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The changing landscape of healthcare communication in Italy: Perceptions and challenges in language brokering services☆

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ABSTRACT

This study investigates the evolving landscape of healthcare communication in Italy, focusing on the use of language brokering services *sensu latu*, including interpreting, cultural and linguistic mediation and other solutions bridging the language gap. With the country experiencing a significant influx of tourists and immigrants in recent years, the need for efficient language services has become crucial to ensure equitable access to healthcare for all individuals. The study examines the perspectives of two key professional groups involved in linguistically mediated medical encounters: language brokers and healthcare professionals. Specially designed questionnaires were administered to each group, and the analysis is conducted within the framework of sociolinguistics, complemented by survey research. The findings highlight various challenges, particularly in the ethical dimension, while emphasizing the potential for collaboration and service quality improvement through mutual adjustments between these professional groups. The results of this study can inform the development of training programmes and regulations that enhance the ability of healthcare professionals and language brokers to address these challenges effectively.

1. Introduction

The importance of effective patient–provider communication is widely recognized in scientific literature (Hale, 2007, p. 36; Berman & Chutka, 2016). However, this fundamental aspect of care is significantly challenged in an era of global mobility. Can we talk about effective patient–provider communication when different languages and cultures are involved? In the Italian healthcare context, are language brokering services always employed to overcome language barriers? Who takes on the role of language brokers, and how do healthcare and language professionals assess their contributions to facilitating effective communication? This study aims to provide preliminary insights into these research questions using two ad hoc surveys applied to the Italian context, with potential implications for other multilingual healthcare settings across Europe and beyond.

The need for linguistic assistance has grown substantially in Italy over the last few decades. A country traditionally exposed to a very high tourist presence, Italy has in recent years also seen a surge in migration (Baraldi & Gavioli, 2016), which has broadened the scope, diversified the coverage, and increased the urgency of language brokering services to ensure equal access to healthcare. Yet, there are many grey areas concerning such services, starting from the very definition of language brokering and nomenclature used to denote language brokers. This study employs the term "language broker" as the general category, including both professional and non–professional solutions (see Section 2.2).

As every interaction is socially embedded, Section 2.1 outlines the context of communication in healthcare, addressing the roles of different participants in terms of their power relations from the perspective of sociolinguistics. Section 2.2 focuses specifically on the communicative dynamics when language brokers are involved, transforming a dyadic exchange between a healthcare professional and a patient into a triadic exchange with a language broker, which may raise some ethical issues. The section also highlights terminological and legislative challenges surrounding language brokering in healthcare. As anticipated,

Abbreviations: HP, Healthcare Professional; LP, Limited Proficiency; LB, Language Broker; OPI, Over-the-Phone Interpreting; QHP, Questionnaire for Healthcare Professionals; QLB, Questionnaire for Language Brokers; VRI, Video Remote Interpreting

☆ Giulia Montenovo wrote Sections 2.1, 2.2 and 3. Jekaterina Nikitina wrote Sections 1, 4.1, 4.2, 4.3, 4.5 and 5. Both authors wrote Section 4.4

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the study draws data from two ad hoc questionnaires described in Section 3. Section 4 presents findings organized in several subsections which analyze convergent and divergent standpoints among healthcare professionals and language brokers. Finally, in Section 5, a discussion is presented offering an intervention framework aimed at increasing the effectiveness of linguistically mediated healthcare encounters.

2. Theoretical background

2.1. Communication in healthcare

Communication is at the core of the patient–provider relationship (Berman & Chutka, 2016, p. 243). When accessing healthcare facilities, patients share sensitive information about their lives and their conditions with the provider, who is expected not to relay this information as per the Hippocratic Oath and the Declaration of Geneva (Bezuidenhout & Borry, 2009, p. 161). When a language broker is called to overcome a language barrier, both the patient and the provider might start worrying about possible confidentiality breaches, especially if they are not familiar with language brokers.

In multilingual and multicultural settings, lacking or inadequate language brokering may impact service quality in a negative way (DeCola, 2011; Flores et al., 2012; Ra & Napier, 2013). For instance, a language barrier with no effective solution (a trained interpreter or mediator) raises serious ethical concerns about the validity of informed consent briefings, addressed more in depth in Section 4.

Healthcare organizations are defined and embedded within a specific linguacultural context which influences how all stakeholders relate to, and consequently communicate with each other (Angelelli, 2019, pp. 22–23). In healthcare settings, as in other institutional ones, context is particularly important as it contributes to creating different forms of power asymmetry between the different participants in the encounter, for example, the practitioner's medical expertise vs. the patient's lack of it, or the vulnerability of the patient seeking help in the healthcare facility (Rudvin, 2006).

In accordance with the sociolinguistic perspective adopted, the study rests on the acknowledgement that participants trying to reach mutual understanding take multiple roles which modify the power balance in the conversation (Li, 2013, p. 128). When a dyadic – a two-party – interaction becomes triadic – that is, when a third party, typically, a language broker, is added – the previous power alignments can shift, modifying the relationships that were created before, while the actors create power alliances (Pope et al., 2015, pp. 546–547). In monolingual healthcare encounters, it is clear that the participant's power is unbalanced, as the provider tends to sift through information and only relay part of it to the patient, thus acting as a 'gatekeeper' (Michalec et al., 2015, p. 166), although there is a rich literature on increasing the agency and role of patients in such interactions, typically labelled as *patient–centred communication* (to list just a few studies, Mead & Bower, 2000; Bigi, 2016; Nikitina, 2022).

When the patient is a Limited Proficiency (LP) speaker, the initial imbalance can be intensified (Michalec et al., 2015, p. 166) unless a language broker, professional or ad hoc, is called upon to fill this gap and allow both the patient and the provider to actively participate (Baraldi & Gavioli, 2016, p. 53) in the encounter. When a medical encounter is linguistically mediated, however, its outcome is affected on multiple levels. Some of the factors that appear to be more of a concern for practitioners can be found in the existing literature on this topic and include increased length of the encounter (Taylor & Jones, 2014), difficulty when building a rapport with patients (Wadensjö, 1998; Masland et al., 2010; Taylor & Jones, 2014) and possible confidentiality breaches (Bezuidenhout & Borry, 2009). On a more positive note, the overall effectiveness of the encounter is perceived to improve with the help of a language broker (Bischoff & Hudelson, 2010; DeCola, 2011). In the questionnaire we developed for healthcare professionals, we drew on the findings of the above-mentioned literature when asking the respondents to evaluate how the presence of the language broker can influence the interaction (see Section 4.4).

To understand the shift in communicative dynamics with the arrival of a third party, Erving Goffman's (1981) concept of 'participation framework' can be particularly helpful. The 'participation framework' describes the set of functions that the participants perform in a specific act of communication, thus comprehensively analysing the conversation and the context it happens in, considering actions as well as words with the aim of understanding what these roles are (Goffman, 1981, pp. 137; 140).

Though our analysis did not specifically focus on the difference in functions or alignments, treatment of the concept in earlier research proved to be useful to understand how the language broker's (deliberate or spontaneous) choice of a specific conversational alignment can affect the communicative dynamics in the interaction. Language brokers can in fact take on many roles throughout the same interaction, but they rarely (if ever) can be considered a mere conduit, that is a neutral "box" providing the same information in a different language in a disengaged way (Valero Garcés, 2012, p. 14). Their role is indeed an active one, and as part of the healthcare team, they contribute to the outcome of the encounter.

In an interprofessional team, understanding which role is more "ethical" is not always straightforward since different professionals do not always share the same codes of ethics (Angelelli, 2019, p. 175).

In the next section, language brokering in healthcare encounters will be analyzed more in depth starting with distinctions between the different types of professional and non–professional figures operating in this field in Italy.

2.2. Language brokering in healthcare encounters

Multilingual and multicultural settings add to the already complex healthcare communication setting described above. Language brokers in the healthcare setting help the communication flow, but they cannot substitute healthcare professionals (Gavioli & Baraldi, 2011, p. 206) nor do they need to carry the whole responsibility for the outcome of the encounter (Rudvin, 2004, p. 274). Understanding the profile of language brokers and their integration into healthcare settings is a fundamental step towards culturally appropriate care.

Linguistic assistance in healthcare may fall under the umbrella term of public service interpreting (PSI) or dialogue interpreting. Dialogue interpreters typically receive professional training and, depending on the country where they operate, they may need to be affiliated with professional associations or be accredited in a national or regional register. In Italy, no national standard registration system for interpreters is envisaged. This creates ambiguity regarding the definition of "interpreter". Although professional organizations for interpreters exist,[1] membership is not mandatory, leading to a wide range of language brokers who operate without adhering to a code of conduct or quality standards. In this study the term "interpreter" is reserved for professional interpreters affiliated with some of the existing professional organizations.

Along with the traditional category of dialogue interpreters, Italy also displays the so called *mediatori culturali o interculturali* ('cultural or intercultural mediators'). This professional category eludes clear definitions, and not just in Italy. As Pokorn and Mikolič Južnič (2020, pp. 83–84) point out, the term "intercultural mediators" carries multiple meanings in Spain as well; also, in France, Germany and parts of Belgium the terms "interpreters" and "intercultural mediators" overlap, leaving any possible role boundaries undefined (Martín & Phelan, 2010, cited in Pokorn & Mikolič Južnič, 2020, p. 89). WHO (Verrept, 2019,

[1] Following Italy's Law n. 4 as of 14 January 2013 (*Official Gazette of the Italian Republic,* 2013) that allowed the creation of professional organisations for otherwise "non–organised professions".

Annex 2) define the intercultural mediator's role as going beyond the conduit role and helping the healthcare provider become more culturally adroit.

Conferenza delle Regioni e delle Provincie Autonome/Italian Conference of Regions and Autonomous Provinces (2009) in an attempt to define this category described "intercultural mediators" as professionals who act as *both* interpreters and cultural mediators; however, they omitted information about specific training or professional qualifications required to practice. Training institutions and universities offering courses in linguistic and cultural mediation (see Montenovo (2022, pp. 26–35) for an overview of curricula) have different curricula: training varies in length and is often open to foreign nationals only, while university education opportunities are generally open to everyone. These university courses on Intercultural Mediation offer language and culture courses, along with electives spacing from economics to law or history which sometimes have roughly the same ECTS value of the language courses themselves (Montenovo, 2022, pp. 26–35); in addition, the most often taught languages do not correspond to the most requested by public services and NGOs (Pokorn & Mikolič Južnič, 2020, p. 100), an issue that we will examine more in depth in the findings section. Moreover, that of mediators is usually not a uniform group. On the contrary, they tend to belong to diverse personal and professional backgrounds, thus making the standardization of training even more complicated (Verrept, 2019). In this study the terms "language mediator" or "intercultural mediator" are used to refer to people who are not affiliated with professional interpreting associations, yet regularly provide services that bridge the linguacultural gap, without necessarily having had a formal training in mediation. Intercultural mediators play a vital role in healthcare settings by serving as cultural intermediaries, helping patients navigate the complexities of the healthcare system, interpreting medical terminology, and even providing emotional support via empathic behaviour (Dal Fovo, 2017).

Finally, besides the existing professional solutions, healthcare encounters may be mediated by untrained bilingual language brokers, a frequent and widespread solution in Italian healthcare settings as observed by Rudvin (2006, p. 57). This practice adds to the category of language brokers another figure, that of a bilingual individual who can be a family member of the patient, another employee of the healthcare facility or an outsider with a presumed knowledge of both languages whose help has been requested for lack of a better and easily retrievable solution. Little is known about the professional background of these ad hoc language brokers, nor is it clear whether their language proficiency in Italian is sufficient to provide such services.

It appears that the group of language brokers is diverse, comprising individuals from different personal and professional backgrounds. This diversity is duly acknowledged throughout the paper, when possible. Unfortunately, as the findings will show, the professionalization status of language brokers is frequently unclear to healthcare professionals who refer to them as "interpreti" or "mediatori" in an interchangeable way. This diversity further complicates the standardization of training and competencies among language brokers.

3. Study design and materials

This study was carried out with two ad hoc questionnaires: a questionnaire for healthcare professionals (QHP) and a questionnaire for language brokers (QLB), with an intent to grasp their respective perceptions of the situation outlined in previous sections.

Both questionnaires were drafted bilingually in Italian and English, were anonymous, and participation was voluntary, based on an initial click–for–consent form.

The questionnaires were distributed online using Google Forms through personal and professional networks. The QHP was disseminated through social media and personal and professional networks of a medical doctor. The QLB was distributed through one of the authors' personal and professional (as an interpreter and a former researcher in a medical university) networks, including the Italian Association for Translators and Interpreters.

The study follows a mixed-methods approach. The two fact–finding questionnaires allowed a quantitative research approach; the qualitative component was restricted to a few open-ended questions that were inserted in both questionnaires. This study design pursued the goal of exploring and describing the evolving landscape of linguistically mediated healthcare encounters from the standpoint of the two professional categories involved, which enabled us to hypothesise potential areas for future intervention. Multiple choice questions used four– or five–point Likert scales. The five–point scale was used for frequency (QHP and QLB) and for positive/negative effect (QHP). A four–point Likert scale was instead used for level of agreement (QHP and QLB) to try to have a clearer idea of the respondent's opinions by forcing them out of a neutral option.

Both questionnaires have a similar structure divided into three parts:

- The first part concentrated on the demographics: age, region, professional qualifications, work experience and language skills (languages spoken for QHP and working language combinations for QLB).
- The second part focused on previous experience with international patients and, in the case of QHP, with interpreters.
- The third part was centred on the respondents' perceptions while working with interpreters (QHP) or with healthcare professionals (QLB). Considering the different professional roles, the questions in this last part were more differentiated than those in the previous sections.

As the questionnaires were administered during the active phase of COVID-19 pandemic, it was not possible to proceed with individual interviews.

In the next section, we will analyzse the findings from these two questionnaires.

4. Findings and discussion

4.1. Demographics

The questionnaire for healthcare professionals (QHP) generated 112 responses, almost equally distributed among four age categories (≤30 years = 26.8%; 31–40 years = 25%; 41–50 years = 19.6%; ≥50 years = 28.6%). Most of the participants (76.8%) reported working in a public hospital. As for professional roles, 46.4% were doctors and 37.5% were nurses, with the rest covering various professional roles (technicians, physiotherapists, researchers, midwives, psychologists, speech therapists, etc). Some of the respondents, mostly doctors, also pointed out their field of specialization, the most common being "Infectious and Tropical Diseases" (22 respondents).

The questionnaire for language brokers (QLB) gathered 16 responses only (≤30 years = 43.8%; 31–40 years = 37.5%; 41–50 years = 12.5%; ≥50 years = 6.3%). We were faced with a distribution problem, as very few professional interpreters declared to work in patient–provider communication, and it was challenging to find non–-professional language brokers who worked in these settings. We asked the respondents to self-define their professional status, and of the QLB respondents, 68.8% were registered interpreters, 18.8% identified as language mediators and 12.5% declared to take on ad hoc occasional interpreting as language brokers. This distribution challenge contributes to highlighting the fact that the scenario of language brokering in Italian healthcare settings is quite diversified. It appears that the widest – and the most difficult to retrieve – category are semi–professional and non–professional language brokers.

Most QHP responders have practiced for many years (≥20 years = 27.7%; 11–20 years =19.6%; 6–10 years =12.5%), which is comparable

with QLB responses (≥20 years = 12.5%; 11–20 years = 43.8%; 6–10 years = 6.3%), despite the fact that QLB respondents were somewhat younger, probably given our distribution bias. The years of practice of both HPs and LBs make their responses very pertinent, despite some distribution difficulties.

4.2. Language profile

As our research was language–oriented, we asked the respondents about the languages they spoke. Most HPs reported speaking at least one language other than Italian (one foreign language = 45.5%; two foreign languages = 33.9%; three foreign languages = 4.5%). At the same time, 16.1% of the QHP respondents declared to speak zero foreign languages, and a third of them (5.4%) also mentioned not having worked with interpreters. Table 1 specifies the languages spoken by the QHP respondents as well as the working languages of the QLB responders besides Italian. However, the most curious data are reported in the third column: languages for which language brokers were most frequently requested, as reported by the QHP respondents. Next to absolute frequencies of mention (one responder may have mentioned more than one language), all data are converted to percentages based on the total number of mentions for comparative purposes.

Table 1 illustrates a clear linguistic divergence among the languages offered by LBs and requested by HPs most frequently. Moreover, "exotic" languages, such as Edo, Yoruba, Pashtu, and so on were mentioned only by those QLB responders who identified as occasional ad hoc language brokers or cultural mediators. The professional interpreters (as well as healthcare professionals themselves) declared more "conventional" languages (English, French, German, Spanish), to which Slavic languages were frequently added, most probably on account of distribution bias, as many people in one of the authors' professional networks speak these languages. The numbers of the third column reveal the reality of linguistically mediated medical encounters in Italy, where linguistic assistance is provided by ad hoc language brokers offering the necessary language combinations, potentially to the detriment of the general quality of interpreted interaction.

This offers an opportunity for a stimulating observation concerning the real language brokering needs, as shown by HPs answers, and the services currently offered. Today, most universities offering courses in public service interpreting cover more widespread world languages, such as Chinese, Arabic, Russian or even Hindi, without offering training with African languages or languages of India and Pakistan (other than Hindi), that is languages of "lesser diffusion" (Salaets et al., 2016). The University of Milan offers a degree in linguistic and cultural mediation with a separate curriculum, called *Stranimedia*, or "Italian language and culture for foreign linguistic mediators", which is only open to foreign nationals and enables them to study Italian language and culture and one foreign language (Montenovo, 2022, pp. 32–33). Potential students could easily be native speakers of one or more minority languages, and such courses could help reduce the linguistic gap in the provision of professional healthcare interpreting services. To the best of our knowledge, this is at present the only university degree

Table 1
Linguistic profiles of healthcare professionals and language brokers.

Languages	QHP		QLB		Languages LBs were requested for by HPs	
	Absolute frequency	%	Absolute frequency	%	Absolute frequency	%
English	***84***	***60.9***	***13***	***27.7***	9	4.2
French	***31***	***22.5***	***6***	***12.8***	2	0.9
Spanish	***14***	***10.1***	2	4.3		0.0
German	3	2.2	***5***	***10.6***	1	0.5
Romanian	1	0.7	1	2.1	12	5.6
Portuguese	–	0.0	2	4.3	2	0.9
Turkish	1	0.7	–		–	–
Korean	1	0.7	–		1	0.5
Japanese	–	0.0	–		2	0.9
Chinese	–	0.0	–		***29***	***13.6***
"Asian language"		0.0			11	5.1
Unspecified	2	1.4	–	–	–	–
Russian	–	–	***6***	***12.8***	12	5.6
Ukrainian	–	–	1	2.1	2	0.9
Lithuanian	–	–			1	0.5
Bulgarian	–	–			2	0.9
Other unspecified "Eastern European languages"					4	1.8
Croatian	1	0.7	2	4.3	1	0.5
Serbian	–		2	4.3	1	0.5
Polish	1	0.7	–		1	0.5
Albanian	–	–	–		9	4.2
Edo (Nigeria)	–		1	2.1	1	0.5
Yoruba (Nigeria)	–		1	2.1	–	–
Bambara (Mali, Westerm Africa)	–	–	–	–	2	0.9
Manding Languages	–	–	–	–	1	0.5
Somali	–	–	–	–	5	2.3
Tigrinya (Eritrea, Ethiopia)	–	–	–	–	1	0.5
Wolof (Senegal)	–	–	–	–	5	2.3
Other unspecified "African languages"					6	2.8
Bengali	–	–	–	–	8	3.7
Urdu	–		1	2.1	***17***	***7.9***
Pashtu	–		1	2.1	6	2.8
Punjabi	–		1	2.1	3	1.4
Hindi	–		1	2.1	–	
Farsi	–		1	2.1	3	1.4
Other unspecified "Languages of India and Pakistan"					9	4.2
"Afghanistan" (could be either Dari or Pashtu)					1	0.5
Arabic	–	–	–	–	***44***	***20.6***
Total	138		47		214	

Table 2
Service frequency for patients with limited language proficiency.

Frequency	QHP: How often have you treated patients who do not speak Italian AT ALL?	QLB: How often have you interpreted for patients who do not speak Italian AT ALL?	QHP: How often have you treated patients who spoke only LITTLE Italian?	QLB: How often have you interpreted for patients who spoke only LITTLE Italian?
Never	3.6%	0	2.7%	18.3%
Rarely	22.3%	0	9.7%	25%
Sometimes	37.5%	37.5%	38.4%	25%
Often	26.8%	25%	33%	18.8%
Very often	9.8%	37.5%	15.2%	12.5%

course in Italy of a kind. As the data in column 3 would seem to suggest, such a training approach, catering for the variety of languages of "lesser diffusion", could provide a systemic solution and prepare professional language and intercultural mediators, potentially decreasing recourse to improvised or non-professional solutions.

4.3. Role perceptions and language barriers

Against the general background described in 4.2 painting a blurred picture of professionalization in healthcare language brokering, we asked the respondents how often they had to treat or interpret for patients who did not speak Italian at all or spoke only little Italian (see Table 2).

Table 2 sheds light on a tendency to rely on medical interpreters (including also language mediators and ad hoc language brokers) only in more critical cases, when the patient does not speak the language at all ("often" and "very often" collectively amounting to 62.5%). Paradoxically, when the patient speaks a little Italian, frequent and very frequent recourse to language brokers is halved to 31.3%. Of the QLB respondents, 43.3% declare that they are never or rarely called when a patient speaks a little Italian, despite the fact that, according to medical practitioners, patients with limited language proficiency are frequent or very frequent in their practice (36.6% of patients not speaking Italian at all; 48.2% speaking only a little Italian). It may be surmised that in cases when interpreters or mediators are not called, other non–professional solutions are activated, such as "getting by" (Villarruel et al., 1999), using facial expressions, gestures, and a few key words or phrases, or recourse to ad hoc language brokers is made, that is anyone who speaks both languages involved. In fact, "patient's bilingual family member or close acquaintance" was the most recurrent non–professional language solution indicated by the HPs (66.7%), along with "native speaker who is not acquainted with the patient" (29.6%), "bilingual healthcare professionals working in the facility" (28.4%) and even automated translation (4.9%).

When asked to assess the need for a language broker in case of a patient with limited (but not absent) knowledge of Italian who has to sign an informed consent (see Table 3), 64.3% of healthcare practitioners strongly agreed with it as compared with 81.3% of strong agreement among language brokers. Moreover, 7.1% and 2.7% of HPs, respectively, somewhat or strongly disagreed with recourse to a language broker in such a situation.

Table 3
Recourse to language brokers in informed consent procedures for limited Italian proficiency patients.

An interpreter / language broker is needed when a patient with limited (but not absent) knowledge of Italian needs to sign an informed consent.	QHP	QLB
Strongly agree	64.3%	81.3%
Somewhat agree	25.9%	18.7%
Somewhat disagree	7.1%	–
Strongly disagree	2.7%	–

Tables 2 and 3 illustrated a worrisome tendency of some healthcare professionals to downplay the importance of language brokering, which raises several ethical questions, especially with regard to informed consent procedures. What can count as *consent* if the patient does not understand the contents of a document detailing the procedure? If the understanding is partial or inadequate, is it ethical to call such a consent *informed*? Perhaps, a more rigid frame of reference for informed consent procedures with LP patients is needed to avoid these non-conformist views on the recourse to language mediation.

As concerns professional language solutions for cross–linguistic patient–provider communication through interpreters and mediators, 61.7% of healthcare professionals declared to have worked with professional interpreters/mediators in person; 40.7% mentioned "professional telephone interpreting", also known as Over–the–Phone interpreting (OPI), and only 4.9% indicated "professional video remote interpreting". These data are echoed by the QLB respondents: 100% of them have collaborated with HPs in person, out of which 43.8% have also done OPI and 31.3% of interpreters declared also using video remote interpreting. The gap in the use of the latter technology by healthcare professionals and medical interpreters is noteworthy. Having a video–enabled communication allows the participants to access non–verbal contextualization cues, such as facial expressions and gestures, which could have a positive impact on the general outcome of the interaction.

4.4. Shifting communication dynamics

It is not an exaggeration to state that linguistically mediated medical encounters are not the same in terms of communication dynamics as the same–language encounters. Garzone (2011) explored the impact of the interpreter's presence and stated that "the interpreter's presence by definition deeply alters discourse dynamics and may occasionally have a problematic impact on the way the interaction functions, leading to a number of shortcomings which may to some extent affect the patient's ability to follow satisfactorily a conversation of which in theory s/he is the addressee and the main object at the same time" (Garzone, 2011, p. 329). We have asked healthcare professionals to assess the impact of the language broker's presence on the communication dynamics in terms of length of the interaction, its efficiency, easiness in rapport building and confidentiality, see Table 4.

To assess which of the four aspects are perceived as the most positive or negative, we used the percentages of Table 4 and assigned a numerical value to all four items. All "positive" answers gave 1 point, and "mostly positive" ones only gave 0.5; no points were added for neutral responses; 1 point was detracted for each "negative" answer and 0.5 for each "mostly negative" one. The resulting "scores" are as follows: 44.6 for confidentiality, 68.25 for time, 73.2 for ease in rapport creation and 81.2 for efficiency. It is evident thus that confidentiality in linguistically mediated encounters is the most negatively perceived aspect, while efficiency is the most positive one, confirming what we found in the literature (See Section 2.1). In other words, healthcare professionals do not trust entirely the language brokers involved in a typical patient–provider interaction, who, as Sections 4.2 and 4.3 illustrated, are frequently untrained bilinguals.

Table 4
Healthcare professionals' evaluation of the language broker's presence on the communication dynamics.

How do you think the presence of the language broker influences the medical encounter in terms of:	Positively	More positively than negatively	Neither positively nor negatively	More negatively than positively	Negatively
Length (time)	64 (57.1%)	33 (29.5%)	9 (8%)	4 (3.6%)	2 (1.8%)
Efficiency	80 (71.4%)	25 (22.3%)	3 (3.6%)	3 (2.7%)	–
Ease in rapport building	68 (60.7%)	32 (28.6%)	8 (7.1%)	4 (3.6%)	–
Confidentiality	37 (33%)	43 (38.4%)	16 (14.3%)	15 (13.4%)	1 (0.9%)

Table 5
Confidentiality and code of conduct.

The absence of a national standard code of conduct or of official professional recognition for medical interpreters can lead to unintentional breaches of confidentiality.	QHP	QLB
Strongly agree	11.1%	18.8%
Somewhat agree	55.6%	50%
Somewhat disagree	33.3%	31.3%
Strongly disagree	–	–

Both respondent cohorts were asked whether a lack of a national standard code of ethics could be accountable for unintentional confidentiality breaches (see Table 5) and gave convergent answers.

It is admittedly challenging to create a realistic code of ethics that covers both the reality of intercultural mediators and community interpreters as applied to healthcare (Pokorn & Mikolič Južnič, 2020), and some authors advocate for abstaining from rigid frameworks favouring instead the empathic behaviour perspective (Merlini & Gatti, 2015, p. 155; Dal Fovo, 2017, p. 35), where the interpreter's emotional intelligence takes the upper hand.

Our data suggested a correlation between the type of language broker/ interpretation mode preferred and the level of trust, see Fig. 1.

The correlation between preference and loss of confidentiality was examined by Fig. 1. The responses regarding preference were compared with those concerning the loss of confidentiality. To determine the level of trust, the responses on the loss of confidentiality were inverted. The purpose was to investigate whether there is any connection between these two aspects. The study found that only the "in-person professional interpreter" type had equal trust and preference values. The least trusted – that is "patient's bilingual family member or close acquaintance" – ranks third in terms of preference (second if OPI and VRI are considered separately). Remarkably, the same professional – that is the interpreter – is perceived as more or less trustworthy according to the delivery mode: in person or remotely. The inability to see the interpreter (or vice versa for the interpreter to see patients and providers) in OPI and the physical detachment in both OPI and VRI can result in the parties' disengagement (Hilfinger Messias et al., 2009, p. 132) and can partially explain why the respondents reported trusting professional interpreters working remotely more. On the other hand, equipment limitations and other technical difficulties can cancel out some of the benefits of remote services (Lara–Otero et al., 2019), which could explain why healthcare professionals reported having a higher preference for in–presence interpreters.

When asked an open question concerning the issue of trust, some of the healthcare professionals, replied that patients are frequently embarrassed to disclose some details in front of their bilingual relatives who act as ad hoc language brokers, see (1) – (2).

(1) The interpreter, *especially if a family member of the patient*, can influence what the patient reports to the doctor by inhibiting the confidentiality of the anamnesis, the patient's account of their medical history.[2]

(2) Patient from Sri Lanka suffering from diabetes mellitus, new finding of HIV infection. The patient is treated in the clinic but does not communicate with anyone, *his brother has always acted as interpreter*. It is *not possible to establish the real awareness of the patient as well as his real wishes*.

4.5. Cooperation and interprofessional training

To hypothesise possible areas of intervention, we asked language brokers[3] how cooperation between interpreters and medical practitioners can be improved in an open–ended question. Their answers, some of which are reported in (3) – (8), unveiled a clear trend: more interprofessional training is needed.

(3) Through greater *recognition of the role of the medical interpreter* and the *proper training* of health personnel on how to carry out their work with linguistic mediation.
(4) I think the basis is to give a preview of the linguistic intervention to be done with the patient, but I believe that the best way to improve cooperation is *by better training the healthcare staff to manage the work with an interpreter*.
(5) *If the healthcare staff knew that interpreters are prepared for this job*. I have often seen healthcare workers use macaronic English without asking for help even though I was literally 2 m away. Perhaps *they think that the intervention of the interpreter slows down the times too much and they prefer getting by to be fast.*
(6) *The team should warn the interpreter before things that can be shocking* happen such as opening the rib cage for example, once I even had a surprise autopsy after a surgery course.
(7) Through *interprofessional training when both parties are still at university*.
(8) *Training medical staff to work with interpreters*, to be collaborative.

Unfortunately, as our data and example (5) state, misconceptions about linguistically mediated encounters still linger and are somewhat fuelled by the lack of regulation of the healthcare system regarding language assistance. Indeed, as recommended also by (7) above and many others, interprofessional training at an earlier stage of career or while at university could be an absolutely feasible and yet effective area of intervention. To the best of our knowledge, currently no medical universities or departments offering degrees in healthcare in Italy offer courses on communication through interpreters, although some courses that acknowledge the changed realia/teaching aids do appear (for example a course in "transcultural nursing" at the University of Ferrara or a seminar in "nursing in a multicultural society" at the University of Modena and Reggio Emilia), but it is not clear whether healthcare professionals are trained to work through interpreters or not. This theoretical overview is corroborated by the answers of our respondents (see Table 6).

The vast majority of healthcare professionals, who face multicultural and multilingual patients on a daily basis (see Table 2), have not been trained how to work through and with interpreters, how to

[2] Unless otherwise specified, emphasis has been added in all examples.

[3] Most of the answers provided in this section were given by professional interpreters.

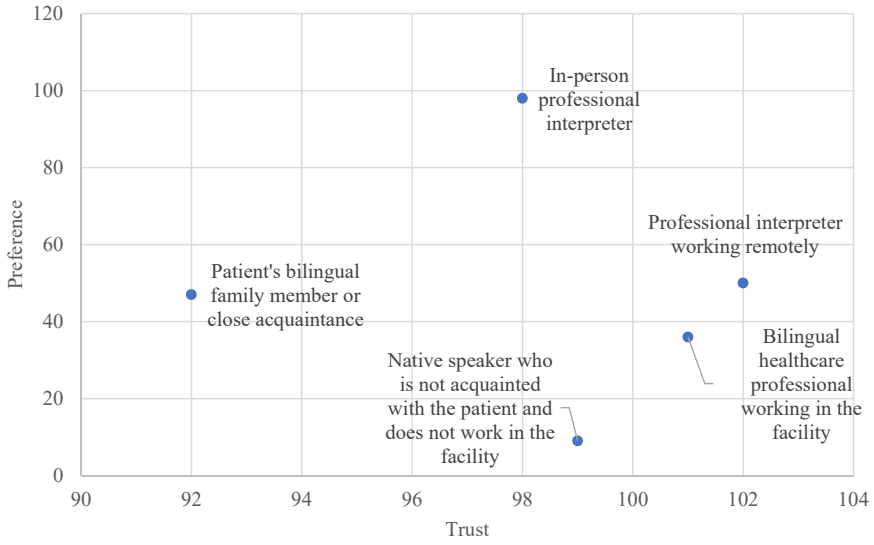

Fig. 1. Two–variable scatterplot showing the correlation between higher trust values and higher preference.

Table 6
Interprofessional training.

	QHP: Have you ever attended training courses, seminars or similar on collaboration with interpreters/language brokers for your profession?	QLB: Have you ever attended an interpreting training where you had to practice medical interpreting with a real medical practitioner (acting or student)?
Yes	12.5%	31.2%
No	87.5%	68.8%

optimise turn–taking, conversation dynamics, and so on. Similarly, although in somewhat less drastic numbers, medical interpreters have never trained with a real healthcare professional, which leaves both parties underprepared for the reality of modern–day patient–provider interactions.

The idea to introduce such courses when both parties are still at the university would also address the issue of trust, or rather lack thereof (9), that some of the QLB respondents mention, when asked about the most challenging aspects of working as part of the healthcare team.

(9) When the colleague [healthcare professional] *doesn't trust what is being interpreted*, making it seem as if you didn't know your job, *instead of asking the question again* so she can hear the interpretation again.

As mentioned in (9), a mutual understanding of dynamics of interpreter–mediated interaction could have resolved a situation of mistrust among the parties.

Interpreters and mediators working in healthcare settings could also benefit from training in psychology, as most of them mention the psychological burden when commenting upon the most challenging parts of the job, see (10 – 12).

(10) With refugee women at the family counselling centre (pregnancies and complicated life stories) – *too great an emotional burden*.
(11) Definitely the experiences with African or Ukrainian refugees. The hardest part of assisting those who suffer is *managing the psychological aspect*.
(12) Definitely a case of [sexual] violence, of which I still clearly remember the signs despite many years have passed since, and the red codes in the paediatric ED, which since I became a mother are more *difficult to manage emotionally*.

A similar commentary is found also in the answers by healthcare professionals, who signal that it is not always easy to establish a rapport with an emotional patient if a language broker (unspecified whether trained or untrained) is involved (13).

(13) The patient was unable to express her needs, and her mood in full, as *they were filtered by a third person*. A certain emotional detachment between all the figures involved was evident.

The positive comments of interpreters on the most rewarding part of working with healthcare professionals revolve around their recognition – highlighting the value of proper professionalization – and their ability to overcome the linguistic barrier, see (14 – 16).

(14) Knowing that you *are an integral part* in the treatment of the patient.
(15) When both the patient and the doctor thanked me for allowing them to communicate *as if they spoke the same language*.
(16) When patients feel free, calm and open up because they *are able to communicate in their language* [with healthcare professionals].

5. Discussion and conclusions

This study reflected on the dynamics of language brokering in medical interactions, outlining and reconciling, where possible, the views of healthcare professionals and language brokers in Italy. Even if limited to this national context, the findings drew a picture of a rather intense flow of patients with limited language proficiency coupled with unsystematic reliance on interpreters/mediators. In cases where the patient had *some* knowledge of Italian, interpreters or other language brokers were not always summoned. This hesitancy can tentatively be attributed to a lack of trust among the participants, placed against the general background of the lack of trained professionals for the languages most frequently requested and the inherent financial reasons. The professional profile of language brokers remained somewhat ambiguous. When we crossed the responses of healthcare professionals concerning the languages for which language brokers were most

frequently called in their practice with responses by language brokers concerning their linguistic combinations, a clear mismatch appeared. The languages declared by professional interpreters were not among the most commonly requested, and few professional interpreters indicated working in healthcare settings overall. Conversely, language brokers who identified as mediators or ad hoc language brokers specialized in languages of "lesser diffusion", which seemed to align with the current demands of healthcare providers. The study encountered a methodological complication in distributing the questionnaire to language brokers. Despite our best efforts to disseminate it (through professional associations, healthcare structures, personal contacts and social media), the questionnaire did not reach as many mediators and ad hoc language brokers as we had hoped. This challenge limits our data on the one hand, but on the other hand it can tentatively be inferred that the majority of language brokers operating in Italian healthcare settings indeed fall into the categories of mediators and ad hoc language brokers, as they are unreachable through any professional community.

Based on the data of our questionnaires, a possible framework of intervention can be proposed.

1. Create more university curricula offering training in mediation for foreign nationals who already speak the languages of lesser diffusion, like the *Stranimedia* curriculum at the University of Milan. It would be naïve to expect universities to offer courses in "exotic" or less common languages; however, a course in linguistic and cultural mediation offering and/or polishing the knowledge of the Italian language and culture among foreign nationals, whose first language is among the most requested for mediators, could be a possible solution for the provision of trained and linguistically competent linguistic mediators working in public service settings.
2. Include courses on working with and through interpreters for healthcare professionals, preferably at an early stage of their career or while at university. By learning the specifics of linguistically mediated interaction, healthcare professionals will acquire more trust in the professional skills of language brokers who become part of a healthcare team and learn if and how to adapt their discursive practices if a medical encounter must be mediated.
3. Possibly integrate language brokers' training with a psychology course pre-empting their needs to manage emotionally charged interactions and developing their emotional intelligence skills.
4. Set up interdepartmental agreements between departments of healthcare sciences and medicine and departments of interpreting and mediation, which could become a viable solution for interprofessional training, fostering interdisciplinary communication and the spirit of collaboration among future healthcare and mediation professionals. The few questionnaire respondents who have had interprofessional training showed on average greater satisfaction levels than those who have not. It could be hypothesized that reasonable, training–based role expectations lead both professional categories to adapt resulting in the improved outcomes of interpreter–mediated encounters.
5. Finally, integration of video remote interpreting technology into the daily practice of healthcare institutions could reduce recourse to untrained bilinguals who tend to be chosen on account of their ready availability. As our data showed, the current practice of over–the–phone interpreting is widespread, but it is assessed as less efficient and less trustworthy than in–person interpreting on account of some quality distortions (lack of proxemics, body language, etc), which can be ensured by passing instead to video remote interpreting.

Under the circumstances, where healthcare interactions are interpreted by people with a different degree of specialization, a binding national code of ethics remains an unreachable ideal, very challenging to implement. The steps proposed above may be small, but they may lead to a leap in the quality of linguistically mediated healthcare encounters and, consequently, the quality of healthcare overall.

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