -giving them support and all the information required, getting in touch with the Police in case of a road accident or violent crime, translating, when applied, a dismissal letter or any other documents needed by the doctors. These are the main tasks , in addition to any possible info of touristic interest or dealing with means of transports to reach other hospitals».
Interviewee 2	«Lavoravo circa 70 ore al mese (anche sabato, domenica e festività in base ai turni). Era previsto un turno la mattina (8.30-13.30), uno la sera (18.30-23) e uno il pomeriggio di circa due ore in altre sedi. Oltre a fare l'interprete facevo anche la segretaria, ovvero mi - occupavo dell'accoglienza e della registrazione dei pazienti e fornivo informazioni se necessario».
Interviewee 3	«We agreed on 2 hours per week. However, this is not a fixed agreement. If there is no work for me, I don't come to the office. Also, I will start a new job soon as a full-time in-house translator, so coming to the office will be difficult anyways. I will continue working for them, but mostly from home. It's not a prerequisite to come to the office, my supervisor also agrees to me working from home».
Interviewee 4	«My typical day looked like a pretty busy one. At 8 o' clock I had already to be in my office, and the first thing I had to do was go go to the Emergency and pick up all the medical reports of the day/night before, as I needed them for my debit recovery activity. I finished working usually at 19.00, but I sometimes stayed longer, if I had other translations to do. I always have considered my job as much fun, rather than tragedy, and I was happy to stay longer at work».

Table 9 - Interviewees' answers to Question 8

B. Categories Chart

Categories	Definition	Reported statements	Codes units (if any)
1 *Job application*	How did the interviewed people applied for this job	Not applicable	It also contains the reason why they accepted to do this job
2 *Aspects of the job*	Description of various aspects of the profession	Not applicable	It also includes personal opinions and emotions with the patients as well as technical issues (omissions or addition of elements to the speech)
3 *Difficult situations*	Overview of difficult situations	Not applicable	It includes also personal opinions about personal opinions/feelings/reactions
4 *Technical issues of translation*	Describing technical issues translation activity presents	Not applicable	
5 *Policies and clauses*	Described if there are any particular policies to respect	"I signed a NDA" (3rd interview) or " Non erano previste norme specifiche, se non quella di indossare il camice."	

Categories	Definition	Reported statements	Codes units (if any)
5.1 *Typical day*	compilare	"My typical day looked like a pretty busy one. At 8 o' clock I had already to be in my office, and the first thing I had to do was go go to the Emergency and pick up all the medical reports of the day/night before, as I needed them for my debit recovery activity. I finished working usually at 19.00, but I sometimes stayed longer, if I had other translations to do. I always have considered my job as much fun, rather than tragedy, and I was happy to stay longer at work." (interviewee 4)	

Table 10 - Categories Chart

Abstract

The present paper aims at analysing communication within healthcare settings. When a person is undergoing medical treatment in another country, it is important to deliver medical information in a correct manner verbally and also in written form. To this end, the role of experts of the language, i.e. interpreters and translators, is crucial.

This paper analyses the work of translators working in such an environment by underlining all the aspects of the profession and the challenges that may arise, not only concerning the linguistic aspects but also the "human" ones, such as the need of third-party supervision in particular cases.

For this study four participants have been interviewed: each of them worked or is working as a hospital translator. They were asked to talk about their experience by mentioning not only the linguistic challenges, but also emotional aspects of their job. The interviews have been carried out by e-mail. Making reference to the research questions and the results collected, similarities have been found out according to linguistic aspects: it has been found that many translators do ask a medical expert for further information or advice when they are facing difficult medical terms; alternatively, they create their own medical glossaries. Other similarities regard the ethical aspects and the importance of not disclosing confidential information. Also working hours and routine are described as similar. Furthermore, the importance of the relationship that may develop between patient and translator was stressed, as the latter may be the only point of reference for the patient.

Willingness to help is also another important aspect that will be treated in this paper, as well as cultural encounter. Regarding the emotional effects of translation in the medical context, supervision sessions have been highlighted as a useful tool and opportunity to overcome difficult situations.

Abstract (Deutsch)

Ziel dieser MA Arbeit ist es, die Tätigkeit der Übersetzer*innen, die im medizinischen Bereich arbeiten, darzustellen. Geschildert werden nicht nur die sprachlichen Aspekte der Tätigkeit, sondern auch die „menschlichen“, wie im Falle einer Supervision im medizinischen Bereich, die von einer Expert*in durchgeführt werden muss.
Für die vorliegende MA-Arbeit wurden 4 Teilnehmer*innen (aus Italien und Österreich) per E-Mail interviewt. Diese Personen arbeiten derzeit oder haben als Übersetzer*innen im medizinischen Bereich gearbeitet. Sie wurden gebeten, ihre Arbeitserfahrung als Übersetzer*innen im medizinischen Bereich zu beschreiben. In den Interviews schilderten sie sowohl die sprachlichen Herausforderungen der Tätigkeit als auch die emotionalen Herausforderungen und die positiven Aspekte, die diese Tätigkeit mit sich bringt.