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# GUIDE FOR INTERCULTURAL MEDIATION IN HEALTH CARE

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# Guide for intercultural mediation in health care

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## **1. Introduction**

### **1.1 Aim of this text**

By publishing this text, we want to contribute to the professionalization of intercultural mediation in health care. At the same time, we want providers and patients to make more use of intercultural mediators when they are confronted with a linguistic or cultural barrier.

The text is not only a guideline for good practices in intercultural mediation but also a guide for organizing intercultural mediation in health care institutions. Quality intercultural mediation is only possible when a number of requirements are met that enable the intercultural mediator to execute his tasks in a good manner.

To achieve our goals, we begin by taking a look at some of the principles of the intercultural mediation program financed by the federal public service Health, Food Chain Safety and Environment and Federal Institute for Health Insurance (FIHI). Afterwards we will discuss the definition of intercultural mediation and the tasks of the intercultural mediator.

After the description of the tasks, you will find some rules for good execution. These standards give intercultural mediators and care providers a point of reference for the evaluation of the performance. We pay special attention to a number of problematic situations that the intercultural mediator and care providers could be confronted with in the field.

The text also includes a code of conduct for intercultural mediators. In most projects people seem to go back to the ethical codes of conduct for (medical) interpreters. We also have in the past. However, they do not offer a solution for many situations that the mediators are confronted with because of the specificity of their job.

We included a series of standards for organizing intercultural mediation in the hospital (or in another healthcare institution) as well. Here, we pay special attention to intercultural mediation via videoconferencing.

Lastly, the collaboration with the Cell Intercultural Mediation & Policy Support: requesting financing for intercultural mediation at the federal public service Health, Food Chain Safety and Environment, certification requirements for intercultural mediators, selection procedures, participating in supervision and training meetings organized by the Cell Intercultural Mediation & Policy Support.

### **1.2 How the guide was developed**

This text is grossly 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.<sup>1</sup> Our approach

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<sup>1</sup> . See among others Kleinman, Eisenberg & Good, 1978; Kleinman, 1988; Greenhalgh, 2006.

is primarily based on the work of American doctor Robert Putsch, American anthropologist who is working in Canada Ph.d. Joseph Kaufert (Kaufert & Putsch, 1997) and the Swiss expert Alexander Bischoff (Bischoff, 2007). In addition, we were strongly inspired by the program and standards of the 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).<sup>2</sup> As far as we know, this is the first time in the world that standards are being developed specifically for the intercultural mediator in health care settings.

After a study of the relevant scientific literature (Verrept, 2012) and analysis of the existing norms for medical interpreting, we first examined with the intercultural mediators if these could be used as norms for their job. These texts appeared to contain guidelines that are also useful and applicable in intercultural mediation. However, they did not offer a satisfactory response in some of the problematic situations intercultural mediators are confronted with.

Secondly, we asked each intercultural mediator to describe to us 3 'problematic situations' in order to have as complete a picture as possible. 'Problematic situations' are situations or jobs in which the intercultural mediator had doubts about how to deal with them in a professional manner. In total about 240 of these cases were discussed in detail during the supervision sessions at the Federal Public Service (FPS). We tried to agree on what would be the best way for intercultural mediator to handle these different situations. When analysing the cases, we also took into account relevant literature and conversations with external experts. The reports of these conversations, the literature study and the external experts were the basis for a draft of this text which was in its turn discussed with the intercultural mediators and their supervisors and was then adapted and corrected.

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

## 2. Perspectives and definition of intercultural mediation

### 2.1 Perspectives

Before taking a deeper look at the actual tasks of the intercultural mediator, it is important to consider the analysis of the question of healthcare for migrants and ethnic minorities (hereinafter: MEMs) which has given rise to our program.

In this case, it is very important to take into account the specific situation in which the care is provided and which is characterized by the very asymmetrical relationship between the parties. On the one hand, we have the care provider who has expert knowledge and who is ranked 'higher' than the patient in the health institution (and in society in general). On the other hand, we have a layman- a healthcare user who depends on the care provider because of his illness and in many cases is even more vulnerable because of fear and distress.

In accordance with the relevant scientific literature, we assume that the accessibility and quality of care for MEMs suffers from the language barrier, socio-cultural barriers and the consequences of interethnic tension, racism and discrimination. If we want to give MEMs the same access to and quality of care, then we will need to minimize the effects of these barriers as much as possible. If we do not, then in many cases the cultural competence<sup>3</sup> will be insufficient to be able to guarantee quality care. This will cause or perpetuate ethnic health(care) disparities.

Experts seem to agree that using intermediaries<sup>4</sup> is one of the most important strategies to improve care for foreign patients (Devillé et al. 2011). The 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 who speak a different language than their care provider the same quality care as patients who speak the same language as their care provider (Flores, 2005; Karliner et al., 2007). The government chose to use intercultural mediators (as opposed to interpreters) because they have larger roles to play. They do not only overcome language barriers but also- at least partly- the other barriers mentioned.

### 2.2 Definition of intercultural mediation

We define intercultural mediation as all 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 creating health care options that are equal for immigrants and native-born patients regarding accessibility and quality (outcome, patient satisfaction, respect for the patient's rights and so on). Intercultural mediation is in fact a way to achieve this by improving communication and thus acting

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<sup>3</sup> Culturele competentie kunnen we omschrijven als het beschikken over de attitudes, kennis en vaardigheden die effectieve hulpverlening mogelijk maken voor alle patiënten, en dit onafhankelijke van hun taal, cultuur en godsdienst.

<sup>4</sup> We gebruiken deze term om zowel naar intercultureel bemiddelaars als tolken te verwijzen.

strategically on the care provider/patient relationship. In this manner especially the patient's position but also but also the care provider's position is strengthened so health care is better suited to patient needs and the care provider can work efficiently.

Besides bridging the language and cultural barrier, an important dimension of intercultural mediation is also facilitating the therapeutic relationship between the care provider and the patient (Qureshi,2011). Intercultural mediation will, according to Chiarenza (quoted in Pöcchacker, 2008), also contribute to complete organisations better adapting their services to the needs of immigrants.

The intercultural mediator is a fully-fledged employee of the hospital and is thus also subject to the rules and procedures valid in 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**

Good intercultural mediation means we need to succeed in creating a situation where negative effects of the above mentioned barriers on the quality of care disappear for the immigrant patient and the native-born care provider. That needs to make it possible for care providers and patients to give care, respectively receive care, in the same manner as a native-born patient. For that reason, we now for example assume that when a native-born patient receives information about his condition, the immigrant patient should also receive information from a doctor. The intervention of the intercultural mediation in this case will take place in the presence of both parties. ('in triad').

The final purpose is to offer both the patient and care provider a chance to take up their respective roles as equal partners. If we can succeed in that, we will have quality intercultural mediation.

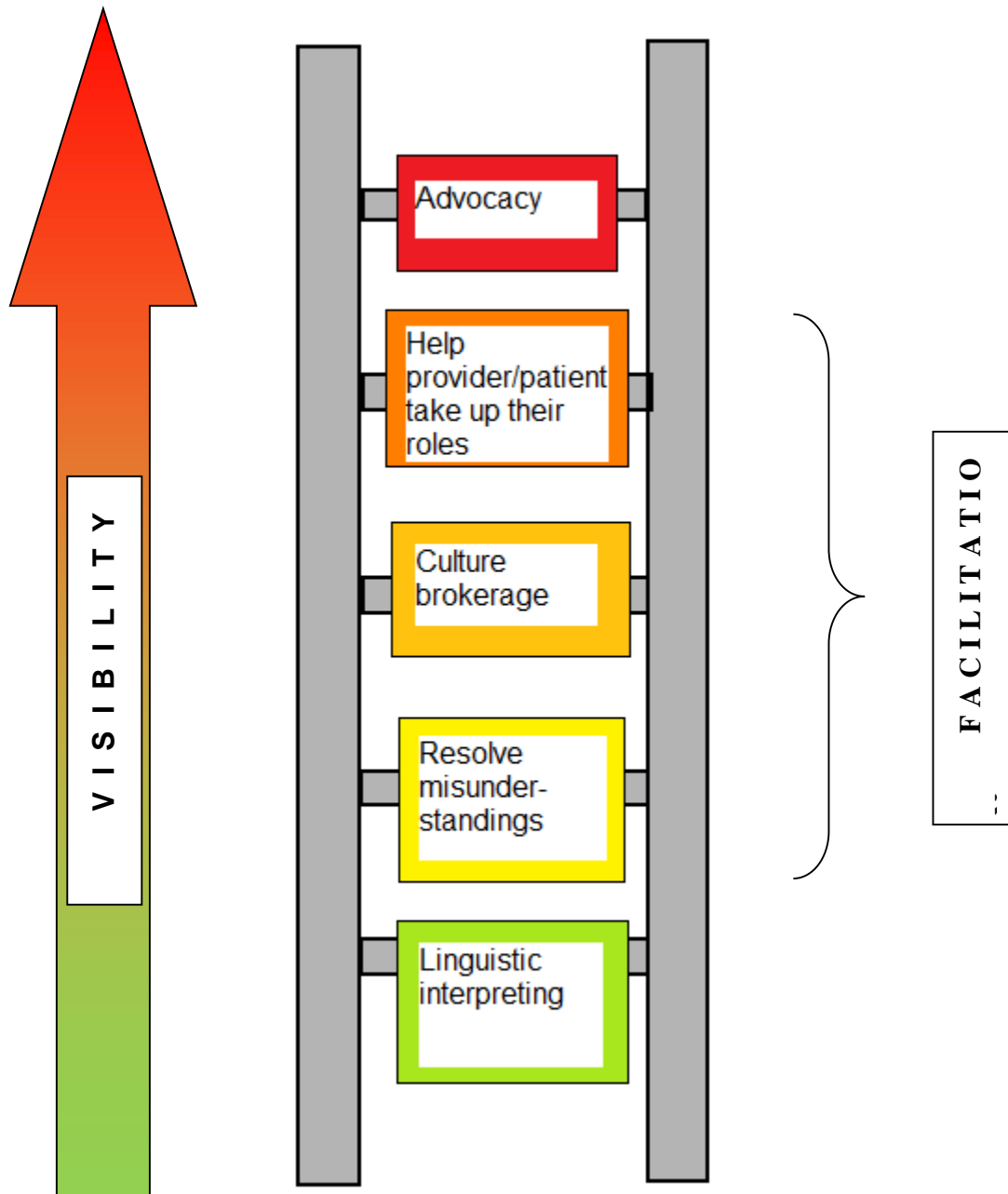
Good intercultural mediation also implies that we strive for minimal intervention in the relationship between care provider and patient, in order to affect the autonomy of the patient and care provider as little as possible. When interpreting according to the 'translation machine model' allows the patient as well as the care provider to collaborate in an effective and efficient manner, we assume that the intercultural mediator needs to limit himself to this task. Only when that is not the case the intercultural will take other tasks, which we describe below, upon himself.

Our analysis has shown that intercultural mediators are frequently confronted with problems they cannot solve alone. This includes the refusal of a certain care provider to work with an intercultural mediator, racist or unfair behaviour of the care provider towards the intercultural mediator and/or the patient, attempts of the patient to unrightfully receive health care via the mediator, threats made by patients and so on. In all of these cases it is very important that the intercultural mediator can turn to his supervisor. He will have more and better defined responsibilities in the intercultural mediation program than in the past.

### 3. Tasks of the intercultural mediator

#### 3.1 The 'ladder- model'

In order to achieve the above mentioned goals, intercultural mediators in health care execute 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 a systematic analysis of the advantages and disadvantages that are connected to the execution of several tasks. When 'linguistic interpreting' the intercul-



tural mediator or medical interpreter is the least visible according to the model of Angelelli (2004). In doing so, he will intervene personally as little as possible in the communication between care provider and patient.

It is also a task for which a series of standards exist on how to execute it professionally and qualitatively. Executing tasks higher on the ladder increase the mediator's visibility. The more visible the intercultural mediator is, the more complex his role is (Angelelli, 2004). It is a lot harder to formulate precise norms or standards. Executing them can also have negative effects. For that reason the higher placed tasks will only be executed when strictly necessary.

For clarity's sake, we have discussed the different tasks of the intercultural mediator separately here. However, it is obvious that the mediator cannot execute these different tasks consecutively during a triadic intervention.

### **3.2 Linguistic interpreting**

At the bottom of the ladder we find linguistic interpreting ('interpreting' in the strict sense) which we can define as the faithful and complete translation of an oral message from a source language into an equivalent message, taking into account content, form and purpose, in the target language. 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 to a patient who speaks a different language. This task will be executed in triad by definition.

Although linguistic interpreting is not an easy feat, 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 of the care giving project are very clear: the intercultural mediator is only responsible for the interpretation, the care provider is responsible for the proper execution of all other aspects of care provision. Of course the patient has a responsibility. By asking the 'right' questions, giving correct information and carefully following the prescribed treatment plan he influences the chance for success.

### **3.3 Facilitate**

Proponents of using intermediaries whose role is limited to linguistic interpreting in health care will state that it – for example when the patient is not able to take on his role- is the healthcare provider's responsibility, and not the intermediaries, to take the necessary steps so the conversation is successful (Bot & Verrept, 2013). When misunderstandings occur during the conversation they believe it should be noticed and solved by the involved conversation partners. According to them, the intermediary has no role.

However, it is clear that solving only the language barrier in many cases will not lead to effective communication and good quality care. The statement in literature that socio-cultural differences and inter-ethnic tensions severely diminish the quality of healthcare proves that care providers often do not have the right cultural competence to provide patient care in an efficient and effective manner. Moreover, many patients probably do not have the skills, a.o. because of a too low level of health literacy, 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 execute a number of other tasks that are more complex, have more risks and ask for more judgment on behalf of the intercultural mediator. Standards for executing these tasks are not available in literature nor on the ground. The three tasks that are above linguistic interpreting on the ladder, all aim to facilitate the contact between the care provider and the patient. These tasks are harder because of their complexity and the absence of generally accepted standards on this subject and thus, they involve higher risks. When intercultural mediators take on these tasks, we assume they have a shared responsibility with the care providers to achieve meaningful communication and an effective collaboration between the patient and the care provider.<sup>5</sup>

Facilitating communication on the one hand means collaborating with the care provider and realizing partnerships with the involved services in order to reach the aims of care. On the other hand, creating a bond of trust between the parties is also an important component. The intercultural mediator will preferably execute these tasks in the presence of the care provider (in triad). If the care provider or patient is not present during the intervention, the intercultural mediator will make sure the absent party is informed on what was discussed.

### 3.3.1 Resolving misunderstandings

‘Resolving misunderstandings’ is definitely the simplest of the three tasks. It implies that the intercultural mediator signals possible misunderstandings to the conversation partners and also tries to solve them and in that manner redirect the conversation. We assume it is obviously unwanted that we lose a part of the (limited) time available for care provision by not resolving misunderstandings that could imply real risks for the result of care providing and can strain the therapeutic relationship.

### 3.3.2 Culture brokering

The task ‘culture brokering’ is one step higher. It entails that the intercultural mediator will signal to the care provider and give more information when he feels the cultural differences are making communication and thus care providing more difficult. Kaufert & Koolage (1984) define the concept as ‘explaining the culture of the care provider to the patient and the culture of the patient to the care provider.’ They rightfully indicate that in some cases the patient might also need information on the customs in health care. The care provider might just as much need explanations on the perception of the illness in the patient’s culture. Together with the care provider and/or the patient the

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

intercultural mediator will look for strategies that minimize the negative effects of this barrier as much as possible.

Let us clarify this task with some examples:

- (1) A Moroccan patient refers to a 'jinn' in his story as the cause of his son's epileptic seizures. The Dutch translation of the term 'jinn' is 'ghost'. If the care 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 care provider be aware that ghosts, who are mentioned in the Koran, are considered as possible causes of among others epilepsy by a large number of Moroccan Belgians and the risk is real that these patients will resort to a specialized, traditional care providing circuit. In a number of cases this will lead to the patient not following the treatment prescribed by the doctor. The intercultural mediator will point this out to the care provider in the context of dealing with cultural differences.
- (2) A female patient that has just given birth from a culture that has a strong sexual segregation 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 mediator 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 care provider can choose to ask the translator 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 care provider on the expectations and wishes of Turkish people after the death of a loved one and can propose 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 usual for the most severe cases to receive priority in the emergency and that this is not a sign of racism.

Dealing with cultural differences is definitely a very useful method of improving the care providers cultural competences and also improving 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. 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 risks. From an anthropological point of view it is not very clear how to best prepare someone to take on this task. Within the mediation program of the FPS, we mainly work with intercultural mediators who belong to the ethnic group they work for. Although, this shared ethnicity does not automatically mean that the person involved is also familiar with all prevailing notions, values customs within the own ethnic group. Biographic and family factors, and intracultural variation result in the intercultural mediator not having a deep enough knowledge of his or her own culture. This means the mediator will be able to identify and clarify cultural barriers in some

cases and not in other cases.<sup>6</sup> Giving cultural information can also contribute to creating stereotypes which in turn will form a barrier between the care provider and the patient and makes the care provider blind to the foreign patient as an individual.

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

### 3.3.3 Helping the healthcare provider and the patient to take up their respective roles

The third facilitating task is supporting or helping the patient and care provider to take on their respective roles as effectively as possible, in order to achieve an optimal result. In that regard, it is very similar to the task ‘culture brokerage’ that we deal with separately because of the specific problems linked to it.

Some examples of this third facilitating task:

- (1) The discourse of the care provider is not understandable for the patient even when it is interpreted either because the discourse contains too much specific terminology or because the patient has a (very) low education level. Or it is not translatable because there is no equivalent in the patient’s language. In such cases, the intercultural mediator will have to develop strategies that enlarge the chance for mutual understanding. He can ask the care provider to simplify his discourse or to make a drawing in order to clarify some aspects. In certain circumstances, the intercultural mediator can simplify the discourse himself. In fact, in this level it often concerns ‘culture brokerage’ between the medical culture of the care provider and the layman culture of the – in many cases low-skilled – patient.
- (2) The care provider asks the patient questions that, for example when taking a psychological questionnaire, that for a patient who is not familiar with these instruments at all, have no meaning at all. In such cases, the intercultural mediator as a facilitator can signal this to the care provider and look for alternative methods with him.
- (3) When a patient feels inhibited in the presence of the care provider, and does not ask questions or does not indicate that he does not understand something, the intercultural mediator can encourage him to ask questions and to indicate when he does not understand something. He can give the patient tips to prepare the consultation by bringing the used medication, making a list of questions he wants to ask or symptoms he would like to report and so on.
- (4) 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.

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<sup>6</sup> We want to note that from an anthropological viewpoint it is not really clear what ‘knowing a culture’ means. That does not take away from the fact that a certain familiarity with someone cultural background can be very helpful in the context of care provision.

### 3.3.4 Some considerations on the ‘facilitation’ role

The three tasks that belong under ‘facilitation’ can be executed in triad or not. The intercultural mediator can notice a misunderstanding during an individual contact with the patient or care provider and correct it. Culture brokerage can take place during a triadic intervention as well as during a patient conversation as well as during a training session for a group of care providers. Supporting patient and care providers in taking their respective roles, can also take place outside the triadic context for example during a preliminary conversation with the care provider(‘how do we handle this conversation best with this patient’) or an individual contact with a patient.

The extent in which these tasks need to be taken by the intercultural mediator depends strongly on the communication skills, the empathy and the cultural competence of the care provider. Facilitating communication and care provision is much more delicate than interpreting and puts a heavier burden on the mediator than giving language assistance.

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

We want to point out that conflict resolution does not belong to the intercultural mediators responsibilities. The conflict resolution question is treated in the ethical code chapter.

### **3.4 Advocacy**

On 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 executed 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 mediator) will advocate for the patient, and possibly leave his impartial position.

In both definitions the intermediary is given the mandate to take initiative in asking certain questions or carrying out certain actions when it is 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 is clear in the examples below.

- (1) The intercultural mediator indicates to the care provider that the patient is allergic to a certain drug, of which he is aware because of other contacts with the patient but the doctor is not.

- (2) A patient ate the morning before a surgery. He neglects to share this with the nurse but did tell the intercultural mediator. The intercultural mediator informs the nurse.
- (3) A patient is treated disrespectfully by a care provider which undermined his dignity. The intercultural mediator will address this subject with the care provider or signal this to his superior.

A fundamental difference between these examples is that in the first two cases the intercultural mediator remains impartial but clearly is not in the third example.

Advocacy, especially when it is paired with an intermediary's biased position, is still controversial in the world of medical interpreting. It has been pointed out that the intermediary is not always capable of determining what is in a patient's best interest. This of course is a prerequisite to be able to defend their interests (Verrept & Louckx, 1997). An erroneous estimate could even damage the patient's interests. In continuation, the effect of advocacy on the continued progress of the care was questioned. It is clear that this type of intervention could mean the end of the care. It is also possible that the intercultural mediator will not be called upon for that reason, especially when the mediator does not receive sufficient support from the management of the institution.

We do notice that advocacy in many cases is mentioned – implicitly or explicitly – in the task description of medical interpreters.<sup>7</sup> Given the risks, the intercultural mediator will execute this task- in interventions where he is not impartial- with the utmost caution and in close collaboration with his superior. When it seems necessary, the problem will be transferred to the hospitals ombudsman.

Defending the patient is a task for everyone working in the hospital and is included in the internal rules of all hospitals. So it is in no way the exclusive responsibility of intercultural mediators. They are in direct contact with a group characterized by a greater vulnerability than the average hospital population. As a result, they have a greater chance of being confronted with these types of problems in the first place. That is why we explicitly included this task in the ladder model of the tasks of the intercultural mediator.

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<sup>7</sup> In the IMIA standards it happens implicitly, in the National Council on Interpreting in Health Care's and the California Healthcare Interpreting Association's standards explicitly (see [www.imia.org](http://www.imia.org); [www.ncihc.org](http://www.ncihc.org); [www.chiaonline.org](http://www.chiaonline.org)).

## 4. Standards for executing the tasks of the intercultural mediator

### 4.1 Before

The boundaries between the different tasks are not always well-defined. Bischoff (Bischoff, 2007; Bischoff & Dahinden, 2008) agrees and even states that a complete separation of these roles (interpreter and facilitator/mediator) in real-life situations is often impossible and undesirable. Moreover, we noticed that the task description of most intermediaries in healthcare that are called ‘interpreters’ in many cases is in fact much more ample than giving linguistic assistance in order to facilitate communication (Bot & Verrept, 2013).

The previous makes it difficult to decide if a certain standard is part of ‘linguistic interpreting’ or ‘facilitating’. Giving linguistic assistance clearly differs from facilitating or advocacy because it is the only task performed in triad by definition (during a face-to-face meeting between the care provider and patient where the intercultural mediator is present physically or via videoconference).

Finally, you will notice that we included different types of standards: some standards describe how a task should (not) be executed, others give the intercultural mediator an explicit mandate and allow him to perform certain interventions.

### 4.2 Giving linguistic assistance

Giving linguistic assistance is, as indicated, the complete and faithful conversion of a spoken or signed 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 it is sufficient to reach to goal of the mediation.
- § 2 The intercultural mediator will prepare the task in order to optimise the chancer for a quality interpreting performance. This includes following the standards below (§ 2.1-§ 2.5):
  - § 2.1 The intercultural will always try to have a briefing with the care provider. The shortest form of this briefing is the question ‘Is there anything I should now before we start?’
  - § 2.2 The intercultural mediator will inform the care provider at the beginning of the consultation if he has already helped this patient before or if it is important he know certain information about the patient.
  - § 2.3 The intercultural mediator at the beginning of the meeting will try to have a general view on the problem(s) at hand. This allows him to prepare the job or to refuse jobs of which he is not sure he will be able to perform (for example on a specialized subject or for emotional reasons).

- § 2.4 The intercultural mediator will from the beginning try to have a clear view of the (number of) conversational partners and their respective relationships. Important. Important considerations in that context are: existing conflicts between conversational partners, interpreting for groups, interpreting for groups of which some speak Dutch 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. And this in order to prevent tells the mediator everything and does not want to repeat it for the care provider. There is also a risk that the patient will tell the mediator things and ask him explicitly not to communicate them to the care provider.
- § 3 The intercultural mediator will direct the 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 care provider or the patient, he is bound by professional secrecy and neutral. He will explain his role to both the care provider and the patient.
- § 3.2 The intercultural mediator will encourage the conversational partners to address each other directly and to have the conversation ‘as if there was no language barrier’.
- § 3.3 The intercultural mediator encourages the conversation partners to face each other during the conversation.
- § 4 The intercultural mediator positions himself so the care provider and patient can see and hear him well, without constricting the direct contact between the conversation partners. If the conversation takes place at a table, he will try and position the conversation partners across each other and himself on the side. This way all of the conversation partners have a clear view of each other and direct contact between the care provider and patient is stimulated. He will strive to sit at an equal distance from the conversation partners in order to accentuate his neutrality and impartiality. When a patient has trouble expressing himself or is hard of hearing, 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 care 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 care 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 propose strategies that guarantee the quality of the intervention. If the intercultural mediator does not succeed in this, he will inform the parties involved and his superior and together they will look for the best solution possible.

Good communication is only possible when:

- The care provider and the patient take direction in the conversation from the intercultural mediator in order to have good quality interpreting: they have to accept turn changes and interruptions by the mediator and the conversation has to be structured so the conversation partners do not talk at once.
  - The number of participants should not be too high. If an intercultural mediator notices that the constitution of the group in need of interpreting makes good quality interpreting impossible, he can propose a solution to the care provider ( for example set a limit to the number of participants to the conversation).
- § 9 The intercultural mediator will make sure 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 (taboo subjects) and avoiding feelings of shame at for example a physical examination.

When shame is an obstacle for the communication and the interpreting intervention, the intercultural mediator will inform the patient on the strategies he follows in these cases in order to limit feelings of shame (e.g. turning around during a physical examination, standing behind a curtain) and the patient can also propose alternatives (such as intercultural mediation via videoconference). The intercultural mediator will strive for the patient to also receive linguistic assistance during examinations.

- § 10 When the patient uses vulgar terminology because there no other terms in his language for e.g. certain body parts and so on, 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 Dutch and others do no, he will make sure none of the participants of the conversation are excluded from the communication.
- § 12 When the intercultural mediator feels that the patient still needs supplementary information at the end of the conversation, he will verify this with the patient and also notify the care provider. The intercultural mediator can ask the patient

at the end of the conversation if he understood everything and if he has any questions for the care provider. If the care provider has already left, then the intercultural mediator can repeat what the care provider has said. If the patient asks ‘new questions’, he will turn to the care provider (and if necessary, make a new appointment with the care provider)

§ 13 The intercultural mediator will 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 care provider and patient, the intercultural mediator will in no way hide the anger of the involved parties nor will he translate swear words literally.

§ 13.2 When the care 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 care provider if this message should be translated (‘Would you like me to translate this?’) and again point out to the care provider that generally he has to translate everything. He will also indicate that when the care 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 Dutch so it is probable they understand at least part of the content of these ‘private’ conversations.

§ 13.3 When for various reasons (limited cultural competence of the care provider, low education level or limited 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 care provider gets angry at a mediator because of the messages 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 care provider.

### **4.3 Standards for facilitation**

As indicated before, we differentiate three subtasks in facilitation: intervening at misunderstandings, ‘culture brokerage’ and supporting the care provider and patient so they take on their respective roles. The limits between these subtasks are not clearly defined either. Proposing to bring up certain subjects in a culturally adapted manner can be placed under supporting the care provider in taking up his role as well as ‘culture brokerage’.

#### 4.3.1 Standards for clarifying misunderstandings

- § 15 When the intercultural mediator identifies a misunderstanding, he will notify the conversation partners and try and resolve the misunderstanding. Be careful: the term ‘misunderstanding’ does not refer to a conflict but to a situation in which the conversation partners do not understand each other’s messages.

#### 4.3.2 Standards for culture brokerage

- § 16 The intercultural mediator will greet the patient in a culturally adapted manner. If this could be confusing for the care provider (for example if he gets the impression that the patient and intercultural mediator are friends because they hug each other), the mediator will give the necessary clarifications.
- § 17 The intercultural mediator will clarify patients’ non-verbal behaviour when the care provider has difficulty interpreting it and when it is a threat to the quality of communication/care provision.
- § 18 When the intercultural mediator has the impression that cultural barriers hamper the communication or care provision, he will indicate this to the care provider. He will consult the care provider on how these barriers can be eliminated so culturally competent care can be offered. If this happens during a triadic conversation, the intercultural mediator will try and do this as transparently as possible<sup>8</sup>.
- § 19 When the intercultural mediator notices that the care provider does not understand the translated messages of the patient (for example explanation models, certain alternative therapies, references to religious aspects) because he is not familiar with their cultural context, he will signal this to the care provider and will explain the relevant phenomena briefly. He will – if necessary – indicate that the given cultural information is merely a hypothesis on the possible cultural background of (story of) the patient.
- § 20 The intercultural mediator can propose communication strategies to the care provider that maximize the chance for culturally competent communication when he deems it necessary for the quality of communication/care provision.
- § 21 When he has the necessary competences, the intercultural mediator can inform the care provider on cultural or religious elements which he can take into account to make certain messages more effective (e.g. point out to a Muslim patient that gender is not relevant in matters of health).
- § 22 When patients have specific wishes for the care provision process because of their religion or culture, the intercultural mediator will inform the care providers

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<sup>8</sup> This implies that he will strive for all persons present to be informed on what he is stating in the context of culture brokerage.

and/or his superior and give the necessary clarifications if the patient is not capable. He will also propose possible strategies to comply to these wishes or to deal with them differently. (Examples: nutrition, wishes to be helped by someone of the same gender, wishes to follow 'traditional' alternative therapies, possibilities for experiencing his religion,...).

- § 23 When the intercultural mediator notices that the autonomy of the patient is affected by cultural factors or if he does not want to follow a certain treatment because of this (for example refusal of epidural anesthesia), he will notify the care provider. He will look for strategies with the care provider that make it easier for the patient to decide himself.
- § 24 When the care provider links certain attitudes or problems of patients to their culture unrightfully, the intercultural mediator will point this out to him.

#### 4.3.3 Standards for supporting the patient and care provider in their respective roles

- § 25 If this is needed for the quality of the communication / care provision, the intercultural mediator will support the care provider and patient to take on their roles in a significant and effective manner.
- § 26 When the language register used by the care provider does not exist in the patient's language or the patient does not understand it (for example use of specific terminology or , register too high), the intercultural mediator will point this out and take on the role of facilitator.

He can use the following strategies among others:

- The intercultural mediator asks the care provider to simplify the message so she can be translated in a way the patient can understand.
  - The intercultural mediator proposes other strategies to the care 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 low-skilled patients.
  - The intercultural mediator simplifies the message himself in consultation with the care provider. He will only simplify the message himself when he is 100% positive of the quality of the used description(s). 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 the patient also becomes acquainted with medical terminology.
- § 27 When the questions that the care provider asks the patient do not mean anything to him even translated and he cannot answer the question, the intercultural mediator will point this out to the care provider when he does not notice it or does not react adequately.

In such a case the mediator can ask the care provider if he agrees that he tries to clarify the question for the patient. When the intercultural mediator takes on the role of facilitator for example when he reformulates or simplifies questions, explains things and so on, he will always signal this to the care provider.

- § 28 When the intercultural mediator feels that the patient is forgetting to mention important elements, the intercultural mediator can ask him if he does not wish to mention them.
- § 29 The intercultural mediator can have contact with a patient individually in consultation with the involved care providers.

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 without the care provider if the documents could also be filled in by a highly educated Dutch-speaking patient without the help of a care provider.
  - To convince a patient of the importance of a treatment in a culturally competent manner on behalf of the care provider, if this could not be done during at least one triadic conversation;
  - In order to create a bond of trust that benefits the collaboration with care providers;
  - In order to inform patients on aspects of care provision they have no knowledge of due to the language barrier, their low education level or 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).
- § 30 Patients who do not have the necessary competences to take on the role of patient, can be supported in this by the intercultural mediator. He can use the following strategies:
- To stimulate the patient to ask questions;
  - To point out to him that he needs to ask for clarifications if he did not understand something;
  - To motivate him to prepare the consultation ( for example by drawing up a list of questions);
  - To remind him of subjects that he eventually did not discuss with the doctor but he did mention to the intercultural mediator;

- To give him the advice to write down (or have it written) the posology of medications;
- To motivate him to speak up when he disagrees with the care provider or the treatment;
- To point out the importance of being punctual to him and eventually remind him of this by phone the day before the appointment;
- To ask him explicitly at the end of the conversation if he understood everything and if he has any other questions.

§ 31

§ 31 The intercultural mediator will indicate obstacles or problems he noticed during triadic or non-triadic interventions to the involved care providers during a feedback or reunion and -if necessary- also to his superior.

§ 32 The intercultural mediator can ask the care provider for a consultation when he is aware of something that could influence the smooth progression of care provision to the 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 things during a triadic intervention.

#### **4.4 Standards for advocacy**

§ 33 The intercultural mediator can tell patients during an individual conversation that certain care providers systematically refuse to work with intercultural mediators.

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

§ 35 When the dignity of a patient is endangered because of a disrespectful treatment (aggressive behaviour, discrimination, racism,...) by a care provider, the intercultural mediator will if possible talk to the care provider about this and ask him to change his behaviour.

When this does not offer a solution, the intercultural mediator will stop the intervention and report the incident to his superior. If necessary, the superior will report the incident to the ombudsman.

An example: a care provider systematically makes unpleasant comments on the fact that patients do not master Dutch/French. In such cases the intercultural mediator could explain that this attitude could affect the atmosphere during an intervention and the bond of trust between a patient and care provider.

## 5. Deontological aspects

### 5.1 Professional secrecy and dealing with confidential information

§ 36 The intercultural mediator is a staff member of the hospital and is therefore subjected to the rules in respect to professional secrecy (art. 458 of the criminal code) in the hospitals. That implies that he will never share information with thirds that have nothing to do with the treatment of the patient in the hospital. This information can be medical, personal, social or financial. When it is unclear for the mediator if certain data on a patient can be shared, he will ask his superior.

S 37 In certain circumstances the professional secret can be shared. That is only the case when five requirements are met:

- The patient (or his legal representatives) should be notified of the information that will be shared and with who it 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 necessary is shared.

Intercultural mediation in hospitals makes it often necessary to exchange confidential information. This confidentiality in first instance protects the patient but it also protects the bond of trust that needs to develop between the intercultural mediator and the care providers (Reusens, 2014).

§ 38

§ 38 The professional secret remains even when the patient is no longer treated in the hospital.

§ 39 There is no infringement on the professional secret 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 he ( or with help from others) is not capable of protecting them;
- 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 (in the case of contagious diseases, sexually transmitted diseases).

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

- § 40 When the patient tells the intercultural mediator he is committing fraud (for example has used someone else's social security card, lied about his health condition): in this case the intercultural mediator remains bound by professional secrecy. Professional secrecy is only overridden when a state of emergency is declared or when this information can have negative consequences on third persons or the community in general. He will turn to his superior in all of these cases.
- § 41 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 care provider.
- § 42 When a patient during an individual conversation with the intercultural mediator insists that certain things are not shared with the care provider, the intercultural mediator will strongly suggest that he (the patient) himself brings this up with the care provider. If the patient refuses, the intercultural mediator cannot tell the patient's secrets because he is bound by professional secrecy.
- § 43 When the intercultural mediator witnessed racist comments, discriminatory behaviour or other types of unfair behaviour from the care provider towards the patient, he will report this to his superior. He will follow the procedures developed within his institution to deal with these types of situations.

## 5.2 Transparency

- § 44 The intercultural mediator will strive for all involved parties during a triadic intervention to be informed as much as possible about all of his activities and the messages being exchanged (that go further than giving linguistic assistance). He will for example inform the patient that he explained a concept that was unknown to the care provider (in the context of dealing with cultural differences), or that he tells the care provider that he has used a description because there is no equivalent in his language.
- § 45 The intercultural mediator will try not to carry out interventions for people he has a personal connection with (family members, friends,...). When that is unavoidable, the care provider is made aware of this at the beginning of the intervention.



### 5.3 Neutrality and impartiality

- § 46 The intercultural mediator remains impartial and is capable of identifying his own feelings and convictions that could endanger his impartiality. When he cannot remain impartial, he will refuse to mediate for the involved patient.
- § 47 The intercultural mediator will make sure his convictions and personal values (political, religious or other) do not influence his interventions. If this is the case and his impartiality is no longer guaranteed, he will ask another intercultural mediator to take the intervention and refuse to interpret for the involved patient.

### 5.4 Responsibility and professionalism

- § 48 When working with a patient invokes such strong feelings in the mediator that his professionalism or well-being is endangered, the mediator will stop the intervention and inform the patient on the other possible tools for communication (intercultural mediator via videoconference, social interpreter). In such cases he will inform his superior.
- § 49 The intercultural mediator has to refuse an intervention when it leads to unsurmountable crises of conscience. He will inform his superior.
- § 50 The intercultural mediator will keep a professional distance from the patient at all times. This implies he will not give his personal phone number or address to the patient and he will not accept gifts.

### 5.5 Limits

- § 51 The intercultural mediator will not interpret for outside people who make use of him outside the context of the treatment of the patient's healthcare issues. Exceptions to the rule are only possible after discussion with the intercultural mediator's superior.
- § 52 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 care provider to Belgian patients,...). Messages in relation to the practical aspects of the care (appointments,...) are exceptions.
- § 53 The intercultural mediator will not make any written translations. Possible exceptions are translating concrete, practical information, for example when an appointment is, how a treatment with medication should be followed.
- § 54 Taking care of the formalities after passing (repatriation ,etc.) does not belong to 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. (Helping with) taking out the plug of deceased people is not part of the intercultural mediator's responsibilities either.

The intercultural mediator can be asked to have phone conversations with organisations in the country of origin for example in the context of repatriation.

- § 55 The intercultural mediator will not take a position on the (psychological) condition of patients. If asked, he can give objective observations in relation to the patient's behaviour to the care provider (e.g. the patient's story is very confusing and difficult to interpret, patient stutters in his mother tongue, patient speaks as a child, ...).
- § 56 The intercultural mediator will not express his opinion on the patient's treatment and will not express himself on the quality of people that are presented as healers by the patient or traditional treatments the patient wishes to follow. He will most likely propose to the patient to discuss these matters directly with the care provider.
- § 57 The intercultural mediator will not express himself on the quality or pertinence of a treatment that is prescribed or executed by a care provider nor on the expertise of the care provider.

## **5.6 The role of the intercultural mediator in conflicts**

- § 58 The intercultural mediator is, as stated before, not a conflict mediator. He can mediate in conflicts when it is clear that they are directly caused by the language or culture barrier.
- § 59 In a conflict between a care provider and a patient, the intercultural mediator will point out to the patient that he can contact the ombudsman.
- § 60 When a patient files a complaint with the ombudsman with the intercultural mediator's help, the intercultural mediator will not intervene in the context of complaint mediation, especially if he witnessed the altercation. He will no longer mediate for this patient or if the case presents itself make an appointment with another intercultural mediator or interpreter.
- § 61 When a conflict between the intercultural mediator and a patient makes interventions impossible, the intercultural mediator will stop the intervention and then will not carry out any interventions for this patient until the conflict is solved.
- § 62 When the intercultural mediator is threatened by a patient, he will immediately inform the present care providers and his superior of this. The mediator will no longer carry out interventions for this patient. The person responsible will take the necessary measures to guarantee the security of the intercultural mediator and to give him advice on the proper course of action in such cases (file a complaint).
- § 63 When there is a conflict between a care provider and an intercultural mediator (for example because of the care provider's behaviour which the mediator feels

is unacceptable, lack of courtesy, racism, ...) which is not solved by a conversation, the intercultural mediator will contact his superior who will take the necessary steps to solve the conflict.



## 6. Organisation of the intercultural mediation service

- § 64 Within the institution a staff member is appointed that is responsible for the framing of the intercultural mediation. This person will create the preconditions that that will allow and efficient and effective use of the intercultural mediator.
- § 65 The intercultural mediator needs to have access to the necessary tools in order to execute his/her tasks in an efficient and qualitative manner. This includes the following elements:
- Having a 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 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 dictionary's and other tools (for example medical encyclopaedias in the mother tongue);
  - For intercultural mediators that use a different script (e.g. Arabic, Cyrillic), adapted keyboards need to be made available in order to be able to do research on the internet in their mother tongue.
- § 66 Within the institution care providers and patients are 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, ...).
- § 67 When several care providers want to use an intercultural mediator at the same time, the care provider who booked first has priority. Only in very exceptional cases ( urgencies) will the intercultural mediator's program be modified for an unplanned intervention.
- § 68 Intercultural mediators can be booked without being disturbed during their interventions (for example an electronic agenda that is accessible for care providers). Standard thirty minutes per intervention are reserved.
- § 69 Within the institution a policy is implemented that stimulates care providers to, as much as possible, make use of the intercultural mediator when they are confronted with a language or culture barrier.
- § 70 The institution develops strategies that keep waiting periods for intercultural mediators as short as possible. The intercultural mediator tries not to be present

for more than 5 minutes before the intervention. The intercultural mediator and patient also should avoid waiting together in the same room.

- § 71 When the intercultural mediator cannot be present at the triadic conversation, alternative strategies will be proposed (intercultural mediation via videoconferencing, phone interpreting, social interpreter on site).
- § 72 When an intercultural mediator is refused by care providers although a patient asked for his help, the intercultural mediator will report this to his superior. He will investigate why the mediator was refused and will request that the care provider does work with the intercultural mediator in the future. Missing in French + location?
- § 73 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 is not linked hierarchically to the intercultural mediator.
- § 74 Care providers have to be trained to work with the intercultural mediators in an efficient and effective manner.
- § 75 Only for hospitals that also offer intercultural mediation via internet (via video):
- For his interventions, the intercultural mediator needs to have a headset and a quiet space that protects the confidential nature of the intervention between the patient and the care provider.
  - The intercultural mediator needs to have followed a specific training ‘interpreting via videoconferencing’ at the FPS Public Health;
  - During the intervention the intercultural mediator needs to be sure that the image and sound is good on both sounds to have a quality interpreting performance. If this is not the case, the intercultural mediator will stop the intervention.
  - The institution designates a responsible for the project ‘intercultural mediation via internet’;
  - The institution will make the intercultural mediation via video project public and guarantee a good internet connection in the hospital.



§ 76 The participation to the obligatory trainings that the FPS Public Health organises for the intercultural mediators, will be considered as hours worked by the hospital (including transport); the transport costs (train ticket, subway, ...) will be refunded to the mediators.

## **7. Collaboration with the SPF**

### **7.1 Request financing – registration activities– reporting**

The FPS Public Health invites the general and psychiatric hospitals every year during the month of December to apply for financing for intercultural mediation (for the functions of intercultural mediator and coordinator intercultural mediation). The application forms have to be submitted to FPS Public Health on 31 January of that year at the latest.

The FPS each year asks the intercultural mediators and coordinators intercultural mediation to register their activities during a certain period. The intercultural mediator and coordinator intercultural mediation will register all their activities during the asked period of one month by using a computer program that the FPS provides them with. This data and a report of the group activities need to be send to the FPS on 31 January that year at the latest.

The coordinators intercultural mediation will also give an activities report that relating to the complete working year.

Interventions via video are registered all year long by the intercultural mediators who execute them. The data, entered in the registration program provided by the Cell Intercultural Mediation & Policy Support, is given to the FPS at the end of each trimester on the 7<sup>th</sup> of the following month at the latest.

### **7.2 Presence on the training and supervision sessions**

Intercultural mediators have to participate in at least  $\frac{3}{4}$  of the supervision and training sessions that are organized by the Cell Intercultural Mediation & Policy Support.

Intercultural mediators who do not dispose of a master in Interpreting or a recognised social interpreting certificate have to follow a basic training module on interpreting techniques that is organized by the FPS Public Health and is given by professors linked to the interpreting universities. The basic module comprises 72 hours of class (12 days of 6 hours of class ounce a month during a year).

### **7.3 Recruitment new intercultural mediators**

When recruiting new intercultural mediators:

Candidate intercultural mediators will be invited by the Cell Intercultural Mediation to test their skills (in a role play). The Cell will afterwards tell the hospital if the candidate has enough skills to be eligible for financing as an intercultural mediator. During this test a staff member of the hospital is allowed to be present. The hospital can ask for a written report of the test. If this is wanted, an audio recording of the test can also be given.

The candidate needs to have the certificate prerequisites defined by law (see text Royal Decree in annex). If no candidate is found that meets these requirements, a motivated

request for derogation from the certificate prerequisites will be made to the Director-General of the DG Healthcare, FPS Public Health, Food Chain Safety and Environment that will announce via letter or mail if the derogation is allowed after consultation with the Cell Intercultural Mediation & Policy Support.

When a new intercultural mediator is hired, the hospital gives the following documents to the Cell Intercultural Mediation & Policy Support:

- A copy of the employment contract between the hospital and the intercultural mediator in which the function title of the intercultural mediator always needs to be mentioned, as well as the appointment percentage as an intercultural mediator;
- A copy of the relevant certificates of the involved intercultural mediator.

#### **7.4 Long absence– illness of the intercultural mediator**

When an intercultural mediator is laid off or is absent for longer than a month due to illness, the hospital will notify the Cell Intercultural Mediation & Policy Support. In such cases we will – in consultation with the Cell Intercultural Mediation and Policy Support- look for strategies to guarantee the continuity of the service as much as possible.



## 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.

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.

MMIA

*Medical Interpreting Standards of Practice*. Boston: Massachusetts Medical Interpreters Association, 1995.

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. (1985).

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

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.

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.

Verrept H.

Notes on the employment of intercultural mediators and interpreters in health care. In: Ingleby D., Chiarenza A, Devillé, W. et al. (eds.). *Inequalities in health care for migrants and ethnic minorities*. Antwerpen/Apeldoorn: Garant Publishers, 2012: 115-127.