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Communi-Care for Migrants and Ethnic Minorities

4th Conference on Migrant and Ethnic Minority Health in Europe

21-23 JUNE 2012, UNIVERSITÀ BOCCONI, MILAN, ITALY



## Notes on the employment of intercultural mediators and interpreters in health care<sup>1</sup>

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Research has made clear that ethnic minorities may systematically receive a lower quality of health care than non-minorities. The Institute of Medicine (Smedley B, Stith A, Nelson A (eds), 2003) has stated that these disparities are partly related to stereotyping, biases and uncertainty on the part of health care providers. They also observe that the conditions in which many clinical encounters take place – characterized by high time pressure, cognitive complexity, and pressures for cost-containment – may enhance the likelihood that these processes will result in care poorly matched to minority patients' needs. The selective impact of health care and social services and the quality of care received by ethnic minorities are factors that are increasingly linked to ethnic health inequalities (Murray-Garcia, 2002).

Differential treatment of ethnic minorities has been studied in some detail in the USA, but much less in Europe. Differential impact of health care services may be linked to discriminatory practices in the health care system, inadequate health care concepts and structures dealing with diversity, but also to a lack of skills of the health professionals. As a result, the health care interventions may be less effective and patients may be less satisfied (David & Borde, 2001). This may in its turn affect their willingness to make use of the health care system.

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<sup>1</sup> . This chapter is a modified and updated version of : Verrept, H. Integrating Ethnic Minorities in Health Care. In: Fernandes, A, Pereira Miguel J., (Eds.). *Health and Migration in the European Union*. Lisbon (Portugal): National Institute of Health, Ministry of Health, Portugal, 2008: 61-71. Reprinted with permission.

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In this paper, we argue that working with intercultural mediators and (medical) interpreters might improve the accessibility of health care services for ethnic minorities, increase the quality of care and as such be an effective strategy to reduce ethnic health (care) disparities.

Starting from recent literature, we first discuss a number of problems that have been identified in the provision of health care to ethnic minorities and that might be resolved by the employment of intercultural mediators and interpreters in health care. Secondly, we briefly describe the results of evaluation studies that have been carried out on the effects of these intermediaries on the quality of care. We will also discuss the methodological limitations of these studies. Building on the results of these studies, we formulate recommendations on the employment of intercultural mediators and interpreters in health care. Finally, we point out a number of issues that should be addressed in future research to make the development of an evidence-based policy in this domain possible.

## BARRIERS TO CARE

### LANGUAGE BARRIERS

Unresolved language barriers have been proved to dramatically affect the quality of care received by allophone ethnic minority patients (Bowen, 2001; Jacobs et al., 2003). Language barriers pose a problem for many patients where health systems lack the resources, knowledge or institutional priority to provide adequate interpretation services. There is compelling evidence that they have an adverse effect on initial access to health care services. These barriers are not limited to encounters with physician and hospital care. Patients face significant barriers to health promotion/prevention programmes (lack of translated health promotion and education material, lack of appropriate methods for reaching marginalized populations with these programmes), (Smedley, Stith & Nelson, 2003; Bowen, 2001; Jacobs et al., 2003).

Research that includes the variables of both ethnicity and official language proficiency suggests that in many cases, language, rather than cultural beliefs and practices of patients, may be the most significant barrier to initial contact with health services. Evidence demonstrates that patients lacking official language fluency also have reduced access to mental health and counselling-related services (Bowen, 2001).

Linguistic barriers, combined with low socio-economic status, may also reduce access to information on the functioning and possible benefits of health care services. A lack of knowledge on the health care system and how to use it may hamper access and lead to inadequate use of health care services.

Good patient-provider communication has been shown to have lasting effects over time and directly to improve adherence and health outcomes. The quality of patient-provider communication is therefore a strong indicator of the quality of the health care provided (Bischoff, 2003). A lot of research has been carried out on the effects of language barriers on the quality of care (Bowen, 2001; Jacobs et al., 2003). In the US and Western Europe, resolving language barriers is considered to be the most urgent, evident and straightforward area in which interventions are needed. The following effects of language barriers have been observed:<sup>3</sup>

- Relatively little is known on the effects of language barriers on health outcomes. Still, research suggests that there are many intermediate effects (such as reduced comprehension and compliance). Language barriers have been associated with increased risk of hospital admission, increased risk of intubation for asthmatics, differences in prescribed medication, greater number of reported adverse drug reactions, and lower rates of optimal pain management. Language barriers may also be related to less adequate management of chronic diseases such as asthma and diabetes;
- Elderkin-Thompson et al. (2001) found that a language barrier does not only impede conveying information about diagnoses or medications, but also the effective use of information for encouraging compliance;
- As a result of language barriers, health care providers may fail to meet ethical standards in providing health care. Language barriers may result in failure to protect patient confidentiality, or to obtain meaningful informed consent. Canadian research has made clear that informed consent was often obtained from patients with limited English proficiency using methods that are normally relied upon for patients who are mentally ill, demented or in a state of coma (Kaufert & Putsch, 1997);
- Language barriers have a negative effect on patient satisfaction. A review of the literature reveals consistent and significant differences in patients' understanding of their conditions and compliance with treatment when a language barrier is present;
- Language barriers have been found to have a negative effect on provider effectiveness and satisfaction. They make it difficult for health care providers to meet professional standards of care, and may, in certain countries, increase their exposure to the risk of liability;
- Finally, there is some evidence that language barriers may have important effects on health care costs, through their impact on service utilisation and health outcomes.

Consensus exists that the provision of professional health care interpreters is an important prerequisite to guarantee equitable access to and quality of care to many ethnic minorities. Professional interpreters may have an important impact on

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<sup>3</sup> Mainly based on Bowen, 2001.

the acceptability of health care services and patient satisfaction in ethnic minority groups. Considerable controversy, however, surrounds the precise definition of the role of the health care interpreter (Bowen, 2001; Tribe & Raval, 2002; Valero-Garcés & Martin (eds.), 2008).

#### SOCIO-CULTURAL BARRIERS

Systematic studies of the effects of (socio-)cultural barriers are very scarce. This may be related to the elusiveness of the concept of culture. Still, consensus seems to exist that inadequate handling of cultural differences may affect the quality of care and that the development of culture competence or cultural responsiveness would add to the efficiency and effectiveness of health care provision to ethnic minorities (Bischoff, 2003). Elderkin-Thompson et al. (2001) have argued that “caregivers may not understand the implications that particular symptoms hold for patients because the perception and interpretation of somatic sensations are frequently defined by cultural idioms”. It was also found that immigrants rate language and cultural differences as their biggest barriers to receiving care.

When cultural differences and cultural needs are insufficiently taken into account (e.g. lack of respect for the values and convictions of ethnic minority patients), this may make health care services culturally unacceptable for these groups. In cultures where modesty is a particular issue, the lack of access to staff members of the same sex may e.g. lead to an unwillingness to rely on health care services for certain health problems. The same holds true when patients are not offered the possibility to have meals that suit their religious and cultural needs at the hospital (Henley & Schott, 1999). When health care institutions lack cultural competence, this may affect the accessibility of the health care system.<sup>4</sup>

Partly culturally determined beliefs, concepts, types of behaviour, traditions and religious convictions may have a profound impact on the expectations and interactions of ethnic minorities with the health care system. In the literature we find many references to examples of ‘cultural diversity’ that may affect the cross-cultural health care encounter: e.g.: views on nutrition/diet, explanatory models, different types of traditional healing systems, views on surgery and transplantation, autopsy, on communication with the diseased (e.g. the communication of bad news), visiting ill persons, the process of dying and death, religious rituals to be executed at birth/death, gender relationships (acceptability of a health care provider of the opposite sex to the patient), (female) circumcision (infibulation) (see e.g. Henley and Schott, 1999; Pavlish et al., 2010).

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<sup>4</sup> . Cultural competence may be defined as the ability to provide effective health care services taking into consideration the individual's gender, sexual orientation, disability, age and religious, spiritual and cultural beliefs (Bischoff, 2003).

Even more important, however, may be the low health literacy that is found in many ethnic minority patients. Greenhalgh et al. (2006) found in a most interesting study carried out in primary health care, that interpreters had to 'double translate', first from English to the minority language and then from medical to everyday talk, often with consequent loss of meaning. It is known that the key determinants of health literacy are socio-demographic factors, such as education, the ability to articulate the problem in any language, the ability to act on advice and instructions given by health professionals, and knowledge of the local health and social care system. A not insignificant number of patients are unable to articulate or understand what may be referred to as 'the biomedical agenda' in any language. Such patients may be completely unable to take up the 'patient role' that is expected from them in our health care systems. In these cases, intermediaries may have to play a critical advocacy role. E.g. when patients do not know what questions they might ask or what they should report to the doctor. Both health professionals and service users believed that failure to communicate the biomedical agenda effectively posed significant clinical risk.

A large body of literature exists that stresses that health care providers should respond adequately to patients' socio-cultural needs. Cultural competence training has been found to be effective in improving knowledge and behavioural aspects of health care providers and building effective communication strategies. Despite progress in the field, however, several challenges exist, including the need to define educational core competencies, reach consensus on approaches and methodologies, determine methods of integration into the medical and nursing curriculum, and develop and implement appropriate evaluation strategies (Smedley, Stith & Nelson, 2003).

The most important aspect of culture competence may well be the ability to communicate clearly, sensitively and effectively with ethnic minority patients, their relatives and colleagues who belong to ethnic minorities. Intercultural communication should, therefore, be part of every program aimed at improving culture competence in health care professionals.

It is known that health education and promotion programmes often poorly reach ethnic minorities. Culturally sensitive health/patient education programmes are needed to give ethnic minority patients more control over actions and decisions that influence their health. Of special importance are programmes that inform patients on how to access and use the health care system in an effective way. Health education material, health promotion campaigns and interventions have to be tailored to the needs and characteristics of ethnic minorities: it may be necessary to translate material, provide audio- or video taped material for (semi) illiterate groups and groups with low educational status and to take cultural issues

into account (e.g. the use of certain pictures or drawings that may be considered perfectly acceptable in one culture and extremely offensive in another). Research makes clear that it is important to involve members of the target groups in the preparation and implementation of health promotion initiatives for ethnic minorities. These can often provide invaluable information on strategies and self-organisations that can help to improve the impact of health promotion activities.

#### EMPLOYING INTERPRETERS AND INTERCULTURAL MEDIATORS TO REDUCE HEALTH CARE DISPARITIES: THE EVIDENCE BASE?

In many European countries, ethnic minority members are being employed as intermediaries in health care, either as interpreters or intercultural mediators. Two systematic reviews of the literature on the effects of interpreters in health care have been published during the last decade in the US (Flores, 2005; Karliner et al, 2007). It may be important to point out that relatively little research has been carried out on the effects of interpreters, and even less on these of intercultural mediators, on the quality of health care. Flores discusses the results presented in 36 articles, Karliner's corpus is even more limited to 28 studies.

Both reviews come to the conclusion that interventions of professional interpreters are associated with an overall improvement of care for patients with low English proficiency. They appear to decrease communication errors, increase patient comprehension, equalize health care utilization, improve clinical outcomes, and increase satisfaction with communication and clinical services. In addition, it was found that professional interpreters improved clinical care more than ad hoc interpreters do, and that they can raise clinical care for LEP patients to match or approach that for patients without a language barrier. Interestingly, it was found by Karliner et al. (2007) that even when the effect of professional interpreters was not separated out from that of ad hoc interpreters, evidence remained for a benefit.

Flores (2005) points out that interpreting positively affects the uptake of preventive screening such as attending clinics for breast cancer screening, obtaining mammograms, occult blood testing, rectal exams. Disparities in flu vaccinations could also be eliminated through the use of interpreters.

Research has also made clear that untrained, ad hoc, interpreters have a greater likelihood of committing interpreting errors with potential clinical consequences, of distorting and omitting information, e.g. the explanation of medication side effects. A growing body of evidence suggests that the use of informal, untrained interpreters can lead to serious miscommunication, and so to inadequate care. Untrained interpreters may be proficient in both languages but may lack

interpreting skills. Poor interpreting leads to misunderstandings, wrong diagnoses and low adherence. In a recent study by MacFarlane et al. (2009), Irish GP's stated that the use of informal interpreters could be inadequate and problematic and could "leave them worried, frustrated and with experience of errors and misdiagnosis". Untrained interpreters who are insufficiently familiar with both cultures are unable to provide the necessary intercultural mediation. Relatives, especially children, are also at a high risk of stress disorders themselves, if they have to translate emotionally charged interviews (e.g. about their parents experiences of violence or forced migration) (Bischoff, 2003). Informal interpreters have been found to manipulate messages uttered by health care providers and/or patients to serve their own interests or the perceived interests of the interlocutors (e.g. hiding bad news from the patient) (Es Safi, 1996; Verrept, 2001/2; Lanza et al., 2010).

It may be important to point out that both review articles draw our attention to the issue of interpreter errors. Although these are more commonly found in the interventions of ad hoc interpreters, they are by no means rare or exceptional in the interventions of professional interpreters. E.g., it was found that in 52% of the interventions of 'nurse interpreters', serious miscommunication problems occurred "that affected either the physician's understanding of the symptoms or the 'credibility' of the patients' concerns" (Elderkin-Thompson et al., 2001). In a study by Flores (2003) in a paediatric care clinic, interpreters averaged not less than 31 errors per encounter such as omitting instructions on the dose, frequency, and duration of antibiotics.

Generally speaking, it was found that trained, professional interpreters improved accessibility, led to higher satisfaction with care and, in a number of studies, also to improved outcomes.

In a number of countries, e.g. Belgium, Italy, Spain, Canada, the USA, intercultural mediation programmes have been developed and implemented in health and social services to improve access and quality of care for ethnic minorities. The intercultural mediators nearly all have in common that they are community members who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked adequate access to care (Witmer et al., 1995). Some of them are mainly involved in health education, whereas others mainly assist ethnic minority patients and health professionals during health care encounters. Although the tasks performed by intercultural mediators may vary between different projects and countries, they generally act as interpreters, are culture brokers (explaining the culture of the physician and the health care institution to the ethnic minority patient and explaining the culture of the ethnic minority patient to the health professional, Kaufert & Koolage, 1984),

are involved in health education, serve as a liaisons between patients and health professionals, and may under certain circumstances, act as patient advocates. Based upon his work in the Reggio Emilia region in Italy, Chiarenza (cited in Pöchhacker 2008), an authority in this field, describes the intercultural mediator as someone who is able "to accompany relations between migrants and the specific social context, fostering the removal of linguistic and cultural barriers, the understanding and the enhancement of one's own culture, and the access to services. In addition the intercultural mediator "assists organisations in the process of making services offered to migrant users appropriate".

Little research has been done on the effects of intercultural mediation. Still, some evidence was found that intercultural mediators are very useful to resolve linguistic and cultural barriers and that they have an important and positive effect on the quality of care delivered to ethnic minority patients as assessed by health professionals and ethnic minority patients alike. They facilitate the exchange of correct and detailed information between health professionals and ethnic minority patients, respect for patients' rights, identifying patients' needs, the provision of culturally sensitive and responsive care, and may have very important and positive effects on patient satisfaction (Verrept, 2008; Rocheron, Dickinson & Kahn, 1988).

#### ROLE-ISSUES IN INTERPRETING AND INTERCULTURAL MEDIATION IN HEALTH CARE

In the literature on medical interpreting, it is often argued that interpreters should execute a number of tasks that go beyond what is sometimes called 'pure interpreting'. Pure interpreting is often used to refer to the model of the interpreter as a translating-machine or a conduit (Bot, 2005). It implies that the interpreter just translates and does not intervene in any other way during the session. In recent years, this approach lost a lot of its former popularity and many authors, often with a background in social and health sciences, have advocated for a more active interpreter role (see e.g. Angelelli, 2004; Hsieh, 2006). It has been argued that tasks that are traditionally more associated with the role of intercultural mediators or culture brokers are necessary if we want to eliminate the barriers that hamper adequate care provision to many ethnic minority members. This is e.g. the case when no exact lexical or conceptual equivalents exist in the languages or the cultures of the health professional and the patient. (Pavlish et al., 2010; Deumert et al., 2010).

A number of researchers have e.g. found that the use of interpreters to educate health care providers and patients in 'cultural issues' added to their effectiveness. They thereby executed the task of 'culture brokerage' which is central to the work of the intercultural mediators (Chen Wu, A, Leventhal, J, et al., 2006; Kaufert &



Koolage, 1984). When interpreters fail to explain the cultural idioms that shape the patient's symptoms, the translation of the messages may indeed sound nonsensical to the physician (Elderkin-Thompson et al., 2001). It has also been argued that he or she may thus miss the opportunity to understand how the patient perceives the symptoms and what concerns need to be addressed in order for the patient to have confidence in the recommended treatment (Pavlish et al., 2010). An interpreter who is confined to a conduit-role would also not be able to inform the provider about culturally sensitive ways to retrieve information to treat the illness (Hsieh, 2006). Arnaert et al. (2006) stress that Inuit language interpreters are not only necessary for translation, but also to bring cultural awareness to interactions between patients, family members and Western health carers.

Greenhalgh et al. (2006) argue that "the interpreter should not be used merely to translate the biomedical agenda but also to convey the key personal, historical, cultural and religious elements that form the context in which a biomedical problem emerges". It was found, that "the interpreter's translator's role had to be juggled judiciously with other potentially conflicting roles, including interpersonal mediator (promoting clinician-patient trust); system mediator [...], educator (increasing health literacy via explanations of medical terms and concepts), advocate (negotiator and cultural broker for the patient's lifeworld) [...]". It must be clear that this very wide task description goes far beyond the traditional role of interpreters.

Further support for a wider role for the interpreter, and indirectly, for the employment of intercultural mediators in health care, is found in a number of studies on 'informal interpreters'. Although many valuable arguments exist against the use of these interpreters, one should not ignore the finding that they may be the patients' preferred option, precisely "because they are not just translating, but often also mediating between their families and the health sector" (Green et al, 2005). Rhodes & Nocon (2003) also found that informal interpreters were often preferred to professionals because the family interpreter can offer support, convenience and, more importantly, greater understanding of the client. One might, however, argue that patients who need interpreters are unable to assess the quality of the interpretation provided by the informal interpreter.

Although the idea to expand the roles of the interpreter to these of the intercultural mediator may seem attractive, this approach is not without its risks. Critics have questioned the implications of this model for ethical practice and the maintenance of standards of professional competence. E.g. it has been argued by Dysart-Gayle (2005) that there is no discussion about how and when an interpreter is to move away from the default mode of information transmission and assume

the tasks of the expanded roles. Also, it is not always clear how tasks such as 'cultural brokering', 'conveying the cultural and religious elements that form the context in which a biomedical problem emerges' should be executed in a professional way and how standards could be developed in these domains.

## DISCUSSION

Results of research indicate that the use of intercultural mediators and interpreters will contribute to the reduction of ethnic health and health care disparities. Unfortunately, however, the impact of medical interpreters and intercultural mediators has clearly been under-researched. Despite increasing need, very few interventions models for resolving language barriers have been adequately investigated, as recently stated by Pavlish et al. (2010). In addition, many existing studies have severe methodological limitations, as has been argued by Flores (2005), Karliner et al (2007), Greenhalgh et al. (2006) and others.

Weaknesses in study design and analyses make it difficult to assess the full effects of medical interpreting or intercultural mediation on the provision of health care. In many cases, little or nothing is known about the participants' need for an interpreter. It is likely that study samples included patients with varying language proficiency in the majority language, ranging from no proficiency to excellent proficiency (Karliner et al. 2007).

In a number of studies, the effects of different types of interpreters (ad hoc vs. professional) are not adequately separated. In addition, little attention is given to the training accomplished by professional interpreters, the roles performed by them ('just translating' vs. the execution of a number of other roles), and the effects of cultural factors or features of the health care setting where they are being employed. In general, and this holds true for EU member states as well as for the US, medical interpreters and intercultural mediators alike, have received very limited training to prepare them for their work. Many interpreters have received not more than 40 hrs of training. In contrast to this, conference interpreters will in most Western countries, accomplish a 4-5 years training program at a university level.

Also, most studies deal with the effects of interpreters who interpret between Spanish and American English. It may be interesting to point out that, researchers working with non –Western groups in particular, often seem to advocate for a wider role for interpreters and for different forms of intercultural mediation (see e.g. Kaufert & Putsch, 1997: working with Inuit and Indian groups; Arnaert et al., 2006: working with Inuit; Verrept & Louckx, 1997: working with Moroccans;

Deumert et al., 2010: working with South-African isiXhosa-speakers). It may very well be the case that different ethnic groups need different types of intermediaries if we want to reach the goal of adequate care provision. We are strongly convinced that this phenomenon has received too little attention until now.

Finally, it should not be forgotten that in many countries, there seems only to be a half-hearted commitment to the issue of the reduction of ethnic health care disparities. Indicators thereof are, e.g., the absence of adequate needs assessments in this domain and the provision of a manifestly insufficient number of (often poorly qualified) interpreters or intercultural mediators in the health care systems. As a result, their impact, may of course be limited, as care providers will have to continue to rely on informal interpreters etc. to provide care to their patients.

However, the above does not imply that the employment of ethnic minority members in health care would not be an effective strategy to reduce ethnic health (care) disparities. On the contrary, many methodological limitations in existing research and existing programmes, may very well imply that the observed impact only partly reflects their effectiveness. This may hold true for the small sample size in some studies, the lack of distinction made between the effects of ad hoc vs. informal interpreters, and the above-mentioned limited training and availability of interpreters and intercultural mediators

As such, these studies should rather encourage policy-makers to further develop interpreter and intercultural mediation schemes, than to discourage them from doing so. An incentive to do so might be the recent finding of Bischoff & Denhaerynck (2010) that the use of interpreters might actually be cost-effective as it seems to prevent the escalation of long-term costs.

Still, it is of the utmost importance that interpreter and intercultural mediation schemes are scientifically evaluated. Better training programmes for medical interpreters and intercultural mediators are badly needed. Research should provide insight in the roles that should ideally be performed by medical interpreters and intercultural mediators, and on how and when these different roles should be assumed to reduce the impact of linguistic and socio-cultural barriers most effectively.

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