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Short title: Cross-border healthcare for all EU residents?

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Cross-border healthcare for all EU residents? Linguistic access in the European Union

Claudia V. Angelelli

Abstract

In 2011, the European Union introduced a Directive to facilitate cross-border healthcare for EU citizens and residents. However, if healthcare services are provided in a language patients cannot fully understand, equal access to safe and high-quality healthcare cannot be guaranteed. This exploratory study examines provisions for linguistically diverse patients seeking cross-border healthcare in areas of Germany, Greece, Italy, Spain and the UK. To address the language needs of these patients, healthcare organisations resort to a number of strategies, ranging from monolingual communication matching the language of the patient, to professional translation, interpreting and cultural mediation, or to informal and non-professional ad hoc solutions. In the absence of formal language guidance in EU legislation, in most observed cases appropriate language services are not provided for patients who are not proficient in the language of the Member State in which they seek healthcare. This study raises ethical questions regarding access and communication and has implications for policy makers, healthcare providers, educators, translators, interpreters and cultural mediators serving the needs of linguistically and culturally diverse patients.

KEYWORDS: ACCESS; CULTURAL MEDIATOR; DIVERSITY; INTERPRETING; LANGUAGE SUPPORT;
TRANSLATION

1 Introduction

The mobility of citizens of the European Union is a right guaranteed by the EU Charter. As such, some citizens reside in a Member State (MS) where they do not know or are not proficient in the societal language, or cross borders to seek healthcare in an MS the language of which they do not speak. These individuals may need various kinds of language support when seeking healthcare: (1) information in their own language, (2) translation of specific documents (e.g. medical records or documents for reimbursement), (3) interpreting and/or (4) cultural mediation. This article focuses on EU citizens' access to linguistic support for healthcare services in five MSs of the EU.¹

No EU document discusses how EU residents may access information or communicate with healthcare providers in a language that is not their own, including the 2011 Directive (2011/24/EU) on patients' rights in relation to cross-border healthcare.² In the absence of formal legislation and policy guidance at the EU level, organisations and patients are left to their own devices to meet communicative needs, at times resulting in unequal access to the highest level of protection that all EU citizens are guaranteed. Paying attention to patients' communicative needs so that EU citizens can communicate adequately with healthcare providers will thus avoid unintended discrimination on the basis of language.

The focus of this paper is on language support for cross-border healthcare that is provided (or not provided) by five participating MSs. We look at how language support occurs and who is responsible for providing it, and we discuss consequences of (non) provision as well as ethical considerations. It is worth noting that the provision of appropriate language support may be particularly difficult in situations where patients receive emergency

care through the European Health Insurance Card (EHIC), rather than seeking pre-planned healthcare as patients under the Directive.

The research reported in this paper is part of a larger study commissioned by the EU. In this paper I report on language diversity and access based on actual instances of information exchange in bilingual healthcare oral and written interactions. I begin by briefly reviewing the relevant literature and the legal framework on linguistic access in cross-cultural/linguistic healthcare, and then proceed to report the findings on the provision of language support in Germany, Greece, Italy, Spain and the UK.

2 Brief review of the relevant literature on cross-cultural/linguistic healthcare access and communication

Well-documented studies of patient–provider communication in the context of healthcare protection have identified factors that make the healthcare setting especially sensitive (Moreno *et al.* 2009; Sarangi and Candlin 2011; Michalec *et al.* 2014; Sarangi 2016). These can be summarised as: (1) uneven levels of health literacy and power differentials in communication between vulnerable participants (patients) and expert participants (healthcare providers); (2) management of sensitive and confidential information (e.g. patient’s medical records, treatment alternatives and their side effects); and (3) decision making and responsibility on sensitive issues that may impact directly on a patient’s health and wellbeing (e.g. provider requesting and patient giving informed consent to a treatment/procedure).

Evidently, patients make informed decisions about their health only through their communication with experts and through the information they can access.

In a cross-linguistic/cultural healthcare communication, this sensitivity is exacerbated (Angelelli 2004): patients’ autonomy relies on their full access to information, but when they do not share the same language as the healthcare organisation/provider, they become even

more vulnerable as they depend on either technology (e.g. machine translation performed by software such as Google Translate) or another party (the translator/interpreter) who bridges the communication gap with the provider (e.g. the hospital nurse, doctor or administrator). Observations of intercultural/linguistic communication in healthcare settings have shown how substandard language provision, both within the EU context or beyond, have resulted in delays in treatment, wrong diagnoses, repeat visits, deterioration of patients' health and unnecessary escalations to emergency cases, as well as deaths (see, for example, the case of patients who, as a result of a translation error in dosing, were given radiation overdoses at the Jean Monnet Hospital in Epinal, France, between 2001 and 2006 – Toviraaj 2007) (Zborowski 1952; Greenwald 1991; Rollman 1998; Cambridge 1999; Ramer *et al.* 1999; Callister 2003; Flores *et al.* 2003; Flores 2005; Jiménez *et al.* 2012).

Managing language diversity and providing language support in the context of health protection is thus of great importance. In the EU, the importance of language support for accessing information about rights and a range of services – e.g. healthcare, justice and education – when these are not provided in the citizen's language has already been addressed by a series of EU-funded projects that document the need for high-quality language support provision.³ In the case of healthcare, such assurances are essential for avoiding unintended violations of patients' rights such as may occur with ad hoc translation or interpreting services.⁴

The three parties that participate in healthcare-related communication across languages – i.e. the patients (and family members) seeking care, the providers supplying it and the healthcare translators/interpreters enabling communication – belong to different speech communities (Angelelli 2000 [after Hymes 1974] and 2004), and members of these diverse cultural groups often understand healthcare systems and practices differently (Angelelli and Geist-Martin 2005). In many areas of the world, research in bilingual health

literacy and intercultural communication (e.g. Kuhajda *et al.* 2011; Arora *et al.* 2012) have shown that providers of language services (e.g. interpreters, language/cultural mediators) perceive their roles in healthcare settings, as one with various degrees of agency to broker power differentials (Angelelli 2008). In addition, in some medical settings (e.g. mental health) it is often the case that linguistic minorities are particularly vulnerable groups and, therefore, power differentials between providers and patients become especially salient.

3 Brief review of the relevant legal framework: language and access in cross-border healthcare

The current legal framework for cross-border healthcare in the European Union can be found in four principal documents. Broad principles relating to non-discrimination are provided by the Charter of Fundamental Rights of the European Union (hereafter ‘the Charter’), which establishes the rights for citizens of the Union and has been legally binding since 2009, and by the Treaty on the Functioning of the European Union (TFEU), which was established from the agreements of the Lisbon Treaty that came into force in 2009 and defines the mechanisms for the governance of the Union. Specific details relating to the provision of healthcare are given in Regulation (EC) 883/2004,⁵ on the coordination of social security systems, and in the abovementioned Directive 2011/24/EU, on the application of patients’ rights in cross-border healthcare.

In keeping with the Universal Declaration of Human Rights (specifically Article 2), the Charter expressly refers to language as one of many protected characteristics, stating in Article 21 (1) that:

Any discrimination based on any ground such as sex, race, colour, ethnic or social origin, genetic features, language, religion or belief, political or any other opinion,

membership of a national minority, property, birth, disability, age or sexual orientation shall be prohibited.

The following Article 22, under the heading ‘Cultural, religious and linguistic diversity’, delves a little deeper into the list of protected characteristics to clarify that ‘[t]he Union shall respect cultural, religious and linguistic diversity.’

Complementary to this, TFEU Article 19 (1)⁶ acknowledges the existence of but prohibits discrimination. It empowers the European Council to ‘take appropriate action to combat discrimination based on sex, racial or ethnic origin, religion or belief, disability, age or sexual orientation’. However, the list of protected characteristics on this occasion does not include language within its number.

Regulation (EC) 883/2004 establishes norms and competencies for the provision of healthcare to certain classes of cross-border patients, but does not contain any explicit reference to the category of language in relation to access. This is also the case with Directive 2011/24/EU, which expands the rights of citizens to seek reimbursement and to be reimbursed for cross-border healthcare, and includes the right to access clear information, to make a complaint and to have sufficient and permanent access to a broad range of high-quality treatment. Furthermore, it specifically mentions the role of health systems as central components of the Union’s high levels of social protection (in Section 3) and their contribution to social cohesion and social justice as well as to sustainable development.

Implicit in all of the above is the notion of linguistic access, yet neither Directive 2011/24/EU nor any other EU legislation defines how language access can be materialised, or how language services are to be provided to cross-border healthcare patients. The aims of the Directive can only be realised in a multilingual environment where language access (written, spoken or sign) is recognised and provided.

A report by the Special Interest Group on Translation and Interpreting for Public Services (SIGTIPS 2011) notes that for persons with limited proficiency in the societal language – whether mobile EU citizens, migrants without EU citizenship or asylum seekers – translation and interpreting (T&I) services play an important role in providing access to public services. T&I make service provision possible and are not limited to non-EU citizens, since any EU citizen may require language provision if unable to access the language of the MS where healthcare is sought. Patients travelling under Directive 2011/24/EU fit into this category. The SIGTIPS also points out that national legislation on T&I services is limited to specific settings or recommendations.

Despite the real need for these services, a broad national legal framework that specifically recognises the right to access them in the public sector is, for the most part, missing. In contrast to this lack of specific national legislation guaranteeing T&I services, the Charter explicitly supports language diversity and prohibits discrimination on the basis of language. An example here is that the EU has taken measures to protect citizens who do not speak the societal language regarding access and communication in relation to criminal proceedings through Directive 2010/64/EU, on the right to interpretation and translation in criminal proceedings, which was commissioned by the Directorate-General for Justice.⁷ This Directive acknowledges the power differential and that those who do not speak/understand the language of the court may be at a disadvantage, and states that ‘the right to interpretation and translation for those who do not speak or understand the language of the proceedings is enshrined in Article 6 of the ECHR, as interpreted in the case-law of the European Court of Human Rights’. It also mandates that those in need have access to adequate language services and that these services be provided in a timely manner and free of charge.

This requirement for the provision of language services under Directive 2010/64/EU is of relevance when considering the healthcare setting and Directive 2011/24/EU. As

discussed above (Section 2), power differentials also exist in healthcare communication and users of healthcare services are in a position of weakness when communicating with healthcare providers. Patients who do not speak the MS language cannot fully access information and services without language services, just as ‘suspected or accused persons’ in cannot fully exercise their judicial rights in criminal proceedings without these.

However, despite these similarities, Directive 2011/24/EU did not mandate T&I services. The lack of clarity on the issue of language this Directive raises questions about the plausibility of access on the part of patients who may not share a language with healthcare providers and, thus, be unable to truly access information (Cohen *et al.* 2005). The current study describes how, in the absence of such guidance, language needs are met (or not met) in the healthcare setting in selected sites.

4. Study⁸ design and methods

4.1 Sampling – Decision-making process

The original study called for a stratified sampling of MSs. However, this was not feasible, given the limited timeline and budgetary constraints imposed on the project. The next-best option was to choose MSs on the basis of criteria that were meaningful and relevant to the goals of the study. Thus, MSs were chosen based on: (1) size as determined by number of seats in the European Parliament; (2) migration patterns in the last 20 years (Eurostat 2017); (3) linguistic consequences of migration (as reported in Kerswill 2006); (4) team access to networks and language combinations within the timeframe for responses to the call for tenders from the EU Directorate General for Translation, which funded this research. As a result, five MSs have been chosen for this exploratory study: Germany, Greece, Italy, Spain and the UK.

Sites and Participants

To address the research question on language provision we targeted the following: sites and informants who represented policy makers working at the national/regional level in healthcare policy; healthcare administrators and providers working in public and private hospitals and clinics in urban and rural areas; lawyers specialising in issues of access and language; medical-insurance companies; consumer-protection agencies; NGOs; language-service providers (companies, agency owners, institutional employees and freelancers); T&I professional associations; language/T&I software developers; and patients and their family members. To provide the geographical context, Table 1 shows names of the cities and towns in each MS in which sites were contacted/visited.

<Insert Table 1: Cities and Towns visited per MS around here>

To collect information and documentary evidence, and to conduct interviews and observations, we contacted the following site types in each MS to request their participation in our study: National Contact Point offices; National and Regional Ministries of Health; policy makers' offices; law offices (specialising in health and access); rural and urban clinics; healthcare centres and hospitals; NGOs; community centres; T&I agencies; T&I professional associations; medical professional associations; cultural mediation associations; T&I list-serves; and universities that teach T&I. We also made direct contact with T&I professionals, ad hoc translators and interpreters and university students through business networks and social media.

In the five MSs 128 sites were contacted to take part in the study. A total of 112 sites agreed to be observed and participated in the study. Table 2 provides a summary of site visits per MS.

<Insert Table 2: Types of sites visited per Member State around here>

A total of 235 informants were contacted directly, of whom 209 participated in interviews and observations. A further 331 responded to surveys sent to organisations for distribution, although the results from these are outside the scope of this study. Table 3 below provides a summary of informants interviewed per MS. To observe confidentiality, names of informants and sites are coded, providing only MS and number.

<Insert Table 3: Informants interviewed per Member State around here>

5 Findings

5.1 *Types of language support and how it is provided*

When participating language providers (translators, interpreters, mediators) were asked about their backgrounds, they provided the following information regarding (1) the language support services they provide and (2) their background in translation/interpreting. The results are given in Table 4.

Table 4: Profiles of language providers ($n = 331$)

Highest relevant educational qualification in T&I	
University degree	36%
University degree in a related field e.g. languages, linguistics or communication)	20%
Certification	31%
No specific education or training	13%
Highest formal training in public service T&I	
University education	23%
Professional development or continuing education through professional associations	35%
In-house training and development	35%
Hospital training	7%

Work Experience in T&I	
2 years or less	23%
More than 2 years up to 5 years	19%
More than 5 years up to 10 years	23%
More than 10 years	35%
Percentage of T&I experience in healthcare settings	
Up to 5%	19%
More than 5% up to 25%	32%
More than 25% up to 50%	23%
More than 50%	26%

Except for the UK, where T&I is mandated by the country’s Equality Act 2010,⁹ language services are neither mandatory nor frequent in healthcare organisations. While only 22% of study participants working in the UK said that T&I services are called upon only as a last resort, the figures were 57% for Spain, 41% for Greece and 70% for Germany.

The language-service delivery models observed and reported by healthcare institutions (See Table 5 below) are used for patient–provider communication and for giving patients access to information and services. These models (inconsistent in quality), when provided by professionals, are necessary to guarantee access to safe, high quality healthcare for linguistically diverse individuals.

<Insert Table 5: Reported delivery models of language provision around here>

Specifically for interpreting provision, Figure 1 below shows the percentage of face-to-face versus remote language brokering; and in terms of qualifications for the job, Figure 2 shows the percentage of interpreters asked to perform translations.

<Insert Figures 1 and 2 around here>

5.2 *Translation*

The provision of a professional translation service for healthcare is not the norm in the MSs of this study. Rather, ad hoc translation of documents is the most common solution for the public and private health centres and hospitals observed in Spain, Italy and the UK. Bilingual staff members may translate documents into the patient's language, and patients are also asked to perform this task themselves. When asked which documents are the most frequently translated, informants mentioned informed consent forms, check-in forms and information materials (e.g. brochures/posters and/or websites). Translations by staff members are usually only available for the most common language combinations; this study found that availability also varies between institution and depends on the demographic profile of the population that each institution serves.

In the public and private healthcare sites visited there were not many examples of professional in-house translation services that are able to fulfil the requests of patients, healthcare providers or staff. The few reported ones function in tandem with interpreting services, with in-house interpreters with translation qualifications also translating documents. This is the practice in the UK. Based on interviews conducted with healthcare providers, administrators and patients, translation is often seen as the responsibility of the patient. However, the general lack of in-house translation offerings across the participating MSs does not mean that hospitals and clinics do not have translation needs.

5.3 *Human translation (written and sight)*

It was reported that translation professionals and ad hoc translators (bilingual employees, interpreters) both undertake translations of written materials. Only five institutions reported having a contract with a translation agency: most instead rely on their own qualified interpreters as in-house translators to perform written translations of documents, reported to be a cost-saving technique. Another commonly reported practice is the sight translation of

documents. Both professional and ad hoc interpreters perform this task, examples given being consent forms, information pamphlets and patients' records and files, as well as prescriptions.

Among issues related to translations, the following problems were mentioned: (1) translations are not always provided for in all the necessary language combinations; (2) translations are only provided for certain types of documents and patients do not have access to the necessary information available to make informed decisions; (3) documents are translated only if they are considered relevant or standard; (4) staff members only decide on the relevancy of any given document and if it is to be translated; and (5) since no permanent translation service is offered to patients who need it, patients are responsible for providing their own translators.

5.4 *Machine-assisted translation and computer-assisted translation tools*

Machine-assisted translation was reported and observed in sites in four MSs that were featured in this study. The Universal Doctor Speaker and Google Translate were the most frequently cited software. The Universal Doctor Speaker was designed in Spain specifically for the healthcare setting. This tool provides translation of common phrases (e.g., as found in explanations, questions and answers) into over 30 languages (Universal Doctor 2015).

Google Translate was reported as being in use by healthcare organisations and providers in Spain (in Galicia and outside Alicante), Italy (Modena, Rome, Forli, Verona, Naples), Greece (Trikala, Athens, Chania, Vamos) and Germany (Mainz, Gernersheim). No informant from the UK reported using any computer-assisted translation tools.

5.5 *Interpreting*

On-site (face-to-face) and remote (video and telephone) interpreting were observed in the settings studied.

5.5.1 *On-site (face-to-face) interpreting*

Some healthcare institutions provide professional face-to-face interpreting services (i.e., a trained professional interpreter brokers patient–provider communication in person). This is frequently the case in the UK. In the other MSs in this study (Germany, Greece, Italy and Spain), professional interpreters are less frequently used, although some are found in private clinics in Spain and Greece. Professional face-to-face interpreting is usually reserved for situations in which the patient needs to communicate with the doctor or healthcare professional directly about medical assistance or treatment. It is not provided, for example, when informing patients about their rights and conditions related to cross-border healthcare. In all the MSs it was reported that non-professional ad hoc interpreters also perform face-to-face interpreting. This has been reported as a practice in the UK (Cambridge 1999) as well as in other countries (Flores *et al.* 2003; Angelelli 2004, 2012, 2014; Baraldi and Gavioli 2012). In Germany, Italy and Spain we noticed a preference for cultural mediators (Martín and Phelan 2010) over interpreters. When we inquired about this preference we were told that ‘interpreters deal with language and mediators know about culture, medicine and language and they can also help patients get familiar with the national healthcare system/practices because they are locals.’ (Informant 3, Italy). In Italy an abundance of companies offer mediation services, and discussions about integrating the figure of the language mediator into the law are current.

Informants in the UK repeatedly discussed the advantages of professional face-to-face interpreting. They reported that it (1) fosters the necessary climate of confidentiality, trust and understanding, (2) is preferred for more complex interactions, (3) avoids recurrent visits due to partial comprehension of treatment, (4) allows for continuity of care and (5) helps to prevent misunderstandings. However, informants interviewed in Germany, Greece, Italy and

Spain noted several disadvantages, in that it (1) cannot always be guaranteed for all language combinations, (2) is costly, (3) requires administrative coordination and may require waiting time (4) and takes more time than a monolingual consultation, and that (5) providers are not always sure about the professionalism of interpreters, especially in less commonly spoken languages.

The advantages and disadvantages of face-to-face interpreting provided by non-professional, ad hoc interpreters were also reported. Saving on cost was a reported advantage but a frequently cited disadvantage was that providers are apprehensive about trusting the quality of information received. There was thus concern about the potential negative implications for health outcomes.

5.5.2 Videoconference interpreting

Of all sites visited, videoconference interpreting was more the exception than the norm. It was found in few private clinics (e.g. British Site 5, Greek Site 1, Spanish Site 7) and in public ones (British Informant 9 and British Site 11). In the private clinics we observed (Greek Site 7) videoconference interpreting is used as a preferred way to respond to detailed inquiries, to describe services and for introductory consultations involving paperwork, etc. It is also used during pre-treatment when patients have not yet arrived in the treatment MS or for follow-ups after they have returned to their home MS.

One public institution in the UK that was part of the study (British Site 5) has implemented videoconference interpreting because it provides service over vast rural regions and islands of northern Scotland. Interpreters are not always able to travel to meet with patients on-site, especially in extreme winter weather conditions. To solve this logistical problem the site 'has invested in videoconference interpreting and currently has 100 Conference Call Units available for use' (British Informant 9).

Informants acknowledge the advantages of videoconference technology; however, their most frequent objection is that it requires a minimum technical infrastructure that many health centres and hospitals are unable or unwilling to put in place. Although videoconference interpreting is a cost-effective solution in terms of language support, the initial investment for the required infrastructure is not feasible yet for many public health institutions visited in all five MSs.

5.5.3 Telephone interpreting

Telephone interpreting has been found to be popular in Germany, Spain and the UK. This type of language support is barely used in Greece and Italy. It is a very common option for providing language services to patients who speak less frequently used languages. The reported advantages of telephone interpreting are that (1) it can provide greater access to a large range of language combinations with less sophisticated technology (even if it means passing the headset between patient and provider) and (2) patients feel less uncomfortable having certain examinations and procedures performed (telephone interpreting is less obtrusive than face-to-face). Emergency operators in Spain who participated all echoed the need to have a direct connection with a phone-interpreting agency to avoid losing critical time. However, reported disadvantages are that it (1) requires a minimum training for the healthcare staff and a greater effort from all speakers, (2) limits the conversation to two speakers, because conversations with more parties become difficult to manage, and (3) the interpreter loses contextual and non-verbal information.

5.6 Providers of language support

In the participating MSs we find a continuum of providers, ranging from professional translators, interpreters, cross-linguistic communicators and cultural mediators to non-

professional ad hoc bilinguals (or alleged bilinguals). The latter are brought in to broker communication on the basis of their language skills and their affiliation with the healthcare organisation (e.g. hospital employees such as receptionists, nurses, cooks, technicians, janitors) or familiarity with the patient (e.g. patients' relatives [including minors] or friends). When inquiring about qualifications, none of the five MSs who stated that they use ad hoc translators or interpreters knew of these ad hoc language brokers having any formal education or training in either translation, interpreting or culture/language mediation, or even languages.

In this study we have observed four categories of individuals who deliver language services. They are discussed in turn the following subsections.

5.6.1 Hired/in-house professional translators/interpreters

Apart from in the UK, professional in-house interpreters and translators are the exception rather than the norm in the majority of sites visited. In some MSs (e.g., Spain) there are examples of bilingual staff who consistently provide T&I services, although not in private clinics. For patients travelling under Directive 2011/24/EU, professional interpreters and translators are even less common, due to language combinations that are not frequently sought within the healthcare setting. The more usual combinations were determined by various factors: demographics and trends of migration (UK, Italy, Spain), tourism (Spain), bilateral agreements between countries (Germany and Spain) and border proximity (France–Germany), etc. Since these translators/interpreters have a permanent position and their work is mainly carried out in a health centre or hospital, they are usually specialised in health interpreting/translation.

5.6.2 Freelance/independent contractor translators/interpreters/mediators

Freelancers are usually provided from a list of freelance language providers that health institutions contact occasionally. The study showed that in Germany, Italy and Spain they are often called on to work for the private healthcare sector. This language support solution has proven to be more flexible than the 'hired/in-house staff', since it offers the opportunity to contact a greater number of professionals from a wide variety of language combinations. This is especially so for telephone interpreters (Germany and Spain). Education in T&I is never a pre-selection criterion when calling for a freelancer; selection is mostly based on language proficiency, which is taken at face value. This may influence the quality of the linguistic services provided and may have a resulting impact on patients' rights and on professionals' work.

5.6.3 Translation/interpreting agencies and mediation cooperatives

T&I agencies and cooperatives in most cases have signed contracts with public health administrations or even with particular centres or hospitals to provide translation/interpreting services for a fixed time period. During our interviews with several agency owners in Greece, Italy and Spain, they referred to the economic crisis. They explained how contracts used to be renewed for two years, then for one year and most recently are not being renewed at all. Hospital administrators confirmed this (in all three countries) when we asked about tenders and budget line items for T&I services. For healthcare organisations, working with agencies has proven to be more flexible than working with hired/in-house staff. Agencies usually advertise a large variety of language combinations and greater flexibility to cope with 'complex' assignments (tight deadlines, large translation assignments, etc.), due to their ability to hire multiple providers at the same time.

5.6.4 Ad hoc translators/interpreters

The use of ad hoc translators and interpreters such as relatives, friends, NGO volunteers or ‘bilingual’ healthcare staff is the most common practice. This kind of solution is used for all language combinations and patient types (i.e. those receiving care under Directive 2011/24/EU, Regulation [EC] 883/2004, immigrants from non-EU countries or political refugees). In one private clinic (ES Site 7), translation and interpreting are performed only by dedicated bilingual staff members. They may or may not have a background in translation, interpreting or language and culture mediation. They are often hired on the basis of their language ability, but this is not measured. Instead, the Human Resources Department of the health centre applies other types of criteria that focus more on proving the versatility of candidates, thus making them more cost-effective (e.g. having more than one language combination, willingness to act as both translator and interpreter, etc.). As evidenced by the empirical data gathered during the observations, with the exception of two out of 108 healthcare organisations observed, the hired or contracted interpreters/translators do not hold a degree in translation and interpreting or language brokering. Many of the individuals hired have instead completed certificate programs, in-house training and professional development workshops.

Overall, the most common ad-hoc solutions implemented by the five MSs studied were as follows:

- asking the patient to have all relevant documents translated
- asking the patient to bring someone ‘who can read or speak the language’, usually a relative or a friend (in many organisations, posted signs are reminders of this need);
- asking a member of the medical staff who allegedly speaks the language of the patient or a commonly spoken language to act as an ‘interpreter/mediator’
- hiring untrained bilingual staff to perform T&I duties

- contacting an NGO to solicit translation/interpreting services from volunteers.

6 Discussion, conclusions and implications

European legislation in general, including various Regulations and Directive 2011/24/EU, do not specifically mandate language support for patients needing cross-border healthcare.

Directive 2011/24/EU describes a series of patients' rights but it does not explicitly mention the right of patients to access communication in a language they understand or through translation, interpreting or mediation. Nevertheless, the right to access communication appears to be a pre-requisite for exercising the rest of these rights. When the parties involved do not share a language, language support is needed to fulfil the requirements of the Directive (such as access to information and to safe and high quality cross-border healthcare in the Union).

The study has made several findings.

First, language support/provision for cross-border healthcare patients is neither guaranteed nor provided in an even manner across the sites observed. This inconsistency could potentially breach the spirit and objectives of Directive 2011/24/EU. It also calls into question the rights and protection of all EU citizens who may, in the course of their work, studies or travels, require medical assistance in an MS in which they do not understand the language well enough to communicate about a medical treatment/emergencies.

Second, among participating healthcare providers and administrators there is a generalised (95%) perception of English as a *lingua franca*. The assumption is that patients, healthcare providers and administrators have sufficient English proficiency to understand technical written and verbal information. In study participants' views, communication equals managing or coping if one possesses some English language ability. However, it is worth

noting that during our fieldwork, many stakeholders (at all levels) could not be interviewed in English and they did not understand consent form content.

Third, there is no consistent provision of translation for documents needed for cross-border healthcare (medical records, reimbursement, etc.). In almost all cases the responsibility for the translation of documents is placed on patients. Except for the UK, professional translation and interpreting services in the context of healthcare is not recognised as a core service, and this is not a line item in the budget. Professional T&I services are perceived as costly and not always essential (especially when compared to other medical needs, such as supplies).

Fourth, healthcare providers' perceptions of confidentiality and privacy differ from those of T&I professionals and from those found in codes of ethics (e.g. SeTIS 2016) that discuss language provision. A proportion of healthcare providers in the study (26.5%) prefer to have patients' family members as language brokers because they are perceived as having more background information about the patient and, thus, to know the patient better.

Fifth, in three of the MSs studied we identified two prevalent assumptions regarding language and culture: (1) that language and culture are not intertwined and can thus be separated ('cultural mediators deal with culture and translators and interpreters with language- Italy Informant 7); and (2) that translators and interpreters deal only with language ('the words'), not culture. Based on their previous experiences, informants in some of these MSs advocate for cultural mediators to fill this gap.

Sixth, in the absence of formal language services, the health and safety of patients are put at risk. Informants reported cases from their personal experience and many other such cases are also documented. This results in inefficiencies for the institution such as missed appointments, misdiagnoses, return visits etc., and consequently in an increased cost over the medium and long term.

In sum, the healthcare organisations observed in this study rely on different solutions in order to provide language access. However, language provision is not always offered with the same degree of quality. Professional services may be available but institutions also turn to non-professional and untrained translators and interpreters for the provision of language services, which could adversely affect quality. Ethical considerations thus become relevant: in the absence of professional translation and interpreting services patients are prone to receiving inferior or inadequate care and their health may be placed at risk. Thus it is imperative that healthcare institutions consider who provides language support in order to maintain acceptable levels of quality.

As regards implications, the findings of this study first and foremost have implications for policy and policy makers. Legislation is a key element that determines the provision (or lack thereof) of quality language support in cross-border healthcare specifically and healthcare in multilingual Europe in general. At the EU level, while legislation has acknowledged a series of rights for EU patients, it has not taken into consideration the need for language support to exercise those rights. This merits attention.

The results also have several implications for current conceptualisations of language support and the provision thereof both for policy makers and for healthcare providers/administrators. Improvised practices by ad hoc bilinguals or volunteers are neither an appropriate nor a reliable form of language support. In a multilingual mobile EU, allowing the implementation of ad hoc communicative solutions that may put at serious risk the life, health and rights of EU patients needs to be re-considered. Volunteers, ad hoc translators or bilinguals acting as language providers in the field of cross-border healthcare (and public service interpreting in general) may lack education in translation, interpreting or intercultural communication/ mediation, and may not have had any specialised training in healthcare

settings. When minimum quality standards cannot be guaranteed there may be implications for the protection of patients as well as serious consequences for their health and choices.

The results have further implications for healthcare providers, administrators and patients. Healthcare providers and administrators who assist linguistically and culturally diverse patients sometimes perceive a different language or a different culture as a barrier or a problem. This also deserves some ethical consideration. Patients coming from a different cultural/linguistic backgrounds do not automatically pose a problem. The problem is created when we, as a society, do not make use of the existing expertise and communicative possibilities we have and thus create inequality simply because the average citizen would not require them. In addition, when it comes to healthcare, expertise is not always shared. Policy makers, healthcare providers, language service providers and patients do not have the same degree of expertise at all the different levels discussed in this paper. They may not all always understand what is mandatory and what is optional (e.g. seeking healthcare in the home MS or in another MS). They may not understand the difference between a professional language provider, an ad hoc one or a software in the making. These differences in how expertise is conceptualised across all parties may lead to undesired inequalities. A diverse Europe calls for a more responsible response to linguistic diversity to provide access to cross-border healthcare to all EU citizens/residents.

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Endnotes

- 1 This study was conducted in 2014–2015, before the BREXIT referendum.
- 2 For the text of Directive 2011/24/EU, see <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2011:088:0045:0065:en:PDF>
- 3 Examples of EU projects related to T&I are: Aequitas (Hertog 2001), the Aequalitas project (Hertog 2003), the Building Mutual Trust I project (Townesley 2011), the TRAFUT project (EULITA 2011) or the Co-Minor-IN/QUEST project (CO-MINOR 2012), among others.
- 4 In this report the terms ‘language provision’ and ‘language access’ refer to translation and interpreting services in all languages, whether sign or spoken.
- 5 For the text of Regulation (EC) 883/2004, see <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2004:166:0001:0123:en:PDF>
- 6 This provision was introduced by the Treaty of Amsterdam as Article 13 (Deakin and Morris 2012: 650)
- 7 For the text of Directive 2010/64/EU, see <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2010:280:0001:0007:en:PDF>
- 8 For further information on the larger study the reader is directed to Angelelli 2015.
- 9 For details of the UK’s Equality Act 2010, see <http://www.legislation.gov.uk/ukpga/2010/15/contents>. Also: Welsh Statutory Instruments 2011 No. 1064 [W.155] (http://www.legislation.gov.uk/wsi/2011/1064/pdfs/wsi_20111064_mi.pdf) and The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 (<https://www.legislation.gov.uk/sdsi/2012/9780111016718/contents>).

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Table 1: Cities and Towns visited per MS

Member State	Cities and Towns
Germany	Berlin, Bonn, Cologne, Coppenbrügge, Cuxhaven

Greece	Athens, Chania, Farkadona, Katerini, Larisa, Litothoro, Trikala, Vamos
Italy	Bologna, Reggio Emilia, Forli, Milan, Modena, Naples, Rome, San Chirico Rapparo, Verona
Spain	Benidorm, Gandía, Lalín, Madrid, Santiago de Compostela, Tui, Valencia, Vigo, Vilajoiosa
UK	Aberdeen, Belfast, Cardiff, Dungannon, Edinburgh, Glasgow, London, Swansea

Table 2: Types of sites visited per Member State

Sites	Germany	Greece	Italy	Spain	UK
National Contact Point	1	1	1	1	2
National Ministry of Health	1	1	1	1	1
Regional Ministry of Health / Regional Health Authorities	4	0	2	2	2
University – T&I Programmes	1		3	1	1
Policy maker offices	2	1	2	2	3
Law offices	2	2			1
Consumer rights office/NGOs	1	2	0	3	2
Community centre	1	2	1	0	1
Hospital (urban)	2	5	2	3	6
Hospital (rural)	3	3	1	2	0
Healthcare centre	2	3	1	3	1
T&I Professional Associations	1	2	2	0	0

Software Developer	0	0	0	1	0
T&I agencies	1	2	1	3	3
Cultural mediation agencies	1	0	3	0	0
TOTAL	23	24	20	22	23

Table 3: Informants interviewed per Member State

Informants	Germany	Greece	Italy	Spain	UK
National Contact Point	1	1	8	2	5
Policy makers	6	2	2	2	2
Lawyers	3	1	1	1	2
NGO officers	1	4	1	3	3
Healthcare providers	9	10	8	1	6
Healthcare administrators	1	4	2	11	6
Researchers in Healthcare communication	2	2	4	1	2
Insurance companies	1	N/A	N/A	N/A	N/A
T&I association presidents	1	1	1	0	0
Medical association representatives	1	1	1	1	2
Social worker	1	1	1	1	1
T&I agency owners/managers	2	2	1	3	1
Institutional T&I management	1	0	0	0	6
Freelance translators	3	3	3	2	2
Freelance interpreters	3	2	3	3	2

In-house interpreters	0	0	0	3	2
Software developers	0	0	0	1	0
Cultural mediators	1	3	3	1	0
Patients and family members	0	2	2	2	3
T&I students	2	1	2	2	2
TOTAL	39	40	43	40	47

Table 4: Reported delivery models of language provision (Yes = reported as being used; No = not reported as used)

Delivery Models	Germany	Greece	Italy	Spain	UK
Translation					
Human	Yes	Yes	Yes	Yes	Yes
Machine-assisted	Yes	Yes	No	Yes	No
Interpreting/mediation					
Face-to-face	Yes	Yes	Yes	Yes	Yes
Telephone	Yes	Yes	Yes	Yes	Yes
Videoconference	No	Yes	No	No	Yes

Figure 1: Remote vs. face-to-face interpreting in participants' workplaces

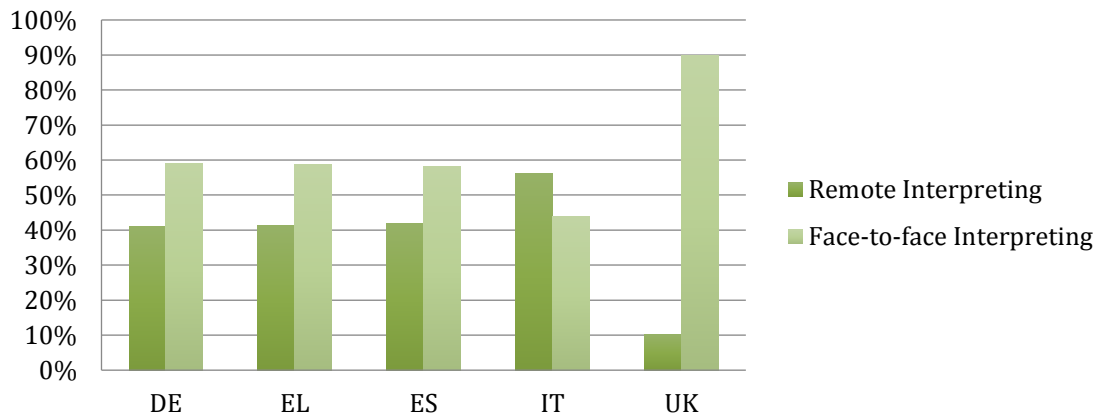


Figure 2: Percentage of interpreters asked to perform translations in participants' workplaces

