

GUIDE FOR
**Intercultural
Mediation** in
Health Care



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1. INTRODUCTION

1.1 AIM OF THE GUIDE FOR INTERCULTURAL MEDIATION

With the publication of this text, we want to contribute to the professionalization of intercultural mediation in health care. At the same time, we want to encourage providers and patients to resort more often to intercultural mediators when they are confronted with linguistic or cultural barriers.

This text is not only a guideline for good practices in intercultural mediation but also a guide for organising intercultural mediation in health care institutions.

To achieve our goals, we will first develop a series of starting points of the intercultural mediation program financed by the Belgian Federal Public Service Health, Food Chain Safety and Environment and Federal Institute for Health Insurance (RIZIV). We will then discuss the definition of intercultural mediation, the guiding principles for the intercultural mediator's work and the tasks of the intercultural mediator.

After the description of the tasks, you will find a description of the way they ought to be executed. These 'standards' provide a point of reference for the evaluation of the mediator's performance. We pay special attention to a number of problematic situations that the intercultural mediator and providers could be faced with in their work.

The text also includes a deontological code for intercultural mediators. In most projects on intercultural mediation, reference is made to the deontological or ethical codes for (medical) interpreters. These, however, do not offer a solution for many situations that the mediators are confronted with because of the specificity of their job.

Moreover, we included a series of standards for organising intercultural mediation in the hospital (or in another health care institution). To a considerable extent, the rate of return of intercultural mediation depends on the guidance and support the intercultural mediators receive. Support from the supervisor and management of the organisation and access to a number of resources (dictionaries, internet, ...) are crucial. Intercultural mediators are often faced with problems they cannot solve by themselves. It is pivotal that they can turn to their supervisors in these cases. Finally, we specify a number of rules for the organisation of video remote intercultural mediation.

1.2 THE DEVELOPMENT PROCESS

This text is strongly based on the work about medical interpreting and intercultural mediation done in the US, Canada and Switzerland. We were mostly inspired by perspectives from medical sociological and medical anthropological research.¹ Our approach is primarily based on the work of American physician Robert Putsch, of the Canadian anthropologist Joseph Kaufert (Kaufert & Putsch, 1997) and of the Swiss nurse and public health specialist Alexander Bischoff (Bischoff, 2007). In addition, the 'Guide' was strongly inspired by the standards of a number of American organisations for medical interpreting, especially the International Medical Interpreters' Association (IMIA), the Californian Healthcare Interpreting Association (CHIA) and the National Council on Interpreting in Health Care (NCIHC)². As far as we know, this is the first time ever that standards are being developed specifically for intercultural mediation in health care settings.

After a study of the relevant scientific literature (Verrept, 2012) and the analysis of the existing standards for medical interpreting, we first examined with intercultural mediators whether and to what degree these could be used as a normative framework for their work. These texts appeared to contain guidelines that are also useful and applicable in intercultural mediation. They did, however, not provide satisfactory answers to a number of problematic situations intercultural mediators are facing.

Secondly, in order to have as complete a picture as possible, we asked each intercultural mediator to submit 3 'problem-cases'. 'Problem cases' were defined as situations or interventions in which the intercultural mediator did not know how to deal with in a professional way. In total, about 240 of these cases were discussed in detail during supervision sessions. We tried to reach a consensus on what would be the best way for the intercultural mediator to handle these different situations. On the one hand, these discussions led to the definition of a number of guiding principles for intercultural mediation in health care. The task description and standards are based on these principles. They can help the intercultural mediator to determine which strategies are desirable and acceptable when he is faced with professional, ethical or other dilemmas. We describe these principles under 2.3. On the other hand, these discussions also led to the description of a series of standards that offer a clear guideline for the work of the mediator and its evaluation by his supervisor.

When analysing the cases, the relevant literature and discussions with external experts were also taken into account. The reports of all these discussions were the basis for a draft of this text which was in turn discussed with the intercultural mediators and their supervisors, and finally adapted and corrected.

¹ . See among others Kleinman, Eisenberg & Good, 1978; Kleinman, 1988; Greenhalgh, 2006.

² . For more information and access to the before mentioned texts we refer to the websites of these organisations: IMIA (www.imia.org), CHIA (www.chiaonline.org), NCIHC (www.ncihc.org).

2. INTERCULTURAL MEDIATION

2.1 MAKING THE CASE FOR PROFESSIONAL INTERCULTURAL MEDIATION

Before taking a deeper look at the actual tasks of the intercultural mediator, it is important to describe the problems in the provision of health care for migrants and ethnic minorities (hereafter: MEMs).

In this context, it is important to take into account the specific situation in which the care is provided and which is characterised by the very asymmetrical relationship between the different parties involved. On the one hand, we have the provider who has expert knowledge and who is ranked 'higher' than the patient in the health care institution (and often in society in general). On the other hand, we have a layman, a health care user who depends on the provider because of his illness and may be very vulnerable because of fear and distress.

In accordance with the relevant scientific literature, we assume that the accessibility and quality of care for MEMs suffer from the language barrier, socio-cultural barriers and the consequences of interethnic tensions, racism and discrimination. If we want to give MEMs the equitable access to quality care, we will need to minimise the effects of these barriers as much as possible. Without doing this, the cultural competence³ of the health care system will in many cases be insufficient to provide quality care. This will cause or perpetuate ethnic health (care) disparities.

Experts seem to agree that using intermediaries⁴ is one of the most important strategies to improve care for MEM- patients (Deville et al. 2011). Its most important effects are: less communication problems, the patient is better informed on his condition and the treatment, and a better outcome of care. Thanks to the use of intermediaries, it is possible to offer patients with limited proficiency in the provider's language the same quality of care as patients who are fluent in the provider's language (Flores, 2005; Karliner et al., 2007). The Belgian government chose to rely on intercultural mediators (instead of interpreters) because their mission is not only to resolve language barriers but also – at least partly – the other barriers mentioned above.

³ Cultural competence has been defined as: having the attitudes, knowledge and capacities to make efficient care available to all patients, regardless of their language, religion and culture.

⁴ This term is used to refer to intercultural mediators as well as interpreters.

2.2 DEFINITION OF INTERCULTURAL MEDIATION

We define intercultural mediation as a set of activities that aim to reduce the negative consequences of language barriers, socio-cultural differences and tensions between ethnic groups in health care settings. The final purpose is to create health care services that are equally accessible and of equal quality (outcome, patient satisfaction, respect for the patient's rights etc.) for MEMs and 'indigenous' patients. Intercultural mediation tries to achieve this by improving communication and thus acting strategically on the relationship between the provider and the patient. In this way, the patient's position in particular, but also the provider's, is strengthened so that health care is better tailored to the patient's needs and the provider is able to provide efficient care.

Besides bridging the language and cultural gap, the facilitation of the therapeutic relationship between the provider and the patient represents an important dimension of intercultural mediation (Qureshi, 2011). According to Chiarenza (quoted in Pöcchacker, 2008), intercultural mediation will also help organisations adapt their services to the needs of MEMs.

The intercultural mediator in Belgium is a fully-fledged employee of the health care institution and is thus also subject to the rules and procedures applicable within the institution. This has implications for a number of deontological dimensions of his work that will be discussed later.

2.3 PRINCIPLES FOR THE EVALUATION OF INTERCULTURAL MEDIATION

1. The intercultural mediator, as a member of the team caring for the patient, has the responsibility to contribute to the health and well-being of the patient.
2. A positive relationship between the provider and the patient is in many cases necessary in order to provide qualitative and effective care. For that reason, the intercultural mediator will stimulate and support the development of this type of relationship as much as possible.
3. Intercultural mediation is successful when we are able to eliminate the negative effects of the above mentioned barriers on the quality of care for the MEM-patient and the 'indigenous' provider. This should allow providers and patients to respectively provide and receive the same quality care as an indigenous patient. This implies e.g., that when a native-born patient is informed on his condition by a physician, that this should also be the case for the immigrant patient; for this reason it is deemed to be unacceptable that this task would be delegated solely to an intercultural mediator for MEM-patients.
4. Good intercultural mediation also implies that we strive for minimal intervention in the relationship between provider and patient, in order to affect the autonomy of the patient as little as possible. If interpreting by the mediator suffices to make the effective and

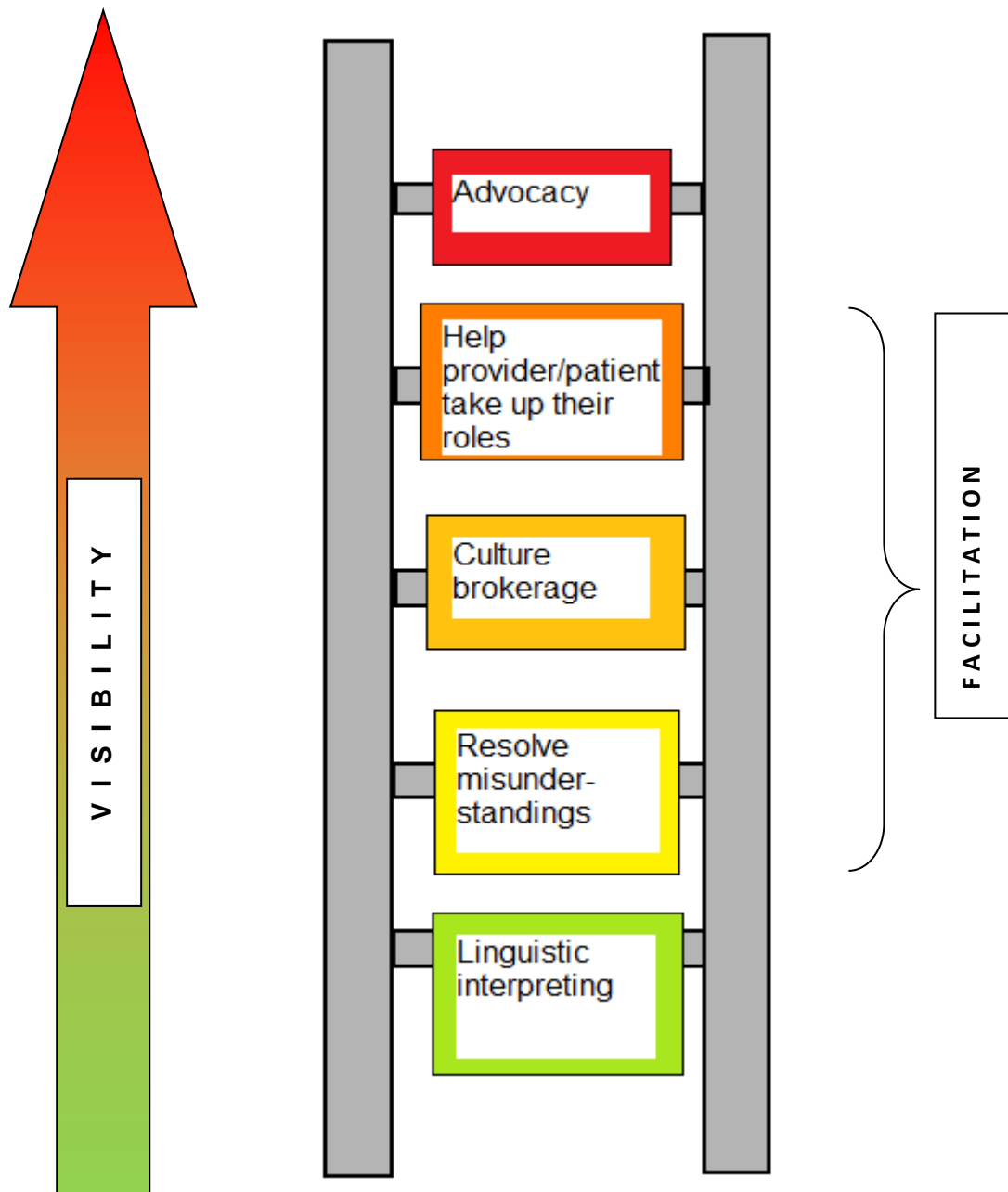
5. efficient collaboration between the patient and the provider possible, we assume that the intercultural mediator should refrain from the execution of the other tasks described below. Intercultural mediation has to respect and stimulate as much as possible the autonomy of the patient and the provider. The final purpose is to offer both the patient and provider a chance to take up their respective roles as equal partners.

6. Due to the specific nature and context of the work of the intercultural mediator, he may be the only one to notice a problem that might seriously impede the outcome of the health care intervention, or even endanger the patient's life. His responsibility for the health and well-being of the patient and the provider - patient relationship may make it necessary to point this out, and if possible, to suggest solutions that can contribute to a positive result.

3. TASKS OF THE INTERCULTURAL MEDIATOR

3.1 THE LADDER MODEL

In order to achieve the above mentioned goals, intercultural mediators in health care carry out a number of tasks that are summed up below in the 'ladder-model'.



The choice of the ladder as a graphic representation of the tasks of the intercultural mediator is based on an analysis of the benefits and risks associated with their execution. The higher a task is situated on the ladder, the more complex it is. When carrying out the tasks higher on the ladder, the mediator's 'visibility' and influence on the health care delivery process increase (Angelelli, 2004). This may – under certain circumstances – be undesirable.

When carrying out the task 'linguistic interpreting', the intercultural mediator or medical interpreter is 'least visible' according to Angelelli (2004). As a result, his impact on the care delivery process will be relatively limited as well as the risks associated with his intervention. It is the task for which a large number of professional standards exist. Given that tasks higher on the ladder are more complex, it is harder to formulate precise norms or standards for them. More risks may be linked with their execution. For that reason the higher placed tasks will only be carried out when they appear to be really necessary.

For clarity's sake, we have separated the different tasks of the intercultural mediator hereafter. However, it is quite possible that the mediator will carry out various tasks from the ladder during one and the same intervention.

3.2 LINGUISTIC INTERPRETING

At the bottom of the ladder we find 'linguistic interpreting', that is, at is, to convert a message uttered in a source language into an equivalent message in the target language so that the intended recipient of the message responds to it as if he or she had heard it in the original

(IMIA, 1995). The background of this step on the ladder is coloured green, which indicates it is a 'safe' task that will be the first choice when we are confronted with a patient who speaks a different language. By definition, this task will be executed during a triadic encounter.

Although linguistic interpreting is in itself a complex task, there are a number of international rules on how it should be executed. This is expressed in a large number of standards for medical interpreters on which our standards for this task are based.

When an intercultural mediator can limit himself to this task, the advantage is that the responsibilities of the different participants involved in the care delivery process are very clear: the intercultural mediator is only responsible for the interpretation, while the provider is responsible for the proper execution of all other aspects of care provision. Of course, the patient has a responsibility too. Asking the 'right' questions, giving correct information and carefully following the prescribed treatment plan will influence the chances for success.

3.3 FACILITATE

Those in favour of limiting intermediaries' roles to linguistic interpreting will argue that it is the provider's – and up to a lesser degree the patient's - responsibility to address all other barriers that may hamper the care process (Bot & Verrept, 2013). When e.g. misunderstandings occur during the conversation, they should be noticed and solved by the provider and/or the patient. According to them, the intermediary has no role to play in this regard.

It is, however, clear that in many cases only overcoming the language barrier will not lead to effective communication and good quality care. The literature shows that socio-cultural differences and inter-ethnic tensions may severely diminish the accessibility, acceptability and quality of health care. In addition, providers often do not have the necessary culture competence to provide patient care in an efficient and effective manner to MEMs. Finally, many MEM-patients' health literacy level is (very) low, making it impossible for them to take on their role as an autonomous partner in the care providing process, and this independently from the language barrier (Greenhalgh et al., 2006).

That is why intercultural mediators carry out a number of tasks that go beyond interpretation and that are more complex, involve more risks and ask for more judgment on their behalf. Standards for executing these tasks are available neither in the literature nor in the field. The three tasks above linguistic interpreting on the ladder, all aim at facilitating the collaboration between the provider and the patient. Because of their complexity and the absence of generally accepted standards on this subject, we have put them higher on the ladder, and on an orange background to urge mediators to execute them with the utmost caution. When intercultural mediators take on these tasks, they will share the responsibility to achieve meaningful communication and an effective patient-provider collaboration with the providers.⁵

The intercultural mediator will preferably carry out these tasks in the presence of the provider (during a triadic encounter). If the provider or patient is not present during the meeting, the intercultural mediator will make sure the absent party is informed on what was discussed.

3.3.1 Resolve misunderstandings

'Resolve misunderstandings' implies that the intercultural mediator signals possible misunderstandings and tries to solve them. We assume that it is not desirable to lose part of the (limited) time available for care provision by not resolving misunderstandings that could negatively affect the patient's health and the therapeutic relationship.

⁵ This is also the view of the National Council on Interpreting in Health Care (NCIHC, 2014).

3.3.2 Culture brokerage

Culture brokerage can - in this context - be defined as 'managing cultural differences' during the health care encounter. It entails that the intercultural mediator is alert to cultural concepts, beliefs and practices that might lead to a misunderstanding and/or hamper the health care delivery process. This may trigger a shift to the culture brokerage (or cultural clarifier) role. Kaufert & Koolage (1984) define culture brokerage as 'explaining the culture of the provider to the patient and the culture of the patient to the provider.' The provider might e.g. need explanations on the perception of or associated meanings with the patient's illness in his culture. They rightfully indicate that, in some cases, the patient might also need information on the culture of the health care system. Together with the provider and/or the patient, the intercultural mediator will in such cases look for strategies that minimise as much as possible the negative effects of cultural differences.

Let us clarify this task with a few examples:

- (1) A Moroccan father refers to a 'jinn' as the cause of his son's epileptic seizures. The Dutch translation of the term 'jinn' is "geest" ('ghost'). If the provider is not familiar with the Moroccan explanatory models, this translation will not transfer the original message. It could be of great importance that the provider is informed that ghosts, who are mentioned in the Quran, are considered as possible causes of among others epilepsy by a large number of Belgians of Moroccan origin. It may also be highly relevant to point out that there's a risk that these patients will call in the help of traditional healers offering their services in Belgium or Morocco. In a number of cases, this will lead to the patient not following the treatment prescribed by the physician. The intercultural mediator will explain this to the provider to make it possible for him to address these issues.
- (2) A female patient originating from a culture that has a strong sexual segregation and that has just given birth is not very talkative when she is being informed about breastfeeding in the presence of her husband. The intercultural mediator could point out to the nurse or physician that giving this type of information in the presence of a man, even if it is her husband, causes a lot of embarrassment for the patient and that this could explain why the patient is not really cooperating. The provider might then decide to ask the husband to leave the room during the consultation.
- (3) In a hospital, conflicts occur regularly after a Turkish patient has passed away. The intercultural mediator can inform the provider on the expectations and wishes of Turkish families after the death of a loved one and can suggest actions that decrease the risk for conflict.
- (4) In the emergency room a Russian patient is mad at a nurse because there are patients who arrived after him but are being treated before him. The intercultural mediator can explain to the person involved that it is standard practice to treat the most severe cases first in the emergency room and that this is not a sign of racism.

Culture brokerage is a very useful strategy for improving the provider's culture competence as well as therapeutic efficiency and effectiveness. That is why it is also included as a task in the job description of most medical interpreters in the US.⁶ Gustafsson et al. (2013) even state that culture brokerage is inevitable since it is an inherent part of the interpreting process.

However, there are also associated risks. From an anthropological point of view it is not very clear how to best prepare someone to take on this task. Within the Belgian intercultural mediation in health care program, we mainly work with intercultural mediators who originate from the ethnic group they work for. This shared ethnic origin does of course not automatically imply that the person involved is also familiar with all prevailing concepts, values and practices within his own ethnic group. Biographic and family factors, as well as intracultural variation, will necessarily limit and bias the view and knowledge of the mediator of his own culture. This means that the mediator will be able to identify, signal and clarify cultural barriers in some cases and not in other. Providing cultural information can also contribute to creating stereotypes which, in turn, will form a barrier between the provider and the patient.

All these reasons make culture brokerage a task that should be carried out with great caution, which is why it is higher up on the ladder and has an orange background.

[3.3.3 Help provider and patient take up their roles](#)

The third facilitating task is supporting or helping the patient and provider to take up their respective roles as effectively as possible, in order to achieve the best possible outcome.

Some examples of this third facilitating task:

The message of the provider is not understandable for the patient even when it is interpreted, either because it contains too much medical jargon or because the patient has a (very) low educational level. Also, it may be impossible to interpret it because no equivalent terms or concepts exist in the patient's language. In such cases, the intercultural mediator will have to develop strategies that enhance the chance for mutual understanding. He can ask the provider to simplify his message or to make a drawing in order to clarify his message. In certain circumstances, the intercultural mediator can simplify the message himself.

The provider asks the patient questions, for example using a psychological questionnaire, that do not make any sense to the patient because he is completely unfamiliar with this kind of tool. In such cases, the intercultural mediator can inform the provider about this and look with him for alternative strategies to obtain the necessary information.

⁶ See for example the standards of the IMIA (www.imia.org), CHIA (www.chiaonline.org), NCIHC (www.ncihc.org).

When a patient feels inhibited in the presence of the provider and does not ask any questions or does not indicate that he doesn't understand something, the intercultural mediator can encourage him to ask questions and to tell when he does not understand something. He can suggest strategies to the patient to prepare the consultation (e.g. bringing his medication to the consultation, preparing a list of questions he wants to ask or symptoms he would like to report etc.).

The patient does not know how to make an appointment with a doctor or physical therapist, which documents he needs to bring to the hospital... The intercultural mediator can assist him in that or give him the necessary information.

[3.3.4 Some considerations on the facilitation role](#)

The three tasks that we list under 'facilitation' can be executed either during or outside a triadic encounter. The intercultural mediator can notice a misunderstanding during an individual contact with the patient or provider and try to resolve it. Culture brokerage can take place during a triadic intervention as well as during a patient conversation or during a training session for a group of providers. Supporting patient and providers in taking up their respective roles, can also take place outside the triadic context, for example during a preliminary conversation with the provider ('how could we best address this problem with this patient?') or an individual contact with a patient.

The extent to which these tasks need to be executed by the intercultural mediator strongly depends on the communication skills, the empathy and the culture competence of the provider. Facilitating communication and care provision is much more delicate than interpreting and lays a heavier burden on the intercultural mediator's shoulders.

An example: a provider asks an intercultural mediator to have an individual conversation with a patient that is not very talkative with the provider. The objective is to gain insight in the circumstances in which certain complaints originated. This requires from the intercultural mediator the ability to lead this type of conversation and to report it in an accurate, synthetic but still complete manner. If the intercultural mediator makes errors, this could obviously have serious consequences for the quality of the care.

3.4 ADVOCACY

At the top of the ladder, and with a red background, is the task advocacy. Advocacy is defined as 'speaking or intervening in someone else's interest' (Van Esterik, 1985). The National Council on Interpreting in Health Care (2005) describes advocacy as 'an activity carried out for someone else that goes further than facilitating communication and with which we aim for a good result of the care'. In general this means that a third party (in our case the intercultural mediator) will advocate for the patient, and possibly leave his impartial position.

In both definitions the intermediary is entitled to take the initiative of asking questions or carrying out certain actions when deemed necessary for the quality of care or the patient's interests. Advocacy can take place in a completely conflict free context, but also in a context characterized by hostility or an overt conflict, as the examples below clearly show.

- (1) The intercultural mediator informs the provider that the patient is allergic to specific drugs. He is aware of this, as opposed to the provider, because of previous contact with the patient.
- (2) A patient had breakfast the morning before a surgical intervention. He neglected to inform the nurse about it but he told the intercultural mediator. The intercultural mediator informs the nurse about it.
- (3) A patient is treated disrespectfully by a provider and feels hurt in his dignity. The intercultural mediator will address this subject with the provider or inform his supervisor.

A fundamental difference between these examples is the fact that in the first two examples, the intercultural mediator remains impartial; this is clearly not so in the third example.

Advocacy, especially when it is paired with the interpreter giving up his neutral position, remains controversial in the world of medical interpreting. It has been pointed out that the intermediary is not always able to determine what the patient's best interests are. This of course is a prerequisite to be able to defend them (Verrept & Louckx, 1997). An erroneous estimate can damage the patient's interests. In addition, advocacy may make providers unwilling to call in the mediator's services in the future. This is especially likely when the mediator does not receive sufficient support from the management of the health care institution.

However, advocacy is in many cases – implicitly or explicitly – referred to in the task description of medical interpreters⁷. Given the risks, the intercultural mediator will carry out this task – in particular during interventions where he will have to give up his impartiality – with the utmost caution and in close collaboration with his supervisor. When necessary, the problems will be reported to the hospitals ombudsman or higher management.

Defending the patient is a task for everyone working in the hospital and is included in the internal rules of all hospitals. As such, it is not the exclusive responsibility of intercultural mediators. But as they are in constant and direct contact with an often highly vulnerable group, the need for advocacy may be especially important among their patients. That is why we explicitly include this task in the ladder model of the tasks of the intercultural mediator.

⁷ In the IMIA standards implicitly, in the National Council on Interpreting in Health Care's and the California Healthcare Interpreting Association's standards explicitly (see www.imia.org; www.ncihc.org; www.chiaonline.org).

4. STANDARDS FOR THE TASKS OF THE INTERCULTURAL MEDIATOR

4.1 PRELIMINARY REMARKS

The boundaries between the different tasks are not always clear-cut. Bischoff (Bischoff, 2007; Bischoff & Dahinden, 2008) argues that a complete separation of these roles (interpreter and facilitator/mediator) in real-life situations is often impossible and undesirable. Moreover, the task description of many intermediaries in health care labelled as 'interpreters' encompasses tasks that go beyond linguistic interpreting (Bot & Verrept, 2013; Souza, 2016)⁸. As a result, it is sometimes hard to decide whether a certain standard pertains to 'linguistic interpreting' or 'facilitating'.

We included different types of standards: some standards describe how a task should (not) be carried out, others give the intercultural mediator an explicit mandate that allows him to perform certain types of interventions.

4.2 STANDARDS FOR LINGUISTIC INTERPRETATION

Linguistic interpretation is, as indicated above, the complete and faithful conversion of a message from a source language into an equivalent message in a target language. In principle, nothing is added or omitted.

- § 1 The intercultural mediator will limit himself to interpreting when this is sufficient to reach the goal of the mediation.

- § 2 The intercultural mediator will prepare this task in order to optimise the chance for a quality interpreting performance. This includes following the standards below (§ 2.1-§ 2.5):
 - § 2.1 The intercultural will always try to hold a pre-conference with the provider. The shortest form of this briefing is the question 'Is there anything I should now before we start?'

 - § 2.2 Before the consultation, the intercultural mediator will inform the provider if he has already helped this patient before or if it is important that he has certain information about the patient.

⁸ In her phd research of 458 medical interpreters from 25 countries, Souza (2016) found that almost all of them (> 99%) indicated they contributed actively to communication by executing tasks that exceeded the actual language interpreting. See also Tipton & Furmanek (2016)

§ 2.3 Before the beginning of the consultation, the intercultural mediator will try to have a general view on the problem(s) at hand. This allows him to prepare the job or to be able to refuse it (for example on a specialised subject or for emotional reasons).

§ 2.4 Before the beginning of the consultation, the intercultural mediator will try to have a clear view of the (number of) parties and their respective relationships. Important considerations in that context are: existing conflicts between parties involved, interpreting for groups, interpreting for groups of which some speak the provider's language and others do not.

§ 2.5 The intercultural mediator will avoid as much as possible spending time with the patient before the beginning of the triadic performance, e.g. in the waiting room, in order to prevent that the patient tells the mediator everything and does not want to repeat it again to the provider. There is also a risk that the patient will discuss certain issues with the mediator and ask him explicitly not to communicate them to the provider.

§ 3 The intercultural mediator will manage the flow of conversation in order to guarantee the interpreting quality. The standards below should be respected in that context (§3.1 – §3.6):

§ 3.1 At the beginning of an interpreting intervention, the intercultural mediator will explain the interpreting role: everything will be translated, no small-talk with the provider or the patient, he is bound by professional secrecy and neutral. He will explain his role to both the provider and the patient.

§ 3.2 The intercultural mediator will encourage the parties to address each other directly and to have the conversation 'as if there was no language barrier'.

§ 3.3 The intercultural mediator encourages both parties to look at each other during the conversation.

§ 4 The intercultural mediator will make sure that the provider and patient can see and hear him well, without constricting the direct contact between the parties. If the conversation takes place at a table, he will try and position both parties across each other and himself on the side. This way both parties have a clear view of each other and direct contact between the provider and patient is stimulated.

He will strive to sit at an equal distance from the parties to emphasize his neutrality and impartiality. When a patient has trouble expressing himself or is hearing-impaired, the intercultural mediator will sit closer to the patient. He will always adapt his position to the situation.

- § 5 If possible, the intercultural mediator will interpret in the first person singular because this improves the chance for direct communication. He will only diverge from this rule if interpreting in the first person singular causes confusion.
- § 6 If the intercultural mediator does not understand the provider or patient, he will ask for clarification.
- § 7 When the patient is not coherent and goes off on tangents, the intercultural mediator will not improve the story by e.g. adding a logical structure. This would make it impossible for the provider to have a clear view of the patient.
- § 8 The intercultural mediator will do everything possible to create a situation that stimulates good quality interpreting and good communication. In a situation in which it is impossible to interpret (or mediate) well, the intercultural mediator will first suggest strategies that guarantee the quality of the intervention. If the intercultural mediator does not succeed in this, he will inform the parties involved, as well as his supervisor, and together they will look for the best possible solution.

Good communication is only possible when:

- The provider and the patient respect the management of the dialogue put in place by the intercultural mediator in the interest of quality interpreting: they have to accept the mediator's management of the triadic relationship (turn taking so that only one person speaks at a time, asking for pauses, ...).
 - If an intercultural mediator notices that the constitution of the group in need of interpreting makes good quality interpreting impossible, he may suggest a solution to the provider (for example set a limit to the number of participants to the conversation).
- § 9 The intercultural mediator will ensure that his presence causes as little as possible inconvenience to the patient. Special attention needs to go to the possible effects of the gender of the mediator (with taboo subjects) and avoiding feelings of shame during for example a physical examination.

When feelings of shame are an obstacle for the communication and the interpreting intervention, the intercultural mediator will inform the patient on the strategies he follows in these cases (e.g. turning around during a physical examination, standing behind a curtain).

The intercultural mediator will strive for the patient to also receive linguistic assistance during examinations and will point out the importance and advantages of it to the patient.

- § 10 When the patient uses vulgar language because there are no other terms for e.g. certain body parts in his mother tongue, the intercultural mediator will adapt the register to the equivalent which is more suited within care provision.
- § 11 When the intercultural mediator is interpreting for a group (e.g. the patient and some family members) of which some speak the provider's language and others do not, he will make sure that none of the participants, in particular those who need his services, are excluded from the communication.
- § 12 When the intercultural mediator feels that the patient still needs supplementary information at the end of the consultation, he will check this with the patient and also notify the provider. The intercultural mediator can ask the patient at the end of the intervention whether he has understood everything and has asked any questions he may still have. If the provider has already left, the intercultural mediator can repeat what the provider has said. If the patient asks 'new questions', he will turn to the provider (and if necessary, make a new appointment with the provider)
- § 13 The intercultural mediator will be allowed to diverge from the basic principle that nothing is added or omitted during an interpreting intervention in the following cases:
- § 13.1 In case of a conflict between provider and patient, the intercultural mediator will in no way hide the anger of the involved parties but he will not translate literally all words exchanged during the conflict.
- § 13.2 When the provider addresses the intercultural mediator and gives him a message that clearly is not meant for the patient and could be very negative for the patient:

Example: 'That patient is a dead man walking. It is truly a horror story.'

In such a case the intercultural mediator will ask the provider if this message should be translated ('Would you like me to translate this?') and again point out to the provider that generally he has to translate everything. He will also indicate that when the provider gives messages during the triadic conversation that are only meant for the intercultural mediator (and not the patient), this could undermine the relationship of trust with the patient. Finally, the intercultural mediator will also point out that the patients who make use of his services

often do understand some of the language that is spoken so it is probable they understand at least part of what is being said.

- § 13.3 When, for various reasons (limited culture competence of the provider, low education level or limited health literacy of the patient, cultural reasons), the communication is not successful and the intercultural mediator deems it necessary to take on the role of facilitator in order to make effective care provision possible.
- § 14 When a provider gets angry at a mediator because of the message of the patient, the mediator will point out that he is only the messenger. The same strategy is used when the patient gets angry at the mediator because of the message of the provider.

4.3 STANDARDS FOR FACILITATION

As indicated before, we distinguish three subtasks in facilitation: resolve misunderstandings, culture brokerage and help the provider and patient to they take up their roles. The limits between these subtasks are not always clear cut. Suggesting to discuss certain subjects in a culturally competent manner can be placed under help the provider take up his role as well as under culture brokerage.

[4.3.1 Standard for resolving misunderstandings⁹](#)

- § 15 When the intercultural mediator identifies a misunderstanding, he will alert the parties and assist in clarifying the possible source of the misunderstanding.

[4.3.2 Standards for culture brokerage](#)

- § 16 The intercultural mediator will greet the patient in a culturally suited manner. If this could be confusing for the provider (for example if he gets the impression that the patient and intercultural mediator are friends because they hug each other), the mediator will provide the necessary clarifications.
- § 17 The intercultural mediator will clarify patients' non-verbal behaviour when the provider has difficulty interpreting it and when it may negatively affect the quality of communication/care provision.

⁹ We do not use the term 'misunderstanding' here to refer to a conflict but to a situation in which the parties do not understand each other's messages.

- § 18 When the intercultural mediator feels that cultural barriers hamper the communication or care provision process, he will point this out to the provider. He will discuss possible strategies to overcome these with the provider so that culturally competent care can be offered. If this happens during a triadic encounter, the intercultural mediator will try to do this as transparently as possible.
- § 19 When the intercultural mediator notices that the provider does not understand the translated messages of the patient (for example explanatory models, alternative or traditional therapies, references to religious issues) because he is not familiar with his cultural context, he will point this out and provide the information needed. He will – if necessary – indicate that the given information on the patient’s culture is merely a hypothesis on the possible cultural background of the narrative of the patient¹⁰.
- § 20 The intercultural mediator may suggest communication strategies to the provider that maximise the chance for culturally competent communication when he deems it necessary.
- § 21 When he has the necessary competences, the intercultural mediator may inform the provider on cultural or religious elements which he can take into account to increase the effectiveness of certain messages (e.g. point out to a Muslim patient that gender is not relevant in matters of health).
- § 22 When patients have specific wishes because of their religion or culture, the intercultural mediator will inform the providers and/or his supervisor and give the necessary clarifications if the patient is not able to do this himself. He may also suggest possible strategies to meet these wishes. (Examples: provide Halal food, refer a patient to a provider of the same gender, make a traditional therapy possible, provide a room for prayer or last rites, ...).
- § 23 When the provider unrightfully links certain attitudes or problems of patients to their culture, the intercultural mediator will point this out to him.

4.3.3 Standards for helping the provider and the patient to take up their roles

- § 24 If required for the quality of the communication / care provision, the intercultural mediator will support the provider and patient to take up their roles efficiently and effectively.
- § 25 When the linguistic register used by the provider does not exist in the patient’s language - or the patient does not understand it (e.g. use of specific terminology, linguistic register too high) - the intercultural mediator will point this out and take on the role of facilitator.

¹⁰ This implies that he will strive for all persons present to be informed on what he is stating in the context of culture brokerage.

In this case he can resort to the following strategies:

- The intercultural mediator asks the provider to simplify the message so that it can be interpreted and understood by the patient.
- The intercultural mediator suggests other strategies to the provider in order to make his message understandable, for example making a drawing or using illustrations, using examples, avoiding referring to statistical data (for example 'there is a 50% chance that...') with patients with a low educational level.
- In consultation with the provider, the intercultural mediator simplifies the message. In such a case, the intercultural mediator will strive to also use the official name of the condition/treatment (for example: 'this is called a gastroscopy') so that the patient also becomes acquainted with medical terminology.

§ 26 When the questions asked by the provider do not make sense to the patient and as a result he cannot answer them, the intercultural mediator will point this out to the provider if he didn't notice it or didn't react accordingly.

In such a case, the mediator may ask the provider the permission to try to clarify the questions to the patient. When the intercultural mediator takes on the role of facilitator, for example when he reformulates or simplifies questions or explains concepts etc., he will always mention this to the provider.

§ 27 When the intercultural mediator feels that the patient is forgetting to mention important elements, he can ask the patient whether he does not wish to mention them.

§ 28 The intercultural mediator may have one-on-one meetings with patients but always after consultation and agreement of the care provider involved.

He can do this with the following goals:

- To track down obstacles in the care provision to individual patients;
- To offer practical help when filling in forms; he will only take on this task in the absence of the provider if the documents would normally also be filled in by an educated Dutch-speaking or French-speaking patient without the help of a provider.

- To convince a patient, on behalf of the provider, in a culturally competent manner of the importance of a treatment, if this could not be successfully done during at least one triadic conversation;
- In order to create a relationship of trust that benefits the collaboration with providers;
- In order to inform patients on aspects of care provision they have no knowledge of due to the language barrier, their low educational level or their cultural background (e.g. what you should take with you to the hospital, how the care provision takes place, how to make an appointment and so on).

§ 29 Patients who do not have the necessary competences to take on the role expected from them, can be supported by the intercultural mediator. In this context, he may apply the following strategies:

- To encourage the patient to ask questions;
- To point out to him that he needs to ask for clarifications if he does not understand what is being told to him;
- To encourage him to prepare the consultation (for example by writing a list of questions);
- To remind him of subjects that he may have not discussed with the doctor but with the intercultural mediator;
- To give him the advice to write down (or have written down) the posology of medications;
- To encourage him to speak up when he disagrees with the provider or the treatment;
- To point out the importance of being punctual and remind him of an appointment by phone the day before it is scheduled;
- To ask him explicitly at the end of the consultation whether he has understood everything and whether he has any other questions.

§ 30 The intercultural mediator will inform providers – and if necessary also his supervisor - on obstacles or problems encountered during triadic or non-triadic interventions.

§ 31 The intercultural mediator may ask the provider for a consultation to discuss issues relevant for the care provision for an individual patient. The intercultural mediator can do this on behalf of the patient or of his own initiative when it appears to be impossible or undesirable to discuss certain issues during a triadic intervention.

4.4 STANDARDS FOR ADVOCACY

§ 32 The intercultural mediator has the right to tell patients during a one-on-one meeting that (a) certain provider(s) systematically refuse(s) to work with intercultural mediators.

§ 33 When the intercultural mediator has the impression that the provider made a mistake in formulating his message, or is forgetting important elements, he can point this out to the provider in the patient's interest and in the patient's presence.

§ 34 When the dignity of a patient is at stake because of the disrespectful treatment (aggressive behaviour, discrimination, racism...) by a provider, the intercultural mediator will stop the intervention and report the incident to his supervisor. The supervisor will then follow the procedures in place in his institution to handle this kind of situation.

5. DEONTOLOGICAL ASPECTS

5.1 PROFESSIONAL SECRECY AND CONFIDENTIALITY

§ 35 The intercultural mediator is a staff member of the hospital and is therefore subjected to the rules in respect of professional secrecy (art. 458 of the criminal code) in the hospital. That implies that he will never share information on the patient with third parties (persons unrelated to the treatment of the patient in the hospital). This information can be medical, personal, social or financial. When it is unclear for the mediator whether certain patient data can be shared, he will consult his supervisor.

§ 36 Under certain circumstances the professional secret can be shared, but only on the condition that the following five requirements are met:

- The patient (or his legal representative) has to be informed of the fact that information will be shared, with whom it will be shared and which information will be shared;
- The patient needs to give his consent for sharing the information;
- Information sharing needs to be in the patient's best interest;
- The information is shared with someone involved in the patient's care;
- Only the information that has to be shared, is shared.

§ 37 The obligation to respect the rules on professional secrecy remains even when the patient is no longer treated in the health care institution.

§38 There is no infringement of the rules on professional secrecy when:

- A state of emergency is declared that causes a conflict of values. For example when someone's physical or psychological integrity is seriously threatened and this person (or with help from others) is not capable of protecting these;
- At a testimonial in court: the mediator has the right to speak but no one can force him to speak;
- When the community is at risk. For example when an intercultural mediator notices that a patient is not telling or is leaving out the truth and that this can have negative

consequences for his direct environment or the community in general, the professional secret can be overridden.

If such a situation occurs, the intercultural mediator will act in consultation with his supervisor.

- § 39 When the patient informs the intercultural mediator he is committing fraud (for example is using someone else's social security card, is providing false information on his health): in this case the intercultural mediator remains bound by professional secrecy.
- § 40 When it is clear that information received during a conversation between the intercultural mediator and the patient will be useful for care provision, the intercultural mediator will encourage him to share it with the provider.
- § 41 When, during an individual conversation with the intercultural mediator, a patient insists that certain themes shouldn't be shared with the provider, the intercultural mediator will strongly suggest that he (the patient) himself brings these up with the provider. If the patient refuses, the intercultural mediator is not allowed to reveal the patient's secrets because he is bound by professional secrecy.

5.2 TRANSPARENCY

- § 42 During a triadic intervention, the intercultural mediator will strive that all parties involved be informed as much as possible about all of his activities and the messages being exchanged (that go further than giving linguistic assistance). For instance, he will inform the patient that he has explained a concept that was unknown to the provider (in the context of dealing with cultural differences), or that he has told the provider that he has explained the term because no equivalent exists in the patient's language.
- § 43 The intercultural mediator will try not to carry out interventions for people he has a personal connection with (family members, friends...). If that turns out to be impossible, the provider will be informed about the existing connection at the beginning of the intervention.

5.3 NEUTRALITY AND IMPARTIALITY

- § 44 Under all circumstances, the intercultural mediator shall remain impartial. He has to be able to identify personal biases and beliefs that might interfere with his ability to be impartial. He has the moral duty to withdraw if unable to be impartial.

- § 45 The intercultural mediator will make sure his convictions and personal values (political, religious or other) do not influence the execution of his tasks. He will refrain or withdraw from assignments if his impartiality is no longer guaranteed. In such cases, he will ask another intercultural mediator to carry out the intervention.

5.4 PROFESSIONALISM

- § 46 When working with a patient invokes such strong feelings for the mediator that his professionalism or well-being is endangered, the mediator will withdraw from the assignment and inform the patient and health care provider on alternative strategies to make communication possible (video remote intercultural mediation, telephone interpretation, community interpreter). In such cases, he will inform his supervisor.
- § 47 The intercultural mediator must refuse assignments if its acceptance would lead to a fundamental moral conflict. He will inform his supervisor if this occurs.
- § 48 The intercultural mediator will keep a professional distance from the patient at all times. This implies that he will not give his personal phone number or address to the patient and that he will not accept gifts.

5.5 ROLE BOUNDARIES

- § 49 The intercultural mediator will not interpret or mediate for external persons who want to make use of his services outside the context of the treatment of the patient's healthcare issues. Exceptions to this rule are only possible after discussion with the intercultural mediator's supervisor.
- § 50 The intercultural mediator will not execute tasks that fall outside his responsibilities and competence level (e.g. social work, therapeutic conversations, sharing medical information that would be given by the provider to Belgian patients...), with the exception of messages in relation to the practical aspects of care (appointments...).
- § 51 The intercultural mediator will not make any written translations. Possible exceptions are the translation of concrete, practical information, for example when an appointment is scheduled, how a treatment with medication should be followed.

§ 52 Taking care of the formalities after passing (repatriation , etc.) isn't part of the intercultural mediator's responsibilities. Mourning guidance will not be taken on by the intercultural mediator without help or guidance from experts in this area. Performing the last offices of the deceased person or assisting in case of death is not part of the intercultural mediator's responsibilities either.

Still, one may ask the intercultural mediator to call organisations in the country of origin, for example in the context of repatriation.

§ 53 The intercultural mediator will not express his views on the psychological or health condition of patients. If asked, he may give objective observations in relation to the patient's behaviour to the provider (e.g. the patient's story is very confusing and difficult to interpret, patient stutters, uses very simple vocabulary, ...).

§ 54 The intercultural mediator will not express his views on quality of the patient's treatment. He will not express himself either on the quality of people that are presented as 'healers' by the patient or traditional treatments the patient wishes to follow. He will encourage the patient to discuss such matters directly with the care provider.

§ 55 The intercultural mediator will not express his views on the expertise of the provider.

5.6 THE ROLE OF THE INTERCULTURAL MEDIATOR IN CONFLICTS

§ 56 The intercultural mediator is not a conflict mediator. He can mediate in conflicts when it is clear that these are directly caused by the language or culture barrier.

§ 57 In a conflict between a provider and a patient, the intercultural mediator will point out to the patient that he may contact the ombudsman.

§ 58 When a patient files a complaint with the ombudsman with the help of the intercultural mediator, the intercultural mediator will refrain from assignments related to this complaint, especially if he witnessed the altercation. He will no longer mediate for this patient and, should the need arise, he will make an appointment with another intercultural mediator or interpreter.

- § 59 When a conflict between the intercultural mediator and a patient makes interventions impossible, the intercultural mediator will withdraw and refrain from any further interventions for this patient until the conflict is resolved.
- § 60 When the intercultural mediator is threatened by a patient, he will immediately inform the providers present and his supervisor of this. The mediator will refrain from interventions for this patient. The supervisor will take the necessary measures to guarantee the security of the intercultural mediator and give him advice on the proper course of action in such cases (for example file a complaint).
- § 61 When there is a conflict between a provider and an intercultural mediator (for example because of the provider's behaviour which the mediator feels to be unacceptable, lack of courtesy, racism...), the intercultural mediator will contact his supervisor who will take the necessary steps to solve the conflict.

6. ORGANISATION OF THE INTERCULTURAL MEDIATION SERVICE

- § 62 Within the institution, a staff member is appointed to be in charge of mentoring the intercultural mediator. This person will create the conditions that will favour the efficient and effective use of the intercultural mediator.
- § 63 The intercultural mediator should have access to the necessary tools in order to carry out his/her tasks in an efficient and qualitative manner. This includes the following elements:
- Having a hospital/institution badge and business cards with the contact information of the intercultural mediator;
 - Having a sign (a hospital apron, badge...) that clearly identifies the intercultural mediator as a hospital/institution's staff member;
 - Having a computer with a personal e-mail address and internet access;
 - Having a personal phone or cell phone in order to be reachable;
 - Having dictionaries and other tools (for example medical encyclopaedias in his mother tongue);
 - For intercultural mediators using a different script (e.g. Arabic, Cyrillic), adapted keyboards should be available so that they can search the internet in their mother tongue.
- § 64 Within the institution, providers and patients have to be informed on the availability of the intercultural mediators, their tasks and how to call on them (via posters, pamphlets, the intercultural mediator's business cards, ...).
- § 65 When several providers want to an intercultural mediator to carry out assignments at the same time, the provider who booked him first has priority. Only in very exceptional cases (urgencies) will the intercultural mediator's schedule be modified for an unplanned intervention.
- § 66 Intercultural mediators can be booked without being disturbed during their interventions (for example through an electronic agenda that is accessible to providers). A 30-minute standard time per intervention is planned.
- § 67 Within the institution, a policy is implemented that encourages providers to make use as much as possible of the intercultural mediator when they face a language or culture barrier.

- § 68 The institution develops strategies that keep waiting times for intercultural mediators as short as possible (preferably under 5 minutes).
- § 69 When it appears that the intercultural mediator cannot take up an assignment, alternative strategies will be suggested (video remote intercultural mediation, telephone interpreting, community interpreter on site).
- § 70 When an intercultural mediator intervention is refused by a provider although the patient had asked for his assistance, the intercultural mediator will report this to his supervisor. He will investigate why the mediator was refused and will request that the provider does work with the intercultural mediator in the future.
- § 71 The institution makes sure that the intercultural mediator has access to emotional support or psychological help when this is necessary or desirable in the context of his professional activities. This support is not offered by a staff member of the hospital who holds a hierarchical position above that of the intercultural mediator.
- § 72 Providers should be trained to work with the intercultural mediators in an efficient and effective manner.
- § 73 Only for hospitals that also offer video remote intercultural mediation:
- The intercultural mediator needs a headset and a quiet space that protects the confidential nature of the intervention between the patient and the provider.
 - The intercultural mediator needs to have followed a specific training 'video remote intercultural mediation' at the FPS Health;
 - During the intervention, the intercultural mediator needs to be sure that the image and sound is good on both sides so that he can carry out quality interpretation. If this is not the case, the intercultural mediator will withdraw from the assignment.
 - The institution appoints someone in charge of the project 'video remote intercultural mediation project';
 - The institution will promote the video remote intercultural mediation project and will provide a good internet connection in the hospital/institution.

7. BIBLIOGRAPHY

Angelleli C.

Medical interpreting and cross-cultural communication. Cambridge: Cambridge University press, 2004: XIII + 153.

Bischoff A.

Zoom auf eine Dolmetscherin. Neues aus einer Nationalfondsstudie über interkulturelle Mediation und Integration. *Soziale Medizin* 2007 (1): 20-22.

Bischoff A., Dahinden J.

Dolmetschen, vermitteln und schlichten in vielsprachigen Basel. *Journal of Intercultural Communication*, 2008 (16: 2), 1-20.

Bot H., Verrept H.

Role Issues in the Low Countries. Interpreting in mental healthcare in the Netherlands and Belgium. In: Schäffner C., Kredens K., Fowler Y. (eds.) *Interpreting in a changing landscape*. Amsterdam/Philadelphia: John Benjamins Publishing Company, 2013: 117-131.

Chiarenza A.

Geciteerd in Pöchacker 2008; Interpreting as mediation. In: Valero-Garcés C & Martin A. (Eds.). *Crossing Borders in Community Interpreting. Definitions and dilemmas*. Amsterdam/Philadelphia: John Benjamins Publishing Company, 2008: 9-26.

Code professionnel des interprètes communautaires, INTERPRET, Suisse, juin 2005

Code de déontologie des médiateurs en institutions de soins adhérent à l'A.M.I.S., avril 2009

Devillé W., Greacen T., Bogic M. et al.

Health care for immigrants in Europe : is there still consensus among country experts about principles of good practice ? A Delphi study. *BMC Public Health* 2011; 11: 699-

Greenhalgh, T., Robb, N. & Scambler, G.

Communicative and strategic action in interpreted consultations in primary health care: A Habermasian perspective. *Social Science & Medicine*, 2006, 63 (5), 1170–1187.

Gustafsson, K., Norström, E. & Fioretos I.

The interpreter – a cultural broker? In: Schäffner C., Kredens K., Fowler Y. (eds.) *Interpreting in a changing landscape*. Amsterdam/Philadelphia: John Benjamins Publishing Company, 2013: 187-202.

Ingleby D.

Good practice in health service provision for migrants. In: Rechel B, Mladovsky Ph, Devillé et al. (eds.). *Migration and health in the European Union*. Maidenhead (vershire, England) : McGraw-Hill (Open University Press), 2011 : 227-242.

Kaufert, J. M., & Koolage, W.W.

Role conflict among 'culture brokers': the experience of native Canadian medical interpreters. *Social Science & Medicine*, 1984 18 (3): 283-286.

Kaufert, J. M., Koolage, W.W., Kaufert, P. L. et al.

The use of "trouble case" examples in teaching the impact of sociocultural and political factors in clinical communication. *Medical Anthropology*, 1984 8: 36-45.

Kaufert, J. M., & Putsch, R.W. I.

Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language and power. *The Journal of Clinical Ethics*, 1997 8 (1), 71-87.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness and care: Clinical lessons, Anthropologic and Cross-cultural research. *Annals of Internal Medicine*, 1978, 88: 251-258.

Kleinman, A.,

Rethinking psychiatry: from cultural category to personal experience (1st ed.). New York: The Free Press, A Division of Macmillan, Inc, 1988: 256.

IMIA

Medical Interpreting Standards of Practice. Boston: International Medical Interpreters Association, 1995: 49.

Pöchhacker, F.

Interpreting as mediation. In: Valero-Garces C. & Martin A.

(Eds.) *Crossing Borders in Community Interpreting. Definitions and dilemmas.* Amsterdam/Philadelphia: John Benjamins Publishing Company, 2008: 9-26.

Putsch, R. W. I.

Cross-cultural communication: The special case of interpreters in health care. *Journal of the American Medical Association*, 1985, 254 (23), 3344-3348.

Souza I.

Intercultural mediation in health care : from the professional medical interpreters' perspective. S.l.: Xlibris, 2016 : XXIV + 327.

Spranzi, M., Interprétariat, droits du malade et éthique de la communication, in : C. Byk (ed.), *La bioéthique : un langage pour mieux se comprendre*, Paris, éditions ESKA/Lacassagne, 2000, pp. 141-168.

Tipton R, Furmanek O.

Dialogue interpreting. A guide to interpreting in public services and the community. Abingdon: Routledge, 2016: XV + 295.

Qureshi, A.

Hermes in the room: challenges and strategies in intercultural mediation in psychiatry.

Presentatie op de studiedag 'Interculturele bemiddeling, het internet en andere ontwikkelingen', 7/10/2011, Brussel.

Verrept H, Louckx F.

Health advocates in Belgian health care. In: Ugalde A, Cardenas G (Eds.). *Health and Social Services among International Labor Migrants: a Comparative Perspective.* Austin (Texas): CMAS-books, 1997: 67-86.