Healthcare interpreting in Italy: current needs and proposals to promote collaboration between universities and healthcare services

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Abstract

The paper reports on an on-going collaboration with healthcare trusts and hospitals in Casalecchio di Reno, Rimini and Ancona aimed at offering medical interpreting students hands-on experience as well as theoretical and practical training based on the institutions' needs.

1. Introduction

The need to ensure that immigrants have full access to healthcare services in Italy is at the core of this paper, which calls for a national approach to define healthcare interpreting services, accreditation and recruitment rules and a more targeted training approach. The paper outlines the current Italian situation and focuses on two regions, Emilia Romagna and Marche.

The author believes that access can be greatly improved by training professional healthcare interpreters for European as well as less diffused languages. A case study is examined and some proposals are made to promote a closer collaboration between universities and healthcare institutions to offer well targeted training programmes for said professionals.

2. Migrants' rights to have access to healthcare services

The right of every citizen to have full access to healthcare services is laid down by the Italian Constitution, as well as by the Charter of Values of Citizenship and Integration (2007) that states:

> [...] 7. Immigrants, as every Italian citizen, have the right to an adequate remuneration for their work, health and insurance benefits, sick leave and retirement according to the provision of the law.
> [...] 9. Citizens and immigrants have the right to receive treatment in public health centres. Health treatments will be provided in full respect of the person's will, dignity and taking into account his/her sensitivity.

Even though those immigrants' rights and entitlements are laid down by the Italian law, no national response has yet been given to organise linguistic interpreting services, solve communication problems and allow immigrants, tourists and foreigners in general to be supported by qualified healthcare interpreters.

As Sandra Hale wrote, the success of healthcare services depends largely on successful communication between healthcare providers and patients, and language does play a major role in this type of communication (Hale 2007).

Italy received large inflows of migrants quite recently, especially starting from the 1990s, that is much later than other European countries, Australia, Canada or the United States, and at international level the development of public service interpreting occurred in different countries at different speeds (Corsellis 2005). At present the number of foreign citizens in Italy is very high. At the beginning of 2010 Istat (National Institute of Statistics) reported the presence of 4,235,000 foreign residents, but according to the estimates that have just been issued by Dossier Statistico Immigrazione Caritas-Migrantes 2010, the total figure actually equals 4,919,000 residents (1 out of 12 inhabitants) if one includes all the persons who are regularly staying in Italy but have not yet been enrolled in the General Registry Office. Thus the presence of foreign citizens showed a three-fold increase over the last decade.

In terms of number of residents, Romanian migrants rank first (almost 900,000), followed by Albanians and Moroccans (almost 500,000), Chinese and Ukrainians (almost 200,000). European citizens account for half the number of migrants, Africans for one fifth and Asians for one sixth, while Americans for one tenth of the total migrants' population.

In June 2010 the Italian government proposed a National Plan for Integration and Security (*Identità e Incontro*), and defined it as an "Italian model" different from the assimilation and multicultural approaches adopted by other European countries. The document mentions various rights and duties, and identifies five major actions to be undertaken: education and learning (from language to values), work and vocational training, accommodation and district governance, *access to essential services*, focus on minors and second-generation migrants.

However, notwithstanding all the above-mentioned measures, it is still difficult for Italian institutions to ensure that migrants have full access to services. For example, according to the second report on district councils by the Ministry of Internal Affairs, only 68% of regular migrants are enrolled in the National

Healthcare System, and this partly explains why there is a high number of admissions to emergency departments.

According to the immigration regulations currently in force, "regular" foreign citizens can be enrolled in the National Healthcare System by filing their stay permits, self-certification of residence and tax code number, and consequently have the same entitlement to healthcare services as Italian citizens. Foreigners who do not have a regular permit of stay may apply for the "STP card" or "temporarily staying foreign citizen card", once they arrive at the hospital or clinic. This card, which has a six-month duration and is valid everywhere in Italy, allows them to obtain urgent examinations, drug administration and referrals to specialists, but not to general practitioners or paediatricians of their own choice (Cremonesi *et al.* 2010).

2.1 Healthcare services organisation and a multi-cultural population

The impact of the above-mentioned demographic changes is felt in several aspects of Italian citizens' lives, and in particular in the provision of healthcare services. In several industrialised countries (North America, Western Europe, Australia, New Zealand as well as areas in Latin America and Asia) greater attention has been paid to the appreciation of the degree to which healthcare services should be delivered in a manner that is appropriate to the cultural and social heterogeneity of the population. The underlying reason is the growing evidence, as Leon Epstein stated, that "healthcare, at all its levels of promotion, prevention, early diagnosis, treatment and rehabilitation, has frequently failed in those sections of society that are different from the major social and cultural groups" (2008a: 5). Hence, the need for cultural competence of health professionals in providing appropriate and quality healthcare to culturally heterogeneous population groups has been highlighted (Epstein 2008a).

Healthcare systems should indeed be able to provide care to patients with diverse values, beliefs and behaviours, and should be able to meet their social, cultural and linguistic needs: "the ultimate goal is a healthcare system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background, or language proficiency" (The Commonwealth Fund, quoted in Epstein 2008b: 15).

3. Healthcare interpreters in Italy

Public service interpreters, and medical interpreters in particular, have not yet received the necessary attention in Italy, as there are no accreditation procedures or national registers for interpreters. Moreover, there are limited educational opportunities available for such professionals, and this has a big impact on their social status, remuneration level and job opportunities.

As there is no national approach to the definition of the role of healthcare interpreters, the requirements they have to comply with and the relevant recruitment are subject to individual regional criteria.

3.1 Healthcare initiatives in the two regions examined

In the Emilia Romagna and Marche Regions great attention has always been paid to social aspects and the protection of citizens' rights.

It was on initiative of the Regional H.P.H. (Health Promoting Hospitals) Network of Emilia Romagna, that the *Migrant-friendly hospitals* (MFH) project was set up, in co-operation with other national and regional H.P.H. networks in Europe (Dallari *et al.* 2005). The project was initially developed by the Health Authority of Reggio Emilia, and every hospital in the Emilia Romagna Region is a member of the MFH network. This project stemmed from the new, emerging problems related to the increasing inflows of migrants not only in Italy, but all over Europe. The rationale of the project is shared by the other regional initiatives described here. The health status of migrants and ethnic minority groups is often worse than that of the average population. These groups are more vulnerable, owing to their lower socio-economic status, and sometimes also because of traumatic migration experiences and lack of adequate social support. Minority groups are at risk of not receiving the same level of healthcare in diagnosis, treatment and preventive services as the average population. Healthcare services are not responsive enough to the specific needs of minorities. To work on these challenges, hospitals from 12 European countries came together as Pilot Hospitals to participate in the *Migrant-Friendly Hospital* project.

3.2 Regional approaches: Emilia-Romagna and Marche

During the last decade, the two regions examined in this paper – Emilia Romagna and Marche – issued a decision on *linguistic* and *cultural mediators* and established the qualifications for these two new professions (Guidelines issued on 30 July 2004 and 8 April 2010, respectively).

Giovanna Dallari *et al.* (2005) pointed out that the region of Emilia Romagna was among the first in Italy to be aware of the need to solve problems of communication and linguistic, psycho-social and cross-cultural difficulties emerging between service providers and foreign migrants. In 2004 the Emilia Romagna Regional Authorities decided to establish regional qualifications for two emerging professions, namely "linguistic mediators" and "cultural mediators". According to the norms issued by the Regional Authorities, intercultural mediators' skills should include the knowledge of: migration phenomena and migration dynamics; characteristics of migrants' presence in their district; spoken and written language of the country of origin; spoken and written Italian; public services and facilities in Italy and their countries of origin (healthcare services, education systems, the labour market etc.); knowledge of procedures, technical terminology, service providers etc.; regional, national and EU rules on migrant citizens' rights and duties; basic communication (and dialogue) techniques; interpreting techniques; intercultural relations: techniques and basic management tools; basic elements of sociology and cultural anthropology; main principles of intercultural pedagogy and immigration psychology.

Consequently, according to their job specification mediators should identify migrants' needs and resources, favour communication between service providers and migrants, and offer linguistic and intercultural mediating services.

Based on the above-mentioned document, the Emilia Romagna Regional and Municipal Authorities organised 300/400-hour post-high school diploma courses for unemployed foreign citizens with a high school diploma, aimed at promoting professional skills and issuing the vocational training qualification of *Mediatore interculturale* ("cultural mediator").

In 2010 the Marche Region issued the guidelines on cultural mediators' qualifications and established that training initiatives would follow.

The main purposes of both documents were: removing cultural obstacles hindering communication between Italian institutions and foreign citizens; promoting migrants' full access to healthcare services, justice, education and cultural activities; job creation procedures; promoting social integration of migrants into local communities; preventing and solving conflicts between migrants and Italian institutions.

Hence the emerging role of mediators, in both regions, is that of acting as intermediaries between migrants and Italian institutions.

The concept of "bridge" is repeatedly stressed in Italian literature to describe this intermediary function. An Algerian cultural mediator working in Genoa, for instance, Fatima Benasla, wrote that the profession of a cultural mediator derives from the need to act as a bridge connecting foreign users and the institutions of the host country. Migrants in fact experience two different cultures: the one of their country of origin they are still rooted in, and the one of the host society, where they have to create new relations (Benasla 2010: 78).

Out of the long lists included in both Regional documents, mastering interpreting techniques is just one of the 11 skills offered and this shows that linguistic skills are not the main focus of said documents.

3.3 Healthcare sector: two professional figures

Although the Regional documents examined above use the term *mediatore culturale* ("cultural mediator"), academic institutions tend to use the term *mediatore linguistico* ("linguistic mediator"), following the reforms of our educational system. Is this just a terminology issue?

As Franz Pöchhacker clearly states: "In Italy […] the 'linguistic and cultural mediator' became enshrined in immigration legislation in 1998, with no immediate relation to the newly reformed university curriculum for *mediazione linguistica*" (Pöchhacker 2008: 22).

The studies conducted in the two regions by the author and her colleagues starting from 2002 showed that regional institutions tend to prefer cultural mediators to "pure interpreters", as they can play an active role in the organisation of services and this contributes to granting immigrants full access to healthcare as well as generally facilitating the healthcare staff's work in medical encounters. Other interesting points that emerged were that service-providers do not tend to consider language skills as essential, and that cultural mediators

should preferably be from the same country of origin as the patients (Tomassini/Nicolini 2005).

This approach is confirmed by Giovanna Dallari *et al*. (2005) who voiced the opinion of most service providers in stating that to be truly efficient "tools", mediators' skills cannot be confined to languages and registers used in interpersonal relations, but have to embrace cross-cultural issues, the specific knowledge of the healthcare systems of the migrants' countries of origin and the specific conditions of foreign users.

"Cultural mediators" are thus given priority over "interpreters", as they can act as a bridge between institutions and migrants, helping institutions to fully understand the migrants' needs, and thus allowing them to have full access to healthcare services.

The studies previously conducted in these two regions, based on interviews and structured questionnaires, examined the organisation of mediation services and the two professional roles as perceived by service providers and mediators. The data collected showed that the respondents' answers are often conflicting (Tomassini/Nicolini 2005) and even contradictory (Rudvin/Tomassini 2008), as service providers' expectations and mediators' perceived roles differ.

Unfortunately, in the author's opinion, universities did not respond adequately and quickly enough to the new emerging needs, and have indeed not yet started collaborating sufficiently with institutions and service providers, and in particular with healthcare institutions. This attitude is also partly attributable to the still existing separation between universities and healthcare institutions, and also between theory and practice. Educational institutions have a major role to play to foster a dialogue with universities in view of mutual understanding and better working practices. It is exactly to bridge the gap existing between theory and practice that special attention must be paid to healthcare interpreters' training. The main issue at stake here is language needs: the high number of immigrants in these two regions and the high number of non-European languages spoken require a prompt response by the relevant training institutions. Although municipal, provincial and regional authorities, and healthcare institutions in particular, started to collaborate with migrants' and cultural mediators' associations in the 1990s, the non-European languages needed were not taught in most Italian universities. This gave unemployed migrants, mainly women, the chance to enter the labour market, even though at a rather low remuneration level; the first pools of mediators – with or without formal training – were thus set up and started working in community services.

France and Spain share a similar attitude concerning cultural and linguistic mediators, while this separation is not common in other European and non-European countries. In their introduction to *Crossing Border in Community Interpreting*, C. Valero Garcés and A. Martin state that "professional translators and interpreters have been facilitating cross cultural communication for many years, fully aware that it is impossible to separate language and culture, that both are inextricably intertwined" (Valero Garcés/Martin 2008: 3). Unfortunately, for those who are not "in the field", interpreting is often just as a technical and linguistic expertise confined to translating words, and not a "complex cognitive

activity with a distinct professional profile and the need for specific training" (*ibid.*).

3.4 Professional liability

Because interpreters act as intermediaries between doctors and foreign patients and severe consequences may derive from malpractice (Shlesinger 2008), the legal aspects of professional liability should not be forgotten when discussing the crucial role of healthcare interpreters. Indeed, civil or criminal legal proceedings can be initiated due to translation/interpreting mistakes leading to invalid informed consent and/or misdiagnosis deriving from incomplete or erroneous information delivered to the patient. For example, if the active principle of a drug is not translated accurately, this may have a significant impact on the patient's health. Consequently, interpreters must be accurate in reporting the interlocutors' statements to the full, ascertain that they have understood well and that they have been understood. Moreover, they have to explain the treatments prescribed accurately, report all the doctors' warnings about what should be done and what should be avoided. In some countries, such as the United States, there is a large number of medical malpractice cases reported every year, but even in Italy the number is on the rise. Interpreters may be held professionally liable for their interpretations, and doctors tend to safeguard their performances by using the formula: "the interpreter reports that…" on their statements, clinical records etc. Consequently, if claims are filed or legal proceedings started, the interpreter will be held accountable. The interpreter's insurance policy should of course protect him/her unless *colpa grave* or *dolo* is ascertainted. No such case has been reported in the regions examined yet, thanks to the mutual trust generally existing between hospital professionals and interpreters.

Service providers, and hospital managers in particular, should be educated not only in terms of the interpreter's role and code of conduct, but also to take precautions to prevent malpractice cases. Hospitals can curb the risks they run of being sued by hiring only accredited and qualified interpreters/mediators, but the problem in Italy is that as yet there is no accreditation system. Furthermore, as recruitment criteria vary in the various Italian regions, there is no guarantee that the mediator will comply with the same code of conduct or will be accurate enough to let physicians make a correct diagnosis.

3.5 Specific training

We have seen how peculiar and multi-faceted the situation in Italy is in terms of terminology, service-providers' and mediators' expectations and needs. The question then is: is specific training needed? Yes, specific training courses are needed to ensure that qualified and highly professional healthcare interpreters operate in this sector, thus safeguarding both patients' right to health and their own professional role.

In Italy there is no specific curriculum for healthcare interpreters within the language mediation syllabus. Individual university lecturers or professors may choose to focus on healthcare topics, but there is no clear-cut indication of training modules to be implemented at national level. Usually, in three-year linguistic mediation courses first-year students concentrate on business interpreting and/or tourism and start addressing interpreting in the legal and/or medical setting in their second or third year.

This leads us to another outstanding issue: who is going to train the trainers? Jan Cambridge stated that in the U.K. there is a "very underdeveloped educational system for the people who train interpreters" (Cambridge 2010: 2). This statement perfectly applies to Italy, where – following several reforms of our education system – language lecturers in modern language faculties are often asked to teach language mediation without clearly knowing what it is about.

As mentioned earlier, language is essential in communication, and it is essential to ensure proper communication between healthcare providers and people who do not speak the language of their host countries through support provided by trained and qualified, specialist linguists.

Universities then have the duty to offer training courses based on actual language needs. They should also offer training opportunities to all the linguistic and cultural mediators who are already present in the labour market and need ongoing education, especially those who received no prior training or attended only short preparatory courses which probably did not include aspects such as code of conduct or terminology. The type of training to be offered by our universities should encompass cross-cultural aspects as well as interpreting techniques and theory, as pointed out by Merlini (2005).

3.6 The languages that are most in demand

Many of the mediators working for healthcare institutions speak non-indigenous languages that are often not even taught in Italian universities. Arabic, Chinese, and Japanese language courses are provided by almost all university faculties of modern languages and interpreter and translator schools, but it is very difficult to find qualified healthcare interpreters for less diffuse languages such as Farsi, Filipino, Urdu etc. The mediators who are currently working for social and healthcare services in the above-mentioned regions have normally attended regional or municipal courses, and have temporary contracts signed by their associations (*Amiss*, *Associazione senza confini* etc.) and the services. As has been said, these courses do not focus on linguistic skills and there is no accreditation or certification system in Italy. The lack or limited knowledge of interpreting skills can seriously jeopardise accuracy and even lead to malpractice suits as well as to considerable damage for all stakeholders (patients as well as institutions). On the other hand, university trainees in interpreting courses are not usually trained in the necessary cultural competence skills. A close collaboration between universities and healthcare providers is essential. One way of doing this would be to offer specific post-graduate specialisation courses. Furthermore, in-service training courses could be offered to practising interpreters or mediators with no

formal qualifications wishing to acquire interpreting/translating skills and specific terminology.

4. A case-study

In 2008 a post-graduate specialisation course for Public Service Interpreting in medical and legal settings was organised at *S.S.L.M. Istituto San Pellegrino*, Misano Adriatico (RN), Italy (now *Fondazione San Pellegrino*). The course is an intensive post-graduate specialisation course (3 months) held on Fridays and Saturdays in order to facilitate students and graduates who are already working and/or live in other parts of the country. Many of the students studied languages, but some work in other subject areas and wish to specialise in this setting. They are trained in 2 languages: English is compulsory, whereas the second language has to be chosen among German, French and Spanish. A third language may also be chosen.

Admission criteria are: either a degree in interpreting/translation or modern languages, or a substantial experience as a professional interpreter but no degree; and, secondly, a high level of proficiency in English along with a good command of their second foreign language and of Italian.

The author designed the course based on her long experience as university interpreting lecturer and conference interpreter, and in particular on the basis of the courses conducted and research work done with M. Rudvin at SSLMIT Forlì (University of Bologna) as well as on the basis of the analysis of similar courses organised in other European countries, and above all in the United Kingdom.[1]

The course modules are:

- Law (basic notions for court and legal interpreters, professional liability issues, the Italian legal system and short comparative analyses with other legal systems);
- Institutions (hospitals, courts, police headquarters etc.);
- Public Service Interpreting – interpreter's skills and tools in health and legal settings;
- Interpreting techniques (dialogue, consecutive interpreting and *chuchotage*);
- Code of conduct, cross-cultural issues and specific medical and legal terminology.

To complete the analysis of healthcare interpreting issues and medical terminology in English, a whole day as well as individual research work are devoted to the European project *Medics on the Move* (*MoM*) which is carried out in the framework of the Leonardo programme and aims at promoting the mobility of healthcare professionals in the European Union. Medical professionals who do not use their first language at work are thus provided with communication tools

1 Several British universities (London Metropolitan University, the College of North West London, the University of Northampton and many others) organise courses addressing those who want to work as public service interpreters in the health or the legal sector (including the police and the courts) and prepare students for the Diploma in Public Service Interpreting (DPSI) examinations organised by the Institute of Linguists. The DPSI is the main qualification for interpreters who work in public services, including legal, health and local government sectors (<http://www.iol.org.uk/>).

designed to help them to function effectively as professionals. Students are trained to use this multi-faceted tool which offers them terminology training as well as insights into medical communication and socio-cultural interaction. *MoM* includes searchable databases of more than 200 workplace-oriented communication scenarios and more than 1,000 everyday medical terms in six target languages (English, Danish, Dutch, German, Italian and Swedish) that allow students to explore lexical, syntactic as well as social aspects of medicine.

The system also enables and encourages interaction with other members of the *MoM* community through forums and chat functions. Of course one three-hour lesson is not enough to examine all the different opportunities offered by this tool, but students were invited to take part in a Forum, report any difficulties, add nouns and relevant pronunciation. We had a very good response on the part of students. After completing their work placements, students were invited to take part in the testing phase of the *MoM* project addressing healthcare professionals who are at beginners' level in the professional language they use in their host countries. This will give them the opportunity to study some of the topics examined in depth (for instance terminology), and to be in contact with other European universities. They will be asked to fill in a questionnaire once a week and to fill in the final evaluation form. Students who complete all five questionnaires will receive a certificate of participation in the research project from Antwerp University.

The main novelty of using such a tool from a healthcare interpreter trainer's point of view is that it is an integrated approach to languages and vocabulary learning, and it is not simply based on terminology lists, but rather on scenarios (a total of 106 scenarios).

Taught sessions are followed up with guided self-study and homework assignments. Teachers include qualified interpreters and/or translators affiliated with professional interpreters'and translators' organisations who also have considerable experience as university lecturers. Workshops are held by university researchers and interpreters (code of conduct, cross-cultural issues, court interpreting) and speakers from public service institutions (the Police and the *Ospedale degli Infermi* in Rimini) who introduce the structure, procedures and vocabulary of the area they work in.

The course is taught interactively, with group discussions, role-plays, work in small groups and in pairs and individual practice. Students are assisted in drawing up accurate glossaries (meant as "work-in-progress", to be constantly updated) and in dealing with the interpreting problems that are specific to each language (sight translation, introduction to note-taking and role-plays).

4.1 On-the-job experience – an essential training tool

There are no exams at the end of the course, but the compulsory work placements offer students the opportunity to put into practice the theories and techniques they have studied and open up employment opportunities. One student who participated in the second edition of the course was hired by the *Ospedale degli Infermi* in Rimini in summer 2010.

The placements are split into two one-week periods: one takes place at the Police Headquarters in Rimini, the other in one of the three hospitals the *Foundation* has an agreement with: *Ospedale degli Infermi* (Rimini), *Ospedali Riuniti* (Ancona) and *Ospedale Maggiore* (Bologna). This on-the-job experience is a short but useful example of an ongoing collaboration with healthcare trusts and hospitals (Rimini, Ancona and Casalecchio di Reno) aimed at offering medical interpreting students hands-on experience as well as theoretical and practical training based on the institutions' needs.

Placements give trainees the opportunity of actually experiencing some of the difficulties they have become familiar with during the course: stress, medical terminology, differences in register, checking that the message has really been conveyed, asking for explanations etc. They also understand how varied and complex interpreters' tasks are here: mastering three languages and a very specific medical terminology, passing from high-register scientific language to a colloquial register, complying with impartiality and confidentiality rules, preventing and solving conflicts – especially those due to cross-cultural issues – and also performing administrative work and doing written translations.

4.2 Work placements in Rimini – the hospital interpreting service

Whilst a number of the other hospitals surveyed have various forms of "language mediation" services (Tomassini/Nicolini 2005, Rudvin/Tomassini 2008), the Hospital of Rimini, *Ospedale degli Infermi*, is an outstanding example of a well-organised interpreting service in the Emilia Romagna Region. As early as the mid-1990s interpreters (*Operatore Amministrativo-Interprete*) were hired and an internal interpreting service office was established (Delli Ponti/Forlivesi 2005). The in-house interpreters are not hired on a permanent basis, but sign temporary 2-year renewable employment contracts as free-lance professionals, and have to be fluent in three foreign languages: English, French, German. The interpreting service was first opened during the summer to cater for tourists, then its availability was extended to cater for emerging needs throughout the year.

The ward, the hospital administration department, or the Interpreting Office hire interpreters for less diffused languages when the need arises. Arabic, Chinese and Russian (when the Russian-speaking interpreter is not working) are the languages most in demand, followed by Rumanian, Albanian, Croatian, Czech, Persian, Polish, Portuguese, Wolof. In-house interpreters have a list of qualified interpreters for those languages. In case of need, foreign embassies are contacted. Only in exceptional cases do wards resort to ad-hoc interpreters (patients' relatives or friends), but if the Interpreting Service is informed, this always occurs with the assistance of an interpreter.

4.3 Work placements in Ancona – the hospital mediation service

The linguistic-cultural mediation service offered by the hospital of Ancona (*Ospedali Riuniti*) is aimed at facilitating migrants' access to healthcare services.

According to *Ospedali Riuniti*'s Charter of Services, mediators should be properly trained professionals who master the language and the culture of origin of the foreign users. Specifically, they have been trained for social services and the healthcare sector, and their tasks include mediating services during patient-clinician dialogues (and treatment explanations), translation of forms and healthcare information leaflets, welcoming migrants and helping them access services, and supporting front-office staff and social workers. When mediation services are needed the cultural-linguistic service coordinator is informed by the Social Workers division, Front Office staff or Health Management Division, and a mediator is called. Services rely on twenty foreign mediators of various nationalities. They are all members of *Gruppo U.M.AN.- Associazione Senza Confini*, the Cultural Mediators' Association which has a yearly contract with Ancona Healthcare Trust.

Mediation services cover the following languages/cultures: English, French, Spanish, Arabic, Russian, Ukranian, Polish, Turkish, Moldavian, Rumanian, Serbian, Croatian, Bosnian, Albanian, Filipino, Urdu, Hindi, Chinese, Greek, Macedonian, German, Bulgarian, Farsi/Dari, Fanti/Ashanti.

As to recruitment criteria, mediators need to:

- be migrants coming from EU member states or from non-EU member states;
- have at least a high school diploma;
- have lived in Italy for at least 3 years;
- know Italian language/culture and one vehicular language well on top of the language/culture of their country of origin;
- have good relational skills.

Normally mediators have other jobs and work as cultural mediators occasionally. They have varying educational qualifications (some of them have university degrees, others a high school diploma), and priority is given to their experience.

Attending a specific social and healthcare mediation course is not compulsory but recommended. Once they are recruited, the Association offers them two or three 30-50 hour courses of theoretical and practical training (in collaboration with the bodies they supply their services to). The courses focus on immigration laws, code of conduct, public healthcare services, analysis of critical cases etc. For less diffused languages such as Bangla individual 2-hour meetings are organised.

4.4 Work placements in Bologna – mediation service

Owing to recent budget cuts, the *Ospedale Maggiore* is no longer endowed with an in-house mediation service (the service was started in 1999), but the relevant Local Healthcare Trust signs yearly contracts with the Cultural Mediators' Association *Amiss*, which in turn calls in mediators based on emerging needs or planned mediation services.

The new *Integrated Mediation Service* was officially opened in July 2009 and includes a Multilanguage Telephone Admission System and scheduled mediation services. The telephone system is operated by mediators through a call centre offering a 24-hour information service. Languages offered are: Albanian, Arabic,

Bangla, Chinese, Croatian, French, German, Hindi, Japanese, English, Polish, Punjabi, Rumanian, Russian, Serbian, Croatian, Spanish, Tigrini, Urdu. Thanks to special telephones, users can select the language they need for a medical conversation by pushing a button with the relevant country flag. Healthcare professionals are connected with the call centre operator who will translate the patients' utterances. A 3-party interlocutor service is thus activated (health professional-mediator-patient) that, at any time of the day, allows them to correctly exchange all the information needed to make a diagnosis. The same telephone sets allow users to activate the scheduled mediation service and thus make an appointment with the mediator in the ward or the doctor's office.
The main purposes of the mediation services are:

- eliminating linguistic and cultural barriers and ensuring that every patient has free access to social and healthcare services;
- supplying healthcare professionals with a service that allows them to make a correct diagnosis;
- offering foreign patients health-education practices;
- offering a tool for identifying the best mediation (immediate or scheduled) service.

Mediators have to attend a social and healthcare training course organised by regional and/or municipal authorities. They have varying educational qualifications (some of them have university degrees, others a high school diploma) but great importance is attached to their work experience.

4.5 Students' Feedback

The course is currently in its third edition. Students report on their experience and share it with their classmates in a forum, and this feedback is then used by the coordinator to better target the course the following year. Adjustments are of course needed every year to target the placements based on both service-providers' and trainees' needs. Students highly appreciated their work placements as they gave them the opportunity to acquire work experience in the field and to put into practice both the theoretical notions acquired and their interpreting and terminology skills. Moreover, they appreciated the positive collaboration they had with police officers, healthcare professionals and interpreters/mediators. The following comments were representative of the students' feedback: "It was a very interesting experience. Interpreters were ready to give explanations"; "I've seen them at work on several occasions, also on the phone and doing written translations. Even though the languages used were not my languages (German and Russian), it was nevertheless interesting"; "The staff was very kind to me and ready to help. I'll go on studying medical terminology"; "I understood the hospital's organisational work – thanks to the Chinese mediator I understood how the mediation service is organised. I also had the chance to talk to foreigners who came to the desk asking for advice, information or explanations".

5. Conclusions

Based on the new needs on the part of healthcare institutions and the new demographic situation, translator and interpreter schools and faculties of modern languages are called upon to give their contribution to facilitate communication at institutional level and organise specific healthcare interpreting courses. Qualified healthcare interpreters should be considered as an integral part of the health professionals' community. As Ann Corsellis stated: "linguists working in public services should become regulated professionals like their colleagues in other public service disciplines such as doctors, lawyers and nurses and for the same reasons" (Corsellis 2005).

The situation existing in the two regions examined and the training experience acquired has led the author to believe that specific post-graduate courses should focus, on top of linguistic and interpreting skills, on specific terminology, cultural competence and work placements in hospitals.

As one of the most compelling needs concerns languages of lesser diffusion, specific courses are also needed to address professionals willing to specialise in this setting and focus on aspects like the code of ethics and specific terminology.

As described above, work placements in hospitals proved to be extremely useful and stimulating to all trainees, and also helped trainers to better understand the increasingly changing needs of service providers in communicating with patients with different languages and cultures.

Italian healthcare institutions, and especially the regional, provincial and local authorities examined in this paper, are now increasingly attentive to cross-cultural issues, and greater attention must be paid by universities to these issues. This growing awareness reflects what is happening in many industrialised countries including the United States, Western Europe, Australia, New Zealand, as well as areas in Latin America and Asia, which have seen an enhanced interest in the need for healthcare services to cater for "the cultural and social heterogeneity of the population" over the last decade (Epstein 2008a: 6). The case study described here shows that closer collaboration between health institutions and universities is needed to offer solutions providing more efficient mediation services and facilitating communication between healthcare professional and foreign citizens.

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Proposals for healthcare reform in the Russian Federation for 2020â€“2022: 1) Improve the situation for healthcare workers.Â This will significantly raise the quality of training for medical staff in universities and colleges. Establish an internship scheme for all medical specialisms and increase the number of unpaid positions in residency training. Create the conditions for CME (continuing medical education), which involves setting aside dedicated time (no less than 1 working day every 2 months) and earmarking financial resources. Bring in the act â€˜On basic healthcare protection for citizens of the Russian Federationâ€™ and provide medical science with 3 times more funding than the current level. 6) Maintain constant vigilance against epidemics and crisis situations. Italyâ€™s approach to healthcare IT, and more specifically e-Health, has three facets. These are based on: National-scale techno-infrastructural requireme.Â In addition, the e-Health programme also aims to accelerate technological innovations and take-up of patient-centred healthcare services. Responsibility for the programme is entrusted to a body called the Cabina di Regia. It is comprised of representatives of both the national government and the regions, and coordinated by the Ministry of Health. New National Healthcare Information System. The New National Healthcare Information System (NSIS) was proposed in early 2001 by the Permanent Committee, which coordinates political issues between the central and regional authorities. The paper reports on an on-going collaboration with healthcare trusts and hospitals in Casalecchio di Reno, Rimini and Ancona aimed at offering medical interpreting students hands-on experience as well as theoretical and practical training based on the institutions' needs. Discover the world's research.Â In this context, Tomassini (2012) analyzes the current needs of healthcare interpreting in Italy and encourages the collaboration between universities and healthcare service providers. Interpreting Studies. Chapter. Equality and Health Inequalities Statement Promoting equality and addressing health inequalities are at the heart of NHS England and NHS Improvementâ€™s values. Throughout the development of the policies and processes cited in this document, we have: â€¢ Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and. â€¢ Given regard to the need to reduce inequalities between pa...