

## **Translocations: Migration and Social Change**

An Inter-Disciplinary Open Access E-Journal

ISSN Number: **2009-0420**

---

### **Interpreters and Cultural Mediators – different but complementary roles**

**Mayte C. Martín and Mary Phelan**

Cultural Mediation Consultant; Lecturer, School of Applied Language and Intercultural Studies, Dublin City University email: [maytecalvo@gmail.com](mailto:maytecalvo@gmail.com); [mary.phelan@dcu.ie](mailto:mary.phelan@dcu.ie)

---

#### **Abstract:**

This article considers the roles of medical interpreters and cultural mediators and proposes that the two should be seen as separate. In the last six years cultural mediators have been trained in Ireland not to be interpreters but to help immigrants from other countries to access and use healthcare services as well as mediating in situations of conflict between health service providers and patients. Meanwhile, interpreters have been hired to bridge the language gap. Codes of ethics for medical interpreters and competencies of cultural mediators are considered in order to clarify role boundaries and to explore similarities and differences between the two roles.

**Keywords:** cultural mediation, interpreting, medical interpreter, ethics, impartiality, professionalism, culture, accuracy.

---

#### **Introduction**

Medical interpreting and cultural mediation are emerging professions in Ireland where large-scale immigration is a relatively recent phenomenon, and as a result the boundaries of both roles have been unclear and confusing for many health service providers. While there has been some uptake of the services of interpreters, the uptake of cultural mediators has been very limited. The service offered by cultural mediators has been in existence for six years and only some health providers have had the opportunity to avail of them. Notwithstanding the limited availability of cultural mediators, the need for both roles has already been highlighted by the Irish health services. The Health Service Executive *National Intercultural Health Strategy 2007-2012* found that ‘cultural mediation has a role in promoting interculturalism in the health service’ and that ‘consideration should be given to ways of optimally using cultural mediators at community level’ (2008: 98). It acknowledged that interpreting services were ‘available on a patchy and fragmented basis across the country, at both hospital and community level, with limited evidence around its quality, effectiveness, appropriateness or service user/service provider satisfaction’ (2008: 101) and recommended the establishment of a national interpreting service (2008: 100). The Strategy acknowledged the importance of both cultural mediation and interpreting in enabling service users from different cultural and linguistic backgrounds to access healthcare.

While the Health Service Executive has shown some understanding of the potential benefit of providing both cultural mediation and interpreting services, there is considerable confusion across Europe about the exact role of cultural mediators. The term 'cultural mediation' is sometimes used as a blanket term to cover both translation and interpreting and the terms interpreter and cultural mediator can appear synonymous. In France, Italy and parts of Belgium and Germany the terms interpreter, cultural mediator and, also intercultural mediator are used interchangeably and the role boundaries are unclear, especially to outsiders. Pöchhacker draws attention to 'the inherent ambiguity and confusion that may result from the equation of 'interpreting' and 'mediation' and to the consequences of this indefiniteness for progress in the field of community interpreting' (2008: 21).

As trainers and researchers in interpreting and cultural mediation<sup>1</sup>, feel that now is an appropriate time to discuss the roles of medical interpreters and cultural mediators. There is much discussion and debate internationally about these and in this essay we provide our views based on our professional experience and practice in the Irish context. For us, the roles of medical interpreter and cultural mediator are complementary and distinct. The ability to speak two languages does not make an interpreter. Similarly, familiarity with two cultures does not make a cultural mediator.

In this essay we will focus on medical interpreting, the role of interpreters, training, and codes of ethics. Under the heading of ethics we will examine the core principles of confidentiality, impartiality, accuracy, professionalism and the more controversial issue of advocacy. Then we will move on to an explanation of cultural mediation, the need for cultural mediators, their role, training, codes of practice and how their core principles resemble or differ from those of interpreters. Finally, we will consider situations when an interpreter is required and situations when a cultural mediator is required.

## **Medical interpreting**

Medical interpreting is the provision of interpreters in healthcare. Patients who are not proficient in the language of the country where they live often depend on family members and friends to act as interpreters for them when they access healthcare but this raises issues relating to confidentiality and also to the accuracy of the information being conveyed by people who are doing their best to help but are not trained interpreters. Bilingual staff may act as interpreters but this may also have an impact on confidentiality and accuracy. Consequently it is more appropriate to hire qualified interpreters to work face to face or over the phone or to recruit staff interpreters.

---

<sup>1</sup> Mary Phelan currently lectures and researches in interpreting in DCU. She has participated in the training of cultural mediators and was a partner in the Roma Cultural Mediation project. Mayte C. Martín has managed several EU funded cultural mediation projects including the Roma Cultural Mediation Project funded by EQUAL. Previously, she worked as an interpreter and lectured in interpreting in DCU.

In the United States, interpreters must be provided by law to patients who have limited proficiency in English and who are being treated in a hospital that receives Federal funding. In Northern Ireland, medical interpreters are provided under anti-discrimination laws and doctors are told that they have a legal duty to provide interpreters. However, in other countries there may be no provision at all. There is great variation in the provision of medical interpreters from country to country and in the training and testing of interpreters who work in this sector.

In Ireland interpreting is an unregulated profession and anyone can call themselves an interpreter even if they have no qualification in the area. It is often assumed that family members, children, friends, security guards, canteen staff and cleaners who speak English and the foreign language can interpret. A further complicating factor is the absence of a clear legal right to an interpreter in healthcare in Ireland (Phelan, 2009). When interpreters are provided they are often unqualified and recruited merely because they speak English and another language. Qualified interpreters, whether trained in Ireland or abroad, are not necessarily prioritised for work.

### *The role of medical interpreters*

The medical interpreter's role is to bridge the language barrier. This involves conveying the information accurately and as completely as possible. It does not mean interpreting on a word by word basis but rather the transfer of meaning. The interpreter is needed to enable communication to take place between the healthcare professional (HP) and the healthcare user (HU). If HPs cannot communicate with patients then they cannot provide a professional, effective service. Similarly, patients who cannot communicate cannot explain their symptoms, provide a medical history or ask questions. Informed consent is a particularly important issue; if HUs cannot understand the implications of a procedure or an operation, then they cannot give informed consent.

Medical interpreters working in Ireland should have an excellent knowledge of both English and the foreign language. They must also have the ability to interpret what they hear accurately. This is a difficult task – the interpreter listens to what is said in English and then interprets the information in the foreign language. Medical interpreters have to keep switching languages, something that makes the task even more difficult.

Medical terminology can be particularly challenging because it is such a diverse area. In an ideal situation interpreters would be informed of the nature of an assignment in advance and would have time to read parallel texts in English and the foreign language, look up information on reputable Internet websites and prepare terminology. Unfortunately the more likely scenario is that an interpreter will be called urgently to an appointment and will not receive any information on the nature of the assignment. Medical interpreters also need to be aware of role boundaries and how to behave in accordance with the code of ethics for interpreters which we will discuss in more detail below.

In the literature on medical interpreting, culture occasionally appears as an issue as in the case of a study by Dohan et al on the issue of disclosure of a diagnosis of cancer to elderly Russian patients where family members felt that this would mean that the

patient would give up all hope. However, this preference is not necessarily confined to Russian people; it may well be the case that some Irish families would prefer not to inform an elderly relative of a diagnosis of cancer. The literature includes few examples of cultural issues arising and leading to an explanation or clarification from the interpreter. According to Hale, ‘..cultural differences can be varied and complex and [that] interpreters need to be confident that the cause of the misunderstanding is a cross-cultural issue before deciding to offer an explanation.’ (2007: 134) Similarly, Angelelli believes that ‘the role of cultural clarifier may prove to be unrealistic, since the concept of culture is too broad to be applied universally’ (2006: 185). If we take the example of a French interpreter from France in Ireland interpreting for a French speaker from Cameroon or Burkina Faso or Ivory Coast – how can the interpreter possibly have the requisite cultural knowledge to be able to clarify cultural issues that arise? In such a case best practice would involve the HP asking the HU for clarification. Some Codes of Ethics for interpreters cover the issue of culture:

Under certain conditions, such as clashing cultural beliefs or practices, a lack of linguistic equivalency, or the inability of parties to articulate the differences in their own words, the interpreter should assist (with the explicit consent of all parties to this intervention) by sharing cultural information or helping develop an explanation that can be understood by all. (National Council on Interpreting in Health Care NCIHC National Code of Ethics)

While a community interpreter is expected to have a general understanding of the cultural background of both parties s/he is not a cultural expert and should be wary when offering cultural advice. (Irish Translators’ and Interpreters’ Association ITIA)

### *Medical interpreting - training*

There is a great deal of variation in interpreter qualifications with systems varying from for example the Diploma in Public Service Interpreting from the Chartered Institute of Linguists in the United Kingdom to a planned new M.A. course at the University of Sussex to accreditation from the National Accreditation Authority for Translators and Interpreters Inc (NAATI) in Australia to short courses in other countries. As yet there is no standard across Europe for medical interpreters.

In contrast, in the United States, there are currently three separate plans for a national certification system. They are the National Board of Certification for Medical Interpreters<sup>2</sup>, the Certificate Commission for Healthcare Interpreters (CCHI)<sup>3</sup> and the National Coalition on Healthcare Interpreter Certification (NCHIC)<sup>4</sup>.

The Graduate Certificate in Community Interpreting course at Dublin City University is the only third level interpreting qualification available in Ireland. The course consists of four modules taught over one semester with a total of 100 contact hours.

---

<sup>2</sup> <http://www.certifiedmedicalinterpreters.org/>

<sup>3</sup> <http://www.healthcareinterpretercertification.org/>

<sup>4</sup> <http://www.ncihc.org/mc/page.do?sitePageId=61824&orgId=ncihc>

Introduction to Interpreting covers the different modes of interpreting, what is expected in different settings and evidence from research. The Ethics module considers codes of ethics for interpreters, role boundaries and ethical dilemmas. The Terminology module helps interpreters prepare for assignments by focusing on how best to find correct terms and what to do when there is no term in one language. Most importantly, the students have four hours of interpreting practice per week. The classes are divided up by language and have an experienced tutor who can provide feedback on students' interpreting and how it can be improved. Interpreters have been trained for Polish, Russian, Romanian, French and Spanish.

### *Medical interpreting - code of ethics*

While codes of ethics are not a substitute for a proper training programme, training in ethics is an important element of training for both interpreters and cultural mediators. The codes of ethics for interpreters and cultural mediators have many principles in common but also some important differences. To facilitate our exploration of the similarities and differences between the roles of interpreters and cultural mediators we will first examine codes of ethics for interpreters and later in the article we will examine the key ethical principles that apply to cultural mediators.

Codes of ethics for interpreters usually cover a number of key points: confidentiality, impartiality, accuracy and professionalism. They provide guidance to interpreters on how to behave but of course there will always be unexpected situations where the interpreter will have to decide on the most appropriate and ethical way to behave. A code of ethics on its own is not enough; interpreters need to tease out the issues involved in ethical dilemmas and decide on the most appropriate action. This should form part of their training. Familiarity with a code of ethics is very useful when an interpreter is in doubt because interpreters rarely have time to consult colleagues about the best course of action; they have to come to a decision immediately.

Most codes of ethics for interpreters are common codes that encompass conference, legal and medical settings. This is the case for the codes of the Chartered Institute of Linguists and AUSIT. In the United States specific codes for medical interpreters have been developed by the National Council for Interpreting in Health Care (NCIHC) and the International Medical Interpreters' Association (IMIA). The NCIHC Standards of Performance provide more detailed information and examples than a code of ethics.

Angelelli writes that:

All principles laid down in codes of ethics or standards of practice should be empirically grounded and tested, rather than prescribed or assumed. (2008: 159)

Without empirical grounding, documents and training developed by professional associations result in professional ideology which many times may be at odds with the reality of the workplace. (2008: 158)

However, the idea of basing a code of ethics on the way interpreters behave in the workplace is problematic if it includes empirical data from the practices of untrained interpreters who may not be aware of a code of ethics or may choose not to abide by

such a code. Hale (2007: 104) noted that untrained interpreters were less likely to appreciate the value of a code of ethics and to understand its ramifications.

There are also issues around what happens if an interpreter does not abide by the code of ethics. What should happen in such a case? AUSIT has a Board of Professional Conduct which deals with complaints. The Chartered Institute of Linguists has a disciplinary framework and procedures. It is important to have procedures in place for exceptional cases where problems arise. It is also essential that interpreters are given an opportunity to explain their actions.

#### *Medical interpreting - code of ethics - confidentiality*

Interpreters and translators shall not disclose information acquired during the course of their assignments. (AUSIT code of ethics)

Confidentiality is absolutely essential in medical interpreting. When a HU consults a doctor or attends hospital they do so in the belief that HPs will not discuss their situation with non-professionals. Similarly, if an interpreter is required, HUs and HPs need to be certain that the interpreter will not discuss their assignment with other members of their language community. For this reason it is essential that interpreters establish a relationship of trust with all parties. It is good practice for interpreters to briefly explain their role at the start of an assignment and to emphasise that they will respect confidentiality. Some HUs prefer to have a telephone interpreter because they feel that this helps ensure confidentiality. Disclosure of information can have serious consequences for HUs. The authors have come across cases where untrained interpreters disclosed confidential information to other members of the HU's community, thereby causing great distress.

#### *Medical interpreting - code of ethics - impartiality*

Impartiality implies that interpreters will treat all parties equally. The Chartered Institute of Linguists Code of Conduct also mentions neutrality, the idea that the interpreter is not engaged on either side. Interpreters should not interpret for friends or relations or anybody else for whom they cannot be impartial. In addition, they are not supposed to provide advice to HUs. If there is a conflict of interest, the interpreter must withdraw from the assignment.

Interpreters will refrain from accepting an assignment when family or close personal relationships affect impartiality. (International Medical Interpreters Association IMIA 2006)

Interpreters and translators shall observe impartiality in all professional contracts. Professional detachment must be maintained at all times. If interpreters or translators feel their objectivity is threatened, they should withdraw from the assignment. (Australian Institute of Translators and Interpreters Inc AUSIT Code of Ethics General Principles)

Practitioners carrying out work as Public Service Interpreters or Conference Interpreters, or in other contexts where the requirement for neutrality between parties is absolute, shall not enter into discussion, give advice or express opinions or reactions to any of the parties that exceed their duties as interpreters (Chartered Institute of Linguists Code of Conduct)

Personal biases or beliefs could arise in many medical interpreting scenarios. Some interpreters may find it difficult to interpret for people who are from their culture but do not conform to religious tenets. Contraception could be an issue for some interpreters, abortion another. Interpreting for victims of sexual abuse is difficult, particularly if the interpreter is exposed to vicarious trauma. Some interpreters may find it difficult to interpret for gay, lesbian and transsexual people. We all have prejudices but medical interpreters need to be aware of those prejudices and to find ways to carry out their work without making those prejudices apparent. Of course if an interpreter's prejudices mean that he or she is not capable of impartiality then he or she should withdraw from the assignment. Interpreting for someone who has been in a serious accident, for parents of someone who has just died, telling a patient that he is terminally ill – there are many difficult situations to be faced.

The interpreter maintains the boundaries of the professional role, refraining from personal involvement. (NCIHC National Code of Ethics)

Interpreters can come under pressure from both HUs and HPs. In some cases the HUs assume that the interpreter, who speaks their language and may be from the same country, is an ally who will help them. Interpreters tell us that bedridden patients ask them to purchase items for them in the hospital shop. One interpreter told us that she drove a discharged patient to the bus station because he did not know how to get there and had no money to pay for a taxi. It can be very difficult for interpreters to refuse to help their compatriots in such circumstances. The danger is that such personal involvement makes impartiality very difficult. Best practice would involve interpreters actively avoiding situations where they are left on their own with HUs but it must be acknowledged that this can be difficult in a hospital environment.

Giving advice is particularly dangerous in a medical setting because the interpreter could provide incorrect information and put a patient's life at risk. It is the doctor's job to advise the HU and if necessary to refer him or her to another specialist. Interpreters are hired to interpret, not to provide medical advice. When interpreters move out of their role of bridging the language barrier, they are moving into a very grey area for which they are unqualified and where they may in fact cause harm.

Interpreters will not interject personal opinions or counsel patients. (IMIA: 2006)

The interpreter limits his or her professional activity to interpreting within an encounter. For example, an interpreter never advises a patient on health care questions, but redirects the patient to ask the provider. (NCIHC Health Care Standards of Performance)

The interpreter strives to maintain impartiality and refrains from counselling, advising or projecting personal biases or beliefs. (NCIHC National Code of Ethics)

Some interpreters may feel that they are being paid from hospital funds, they were called by HPs and they should do everything they can to facilitate HPs. This problem is exacerbated by the aforementioned confusion around the nature and boundaries of

the role of medical interpreters among HUs and HPs. HPs can also put pressure on interpreters to move outside their role boundaries:

For example, it is difficult for interpreters to reconcile the ethical principle of impartiality when in many healthcare agencies where they work they are asked to play the role of an advocate or a social worker. (Angelelli, 2008: 150)

Most HPs in Ireland have received no training in how to work with interpreters and as a result do not have a clear understanding of the exact role and functions of the interpreter. Many interpreters have experienced situations where a HP asks them what they think of a HU's symptoms or situation. When this happens, the interpreter should politely explain that he or she is not qualified to assess a patient or confirm a diagnosis.

### *Medical interpreting - code of ethics - accuracy*

As Mikkelsen points out, 'The interpreter's very difficult role is to attempt to understand the intention of the utterance and portray it as faithfully as possible in the other language' (2008: 115). Accuracy involves working on the level of meaning rather than on a word for word level and is a key feature of codes of ethics for interpreters. According to the ITIA code, 'Accuracy is essential to ensure the transfer of an undistorted message.' The IMIA code mentions that 'Interpreters will select the language and mode of interpretation that most accurately conveys the content and spirit of the messages of their clients.' The NCIHC Code focuses on omission and distortion of messages:

Interpreters need to remember that everything that is said is a potential source of data. Offensive language use by a patient may sometimes be part of their condition. If the interpreter omits such language, the provider is losing a valuable piece of data that could lead to the appropriate diagnosis. (NCIHC National Code of Ethics)

But in no instance should interpreters decide to omit or distort messages because these are personally offensive to them or because they are uncomfortable with the language or content of the message. (NCIHC National Code of Ethics)

In medical settings where doctors and other staff are under pressure of time, they may encourage interpreters to summarise information or just to interpret what they consider important. This can mean that the HU's voice is not heard. It can also mean that the HPs lose access to potentially important information. When an interpreter is expected to summarise, he or she has to make a decision as to what information is important and what can be omitted but he does not have the medical expertise to be able to do this. In contrast, a HU who speaks English and does not need an interpreter is free to speak about as many irrelevancies and problems as he or she wishes. The doctor selects the relevant elements in order to work out the nature of the problem.

### *Medical interpreting - code of ethics - professionalism*

For interpreters, professionalism includes arriving on time for appointments, interpreting accurately, dressing appropriately and keeping up to date with terminology.

Interpreters will refrain from accepting assignments beyond their professional skills, language fluency, or level of training. (IMIA)

Practitioners who are interpreters shall only carry out work which they believe is within their linguistic and the relevant specialist competence. (Chartered Institute of Linguists Code of Conduct)

Medical interpreters are regularly faced with situations where appointments run on longer than expected, making the interpreter late for the next assignment, where the HU does not in fact speak the interpreter's language, or where the interpreter is faced with an unexpected specialised area of medical terminology. It is very important for interpreters to be aware of their own limitations and to be prepared to alert HPs to them. In Ireland we have come across cases where Polish interpreters are asked to interpret for Slovak HUs. The interpreters are often reluctant to do this work but in some situations they may agree because they fear that otherwise the Slovak speaker will be left with no interpreter.

Interpreters who live in small towns or villages may bump into clients in the course of their everyday life and will have to show their professionalism by being polite and acknowledging people but also by being very careful not to be drawn into personal conversations which could affect the interpreter's impartiality at a future date.

### *Medical interpreting – code of ethics - advocacy*

Advocacy is the most controversial element of codes of ethics for interpreters. The Chartered Institute of Linguists Code of Conduct (2007), the AUSIT code of Ethics and the Irish Translators' and Interpreters' (ITIA) Code of Ethics for Community Interpreters make no mention of advocacy. After all, it is difficult to reconcile advocacy with impartiality because if impartiality is to be a central tenet of a code of ethics, it is evident that an interpreter cannot advocate for the HU. However, the IMIA and NCIHC, both American organizations, do cover this topic perhaps in part because they are specific guides for healthcare settings rather than codes applicable to interpreters working in all settings. There is no leeway or flexibility for interpreters who work in legal situations such as police stations and the courts; impartiality is a key aspect of their role. However, at least in the American system, there does seem to be some acceptance that in exceptional circumstances, medical interpreters can temporarily put aside impartiality and act as an advocate:

Interpreters will engage in patient advocacy and in the intercultural mediation role of explaining cultural differences/practices to health care providers and patients only when appropriate and necessary for communication purposes, using professional judgment. (IMIA: 2006)

Merriam-Webster's Online Dictionary defines advocacy as 'the act or process of advocating or supporting a cause or proposal'. The IMIA seems to conflate 'patient advocacy' and 'the intercultural mediation role' which could lead to confusion but

their code does specify that such roles should be restricted to 'when appropriate and necessary for communication purposes'. It is unfortunate that 'professional judgment' is subjective and vague. The NCIHC code explains what they mean by advocacy:

When the patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must be undertaken only after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem. (NCIHC National Code of Ethics)

The idea of advocacy is couched in careful language and the NCIHC code advises that other measures be tried first. Examples of cases where advocacy was appropriate would be helpful but such examples are not generally included in codes of ethics.

The act of advocacy should derive from clear and/or consistent observations that something is not right and that action needs to be taken to right the wrong. On a deep level, advocacy goes to the heart of ethical behaviour for all those involved in health care – to uphold the health and wellbeing (social, emotional and physical) of patients and ensure that no harm is done. (NCIHC National Code of Ethics)

To some extent the NCIHC envisages the interpreter taking over the role of the doctor or other health professional. After all, the doctor's first duty is to do no harm. The NCIHC standards of performance provide more detail:

Ethical Principle: When the patient's health, well-being or dignity is at risk, an interpreter may be justified in acting as an advocate.

31. The interpreter may speak out to protect an individual from serious harm.

For example, an interpreter may intervene on behalf of a patient with a life-threatening allergy, if the condition has been overlooked.

The idea that the interpreter should intervene about a life-threatening allergy is fine if the interpreter happens to realise that this is an issue. However, it is the job of the HP to take a medical history and to refer to it when deciding on treatment. We think that this example places a big responsibility on the interpreter who does not have written records and is reliant on memory.

32. The interpreter may advocate on behalf of a party or group to correct mistreatment or abuse.

For example, an interpreter may alert his or her supervisor to patterns of disrespect towards patients. (NCIHC Health Care Standards of Performance)

Interpreters can find it very frustrating and upsetting when they come across situations where they feel the HU is not being treated properly by the HP. However, in many hospital settings it is very difficult for them to know whom to complain to and translation agencies which provide work will probably not be particularly interested

or helpful. In countries where interpreters are hospital employees it may be easier for the interpreter to highlight problem cases.

## **Cultural Mediation**

### *The need for cultural mediators*

Schott and Henley define culture as “a set of norms, values, assumptions and perceptions (both explicit and implicit), and social conventions which enable members of a group, community or nation to function cohesively” (2003, 1996: 3). Culture provides us with a specific way of viewing and understanding the world around us and is the context in which we insert everything we say and do.

Similarly, our cultural background will determine how we view health and health care, what affects our health status as well as who should deliver health services. Where to get health services and what to expect from them is also influenced by our cultural background as is how we interact with HPs.

Sharing the same language is not the only key to establishing a satisfactory interaction between HPs and HUs. We also communicate through non-verbal messages. Gestures, for example, form part of our cultural heritage and we use them constantly to convey messages. Communicating effectively is often not an easy task; our everyday interactions are filled with misunderstanding and frustrating situations even when we share linguistic and cultural backgrounds with our counterparts.

These differences will often result in conflicting relationships and communication breakdowns between HPs and HUs. The different cultural background, however, is not the only reason for conflict. The socioeconomic and informational barriers often suffered by the HUs, added to the prevalence of stereotypes and prejudices within the system, can render access to health services difficult for many families.

Cultural mediation is required when lack of cultural awareness and understanding of the system is the main impediment for the migrant population to access and benefit from health services. HUs might, for example, try to access the emergency unit in hospitals when they feel the need of medical attention even if it is not an emergency. Particular roles of HPs might be new to HUs such as the role of public health nurses. Some HUs might be reluctant to follow recommendations from HPs who are women. In a similar way, HPs might find it difficult to keep their professional distance when they think they have been disrespected or ignored. Erroneous assumptions and judgemental attitudes from both HUs and the HPs often cause their interactions to be conflicting and tense. Engaging cultural mediators can prove useful to manage these interactions. Cultural mediators (CMs) facilitate a constructive relationship between HPs and HUs as well as fostering mutual understanding and intercultural competence. Preventing conflict is as important a part of a CM's job as is mediating in situations where conflict has already erupted.

### *The role of cultural mediators*<sup>5</sup>

The tasks that CMs perform are several and varied. They need to be able to assess a situation and propose a plan of action all the while including both parties<sup>6</sup>. Cultural mediators help HPs to understand and be aware of cultural practices which might have a bearing on the way HUs approach the health services. They are also a resource to inform patients of their entitlements and the way the health system works and how it should be accessed. In addition, CMs play an important role in empowering patients, by informing them and encouraging them to voice their needs and concerns. CMs also help HPs to monitor the progress of their patients and ensure that there is appropriate follow-up. When several services are involved, CMs can also act as a point of contact and a link between HPs and their patients.

It is the responsibility of cultural mediators to create a space of dialogue in which HPs and HUs can establish an effective and respectful relationship. This role often requires CMs meet HPs and HUs individually before both are brought together. It is only during these encounters CMs need to convey messages between HPs and HUs if they come from different linguistic backgrounds, CMs should not, however, be expected to act as interpreters.

Conflicting relationships might also occur between HPs and HUs who share the same language but come from different cultural backgrounds. In Ireland, this is the case for many Nigerian nationals who speak perfect English but might have no knowledge of the Irish health system. In Spain, cultural mediation has been in operation for the last 15 years for the indigenous Roma population, a minority ethnic group who have suffered discrimination for centuries and who face enormous barriers when accessing health services even though their mother tongue is Spanish<sup>7</sup>.

Cultural mediators are often described as cultural brokers who can bridge two different views of health and healthcare. CMs thus become a tool to prevent conflict and a vehicle to inform services of the health needs of the different groups of population (Giménez, 1997). As a result cultural mediators could become agents in bringing about change in the healthcare services by fostering equality and fairness. By steering HUs to use the proper services and HPs to better understand HUs' needs, CMs also help to increase effectiveness in healthcare.

### *Cultural mediators - training*

---

<sup>5</sup> For case studies of cultural mediation, please see *Fitting In: How Cultural Mediation Supports the Integration of the Roma Community in Ireland*, Funded under the EQUAL Community Initiative, <http://www.ideasbank-equal.info/files/FittingIn.pdf>

<sup>6</sup> When we mention both parties, we are referring to the Health Provider and the Health User. Even if there are several health services and family members involved in a particular case, they will usually place themselves on either side.

<sup>7</sup> Many reports document the difficulties that Roma people encounter when trying to access Healthcare in Spain. An example of such reports: *Salud y Comunidad Gitana*. Fundación Secretariado Gitano y Dirección General de Salud Pública Ministerio de Sanidad y Consumo (2004). [http://www.gitanos.org/publicaciones/SaludyCGitana/Salud\\_y\\_comunidad\\_gitana.pdf](http://www.gitanos.org/publicaciones/SaludyCGitana/Salud_y_comunidad_gitana.pdf)

Cultural mediators need to develop specific knowledge as well as people, communications and mediation skills. Cultural mediators need to be familiar with the different methodologies used in mediation and to know when and how to apply them. They also must acquire a good knowledge of the way culture and contextual factors affect the way HUs view health, and interact with HPs. Cultural mediators also are required to have the right attitude to continuously seek to empower patients and strive to facilitate a dialogue between HPs and HUs which ultimately will render their services redundant. In addition to this, cultural mediation will involve working with very vulnerable families and sensitive issues. CMs must be trained to work under a lot of pressure from both HPs and HUs.

Training in cultural mediation varies from two-day to two-year programmes. In some European countries, courses in cultural mediation are part of postgraduate studies.

Although CM training is not recognised under the National Framework of Qualifications in Ireland, some training programmes have been developed with European funding in recent years. While unrecognised, these programmes contain much of the information that could inform future training.

#### *Cultural mediators – code of practice*

We would like to point out that when approaching the area of interpreting we are able to support our views with current codes of practice from the United States, United Kingdom, Australia and Ireland, whereas when explaining cultural mediation we draw heavily on our experience in the design of training programmes and management of services in health settings because there is limited available literature on codes of ethics for cultural mediators.

Although projects have developed different principles and guidelines in cultural mediation as a response to their particular needs, there is no recognised, unified code of practice. With this paper we hope to highlight the importance of setting standards for cultural mediation as a necessary step for its recognition as a profession. This recognition would permit cultural mediation to develop and maintain standards at national and international level.

Similarly to interpreters, cultural mediators should abide by a code of practice which ought to include at the very least the elements of confidentiality, impartiality and professionalism. These three principles are recognised as fundamental for cultural mediators in Spain<sup>8</sup> as well as for the mediators from the Roma Cultural Mediation

---

<sup>8</sup> In *Retos en los contextos multiculturales. Competencias Interculturales y resolución de Conflictos*. Fundación Secretariado Gitano, 2007. This publication gathers information from several cultural mediation services in Spain. <http://www.gitanos.org/publicaciones/retoscontextosmulticulturales/interaccion.pdf>. The competencies of cultural mediators coincide with the guidelines established by the Roma Cultural Mediation Project except for the principle of linguistic proficiency which is included due to the fact that cultural mediators in Spain also act as interpreters.

Project<sup>9</sup> (RCMP). In the next pages we approach these and other principles that we believe should be part of any code of practice for cultural mediators.

#### *Cultural mediators – code of practice - confidentiality*

Cultural Mediators work with very vulnerable families and their work often involves very sensitive situations which require strict confidentiality on the part of cultural mediators. Given the relatively small size of the different ethnic communities in Ireland it is easy to understand how the privacy of many families could be jeopardised.

Because they fear that their life and circumstances might become the latest topic of gossip in their communities, many families prefer to be assisted by cultural mediators who are from different ethnic communities to theirs. Training and adherence to a code of ethics protect the families that CMs assist. Equally, codes of ethics protect CMs from pressure to disclose information.

#### *Cultural mediators – code of practice - impartiality*

Cultural mediators should remain impartial and respect their professional boundaries. Impartiality for CMs means that they should not side with any of the parties. In order to gain the trust and the confidence of both HPs and HUs, CMs should refrain from allying themselves to any party and taking HUs' cases in a personal manner. CMs should never lie or withhold information on behalf of HUs.

Unlike interpreters, CMs should express their opinions when meeting HPs and HUs alone. As part of their job, CMs need to evaluate situations and propose plans of action. They should therefore give voice to their assessments which ought to be based on knowledge and methodology gained through training. CMs should however be cautious as to the type of advice they provide; this must always be grounded on professional analysis and never be personal. Furthermore, it should not be the job of CMs to provide counselling to HUs. If they deem that a patient is in need of such a service, they should advise the HP involved in the case.

The CM's impartiality (or lack of it) is a key feature that distinguishes trained cultural mediators and untrained intermediaries. Friends and relatives might accompany HUs because they have experience with the system, speak the language better, or simply feel they have a right to interfere. These intermediaries often end up complicating the situation further and making it more conflicting by alienating HPs and disempowering HUs even further. However good their intentions are, untrained intermediaries usually put themselves at the centre of the conflict, unaware that fostering a good relationship between HPs and HUs is the best way to meet the health needs of their friends. Even for trained CMs, provision of assistance to relatives or friends might compromise their impartiality. CMs should be aware of this and turn down these cases.

Maintaining impartiality is not easy for CMs who work under significant pressure from HPs and HUs. As we have already detailed in relation to interpreters, families

---

<sup>9</sup> Code of Practice written by Mayte C. Martín for the Roma Cultural Mediation Project. The RCMP was funded by EQUAL Community Initiative, 2005 – 2008. For more information on project documentation see: <http://www.ideasbank-equal.info>

from the same cultural or linguistic background perceive CMs as allies. Even when CMs clarify their position as impartial agents, they have to work under a lot of emotional pressure that is difficult to ignore, especially in view of the terrible human stories that they witness.

CMs may need to emphasise their impartiality to HPs who sometimes assume that they have the power to convince HUs to do or accept anything. In other instances, HPs might assume that their relationship with HUs can be replaced by the relationship between HUs and CMs, placing an additional burden on CMs and making their job impossible to accomplish. When CMs' work is remunerated by the health services, some HPs might get the wrong impression that CMs "work" for them, and as a result are reluctant to respect their impartiality.

CMs need to know about HUs and their particular circumstances. This places them in a more vulnerable situation. Respecting boundaries under these circumstances can prove difficult. Having a code of practice to abide by helps and guides CMs in their jobs and is also a tool to combat the pressure they might feel.

#### *Cultural mediators – code of practice - accuracy*

While accuracy is very important in the work of interpreters, it does not apply to CMs in the same way because as we argue in this paper their job is not to transfer messages between parties. To do their job well, cultural mediators need to know the HUs' and HPs' languages well, they do not, however, need to possess the same level of English and knowledge of terminology as interpreters. Sometimes, CMs need to convey messages between HPs and HUs in order to establish a relationship between them but once the relationship is established, CMs should leave HPs and HUs to interact with the assistance of interpreters.

We suggest that a code of practice for CMs should include a commitment to respect all HUs equally regardless of their background and not to allow any personal bias to misrepresent them and their cultural background.

#### *Cultural mediators – code of practice - professionalism*

It is important for CMs to conduct themselves in a professional manner. For many CMs a professional and unbiased outlook ultimately helps them to be accepted by their communities, especially for women CMs in patriarchal societies which would not allow their involvement otherwise<sup>10</sup>. Conducting themselves in a professional manner will aid CMs to gain the respect and trust of both HPs and HUs.

Similarly to interpreters, CMs should have the flexibility to reject cases and pull from the process if they believe that their professionalism is compromised in any way.

In addition to their commitment to respect all HUs, any code of practice for CMs should include an assurance not to abuse the power that they often have over the process and to some extent the outcome of cases. Working closely with vulnerable families might give CMs an opportunity to manipulate the situation. The role of CMs

---

<sup>10</sup> Documentation on this can be found in the reports produced by the Roma Cultural Mediation Project [http://ec.europa.eu/employment\\_social/equal/practical-examples/asyl-06-ie-roma\\_en.cfm](http://ec.europa.eu/employment_social/equal/practical-examples/asyl-06-ie-roma_en.cfm)

and the limits of their work should be clarified to HPs and HUs at the initial stages. HPs and HUs should bear in mind that CMs shouldn't impose solutions nor should they be considered judges. CMs must not be the voice of HPs nor HUs; rather they should encourage and empower HUs to express their own views.

### *Cultural mediators – code of practice - advocacy*

Advocacy is also a controversial principle for CMs and their code of practice. The level of advocacy that CMs carry out sometimes depends on the organisation or institution that is hiring them. If CMs have been engaged by a community organisation, they might feel compelled to defend the position of their HUs. When the health service is their employer, CMs might feel that they have to speak or justify the HPs' decisions and the health services.

CMs work in situation of power imbalances and consequently an important part of their job is to empower HUs, to assure that they have the capacity and the information to make their own choices regarding their own health. On the other hand, CMs will strive to unknit cultural misunderstanding and will furnish cultural explanations that might be affecting directly or indirectly the health of HUs and their interaction with the services. As a result of this role, CMs are wrongly perceived as advocates.

It is our opinion that advocating for HUs should not be part of the CM's job as this extra burden would only serve to make their job more difficult. CMs often place themselves in a delicate position where they have to maintain a balance that can be easily compromised should they tilt to one side or another. They must keep all parties included at all stages of the process and they must foster their equal participation. If CMs are perceived as the "defenders" of HUs, their relationship with health providers will change and CMs would lose much of the leverage to negotiate. If HPs see CMs as an objective agent who is there to assist the service, then it is more likely that HPs will take a positive view of CMs.

When faced with situations where HUs or they themselves are victims of racism, flagrant mistreatment or danger to their well being and dignity, CMs should be given the capacity and the means to counteract this situation.

### **When is a medical interpreter required and when is a cultural mediator required?**

It is the authors' opinion that cultural mediation should not be considered an alternative to interpreting or even worse, an "added value" that interpreters from different cultural background might provide. Interpreting and cultural mediation should be availed of in a complementary manner.

We suggest that cultural mediators be called upon initially to help HUs to navigate the system and to encourage them to express their concerns and needs. At this initial stage, CMs could also provide relevant cultural information to both HPs and HUs. In this way, CMs have a role in assisting both parties at the same time. To carry out this work CMs might meet both parties individually. We propose that the same approach be taken in cases of conflict: we advise that CMs meet each party alone to assess the situation before bringing them together.

Once HPs and HUs are interacting positively to the satisfaction of both parties we consider there is no need to continue to engage a cultural mediator. If a particular case involves HPs and HUs from different linguistic backgrounds, then once the task of a cultural mediator has been completed, we propose that an interpreter be engaged to bridge the communication gap. In other words, CMs could intervene before interpreters in order to smooth the path for them.

At this point, we would like to add that we are not suggesting that all migrants need the assistance of CMs when accessing or using health services. We see it as an optional service and as such, HUs should be able to decline it. If HUs, however, do not speak English fluently, we believe the services of interpreters should always be engaged.

## **Conclusion**

We have seen that the term ‘cultural mediator’ or ‘intercultural mediator’ is defined in various ways across Europe and that this can lead to confusion concerning whether a cultural mediator is an interpreter or someone with a different, undefined brief. We believe that inconsistent use of the term can cause confusion to interpreters and indeed to medical staff who may expect interpreters to do more than provide interpreting.

We have examined the role of the medical interpreter and the importance of impartiality along with a reluctance for interpreters to act as advocates. Because interpreters cannot get involved in cases, there may be some situations where patients need extra help in order to access services. We believe that this help should be provided by cultural mediators. We have looked at the role of the CM as it has developed in the Irish situation, where cultural mediators mostly assist healthcare users to use services and HPs to better understand the needs of their patients. We have seen that cultural mediation is not synonymous with interpreting but rather is an additional service that fills a gap that interpreters cannot really fill if they are to comply with their code of ethics. We have compared codes of ethics for interpreters and cultural mediators and found that these share many basic principles. Impartiality is important for both interpreters and cultural mediators but the latter have more flexibility in that they can meet with HPs and HUs alone and they have to evaluate situations and propose a plan of action. However, cultural mediators’ opinions should not be personal; they should be grounded on professional analysis. Professionalism is important for both interpreters and cultural mediators and both should withdraw from assignments if for any reason they cannot carry them out appropriately. The role of the cultural mediator diverges from that of the interpreter in that the cultural mediator aims to empower the HU and help him or her to make choices. Cultural mediators often have to provide cultural explanations to explain a barrier or perhaps a patient’s unwillingness to participate whereas interpreters usually allow the other participants to sort out a cultural problem by allowing them to ask more questions and the interpreter only provides a cultural explanation as a last resort. This essay highlights the importance of codes of ethics and their function in clarifying the role of both the interpreter and the cultural mediator.

## References

- Angelelli, C., (2006) "Validating professional standards and codes. Challenges and opportunities" in *Interpreting* 8:2, pages 175-193.
- Angelelli, C., (2008) "The role of the interpreter in the healthcare setting" in *Crossing Borders in Community Interpreting: definitions and dilemmas* ed. Valero Garcés, C. and Martin, A., John Benjamins Amsterdam and Philadelphia.
- Australian Institute of Translators and Interpreters Inc. (AUSIT) Code of Ethics <http://server.dream-fusion.net/ausit2/pics/ethics.pdf> Accessed 5th August 2009.
- Australian Institute of Translators and Interpreters Inc. (AUSIT) Code of Ethics General Principles <http://www.ausit.org/pics/CoEsummary.pdf> Accessed 5th August 2009.
- Australian Institute of Translators and Interpreters Inc (AUSIT) Board of Professional Conduct <http://www.ausit.org/eng/showpage.php3?id=961> Accessed 17<sup>th</sup> December 2009.
- Chartered Institute of Linguists (2007) *Code of Professional Conduct* <http://www.nrpsi.co.uk/pdf/CodeofConduct07.pdf> Accessed 4th September 2009.
- Chartered Institute of Linguists Disciplinary Framework and Procedures <http://www.iol.org.uk/membership/DisciplinaryProceduresCouncil171107.pdf> Accessed 17th December 2009.
- Dohan, D., Levintova, M., Barriers Beyond Words: Cancer, Culture, and Translation in a Community of Russian Speakers *Journal of General Internal Medicine* 22 (Suppl 2) pp 300-305.
- Fundación Secretariado Gitano (2007), *Retos en los contextos multiculturales. Competencias Interculturales y resolución de Conflictos* <http://www.gitanos.org/publicaciones/retoscontextosmulticulturales/interaccion.pdf>.
- Giménez Romero, Carlos (1997) "La naturaleza de la mediación intercultural", *Revista de Migraciones*, 2, pp. 125 – 159.
- Hale, S., (2007) *Community Interpreting* Palgrave Macmillan
- Health Service Executive (2008) *National Intercultural Health Strategy 2007-2012*
- International Medical Interpreters Association Code of Ethics <http://www.imiaweb.org/code/default.asp> Accessed 4<sup>th</sup> August 2009.
- Irish Translators' and Interpreters' Association (ITIA) Code of Ethics for Community Interpreters [http://translatorsassociation.ie/component/option,com\\_docman/task,doc\\_download/gid,230/Itemid,61/](http://translatorsassociation.ie/component/option,com_docman/task,doc_download/gid,230/Itemid,61/) Accessed 5<sup>th</sup> August 2009.
- Martín, Mayte C., Roma Cultural Mediation Project Code of Practice <http://www.ideasbank-equal.info/files/Mediation-code-of-practice.pdf>. Accessed 4th September 2009

Martín Mayte C. and Hibernian Consulting, *Fitting In: How Cultural Mediation Supports the Integration of the Roma Community in Ireland*, Funded under the EQUAL Community Initiative, <http://www.ideasbank-equal.info/files/FittingIn.pdf>

Mikkelsen, H., (2008) "Controversies over the role of the court interpreter" in *Crossing Borders in Community Interpreting: definitions and dilemmas* ed. Valero Garcés, C. and Martin, A., John Benjamins Amsterdam and Philadelphia.

National Council on Interpreting in Health Care National Council Surges Ahead with National Healthcare Interpreter Certification  
[http://data.memberclicks.com/site/ncihc/NCCRelease%20Final%201%2028%2009%20logo%20\(2\).pdf](http://data.memberclicks.com/site/ncihc/NCCRelease%20Final%201%2028%2009%20logo%20(2).pdf) Accessed 9<sup>th</sup> September 2009.

National Council on Interpreting in Health Care *National Standards of Practice for Interpreters in Health Care*  
<http://data.memberclicks.com/site/ncihc/NCIHC%20National%20Standards%20of%20Practice.pdf> Accessed 4<sup>th</sup> August 2009

National Council on Interpreting in Health Care (2004) A National Code of Ethics for Interpreters in Health Care  
<http://data.memberclicks.com/site/ncihc/NCIHC%20National%20Code%20of%20Ethics.pdf> Accessed 16<sup>th</sup> August 2009.

Phelan, M., (2009) "Interpreter Provision in Healthcare in Ireland" *Medico-Legal Journal of Ireland* 15:2, Round Hall pp. 93-104.

Pöchlacker, F., (2008) "Interpreting as Mediation" in *Crossing Borders in Community Interpreting: definitions and dilemmas* ed. Valero Garcés, C. and Martin, A., pp. 9-26. John Benjamins Amsterdam and Philadelphia.

Schott J. and Henley A. (1996) *Culture, Religion and Childbearing in a Multiracial Society*, Edinburgh: Butterworth - Heinemann