Interpreting Services in the Maltese Healthcare Context: An Investigation

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Abstract

The quality and timeliness of the healthcare provision by the Maltese public healthcare system is possibly at risk due to the migrant influx and the resulting demographic shifts. Language barriers are a potential common occurrence in the Maltese healthcare context; their impact may be hindering the healthcare provision service. The literature focuses on the interactions between practitioner and patient or client, interpreting accuracy and budgeting across different healthcare systems. With regards to the local context, the present study was aimed at discerning if language barriers are in fact a significant obstacle in providing healthcare. To this end, a quantitative study setup was employed to answer the research questions.

A questionnaire was sent to 77 practitioners hailing from different professions by way of inquiring on the frequency of language barriers, on the practitioners' knowledge of healthcare interpreting and on their inclination towards a potential uptake of a healthcare interpreting service. Results show that language barriers, specifically patients or clients who exhibit limited Maltese or English, are common across the professions involved in this study. Additionally, the presence of language barriers may be veritably hindering the quality and timeliness of healthcare provision. Finally, the majority respondents are aware that a healthcare interpreter can offer significant help, despite displaying a potential lack of understanding of the interpreter's precise role in healthcare interactions. Future efforts can then be aimed at gaining qualitative information on healthcare interactions in the Maltese public healthcare context, similar to the present pool of studies. Additional costs incurred and strategies employed by practitioners to overcome language barriers such as ad hoc interpreting should also in focus in subsequent research efforts.

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List of Abbreviations

UK – United Kingdom

EU – European Union

USA – United States of America

SPSS – Statistical Package for the Social Sciences

NSO – National Statistics Office

LEP – Limited English Patients

NRSPI – National Register of Public Service Interpreters (UK)

NCIHC – National Council on Interpreting in Health Care

AUSIT – The Australian Institute of Interpreters and Translators

NZSTI – New Zealand Society of Translators and Interpreters

ITI – Institute of Translation and Interpreting (UK)

MARTI - My Accessible Real Time Trusted Interpreter system

BSL – British Sign Language

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Chapter 1.0: Introduction

Healthcare interpreting is nowadays a crucial part of the healthcare provision in many multicultural societies around the world. Language disparities stand in the way of providing quality, equitable healthcare provision in today's globalised world (Crezee, 2013). Language services are thus a necessary tool to help bridge the discrepancy between healthcare provision and a multilingual caseload whose health, prevention of health conditions and long term quality of life are jeopardised everyday by language barriers. The UK interpreting services, for example, cater for close to 300 community languages excluding dialects. In Malta, this potential issue is being exasperated by the ever-increasing migration flows from EU citizens and third country nationals and the resulting demographic shifts. Due to the absence of widespread language services within the nationally funded public healthcare system, an issue of language barriers in providing healthcare has never been so relevant. In addition, this research scope is yet to be explored in Malta.

Research provides strong evidence that language disparities lead to risks throughout the entire healthcare provision process (Leanza, 2007). Language discordance in such contexts can lead to briefer physician visits, inaccurate diagnoses, incorrect treatment, exasperation of present health conditions, fewer follow ups, more frequent readmissions to hospital, decreased quality of life and in rare cases death (Crezee, 2013; Estrada, 2014; Quan & Lynch, 2014).

The established literature on healthcare interpreting investigates precisely how and why the latter adverse outcomes occur. Although scientific efforts are recent in the interpreting community, different authors have taken different routes in analysing interpreting in the healthcare context. A common approach is the dyadic model, through which the relationship between the healthcare practitioner and interpreter can be studied. More recently, however, the triadic approach has been gaining traction; it includes the patient as well as the

practitioner and interpreter (Estrada, 2014). Despite the inherent additional complexities of including the patient as well, situational and discourse analyses and modern equipment allow the researcher to record and analyse interpreter-mediated healthcare interactions. Furthermore, post-healthcare interaction questionnaires were proven useful. This approach aids the researcher in collecting qualitative data pertaining to such interactions. The results from such studies are used to qualitatively describe healthcare interactions, their outcomes and study the role of the different stakeholders as conceptualised by each other. The researcher can then draw conclusions pertaining to the macro-ecology of the healthcare system under study. They can also infer from the interactions' impact on issues related to long term outcomes such as additional costs incurred by the system and long term quality of life for the patients. The latter inferences are dependent on countless variables and are not easy to make.

This study seeks to pursue similar aims using scientific methods. However, scientific studies into the Maltese healthcare system and interpreting are virtually non-existent. Due to this, this study was dedicated to uncovering the need for healthcare interpreting in the Maltese healthcare system. To this end, a questionnaire was distributed to healthcare practitioners hailing from different professions by way of conducting a preliminary investigation into the need for healthcare interpreting in the Maltese healthcare context. Furthermore, the questionnaire seeks to reveal potential healthcare disparities due to language barriers. Finally, the practitioners' opinion on a prospective healthcare interpreting service and current awareness of such a service can help to tentatively gain their inclination to uptake healthcare interpreting. Readiness for healthcare interpreting service uptake may be a pertinent factor for future efforts. This study does not build on previous undertakings due to lacking local efforts, but adds the Maltese healthcare dimension to the global pool of studies.

By way of investigating the need for healthcare interpreting in the Maltese healthcare setting, the following research questions were put forward:

'In the context of a multicultural Malta, new challenges and questions arise; is the healthcare system capable of offering the best service possible?' 'Are local healthcare practitioners witnessing healthcare provision disparities due to language barriers?' In addition, 'what do local healthcare practitioners think of the proposition of introducing an interpreting service?'

The research questions aim to uncover any adverse outcomes in relation to language barriers in healthcare context as outlined in the literature. To this end, a scientific methodology was adopted to reliably gain valid information from healthcare practitioners regarding healthcare disparities born out of language discordances. A representative sample of participants was not achieved; therefore, generalisations are only possible in a tentative capacity. However, efforts were made to set up a scientifically sound methodology in a bid to draw correct conclusions and serve as a model for future studies into the Maltese healthcare system and interpreting. Quantitative data was then extracted and analysed using the statistical tool SPSS and presented prior to the discussion chapter.

This study has the potential to uncover a chronic occurrence of high pertinence to the Maltese healthcare provision since language barriers can lead to profound adverse effects along the healthcare provision process. This can alter the way healthcare interactions with patients exhibiting limited Maltese and English skills are tackled. Additionally, this study can prove to be an effective way to raise awareness on such issues and on healthcare interpreting. It can also pave way for future studies in a bid to ultimately build a strong case in favour of introducing a widespread healthcare interpreting service. On the other hand, this study may not uncover any preliminary basis for further investigations as the current healthcare system could be equipped to deal with language barriers.

Chapter 2.0: Literature Review

The crux of healthcare interpreting is to provide better care for patients with limited language proficiency. The interpreting profession in the healthcare setting is present in many countries across the globe and studies show that interpreting for patients is effective in improving care, mitigating expenditure and facilitating the interaction between the patient and the healthcare practitioner.

Healthcare interpreting was born out of an increasingly globalised world; immigration and the accompanying demographic shifts resulted in multicultural societies speaking a number of different languages. For example, 20% of the population in the United States do not speak English and a further 25 million Americans possess limited English proficiency (Siyu Wu & Rawal, 2017). In the UK, 4.2 million people reported having a main language other than English, with Polish being the most common. A further 1.3% reported limited English proficiency (Office for National Statistics, 2013). On top of these, there are roughly 10 and 9 million deaf people in the USA and UK respectively (Mitchell, 2006; British Deaf Association, 2016). These are millions of people in at least two countries who may be hindered in communicating their afflictions properly in any healthcare setting due to a language barrier. The language barrier may result in longer hospital stays, higher odds for readmission, inaccurate diagnoses and in rare cases, death (Karliner, Kim, Meltzer, & Auerbach, 2010; Quan & Lynch, 2014).

To this end, this research will focus on investigating a potential niche for interpreting in the Maltese healthcare context with the intent to start raising awareness on a possible need for policy change. Over the past few years, Malta has witnessed a large influx of migrants from different countries; resulting in a more culturally diverse population. By default, this means an introduction of new languages, religions, customs and expectations, amongst others. “In the context of a multicultural Malta, new challenges and questions arise; is the

healthcare system capable of offering the best service possible?" "Are local healthcare practitioners witnessing healthcare provision disparities due to language barriers?" "In addition, what do local healthcare practitioners think of the proposition of introducing an interpreting service?"

2.0 Local Demographics: Growing Multiculturalism

According to the National Statistics Office (NSO), the net increase in population in 2015 derived from immigration as opposed to births (National Statistics Office, 2016). Over 12,000 migrants came to Malta that year; the highest registered difference between immigration and emigration (4,176) for this decade. Third-country nationals (countries outside the European Union) account for 44%. The result is a multicultural Malta, diverse in languages, customs and beliefs (National Statistics Office, 2016). According to the Maltese Obstetrics Report 2016, 19.9% of births in 2016 were Non-Maltese, while an additional 0.1% did not have a nationality specified (Directorate for Health Information & Research, 2017).

2.1 History of Interpreting Research

Interpreting is commonly thought of as a linguistic exercise; however, it can be argued that, above all else, it is a cultural-linguistic translational activity. The latter is a recent rendition of this role. In the past, research mostly focused on "Translation and Interpreting studies", a single-path approach. However, interpreting has slowly branched out and re-defined both translation and interpreting in the process. Since the 1950's, methodical research in both fields progressed under the premise of linguistic comparison and accurate message transcoding, a mechanical process notwithstanding written or spoken transfer loss. This involves interactions between sender and receiver with the translator or interpreter acting as a conduit. The assumption underpinning the latter model is that no loss during message transfer occurs (Schäffner, Kredens, & Fowler, 2013). This may be somewhat erroneous; in fact, this notion started to be contested as studies started to focus on the institutional, situational and

socio-cultural aspect (Wadensjö 1998; Mason 2001, cited in Schäffner, Kredens, & Fowler, 2013). This paved way for new research questions and a wider literature scope.

This new direction has never been so relevant for Malta given the aforementioned demographic shift discussed above. Before delving into interpreting and the cultural implications involved, 'culture' has to be defined. Culture has been described differently across the cultural sciences. However, the ultimate interpretation of culture takes the form of a natural manifestation of a variety of traits evidently observable when people interact. Culture is class, gender, age, education and, amongst others, profession specific because culture is an expression of these traits found in individuals within a specific society. It has been described in the anthropological field as a complex that encompasses knowledge, beliefs, art, laws, skills and as a system of shared ideas, rules and concepts. These characteristics are passed down to successive generations of the same society (Schäffner, Kredens, & Fowler, 2013). Language is one of these traits falling under the umbrella term 'culture'; meaning that the definition of strictly linguistic interpretation implies an activity limited to this subsidiary trait and does not take into account all the complexities of all the cultural traits of an individual during an interpreting exercise (Leanza, 2007). As a result, an interpreter working strictly in the linguistic capacity may not be coming across accurately to clients or patients belonging to different cultures.

Consequently, it can be argued that an effective interpreter is a cultural broker; a much wider remit than the conventional linguistic parameters traditionally assigned to interpreters (Pöchhacker & Shlesinger, 2007). This wider remit brings with it additional implications when working in different sectors, perhaps more so in the healthcare sector. In broad terms, the interpreter has to take account of the recipient's cultural background in delivering the translated message. A culturally insensitive approach may lead to communication breakdown, as communicative customs are not universal. For example, in

some cultures, women do not make eye contact with men as it may not be culturally acceptable in a specific context. In the healthcare context, this behaviour can mean that certain gestures, body language and even terminology may be misinterpreted by the patient or healthcare provider alike to the detriment of the patient's health if delivered through a culturally insensitive channel. The conclusion one can draw from this is that the healthcare interpreter has to possess cultural knowledge so that the linguistic element in an interaction does not manifest itself in a vacuum. It is futile to solely know the language if conveyed under the customs of a different society.

Research shows that language disparity may put additional burdens on the healthcare system in providing a service to patients who are not fluent in the first language (Hadziabdic, Heikkilä, Björn, & Hjelm, 2011). The authors reported an adverse chain reaction throughout the healthcare procedure when faced with lacking interpretation.

The problems reported led to incorrect use of time and resources, which increased the workload and thus delayed treatment. Other consequences were limited possibilities to communicate and thus consultation was carried out without a professional interpreter, using family members instead. The results highlight the importance of developing good cooperation between the interpreting agency and the primary healthcare centre in order to fulfil the existing policy of using professional interpreters to provide the right interpreter at the right time and guarantee high-quality care (Hadziabdic, Heikkilä, Björn, & Hjelm, 2011).

The interpreter has to know beforehand what kind of reactions the patient might exhibit depending on their culture. In navigating the different cultures, the interpreter ideally has to predict how people will express emotions such as anger, love, and concern, how they show respect and what gestures or body language can be misinterpreted from a particular culture. The interpreters' cultural sensitivity will help to avoid any cultural pitfall, steer clear from their own subjectivity and ultimately contribute to providing the best healthcare

possible. A study conducted in the USA reported that out of the 3071 LEP participants, the 61% who did not receive language interpretation on both admission and discharge had a longer length of stay in hospital of between 0.75 and 1.47 days. In addition, the 39% who received language interpretation were less likely to be readmitted in the following 30 days (Lindholm, Hargraves, Ferguson, & Reed, 2012). Furthermore, extra time was invested in healthcare interactions without interpretation were found to be more stressful for both the practitioner and the patient in Sweden (Fatahi, Mattsson, Hasanpoor, & Skott, 2004).

Our cultural roots have a profound effect on our approach to health, sickness and pain. As a result, the interpreter has to be in touch with the two or more cultures at play in order to deliver an accurate interpretation. Healthcare interpreters are thus highly sought after in many different healthcare systems.

The common understanding in the healthcare setting is that cultural discordance in practitioner – patient exchanges may lead to seriously adverse result, or even result in death. In a typical healthcare interaction between practitioner and patient, we consider our cultural background to be the 'norm', so we may therefore overlook certain communicative traits or carry certain incompatible expectations in our interactions. Gender specific behaviour provide a stark difference between cultures. For example, women may not be allowed to speak to a man and discuss gynaecological conditions with a male practitioner or interpreter. Another cultural contrast with potentially profound effects is how people handle cancer. It is not culturally appropriate to mention the word "cancer" in certain cultures and it may be considered a shameful affliction in others (Daher, 2012). This is especially true in Middle-Eastern countries, where cancer stigma is tied to both the affliction itself and its treatment. Daher (Daher, 2012) highlights some of the reasons:

- Cancer is seen is a punishment leading to an inevitable death;
- Cancer is seen by some as contagious;

- Cancer types more common in women, such as breast or cervical cancer are not discussed as those parts of the body 'are not to be spoken of';
- Treatment can be seen to exasperate the spread of cancer.

Therefore, it may be difficult for a practitioner to extract information from such a patient. The interpreter, as a cultural liaison, has to make sure the patient's cultural beliefs are respected while delivering the practitioner's information and questions accurately and vice-versa as required from a professional interpreter (NRPSI, 2016). In such cases, the interpreter's cultural expertise and sensitivity allows them to be more accurate.

2.2 Accuracy: Misguided or Targeted Healthcare

The ever-evolving discussion of accuracy plays an integral part in the interpreter's role as a cultural liaison, so much so that numerous studies focus on it and use it as a measure for interpreting success (Jackson, Nguyen, Hu, Harris, & Terasaki, 2010; Esposito, 2001; Butow, *et al*., 2011). Accuracy in interpreting does not merely imply the accurate linguistic rendition of an utterance, but the interpretation of the meaning and conveyance into the target culture. Translating word by word will inevitably lead to inaccuracies, possible misdiagnoses, negative healthcare outcomes and additional burdens on the healthcare system (Estrada, 2014).

Accuracy in the healthcare settings requires a specific skill set and background knowledge, similar to how local court interpreters occupy that niche because of their law qualifications. In order to deliver the best work possible, maintain professionalism and safeguard the health of their patients, healthcare interpreters need expansive cultural and medical knowledge. Medical knowledge is of pertinence to any exchange between the patient and the practitioner due to the basic understanding that you cannot interpret what you do not understand (Crezee, 2013). The stakes can also be high in the provision of healthcare; an interpreter who is oblivious to the difference between a colon cancer and a cervical cancer or

between heart burn and heart failure may transmit some very misleading information to the detriment of the patient and the healthcare institution.

Similarly, medical knowledge ties in with cultural knowledge as well, as layman's medical terminology varies from one culture to another, this means that it may be tricky to interpret a patient's description of an affliction correctly. It is the author's personal experience that Maltese layman's terminology may be vague, physiologically impossible and require further clarification. For example, a common phrase is "għandi riħ f'dahri" (a cold affecting your back). Perhaps the only medically relevant word here is "dahri", which means back; therefore, the only plausible scenario a healthcare practitioner can think of is that the patient has something wrong with their 'back'. In other cultures, serious conditions may be played down, sometimes unintentionally too, for example, lung cancer may be described as "lung infection" in some cultures due to cancer-taboo. An ad hoc interpreter belonging to the same culture may verse 'lung cancer' as "lung infection", again, possibly leading to profound adverse health implications, time inefficiency and resource wastage. Distortion and censoring of information is something a professional interpreter is bound not to do. With this in mind, the interpreter is also expected to anticipate culture-specific reactions. For example, a doctor's reluctance to intervene may be interpreted by some cultures as an opportunity for bribery. The interpreter must make sure the patient or client does not misinterpret this. Such culture-specific misunderstandings are commonplace and portray the kind of cultural pitfalls the healthcare interpreter must navigate in order to relay meaning accurately. In the latter case, it is the interpreter's duty to clarify what is meant by the practitioner. Failure to do so may result in misguided efforts by the patient, unnecessary stress and psychological burden. This very much ties in with the interpreter's code of ethics and prior knowledge of such cultural differences (discussed above).

2.2.1 Maintaining conversational flow: untrained and trained healthcare interpreters. As a professional, the healthcare interpreter is responsible for setting the ground rules governing interpreting in order to deliver the best possible service (Crezee, 2013). The interpreter knows that a particular delivery mode has to be established in accordance to the particular setting and needs; the service can be simultaneous or consecutive (with note taking). The professional interpreter should also be aware that the main interlocutors of the interaction are the patient and practitioner, and so these should address each other face to face, with the interpreter being on the side to form a triangular formation (Crezee, 2013). The physical setting of the interaction plays a vital role in maintaining the natural flow of the conversation and preserve accuracy, thereby allowing the possibility of impeccable interpreting. Furthermore, now that the practitioner and patient are positioned as the main interlocutors, it is more natural for the interpreter to put to practice the ground rules established prior in accordance to the context.

Untrained or ad-hoc interpreters do not usually employ an advantageous physical setting nor the best methods to deliver an imperceptible service. This can lead to interpreting inaccuracies and almost certainly a communication breakdown due to amateur mistakes such as unconsciously taking sides, omitting seemingly useless information, or using the third person instead of the first person in addressing the interlocutors. Research shows that first person use is pivotal for the interpreter to seamlessly convey information between the main interlocutors (Juckett & Unger, 2014). First person or direct speech use is of particular weighting not only to relay messages accurately but also to maintain ownership of the interpreted utterances. First person use is, therefore, a staple in interpreting and in the different codes of ethics and the literature shows that, especially in court instances, direct speech can be manipulated for the interpreter to distance themselves from the interaction. In a study of a US courtroom by Berk-Seligson (Berk-Seligson, 1990), numerous interpreters

tended to selectively use the direct speech as a distancing technique. Specifically, the subject pronouns “I” and “you” were avoided particularly when the judge was giving a sentence. The author concluded that the shift from direct to indirect speech was a defensive measure to avoid being the target of a possibly livid defendant when found guilty, as they may assume the interpreters’ rendition is their own.

Further to the context of untrained or ad-hoc interpreters, these mediators are often family members or underappreciated volunteers who, in most cases, are not inclined to respect the professional interpretation process, the medical interaction itself and possibly do not possess adequate medical and/or cultural knowledge to mediate successfully. A medical interaction seeks to establish a functional rapport primarily between the medical practitioner and the patient; the quality of which will directly influence the exchange of information and therefore the healthcare provision (Hale, 2007). This means that the interpreter’s role is to be as inconspicuous and effective as possible. To achieve this, extensive medical and cultural knowledge along with interpreting techniques is necessary for a seamless performance.

The following list is a compilation of reasons to avoid using untrained/ad-hoc interpreters or children (except for emergencies) in the medical field:

- Lacking accuracy, while simultaneously omitting to mention important things they do not comprehend. Accuracy is tied to the requisite medical and cultural knowledge in order to interpret successfully;
- Lacking absolute confidentiality;
- Lacking impartiality: it is somewhat easy for untrained interpreters to fall into the trap of unconsciously taking sides. This will distort what needs to be interpreted, relaying only what the favoured party wants to hear;
- Failure to point out potential conflicts of interest (even their own personal ties or connection to the patient/client);

- May interfere with any tests being undertaken by the patient/client, for example by giving away answers which are diagnostically relevant to the practitioner;
- May be limited to strictly linguistic interpretation, not acting as a cultural liaison;
- Omit from setting up the ideal positioning and not regarding the practitioner and patient/client as the main interlocutors;
- Using third person/indirect speech instead of first/direct speech;
- Not correctly implementing a consecutive or simultaneous technique, while failing to explain the techniques in question or any other relevant standards of interpreting procedure to the interlocutors;
- Failing to adhere to a code of ethics.

Similarly to the untrained interpreter's scenario, trained healthcare interpreters and their work in the community have also been under the research scope. In one particular study conducted in Sweden, it was found that a trained interpreter acts in a contrary fashion to the list above (Dimitrova, 1997). Dimitrova's (1997) findings reveal that a trained healthcare interpreter first and foremost makes sure that the healthcare practitioner is in control of the interaction, not the interpreter. The close proximity nature of community interpreting puts further weight on who is monopolising the interaction and on measures to maintain the ideal flow of exchanges compared to, for example, court interpreting. An important consideration on such measures made by Dimitrova (1997) were turn-taking and overlapping speech, which are prominent features of community interpreting due to the aforementioned close proximity nature of community interpreting. Dimitrova's participant interpreters maintained an authentic flow, as if there was no third speaker. The trained interpreter was also found to interpret using direct speech or the first person and every utterance accurately. There is a perceivable advantage to interpreting accurately when compared to the arbitrary nature of untrained interpreting; this stark contrast was evident in Dimitrova's study (1997). Her

findings suggest that the interpreter's role has to initially be established in terms of setting goals to achieve and mode of interpreting by way of allowing seamless interpreting and conversation between the practitioner and patient. For example, should the interpreter use gestures to signal a pause, to allocate a turn or to deliver consecutive interpretation? Dimitrova's questions and many others' helped in one way or another in shaping many codes of ethics across the globe, which dictate what should and should not be done by the community interpreter.

Finally, in Dimitrova's study, doctors were spurring the conversation and were able to maintain a leading role in investigating the medical case. This is crucial to maintain optimal healthcare provision; in fact, the latter is in line with the standards of the interpreting and medical profession (AUSIT, 2018; O'Daniel & Rosenstein, 2008).

2.3 The Interpreter's Code of Ethics

Liaison interpreting is a profession where, like medicine, teaching and the law, the client's welfare is usually affected directly. This is not only because most liaison interpreting takes place in the context of other professions such as medicine, teaching and the law, but also because interpreting has its own particular kinds of knowledge, skills and practices which require particular ethical considerations. Liaison interpreting is, then, subject to ethical considerations both along the lines of any other profession and along lines of its own. And because liaison interpreting takes place in the context of so many other professional institutional settings, ethical conflicts often arise for the interpreter (Gentile, Ozolins, & Vasilakakos, 1996).

To this end, different codes of ethical behaviour exist in different countries and parts of the world (NRPSI, 2016; NCIHC, 2018; AUSIT, 2018; NZSTI, 2018). Despite their numbers, they all follow the same basic principles. These principles certify the status of the interpreter and guarantee a quality service and confidentiality. A code of ethics may help in

steering the interpreter away from arbitrary decisions, thereby increasing the chances of a positive outcome in healthcare. Furthermore, a code of ethics complements professional or academic training to guide the interpreter in making choices in accordance with the standard set by it.

The code of ethics exists to guide the interpreter through the best practices in view of protecting the patient. It is therefore important that the healthcare interpreter adheres to a code if they are to use every tool possible to help deliver the best service possible service. The code of ethics is what separates a professional interpreter from an ad hoc one, or any untrained individual or language aide willing to lend a hand. The healthcare system or practitioner can expect a trained interpreter to be unbiased, focused, willing, culturally sensitive, tactful, confidentially bound, accurate and worthy of the respect of all interlocutors. In the healthcare setting, interpreter training is necessary for a quality standard of service as they are bound by said code of ethics (Crezee, 2013).

However, not all interpreters agree on the effectiveness of a code of ethics. A study conducted in Australia revealed highly contrasting views on the Australian Institute of Interpreters and Translators (AUSIT) code of ethics between practicing interpreters (Hale 2005, cited in Hale, 2007). Five-hundred questionnaires were sent and only 21 interpreters replied. They reported polarising views on the AUSIT. The poor response rate itself may already be a general indication of how the AUSIT is viewed. Response rate notwithstanding, it is important to explore why a number of interpreters swear by the AUSIT and regard it as a “bible”, while others view it as “mess and quite ridiculous”. A number of respondents had an intermediary response, neither vouching nor disregarding the AUSIT. The demographic data from this questionnaire shows that the majority of respondents were trained in the field of interpreting, possibly skewing the results. This may in turn indicate that the AUSIT is not well represented beyond the academic or professional training circles. In fact, the more

trained the respondents were, the more likely they were to vouch for the AUSIT as a guideline for everyday interpreting practice, or likewise any code which values the ethical responsibilities involved in healthcare interpreting. Professional training may be making interpreters aware of the ethical dilemmas involved. Moreover, the participants said that they felt training was necessary in order to comprehend the code of ethics. A respondent also expressed concern on the code's relevance, as perhaps it had not been updated with the times. For example, adding a legal capacity would be ideal given the nature of the work (Hale, 2007). The literature in question can contribute in shaping Malta's way forward in this sector.

Locally, the interpreting industry is not regulated and still in its infancy compared to the rest of the world and the research base in healthcare interpreting is still limited. A code of ethics is an option worth considering in laying the foundations for a possible introduction of healthcare interpreting in Malta. In addition to giving interpreters a practicing guide, possible legal protection and safeguarding the client's best interests, a Maltese code of ethics would help solidify this sector and help it transcend its infancy. Malta has only just begun to break ground in translating healthcare documents. For example, the newly built Sir Anthony Mamo oncology centre requested one of the few translations of their patient information brochures (Government of Malta, 2017). The request was issued to the University of Malta and translated by the author. Similar commissioning is rare and sparse in the public sector.

The challenge in setting out a code of ethics is making sure it is applicable (Hale, 2007). Therefore, it is being taken for granted that in an effort to formulate such a code, the authors have to make sure the code is applicable, perhaps they could ask themselves, "is the code applicable enough to be effective in protecting the patients/clients while retaining the workload efficiency or perhaps even improve it?" And, "what kind of upkeep does it require?" In this text, an attempt to find the best applicability will be made by pinpointing the aspects common to 16 codes of ethics from around the world as assimilated in a study by the

author Sandra Hale (Hale, 2007). These aspects are considered not only important by the body governing the code and the interpreters, but also effective in safeguarding the profession and the patients/clients. In respective order, the following aspects are the most common in 16 different codes of ethics hailing from different countries as listed in the study in question (Hale, 2007):

- Confidentiality;
- Accuracy;
- Impartiality.

In expounding the aforementioned study, this text considers the three points above as tentative pillars in compiling an effective code of ethics, but also acknowledges the potential pitfalls that must be accounted for by the said code of ethics. For example, the sociocultural background tied to accuracy. It is not enough to render an utterance word by word, the interpreter must reflect on the different meaning an utterance can take in a different culture and interpret accordingly to the target culture. The latter point is a potential pitfall worth addressing in stipulating what constitutes "accuracy" in the interpreting profession. A clear instance of this is found in the California Rules of Court, where it states that;

An interpreter must use his or her best skills and judgment to interpret accurately without embellishing, omitting, or editing. When interpreting for a party, the interpreter must convey everything that is said during the entire proceedings. When interpreting for a witness, the interpreter must interpret everything that is said during the witness's testimony (California Courts, 2007).

The latter policy is open ended enough that the "best skills and judgement" can include cultural sensitivity, although it is not specified. Additional information on accuracy is provided above.

Impartiality is an important factor in achieving accuracy and objectivity when interpreting (Siyu Wu & Rawal, 2017). Impartiality is covered in many a code of ethics for it stipulates that the interpreter must not stray from objectivity. Personal feelings, beliefs, their own cultural background or any other inclination may interfere with the primary purpose of rendering the patient's message in the most accurate and objective way possible. An impartiality clause automatically addresses any potential conflict of interests which may endanger the health of the patient. It is pertinent in guaranteeing a professional interpreting service worthy of its presence in the healthcare context. However, it may conflict with the interpreter's moral duty to help provide the best healthcare result possible for the patient. Impartiality may be interpreted as limiting the interpreter to the concepts conveyed by the patients, meaning that anything the interpreter feels should be added (of a linguistic or medical nature) for the sake of the patient may not be allowed when adhering to confidentiality and impartiality rules stipulated in a code of ethics. Hence, it is ideal to include text to counteract this limitation. Such instances of this are found in, for example, the United Kingdom Institute of Translation and Interpreting (ITI), which stipulates the following:

Members shall interpret impartially between the various parties in the languages for which they are registered with the Institute and, with due regard to the circumstances prevailing at the time, take all reasonable steps to ensure complete and effective communication between the parties, including intervention to prevent misunderstanding and incorrect cultural inference (ITI, 2018).

Similar rules on impartiality are also set by the Australian Institute of Interpreters and Translators and the Association of Visual language Interpreters of Canada (AUSIT, 2018; AVLIC, 2018) and numerous other codes of ethics. In light of the considerable medical knowledge the medical interpreter requires in order to work in the healthcare setting, any

medical input outside of the parameters of impartiality should ideally not be discounted given the language barrier in place.

2.4 Healthcare Service Cost and Utilisation

A number of research efforts were made in attempting to calculate the costs of adding a healthcare interpreting service and healthcare utilisation by patients with limited English skills in the US (Jacobs, Shepard, Suaya, & Stone, 2004; Kravitz, Helms, Azari, Antonius, & Melnikow, 2000; Tocher & Larson, 1999). The studies also focused on ascertaining whether a medical institution makes a financial loss or gain in offering such services. Healthcare service costs and utilisation time complement each other as the overall costs go beyond resource use and both contribute to the ultimate financial costs. The challenge lies in calculating and researching utilisation costs because it can be hard to quantify. It includes physician visit time, laboratory tests, frequency of follow-up visits, a multitude of multidirectional factors and other less tangible aspects such as psychological state. This may present issues for any future policy considerations on introducing a healthcare interpreting service in Malta.

Financial cost calculations may be difficult to represent as many variables are at play; Jacobs (Jacobs, Shepard, Suaya, & Stone, 2004) highlighted, amongst others, data on long-term costs and healthcare utilisation time by patients with limited English skills. The former may be difficult to extract due to the speculative nature of long-term costs. It is less challenging to quote tangible short-term costs included in a medical bill (such as the interpreting service or laboratory tests); however, it may be difficult to account for healthcare costs tied to follow-up visits, successful prevention of near-future medical complications, readmissions and additional medical prescriptions due to the enhanced healthcare provision associated with interpreting. Healthcare practitioner utilisation time and its attributed costs may also be difficult to account for.

Utilisation time carries a lot of weight in the overall healthcare provision cost and is therefore important in budgeting costs. Research shows that interpreters can lower utilisation time; specifically in terms of physician visit time, office visits, phone calls, prescription filling and preventative services; meaning that it spans across the start and finish of the healthcare provision process (Jacobs, Shepard, Suaya, & Stone, 2004; Kravitz, Helms, Azari, Antonius, & Melnikow, 2000). Despite this, contrasting views have also been observed in the US. Tocher and Larson (Tocher & Larson, 1999) found that physician time in English speaking patients was comparable to non-English speaking patient, the study recruited individuals speaking 22 different languages. The physicians' personal perception of their time use with non-English speaking patients revealed they felt more time was spent providing healthcare for them. This may be due to the perceived language barrier. The quality of the healthcare provision between the two participants groups was not gauged. A possible reason for the comparable physician time is the way hospitals are run in the US. According to Estrada et.al (Estrada, 2014), physicians have a specific time-slot per patient as hospitals in the USA are set up to maximise efficiency and profits, which means that uncompromising logistics may be prioritised over extraordinary patient care, possibly explaining why physicians spend the same amount of time with every patients regardless of the language barrier. The authors specified that deviations from this process might lead to discrimination, stigmatisation or possible exclusion from the system. A patient/client may be perceived as demanding if they ask too many questions or perhaps deviate from the physician's recommendations. This is a contrast from Malta's public health system where healthcare institutions are run differently to the USA. Physician visiting time is worth looking into as it would be beneficial to compare the visit times in a similar fashion and know if practitioners in Malta perceive such interactions in the same way.

As for the cost of the interpreting service itself, insurance companies in the USA cover interpreting services. The different insurance packages are tangible costs and thereby simple to include with the total expenditure. Concerning Malta, private health insurance has less market penetration compared to the USA at approximately 70% in 2016 and 100,000 individuals in 2013 in Malta (census.gov, 2016; maltainsurance.org, 2015). This means that a potential publicly funded interpreting service could include a standard cost, which would legally cover the whole of the Maltese population as healthcare is publicly funded and makes it less of a challenge to consider in adding up the costs.

Despite the evident healthcare benefits to the patient/client, healthcare interpreting has to be financially viable to help trigger a policy change. The timing for Malta is optimal as spending in healthcare as a percentage of GDP is ever increasing (Azzopardi-Muscat, Buttigieg, Calleja, & Merkur, 2017). Many health institutions shy away from implementing a health interpreting service due to the upfront costs. This could be viewed as short-sighted approach as healthcare interpreting has been shown to improve the provision of healthcare and potentially saves costs as well. Failure to properly analyse the dynamic between healthcare provision and interpreting could possibly be due to the complexity involved in calculating the overall short-term and long-term costs. Studies show that a professional healthcare interpreting service will help overcome language barriers and save overall costs (Jacobs, Shepard, Suaya, & Stone, 2004; Baker, Parker, Williams, Coates, & Pitkin, 1996; Tocher & Larson, 1999). Jacob et.al (Jacobs, Shepard, Suaya, & Stone, 2004) conducted arguably one of the most thorough studies in this field. They extracted data on costs and service-utilisation from upwards of 4000 patients across a two year period. The researchers collected cost data from the direct costs of providing healthcare interpreting and calculated the net cost-changes of healthcare after the interpreting service was implemented. Participants were split into two groups; patients who used the interpreting service at least once during the

2 two year period populated the interpreting group and the other was the control group; the patients of which did not make use of said interpreting service.

The results show that the patients who utilised the interpreting service enhanced their access to healthcare: It increased overall provision of preventive care, physician visits and prescription medication, thereby indicating an improved healthcare provision. Costs data shows that the overall expenditure increased for both groups across the two year period. Emergency department costs decreased in the interpreting group while it increased in the comparison group. However, the increase in the cost of primary care was greater for the interpreting group. The study concludes that given the enhancement in healthcare provision, the added cost of an interpreting service is more than justified. This point is further accentuated when considering that the service cost amounted to approximately 12%, 14% and 17% of the annual cost per person for heart disease, mood disorder and diabetes respectively. In addition, the improved healthcare access and provision (particularly preventive care) may reduce follow-up visits and any long-term costs, thereby further justifying the interpreting service. The costs in this study may have been better accounted for if the interpreting group was studied across a period longer than one year post-interpreting service implementation, indeed an important factor to take on board for future research efforts.

2.5 Language Barriers and Malpractice Lawsuit Cases in the US

There are many recorded cases were a language barrier lead to adverse circumstances. As discussed in the previous section, without the help of a trained interpreter, language barriers can pose a threat to the quality of healthcare provision ranging from trivial to serious. There are numerous recorded hospital deaths related to mistakes by untrained interpreters or resulting from a language barrier in-general (Quan & Lynch, 2014). To counter act these serious incidences, an interpreting service has to first be in existence and accessible at a moment’s notice. Healthcare interpreting in the USA is offered in a multimodal fashion.

Services include onsite interpreting; traditional face to face interpreting in either consecutive or simultaneous modes and remote interpreting. The latter service can be offered via telephone or video conference. The latter two have different implications in the healthcare context.

2.5.1 Telephone and Video Interpreting. Telephone interpreting is a recent addition to interpreting services. The mode in question is widespread in the USA and is offered in a large number of languages, thereby having extensive applications and the advantage of immediacy over face to face interpreting (Phelan, The Interpreter's Resource, 2001). For example, an individual conducting business via telephone outside of their country can call a telephone interpreting service. Interpreters over telephone are paid by the minute or by chunks of interpreted minutes. It stands to reason that telephone interpreting can be a largely effective tool for healthcare interpreting as it is available round the clock and enhances access for multitudes of language combinations. The possible disadvantages of telephone interpreting stems from the spatial distance from the interaction itself. Paralinguistic and non-verbal communication are very much ingrained in our way of discourse, in some cultures more than others, and thus a telephone interpreter may miss out on a meaning-altering facial expression, stern gestures highlighting certain sensitivity on the subject or at the very least sarcasm. In conjunction with the medical cues which can be picked up in the physical, telephone interpreting would perhaps make more sense as an alternative to no interpreting. Recent breakthroughs in voice recognition and artificial intelligence may render this service obsolete via machine interpreting.

The rapidly developing video interpreting technology (such as the ‘My Accessible Real Time Trusted Interpreter system (MARTI) in the USA) has similar implications for healthcare, with the added advantage of visual contact. However, it is more complex to set up than telephone interpreting. The equipment required includes a strong internet connection, a

screen, a camera, a microphone and specific software to allow visual audio exchange. The result is increased susceptibility to interoperability and overall compatibility (Phelan, The Interpreter's Resource, 2001).

Despite the perceived disadvantages compared to on site interpreting, remote interpreting is, overall, still considered effective in the different contexts it is used in, such as court or medical interpreting. In the studies reviewed, all modalities of interpreting were considered satisfactory for relaying information in a medical context (Locatis, *et al*., 2010; Pérez-Stable, Nickleach, Price, López, & Karliner, 2012). In both studies, on site encounters were considered the most ideal mode of interpreting by patients, interpreters and service providers. Remote interpreting was the lesser preferred method by all types of participants, with video interpreting being considered the ideal method of remote interpreting over telephone interpreting. Despite this, telephone interpreting was still deemed adequate to interpret successfully by all parties involved in the studies. In both studies, however, telephone interpreting interactions were the shortest; this may have implications on the quality of interpreting and may have been due to the arguably more impersonal channel of communication. The interpreters in the study conducted by Price et.al (2012) stipulated that on site interpreting was preferred due to added interpersonal element; specifically for mediating the practitioner’s comprehension of the patient’s or client’s social and cultural background.

A stark example of the consequences at play when no professional interpretation is provided by the case of a nine year old Vietnamese girl in the USA (Quan & Lynch, 2014). She died from an easily avoidable adverse reaction to a drug meant to prevent nausea, vomiting and other gastrointestinal distress in cancer patients. Her interpreter was her 16 year old brother (minor age), not a professional interpreter, and her parents spoke primarily Vietnamese. No trained interpreter was provided for the patient. The patient manifested a

rapid onset infection with great severity, low blood volume and a heart attack that ultimately claimed her life. This was due to a misdiagnosis and miscommunication about her allergy to the drug Reglan. The hospital was sued as a result. A professional interpreter was appointed in court as an expert witness. Having reviewed the case and medical records, the witness interpreter said: Conducting the communications without a professional medical interpreter failed to meet the standards of care applicable for the physician and the facility. The effect is [that] she did not receive the care she should have. The parents were not able to adequately understand and address her medical needs. In my opinion, the failure of the doctor and the facility to provide a professional medical interpreter was a substantial factor in causing [patient]'s death (Quan & Lynch, 2014, p. 4). The witness went on to explain that the alternative scenario would have been identifying the exact interpreting needs for the patient upon admission into the hospital. This could have been easily done by offering the service to the parents. In addition, even if the parents declined the service, a minor should have never served as an interpreter. The witness added that despite the fact that the patient spoke English, her tender age made her inadequate to interpret for herself. As a result, the parents were the ones eligible for informed consent and plausibly able to comprehend the child's medical requirements and repercussions. Direct communication between the parents and provider was needed to address the potential issues that led to her death. Finally, her discharge documentation outlining the side effects justifying the emergency service was all in English, nothing was translated into Vietnamese.

Another informative case is about a 17-year-old patient who was hit with a tennis racquet, which ultimately led to her death (Quan & Lynch, 2014). Two weeks had passed until she went to the hospital emergency room, feverish and with an intense headache. She was able to interpret for herself until she suffered a respiratory arrest and was transferred to the intensive care unit due to a brain abscess. The defendant specified that he had discussed

her condition with her mother, stepfather and godmother while she was also interpreting for them. The patient was, therefore, responsible for interpreting for her relatives and herself. The latter involved complicated medical terminology and deliberations on her life-threatening condition prior to suffering respiratory failure, after which an untrained family friend acted as an interpreter. The 35 detailed cases featured in this literature are similar to the above two and some involved millions of dollars paid in damages.

2.6 Legislation on Healthcare Interpreting: USA and the European Union

2.6.1 USA. The USA has legislative structures in place to protect the right for access and timely access to healthcare for people who are considered 'limited English patients' (referred to as LEPs in this review) (Chen, Youdelman, & Brooks, 2007). One in five residents of the USA speak a language other than English at home, thereby justifying the provision of healthcare interpretation services across the USA. Federal laws and regulations stipulate that LEP patients and disabled patients have language access rights. Title VI of the Civil Rights Act (Justice T. U., 2016) dictates: "Title VI, 42 U.S.C. § 2000d et seq., was enacted as part of the landmark Civil Rights Act of 1964. It prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance." Title VI does not allow LEP patients to receive healthcare without the appropriate interpretation services. In the year 2000, then President of the United States Bill Clinton issued Executive Order 13166 (Justice, 2015). This order states that healthcare providers receiving federal funding must analyse the interpretation services currently in place in a bid to ensure that they meet the interpretation services LEP patients need (Jacobs, Ryan, Henrichs, & Weiss, 2018). Four guidelines are outlined by the executive order for healthcare providers to consider:

- How many LEP patients are being served by a particular healthcare provider;
- Which languages appear frequently in that service;

- The nature or importance of the services provided and the cost of those services;
- The allocation of funds for interpretation based upon the size of the provider.

A more recent extension to language access rights is the Affordable Care Act, or Obamacare, which managed to increase healthcare insurance coverage by up to 8% in certain states (HHS, 2017).

Frequent violations of the aforementioned laws include (Hunt, 2010):

- Providers who refuse to provide language access services or who use untrained personnel to provide them;
- Providers who attempt to charge for or otherwise recoup the cost of language assistance services directly from the patient;
- Providers who insist that patients must provide their own interpreters and, in effect, condition the receipt of medical services on patients providing their own interpreter;
- Providers who deny medical care to a particular class of patient because of the additional costs of providing language access services to those patients;
- Providers who subject LEP or ADA (Americans with disabilities act) patients to lengthy delays because of the lack of readily available interpreters.

2.6.2 The European Union. In the year 2000, the EU issued the Race Directive; a relatively recent action in the field of discrimination (eur-lex, 2000). The directive in question does not specifically cover language access rights to its people, which created space for speculation: It is up to the EU Member States themselves to issue national law/s governing language access rights and/or healthcare interpreting. As of yet, such rights are not widespread. For example, in 2011, the Danish government motioned to cease covering costs for healthcare interpreting for patients who had been residents in Denmark for seven years or more the following year (Phelan, 2012). Similarly, in 2012 the Dutch Ministry of Health had decided to completely

stop covering the costs for translation and interpreting. In addition, the EU was slow to sign up to international agreements protecting the rights of migrant workers.

An important consideration to make is the 'Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine' issued on 1 December 1999 referenced ETS No. 164 (Council of Europe, 2018). Fifteen EU Member States, including Malta, signed and ratified the above convention, which stipulates that equitable access to healthcare is to be upheld by using "available resources". The latter is an open-ended clause with no specificity to healthcare interpreting and ultimately providing healthcare interpreting is still at the discretion of national law.

Below are a few examples of practices by EU Member States in the sphere of healthcare interpreting:

There is no legal obligation in Belgium to provide healthcare interpreting. However, such services are provided by the Intercultural Mediation Program at federal level, financed by the federal public service Health, Food Chain Safety and Environment and the Federal Institute for Health Insurance (Insurance, 2016). Belgium defines intercultural mediation as all activities that aim to reduce the negative consequences of language barriers, socio-cultural differences and tensions between ethnic groups in healthcare settings. The final purpose is creating healthcare 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 strategically on the care provider/patient relationship. In this manner both the patient's position and the healthcare provider's position is strengthened. 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. For more than 15 years, hospitals have successfully employed intercultural mediators. They have had a wide variety of tasks:

- Interpretation, accompanying, listening to and supporting patients, conflict resolution;
- Defending the rights and interests of patients, or simply;
- Providing information to patients.

In Estonia, the hospitals need to provide the necessary interpretation into a language that can be understood by the patient and this is included in the service price. It is different in the case of refugees that have arrived to Estonia in the context of the set quotas. In this case, the national authority has designated a support person who accompanies them (and interprets for them) from the initial to the final stages of their stay in receiving healthcare or while being served by other establishments too, such as banks.

In Finland, the need for interpretation services has increased in recent years. For example HUS, the largest healthcare district in Finland (covering the Helsinki metropolitan area and its surroundings), spent about 3 million euros for interpretation services in 2015. The most frequently interpreted languages were Russian, Somali and Arabic. Interpreters were needed in almost 40 languages altogether. In 2016, HUS acquired interpretation in 63 languages.

In elective health services, interpreters are requested in advance whereas in acute situations it is more difficult to get an interpreter at place. In those situations, it is common to use interpretation over telephone or video (more information on telephone and video interpreting in section 1.5). The decision to use an interpreter is made by the attending physician and the costs are borne by the public healthcare provider.

The Act on the Status and Rights of Patients (785/1992; http://www.finlex.fi/en/laki/kaannokset/1992/19920785) provides that:

…the health care professionals should try to give the information in such a way that the patient can understand it. If the health care professional does not know the language used by the patient or if the patient because of a sensory handicap or speech defect cannot be understood, interpretation should be provided if possible (Section 5.2).

Health Insurance companies in Germany are not obliged to pay for interpretation during medical treatments as the Federal Social Court decided that interpretation is not a part of medical treatment. In some cases social assistance pay for interpretation costs and in most cases the municipalities bear the costs. The Federal States Health Ministers Conference demands the Federal Government to include necessary interpretation in the catalogue of benefits of the Statutory Health Insurance but the Federal Government is currently refusing. Cost estimates in Germany have a wide range: from 70 million €/year to 900 million €/year.

No interpretation services are provided for foreign patients by the Greek healthcare system.

In Ireland, it is the hospital or other healthcare service provider who is required to provide and pay for the interpreting service (including for sign language) In addition, interpreters have to be trained. Providers cannot use relatives or staff as interpreters.

National health authorities in Latvia do not provide interpretation to foreign residents who do not speak the same language as the health professional under treatment within the health system. The provision of healthcare interpretation services is up to the authorities of the particular healthcare institution.

In the Netherlands, t`here is no general reimbursement for interpretation services. However, interpretation services exist for certain groups who cannot be expected to have learnt Dutch (yet). As of late, the following groups have access to government funded interpretation services:

- Asylum seekers in asylum seeker centres;

- Women in women's shelters;
- Victims of human trafficking.

In addition, a temporary government funded interpretation services programme has been put in place for so-called "asylum status holders" during the first six months after they have received their status as resident. This programme will run until May 1st 2019. The interpretation services are provided for general practitioner visits only.

In Slovenia within the area of Italian and Hungarian National Community, the public health institutions must provide bilingual services. For this act, public health institutions receive an extra financing. There are no other payments via the Health Insurance Institute of Slovenia.

The Spanish legislation does not state anything regarding the issue of necessary interpretation services for foreign residents. It is not compulsory to provide healthcare interpreting services. Nevertheless, the regional health authorities have established, according to their competences, interpretation services to provide help for foreign residents that can´t speak Spanish in order to make the health assistance as effective as possible to all population. These services are fully assumed by the health authorities, joint in some cases by immigration authorities. Such policies are put in practice to ease the integration of this population and guarantee the access to correct health coverage.

The National Health Service (NHS) in the UK does provide interpreting services for people who speak community languages (e.g. Farsi) but who do not speak English well enough to be able to communicate with their health professional. The NHS also provides British Sign Language (BSL) interpreting where needed. The NHS pays for it but the individual NHS organisation may vary. Sometimes it is the hospital (the service provider); other times it is the commissioning organisation.

In conclusion, as far as legislation is concerned, Malta has full control. Malta has to take stock of its healthcare provision; specifically its obstacles, opportunities for improvement and strong points regarding healthcare provision to migrants. The lack of EU competency in this sector possibly makes it less bureaucratic to affect policy and legislative change. The most equitable system appears to be the Irish one; however, the different systems around Europe warrant a deeper analysis into their effectiveness as this could shed light on the best way forward for Malta. This study is an initial step in exploring the need for interpretation services for Malta's publicly funded healthcare system.

Chapter 3.0 Methodology

The literature review sheds lights on how the theoretical and empirical facades of research are aligned and elaborates the theoretical and empirical hypotheses of healthcare interpreting. Limited amount of work was performed in the local context. This study seeks to establish Malta's views on healthcare interpreting from quantitative data as extracted from the healthcare practitioners working in the public sector. The following research questions were posed: "In the context of a multicultural Malta, new challenges and questions arise; is the healthcare system capable of offering the best service possible?"; "Are local healthcare practitioners witnessing healthcare provision disparities due to language barriers?" In addition, "What do local healthcare practitioners think of the proposition of introducing an interpreting service?"

This study is a preliminary effort in the field of healthcare interpreting in Malta as no structure or guidelines exist to accommodate or regulate this profession; a need that is increasingly becoming more relevant.

The methodology is crucial to any scientific study by way of describing the practical efforts of the researcher in collecting the data, processing it, maximising validity and reliability, and finally, implement the methods used to answer the research questions in the least fallible way and/or formulate new research questions. As translation and interpreting research started to take distinct paths, researchers also used distinct methodologies to address the issues of their respective fields (Schäffner, Kredens, & Fowler, 2013). Both translators and interpreters traditionally did not employ empirical research; even authors such as Chesterman (1997; 2000), who are strong advocates of the empirical model, did not conduct empirical research to test his own theories (Schäffner, Kredens, & Fowler, 2013). Conventionally, translation research addressed ideological, cultural and sociological research questions while interpreting scholars studied interpreter-training programmes and worked

within the humanities, and so implementing new research methods such as the empirical method was a difficult path to undertake (Gile, 2013). The two fields differ in history, emphases, academic environment and tradition (Schäffner, Kredens, & Fowler, 2013).

Interpreting probably has a significantly longer history as its renditions are oral, not written texts. It is therefore plausible that interpreting, as an exercise, occurred prior to translation or indeed before writing was even available. However, current literature on interpreting has only picked up over the last 70 years and rarely refers to literature dating back beyond the 20th century (Schäffner, Kredens, & Fowler, 2013). Translation texts, on the other hand, are older and some even mention theoretical contributions dating back to the Roman times (Venuti, 2000). This historical discrepancy accounts for the contrast in methodologies for translation and interpreting research.

Before translation was considered a profession, many scholars dedicated their work to translation and many liaised with each other on the best practices. Their texts were given very high importance across civilisations due to their usefulness as they addressed scientific, political or religious writings, amongst others, and were usually written by important people who wielded a certain degree of power in their society. As a result, mentions of the Bible, literary authors and philosophers are often made in translation literature. Additionally, translated text had a longer lifetime than interpreted efforts. Translated texts can survive for generations and are available for a much wider audience than interpreted oral renditions; which have a very limited audience and last a mere few seconds, thereby making research continuity difficult. With the technical advances of the 20th century, voice recording made it possible to store, revisit and share interpreting renditions and they could finally be stored. This vast historical contribution to translation literature potentially helped shape the profession and its academic modus operandi. On the contrary, interpreting research contains

no deliberations or academic input from past centuries, which in turn means that interpreting research as we know it today was not influenced as such.

Due to the historical roots of translation, research focused on translation itself; the relationship between a translated text and its source. The latter was conducted throughout the centuries, thus providing ample literature and citations to further research easily. This is an evident advantage academic interpreters cannot enjoy; however, this unilateral approach found in translation makes it more challenging for translation researchers to avoid the conventional humanities-inspired route and apply an empirical process of research since the traditional research route is by default easier to access due to its long-standing use (Schäffner, Kredens, & Fowler, 2013).

As previously discussed, interpreters started focusing on research significantly later than translators, some seventy years ago in fact (Schäffner, Kredens, & Fowler, 2013). Additionally, professional interpreters followed interpreting programmes, not academic courses like translators. This means that interpreters are potentially less inclined towards an academic profession and more willing to pursue an interpreting career. This inclination became more prominent as remuneration for conference interpreting improved in the 1960's and 70's. This pushed the interpreter more towards personal gain and less towards an academic profession, which could have been a beneficial contribution to interpreting research. As a result, the interpreting community lacks academics and empirical research efforts.

Decades later, the situation changed due to several developments. Interpreting started to grow in human resources. The first generation interpreters had their own students and the pool of interpreters grew exponentially. An increase in the popularity of institutionalisation research meant that more students and professionals are now focusing on research. The significant technological advancements over the past two decades facilitated the sharing of

information; suddenly, prospective interpreters and researchers had access to powerful communication tools with which best practices could be exchanged from thousands of miles away. Consequently, empirical research increased in the interpreting field (Gile, 2000). Upon closer scrutiny, however, it seems that the majority of research stems from graduation theses, not studies conducted by experienced academics in pursuit of furthering the field of interpreting.

3.1 A Common Methodology

As discussed in Chapter 2.0, translation and interpreting have started on a different path, had different sociological and academic implications and thus fostered contrasting traditions and foci. Despite their historical differences, the two fields are often taught in tandem and have become increasingly aligned throughout the years. They both warrant a common methodology template that bridges translation and interpreting and retains their academic relevance by applying the golden standard of research methods: the scientific method. As Gile (2013, p. 10) explained:

…phenomenologically, they share a deep common basis and recent developments have also narrowed the gap between their environments and foci. As research disciplines, they also share epistemological, methodological, institutional and wider sociological concerns and do not seem to be in territorial competition. It, therefore, makes much sense for both disciplines to work together in spite of the differences.

A common approach allows research continuity for subsequent studies, even if they belong to a different language field. For example, a colleague can adapt findings from the other field, or indeed any other language discipline, all the while retaining validity due to having a standard methodology. There are additional advantages as discussed below; however, validity is the ultimate aim in implementing a common methodology. Any scholar would want their study to be intrinsically valid and, therefore, relevant to their respective

field which in turn makes it a viable reference point for future studies. A common research process can be applied to both translation and interpreting in order to reap its benefits and improve the quality and quantity of research gains.

3.2 The Scientific Methodology

The scientific methodology is a valid proposition as a common methodology for both translation and interpreting. A valid scientific methodology is one based on logical validity and empirical affirmation in order to put forward a scientific claim. Consequently, a scientific methodology is valuable for all sectors and types of research as it provides rigour and limits fallibility as much as possible. Due to the latter reason, scientific methodologies are implemented in translation and interpreting research. However, notwithstanding its evident advantages, scholars of interpreting and translation refrain from referring to their respective fields as "scientific" and still do not conduct empirical research, which is the basis of scientific research (Schäffner, Kredens, & Fowler, 2013). The scientific methodology is the tool to accurately confirm, reject and/or pose new questions to the hypotheses outlined in the literature review. For the study to be valid, the methodology needs to be infallible or as least fallible as possible.

3.3 Advantages and Disadvantages of the Scientific Method

The undertaking of a scientific study incurs greater time consumption, work and thought. Nevertheless, this methodology of choice has great advantages when applied to the field of interpreting (Schäffner, Kredens, & Fowler, 2013):

- Study replication: a detailed account of the methodology employed (as the scientific method necessitates) is needed for a study to be replicated. Although it may seem counter intuitive to replicate a study, replication allows successive researchers to confirm or reject the previous study. By applying a universal methodology, researchers can successfully do so;

- Study alignment: different researchers working in different places and/or at different times can apply a common methodology in order to reach the same aim. The collective effort would retain its validity despite having different authors due to the common methodology. Furthermore, research outcomes from using different languages can also be added to the data collected, thereby widening the pool of research endeavours;
- The scientific method allows improved collaboration between the fields of translation and interpreting. Translators and interpreters alike can lend, understand and successfully apply ideas expressed in their respective studies as the theoretical, methodological and analytical level would be reported in a detailed fashion;
- Along the lines of the previous point, a detailed report of all the levels of the study allows additional researchers to contribute or participate in a study. This would not be possible without a clear and common methodology. The potential benefit is an increased range in the results obtained, thereby strengthening the study.

The disadvantages outlined below are not intrinsic to the scientific method, but of the scientific method in the context of the field of translation and interpreting. According to Gile (Gile, 2000, as cited in Schäffner, Kredens, & Fowler, 2013), the lacking use of the scientific method in interpreting means that it is not the preferred choice in conducting research and makes it difficult to obtain the skills necessary to do so. Even when solely low technological instruments are needed, the scientific method requires designing a reliable technique to collect data, picking the right measuring instruments in order to extract the required data (thus avoiding redundancy) and finally using the appropriate statistical tools in order to analyse the data correctly. This issue can be avoided if training in research methods at Masters and PhD programmes is provided for students and academics. In Malta, no such ECTS credit is currently offered when reading for M.A Interpreting Studies. A more holistic

approach is required in interpreting studies in order to further the field through empirical research.

3.4 Research Design

This study makes use of a questionnaire by way of collecting data from 77 participants working in the healthcare sector. The participants belong to the field of medicine, nursing or therapeutic care and often face language barriers in their work due to the influx of migrants in Malta. The aim of the questionnaire is to address the research questions outlined in Chapters 2.0 and 3.0, which in turn aim to provide preliminary understanding of the perception for the need of healthcare interpreting.

A questionnaire was chosen in order to gather as much subjective and/or objective information from as many people as possible in a single effort to address the research questions. The latter is in line with what Hale (Hale, 2007, p. 219) outlined; the information gathered can be “relatively factual” and aimed to collect from a “large number of respondents”. Hale (2007) went on to explain that surveys delivered via questionnaires are often utilised to trigger a policy change. Surveys of this type can help to focus research to address issues with the status quo of a profession and to canvass specific perceptions and inclinations, as is the case with this study.

This study employs the use of the statistical software application SPSS version 25 in order to analyse the data collected from the questionnaire. The questionnaire was activated on 17 April 2018 and was disabled on 1 July 2018. Participants took an average of 2 minutes 57 seconds to complete the questionnaire with an average completion rate of 100%.

3.5 Participants

Participants were healthcare professionals working in the public sector belonging to the field of medicine, nursing or the therapeutic professions. Permission was requested from the Principal General Practitioner to disseminate the questionnaire. Upon approval, the questionnaire was forwarded to the heads of the aforementioned fields for them to disseminate amongst their healthcare practitioners. This means that a non-probability, snowball sampling method was employed in recruiting the participants (Elfil & Negida, 2017). Not all heads of fields acknowledged the questionnaire; therefore, even within the non-probabilistic target sample, not all practitioners had an equal chance to participate. Seventy-seven healthcare practitioners ended up filling in the questionnaire. Table 2.1 quantifies the number of healthcare practitioners as stipulated by the Directorate of Health Information and Research (DHIR, 2017):

Table 1

Total Head Count by Profession

	Total Head Count
Nurses and Midwives	3,662
Physicians	1,326
Physiotherapists	264
Other healthcare professionals	1,035
Total	6,287

Table 1 is a frequency table showing all practitioners by their profession as supplied by their respective departments.

Table 2

Total Number of Respondents by Profession

Professions	
Speech Language Pathology	17
Nursing	10
Podiatry	18
Physiotherapy	1
Medicine	18
Other	11
No Replies: unknown profession	2
Total	**77**

Table 2 is a frequency table showing all respondents by profession as specified in the last optional question

3.5.1 Inclusion Criteria. Participants' responses were included if they worked in the fields of medicine, nursing, therapeutic professions and other non-specified professions. 100% of the responses were included as the questionnaire was disseminated exclusively amongst healthcare practitioners belonging to the aforementioned medical fields.

3.6 Ethical Considerations

Permission to circulate the questionnaire was requested from the Principal General Practitioner Mario Vella, who forwarded the questionnaire to the heads of different healthcare professions. No personal or patient information was requested. Participation rights outlined in the consent form were in line with the recently introduced GDPR legislation amendments. The consent form can be found in Appendix A.

Ethical approval for research was sought by the Faculty of Research Ethics Committee (FREC). Permissions sought:

- Permission to conduct research from FREC;
- Permission to circulate questionnaire from the Principal General Practitioner.

3.7 Data Collection Method

The data was collected via a questionnaire. Permission to gather the data in question was requested from Principal General Practitioner Mario Vella, who in turn disseminated the questionnaire to healthcare practitioners working in the public sector. The participants were presented with 10 questions relating to language barriers they potentially face. The aim was to collect preliminary and subjective information about language barriers in the healthcare sector in light of the influx of migrants in Malta and the prospective use of healthcare interpreters to aid communication, improve healthcare provision and increase cost-efficiency. The occurrence, frequency and intensity of said languages barriers are investigated by the questionnaire in a bid to answer the research questions posed in the literature review and this chapter. Descriptions of the questionnaire and participant rights in accordance with the new GDPR laws were communicated to the participants beforehand. In addition to the questions, the participants were finally given free rein to mention their profession and divulge their experiences and opinions. The latter were taken on board and are considered in the discussion chapter.

3.7.1 Tools. Very few tools were needed to execute the data collection:

- Survey Monkey, Standard Plan with monthly payments. Survey Monkey was used to extract the raw data for processing and analysis;
- Email address by way of requesting permission to disseminate questionnaire;
- SPSS Statistics by SPSS Inc. The software in question is a powerful statistical analysis tool.

3.8 Validity and Reliability

Validity and reliability are crucial aspects of the scientific methodology in order to ensure appropriateness and, by default, effectiveness of the tools chosen to collect data. Ascertaining validity and reliability means extracting valid data pertaining to the research questions, which makes the study accurate and consistent. According to Bolarinwa (2015), the inferences made from a study depend on the type of measurement. In order to measure, accurate and targeted tools are necessary to collect the required data. Questionnaires, a predetermined set of questions, are often used in the fields of social and health sciences and are often associated with quantitative studies such as this one (Bolarinwa, 2015).

There are a number of highly researched methods to ensure validity of a tool. However, the list compounded below shortlists the ones pertaining to the questionnaire of this particular research effort:

- Theoretical construct methods: both subordinate methods of the theoretical construct outlined below explore how well the tool investigates the hypothesis. In this study, the tool is the questionnaire and the theory is explained in the literature review. Both face and content validity have been deemed too ‘subjective’;
    - Face validity: it is the reviewing of a questionnaire (the tool) by the author, or ideally an expert in the field, in order to conclude if the tool is fit to collect the data required;
    - Content validity: it follows the same logic as face validity, but to a less superficial extent. Consequently, the author or expert would dissect and scrutinise a questionnaire thoroughly. A process of rational analysis can be executed by a group of experts who determine the degree to which a certain question is valid. The degree of validity per question can also be subjected to rating procedures in order to accurately compare validity. A rating can be a

simple binary one or a complex index such as the Likert scaling or the Fog Index. The latter indices are formulas used to determine validity.

Reliability of the methodology tools refers to the output consistency; meaning, how consistent the output achieved by a particular tool over time is (Mason, 2002) A reliable tool is deemed reliable if it yields the same results when used at a later stage. Mason (2002; pg. 187) stipulates that "Reliability is therefore being conceptualised in terms of how reliable, accurate and precise the research tools or instruments are, and this in turn is being judged by the consistency with which known instruments produce certain 'measurements'". According to Bolarinwa (2015), the measures to test the reliability of a questionnaire are:

- Test-retest reliability;
- Alternate-form reliability;
- Internal consistency reliability.

3.9 Generalisation of Findings

As Mason (2002) elaborated, a generalisation is a wide claim inferred from research and analysis. A sound generalisation is the product of strong research validity and reliability. A generalisation can be focused on the context under scrutiny in an empirical fashion, or it can have a broader theoretical scope. As a manifestation of the study's validity and reliability, generalisations need to be accounted for beforehand as a derivate of, amongst others, the research questions, analysis and data organisation, and participant sampling. In this particular study, the sample employed was chosen due to its patient caseload mix; from free primary care in the community, to free secondary care in the general hospital and free tertiary care. As a consequence of this caseload mix, no remit was spared in disseminating the questionnaire to the concerned professions (medicine, nursing and the therapeutic professions), thereby realising a representative collection scope. This sampling strategy was picked beforehand in a bid to compensate for a possible failure to collect data from a representative sample of the

population; a representative sample was not achieved. In addition, the sample was recruited using a non-probability, snow-ball sampling method. The latter means that any generalisations will not be statistically relevant in true theoretical form to the entire population of healthcare practitioners, but at least be characteristically relevant (representing the appropriate type of participant, thereby eliminating atypical generalisations) and possibly a reliable preliminary base of understanding.

Finally, one has to base the generalisations on the rigour of the analysis while being able to demonstrate that the study in question is valid and reliable in order to justify the accuracy of any generalisations.

3.10 Limitations

- Participant sample is not representative of the total population and a non-probability one. Seventy-seven participants out of 6287 yields a margin of error 11.15% with a confidence level of 95%. This poses adverse implications in attempting to generalise on the findings of this study. Reminders were issued multiple times, but to no avail. Some heads of professions failed to acknowledge the initial invitation for the survey; thereby, it can be safely assumed that practitioners hailing from particular professions were not aware of the questionnaire. For example, no occupational therapists filled in the questionnaire and this may have skewed the results;
- A possible limitation tied to reliability exists as no expert on healthcare interpreting could be appointed to vet the reliability of the questionnaire as ideally required to ensure validity;
- Empirical studies in the Maltese interpreting context and medical sector on healthcare interpreting are lacking. This created an unprecedented learning curve;

    - lacking local expertise and best practices to follow or share, limited information on language barrier repercussions in the healthcare sector in Malta, lacking local literature on the field in question;.
- Limited number of questions. Only 10 questions were included in the survey in view of a practitioner's busy schedule and to ensure high participant uptake. The 10 questions covered various aspects of healthcare interpreting, and as such aimed to collect concise information on the said various aspects healthcare interpreting as much as possible due to this study being a preliminary investigation. They served to branch out as many future niches of investigations as possible.

4.0 Data Analysis and Results

In this chapter, the data from the questionnaire will be presented graphically and analysed via Chi-Square tests and Cross-tabs using SPSS version 25. Each question will be analysed and graphically represented on its own. Cross tabulations will then be presented to display noteworthy interactions between different questions. The statistical tests were picked based on data type, sample and purpose. The study sample was employed using a non-probabilistic, snowball method; thereby limiting generalisation significance to the study population, not the target population. In addition, the number of participants is not representative of the target population.

The data collected is mostly nominal, with two questions employing a Likert scale response, thereby making the data collected ordinal. This limits the data analysis to descriptive and non-parametric tests; specifically Simple Bar Charts for individual questions and Chi-Square test to compare two questions. The following questionnaire was disseminated amongst 77 healthcare practitioners working in different fields in order to gain a preliminary understanding of language barriers in the healthcare setting, to investigate interpreting services in the healthcare context and answer the research questions: “In the context of a multicultural Malta, new challenges and questions arise; is the healthcare system capable of offering the best service possible?” “Are local healthcare practitioners witnessing healthcare provision disparities due to language barriers?” In addition, “What do local healthcare practitioners think of the proposition of introducing an interpreting service?”

Table 3

Total Number of Respondents by Profession

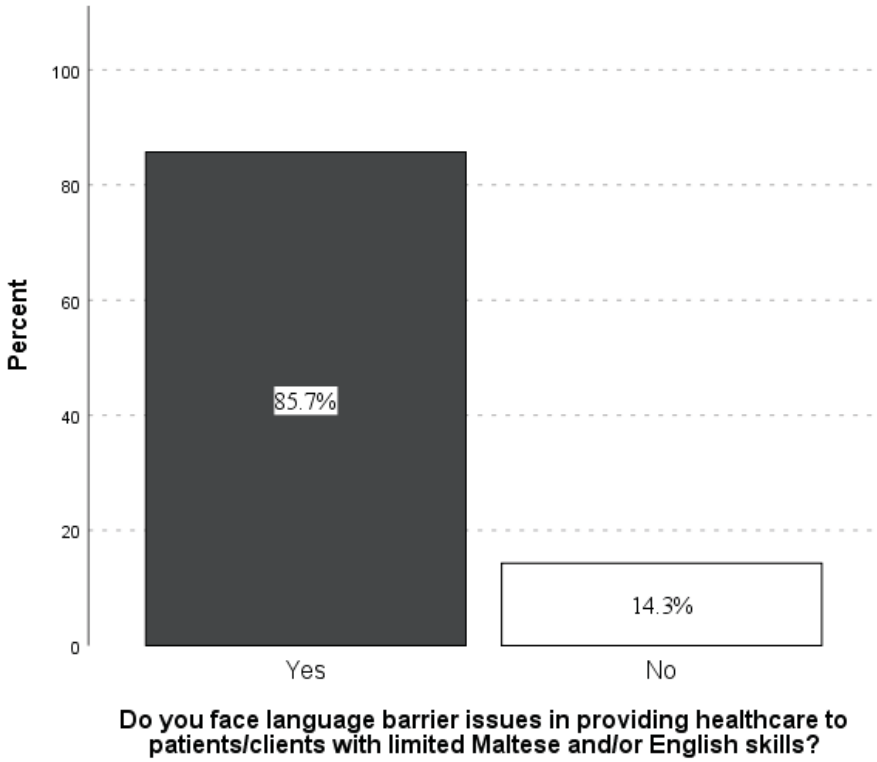
Professions	
Speech Language Pathology	17
Nursing	10
Podiatry	18
Physiotherapy	1
Medicine	18
Other	11
No Replies: unknown profession	2
Total	**77**

4.1 Simple Bar Charts

Data extractions per question are presented below in the form of simple bar charts displaying percentages. The total number of participants was 77 as displayed in table 3.1

Figure 1

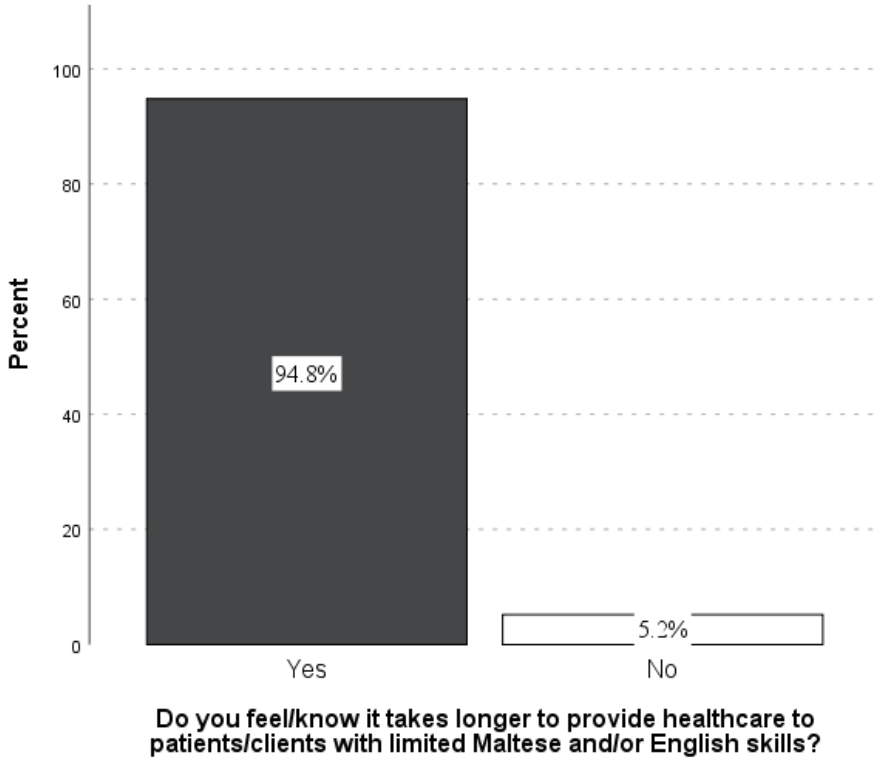
Question 1



85.7% of respondents affirmed that they face language barriers in providing healthcare to patients or clients with limited Maltese and/or English skills.

Figure 2

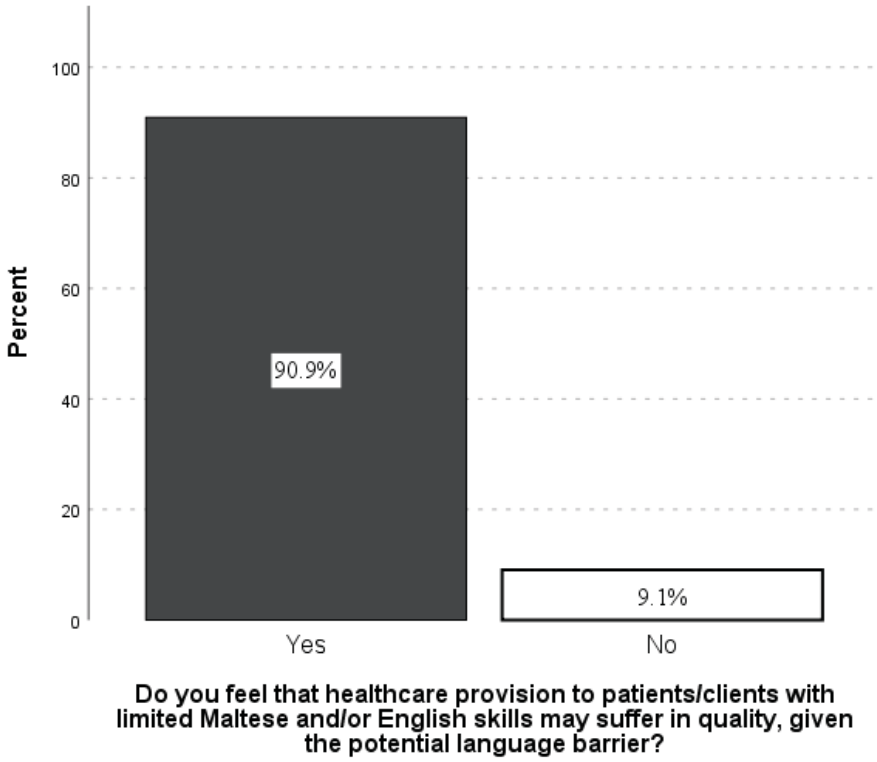
Question 2



94.8% of respondents affirmed they feel or know it takes longer to provide healthcare to patients or clients with limited Maltese and/or English skills.

Figure 3

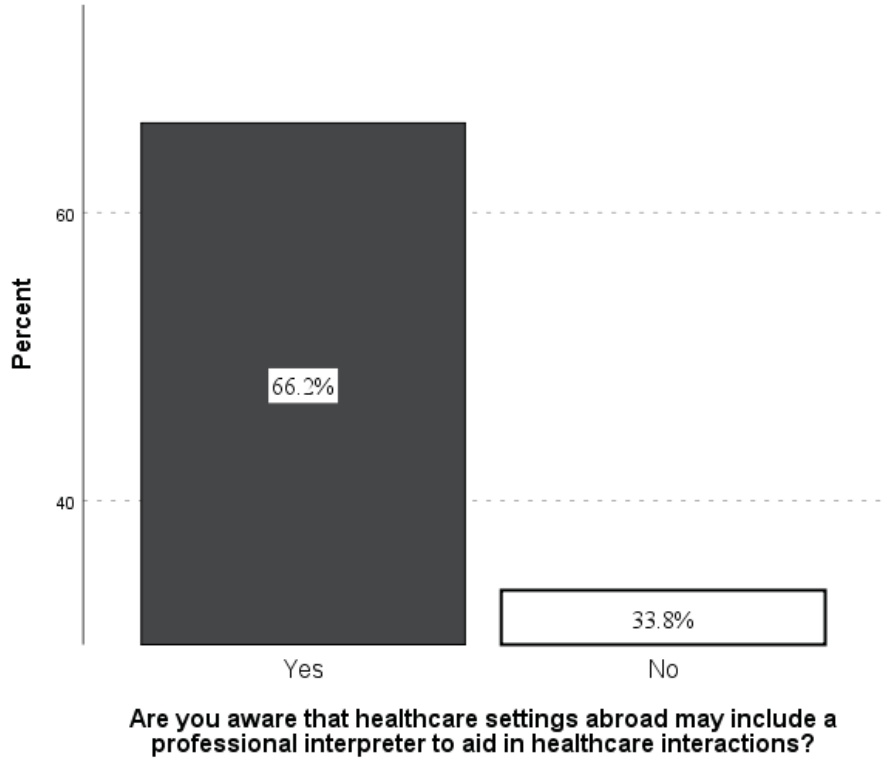
Question 3



90.9% of respondents feel healthcare provision suffers in quality when a language barrier is at play.

Figure 4

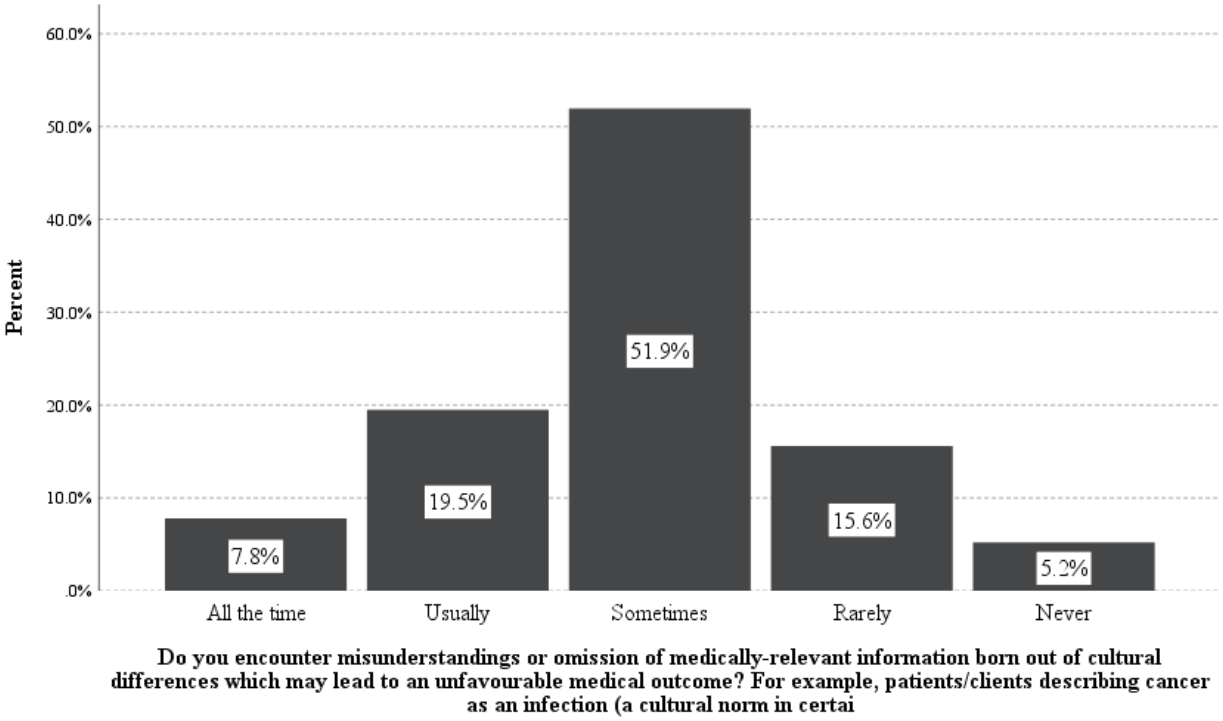
Question 4



66.2% of respondents are aware that healthcare settings abroad may include a professional healthcare interpreter

Figure 5

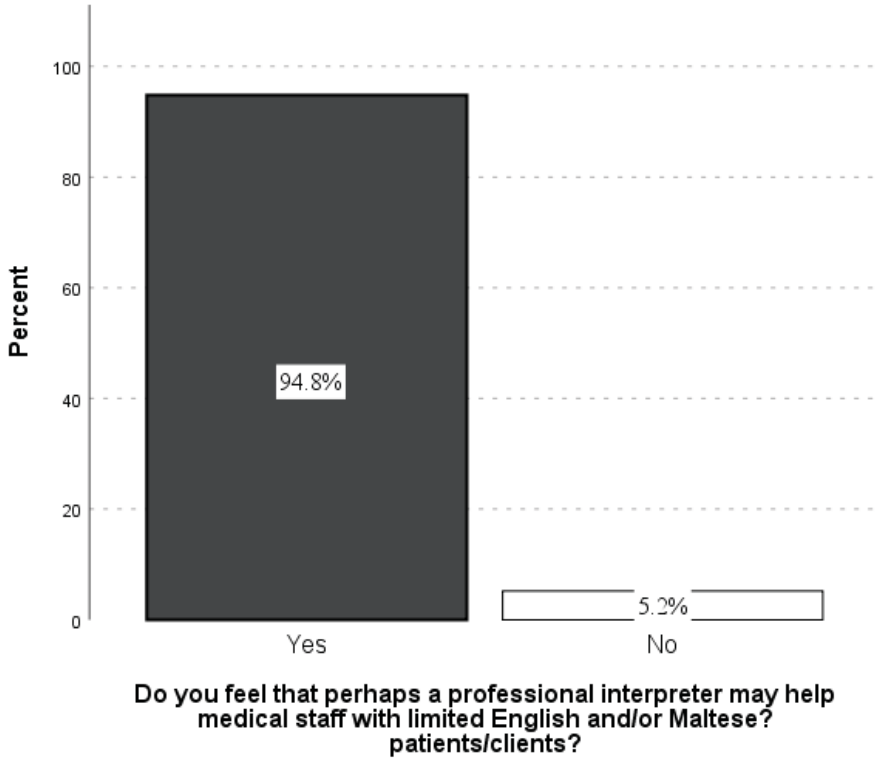
Question 5



51.9% of respondents affirm they sometimes encounter misunderstandings or unfavourable medical outcomes due to a language barrier, while 5.2% affirm it never happened to them.

Figure 6

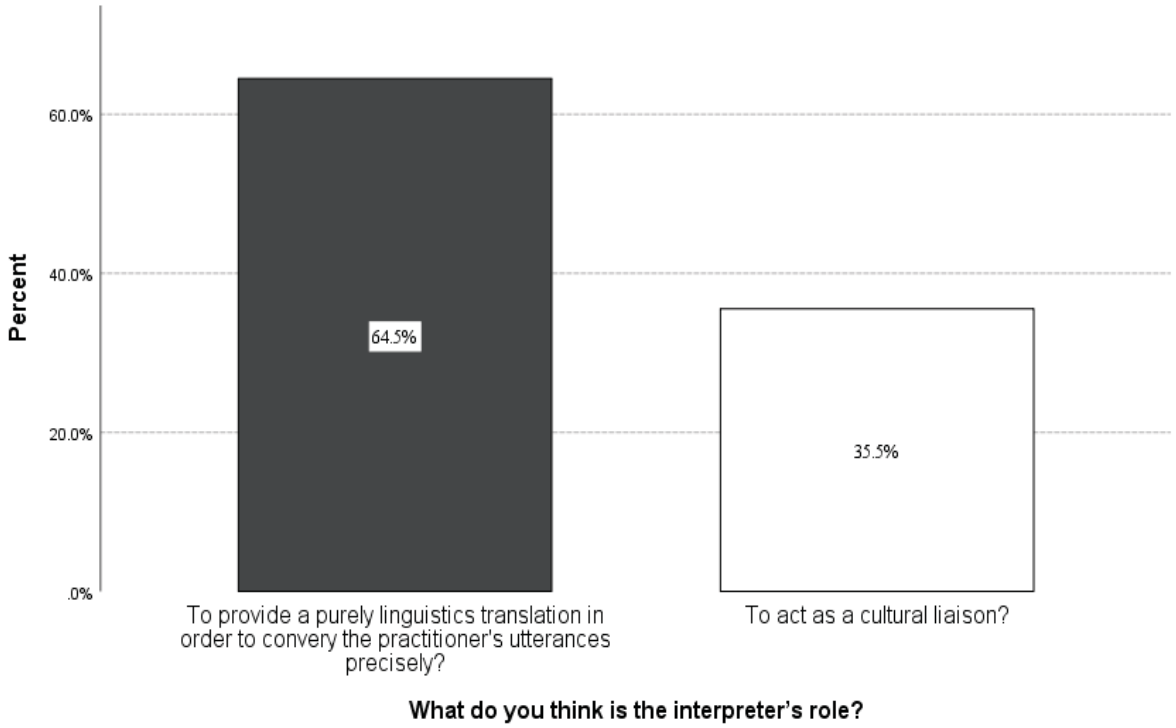
Question 6



94.8% of respondents feel that a professional interpreter may help the medical staff in dealing with patients or clients with limited Maltese and/or English.

Figure 7

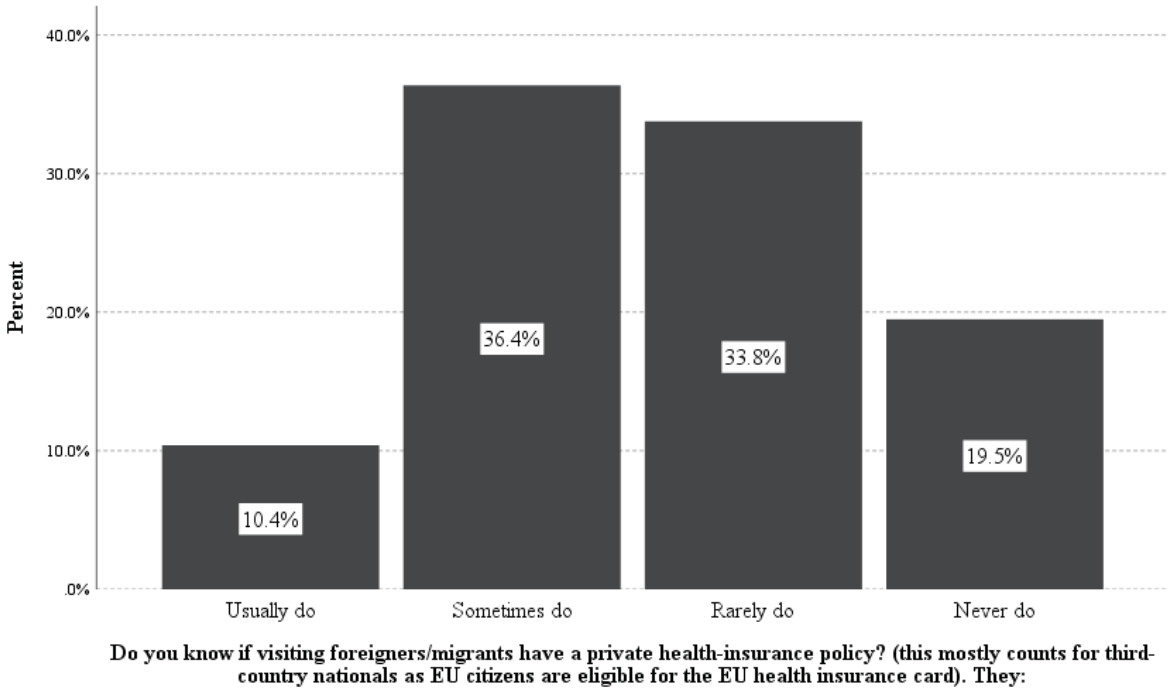
Question 7



64.5% of respondents believe the interpreter's role is to provide a purely linguistic translation in order to convey the practitioner's utterance precisely.

Figure 8

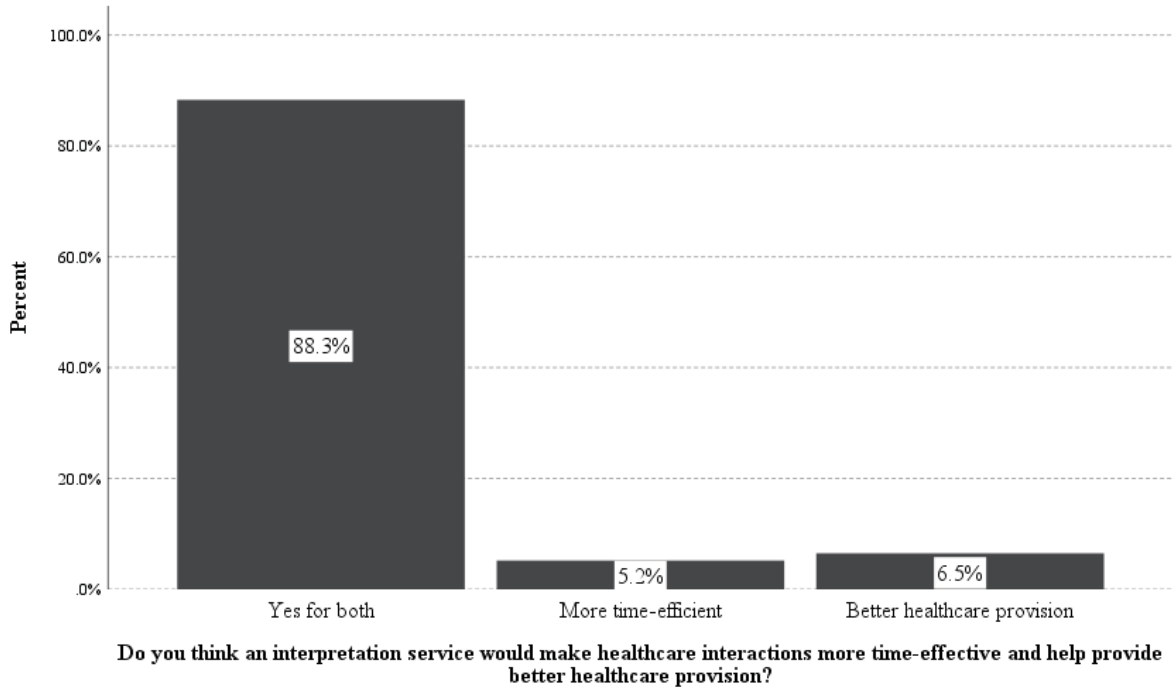
Question 8



36.4% of respondents affirm that sometimes ‘visiting foreigners/migrants’ from third countries have a private health-insurance policy, while 19.5% affirm they never do.

Figure 9

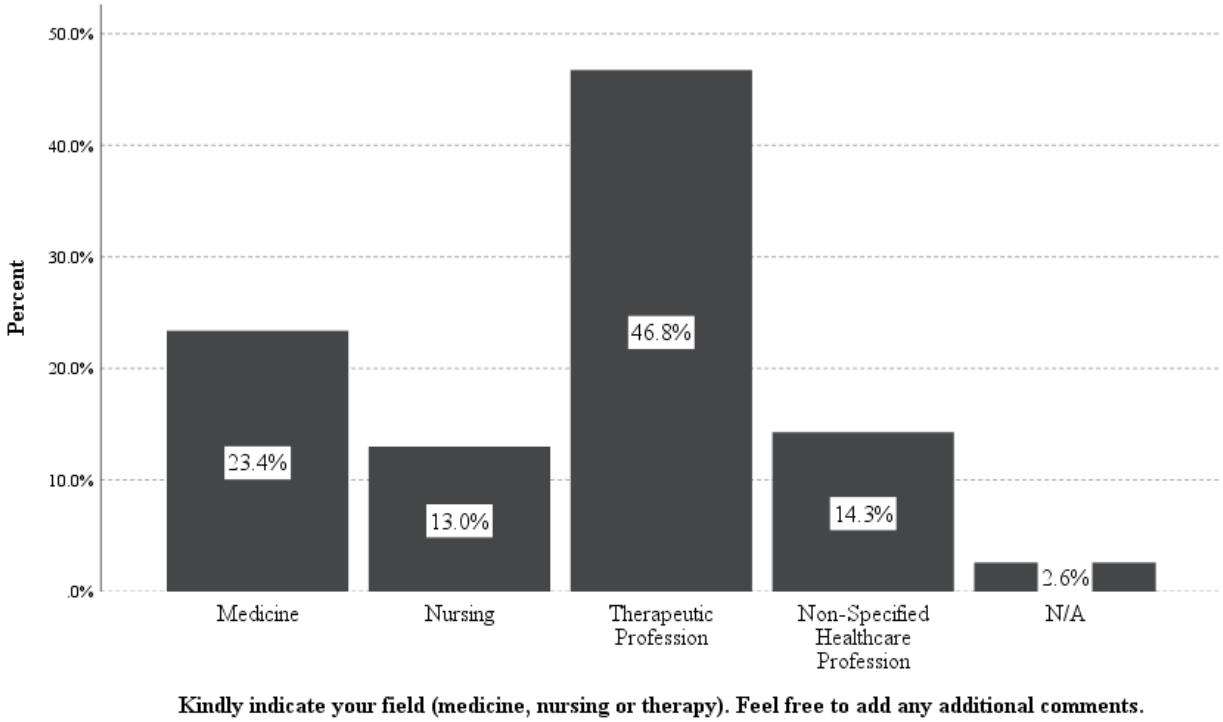
Question 9



88.3% of respondents believe an interpretation service would improve time-efficiency and improve healthcare provision for patients or clients with limited Maltese and/or English.

Figure 10

Question 10



46.8% of respondents hailed from the therapeutic professions. The respondents' additional comments are included in the appendix and discussed in the following chapter.

4.2 Cross tabulations

Statistically significant data extractions between sets of two questions are presented below in the form of Cross tabulations.

Table 4

Questions 1 & 2

			Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?		
			Yes	No	Total
Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	65	1	66
		Percentage	**98.5%**	1.5%	100.0%
	No				
		Count	8	3	11
		Percentage	**72.7%**	27.3%	100.0%
Total		Count	73	4	77
		Percentage	94.8%	5.2%	100.0%

X^2 (1) = 12.701, P < 0.001

Of those participants who face language barrier issues**, 98.5%** feel or know that it takes longer to provide healthcare to such patients. Conversely, of those participants who do not face language barrier issues, **72.7%** feel or know that it takes longer to provide healthcare. The P value of the Chi-Square test **(**approx. 0.000) indicates that the difference between these two percentages is significant and cannot attributed to chance.

Table 5

Questions 1 & 6

			Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese patients/clients?		
			Yes	No	Total
Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	65	1	66
		Percentage	**98.5%**	1.5%	100.0%
	No	Count	8	3	11
		Percentage	**72.7%**	27.3%	100.0%
Total		Count	73	4	77
		Percentage	94.8%	5.2%	100.0%

X^2 (1) = 12.701, P < 0.001

Of those participants who face language barrier issues, **98.5%** also answered 'Yes' to question 6[1]. Conversely, of those participants who do not face language barrier issues, **72.7%** answered 'Yes' to question 6. The P value of the Chi-Square test **(**approx. 0.000) indicates that the difference between these two percentages is significant and cannot be attributed to chance.

[1] Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese patients/clients?

Table 6

Questions 1 & 10

			Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?		
			Yes	No	Total
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	18	0	18
		Percentage	**100.0%**	0.0%	100.0%
	Nursing	Count	6	4	10
		Percentage	**60.0%**	40.0%	100.0%
	Therapeutic Profession	Count	30	6	36
		Percentage	**83.3%**	16.7%	100.0%
	Non-Specified Healthcare Profession	Count	11	0	11
		Percentage	**100.0%**	0.0%	100.0%
Total		Count	65	10	75
		Percentage	86.7%	13.3%	100.0%

X^2 (3) = 10.962, P = 0.012

In all 4 professions there was a larger percentage of participants who stated that they face language barrier issues when providing healthcare to the patients. However, these percentages (100% Medicine and Non-Specified Healthcare Profession, 83.3% Therapeutic Profession and 60% Nursing) vary significantly since the p value is 0.012 is less than the 0.05 level of significance. Hence, it can be tentatively said that nursing staff and therapeutic professions find language barriers less of an obstacle in providing healthcare to patients when compared to respondents belonging to the ‘Medicine’ and other healthcare professions.

Table 7

Questions 3 & 9

			Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?			
			Yes for both	More time-efficient	Better healthcare provision	Total
Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?	Yes	Count	63	2	5	70
		Percentage	**90.0%**	2.9%	7.1%	100.0%
	No	Count	5	2	0	7
		Percentage	**71.4%**	28.6%	0.0%	100.0%
Total		Count	68	4	5	77
		Percentage	88.3%	5.2%	6.5%	100.0%

X^2 (2) = 8.849, P = 0.012

Of those respondents who answered 'Yes' to question 3[2], **90.0%** also answered 'Yes to Both' for question 9. Conversely, of those respondents who answered 'No' to question 3, **71.4%** answered 'Yes to both' question 9[3]. The P value of the Chi-Square test is 0.012; therefore, the percentage difference between the two figures in question is statistically significant and cannot be attributed to chance.

[2] Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?

[3] Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?

Table 8

Question 4 & 8

			Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?		
			Yes	No	Total
Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:	Usually do	Count	2	6	8
		Percentage	25.0%	**75.0%**	100.0%
	Sometimes do	Count	17	11	28
		Percentage	**60.7%**	39.3%	100.0%
	Rarely do	Count	19	7	26
		Percentage	**73.1%**	26.9%	100.0%
	Never do	Count	13	2	15
		Percentage	**86.7%**	13.3%	100.0%
Total		Count	51	26	77
		Percentage	66.2%	33.8%	100.0%

X^2 (3) = 9.808, P = 0.020

A larger percentage of the respondents who answered 'Yes' to question 4[4], **60.7%**, **73.1%** and **86.7%** of the respondents answered 'Sometimes do', 'Rarely do' or 'Never do' to question 8[5] respectively. Conversely, a larger percentage of respondents answered 'No' and 'Usually do' for the same questions; **75.0%**. The percentage difference between the figures in question is statistically significant as evidenced by the Chi-Square P value of 0.020.

[4] Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?

[5] Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:

Table 9

Question 4 & 10

			Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?		
			Yes	No	Total
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	14	4	18
		Percentage	**77.8%**	22.2%	100.0%
	Nursing	Count	9	1	10
		Percentage	**90.0%**	10.0%	100.0%
	Therapeutic Profession	Count	18	18	36
		Percentage	**50.0%**	50.0%	100.0%
	Non-Specified Healthcare Profession	Count	8	3	11
		Percentage	**72.7%**	27.3%	100.0%
Total		Count	49	26	75
		Percentage	65.3%	34.7%	100.0%

X^2 (3) = 7.920, P = 0.048

The majority of respondents hailing from Medicine, Nursing and Non-Specified Healthcare profession (**77.8%, 90.0%,** and **72.7%** respectively) are aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions. Meanwhile, **50%** of the participants hailing from a Therapeutic Profession are aware of a professional interpreting service abroad. The percentage differences were found to be statistically significant as evidenced by the Chi-Square P value of 0.048.

Table 10

Question 7 & 10

			What do you think is the interpreter's role?		
			Purely linguistics translation?	To act as a cultural liaison?	Total
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	7	11	18
		Percentage	38.9%	61.1%	100.0%
	Nursing	Count	5	5	10
		Percentage	50.0%	50.0%	100.0%
	Therapeutic Profession	Count	29	6	35
		Percentage	**82.9%**	17.1%	100.0%
	Non-Specified Healthcare Profession	Count	7	4	11
		Percentage	**63.6%**	36.4%	100.0%
Total		Count	48	26	74
		Percentage	64.9%	35.1%	100.0%

X^2 (3) = 11.278, P = 0.010

In 2 out of 4 profession categories, a larger percentage of participants stated that they think a Healthcare Interpreter's role is to provide a purely linguistic, word for word interpretation of the practitioner's utterances (**82.9%** and **63.6%**). However, the percentage differences across professions for question 7 was still statistically significant as the P value resulting from the Chi-Square test is approximately 0.010. Therefore, we can conclude that the percentage difference cannot be attributed to chance.

4.3 Data Analysis: Summary

In the Data Analysis chapter, the author presented quantitative findings from a questionnaire distributed amongst 77 healthcare practitioners by way of gaining a preliminary understanding on the potential need for Healthcare Interpreting in the Maltese context. The main test employed was the Chi-Square test; a test for independence between two categorical variables.

The 10 questions posed to the participants were presented together with the statistically significant cross tabulation results. The rest of the cross tabulations are presented in Appendix B.

The design limitations limit generalisations and validity of the results due to:

- Non-probabilistic sample; due to the gatekeepers and snowball sample
- Limited sample size
- Un-validated collection tool (the questionnaire)

The research design in question could have been remedied by addressing the limitations above. Future research in this field can be better undertaken by obtaining the individual email addresses of all healthcare practitioners; potentially requiring liaison with the data protection officer and/or human resources department. These manoeuvres would address the first two bullet points above. Moreover, a test re-test exercise can be run to ascertain or amend the data collection tool. Confirmation or better validity of the questionnaire could have been achieved by distributing the questionnaire to experts in the fields and assimilating any of their constructive criticism.

Chapter 5.0 Discussion

The literature reviewed in this study places high pertinence to healthcare interpreting in providing the best healthcare possible when faced with language barriers, in maintaining time-efficiency and increasing cost-efficiency of healthcare interactions and in sensitising the linguistic interpretations for the target culture. There is substantial evidence which shows that healthcare interpreting helps maintain the latter benefits during a healthcare interaction (Karliner, Kim, Meltzer, & Auerbach, 2010; Quan & Lynch, 2014). To this end, a strong emphasis emerged on viewing the interpreter as a cultural liaison, as opposed to a strictly linguistic interpreter. The literature also stipulated that, generally, the interpreter is not usually seen as a cultural liaison and that healthcare staff have a poor understanding of the subject (Crezee, 2013; Bischoff & Hudelson, 2010). As result, this leads to the use of many ad hoc interpreters which create an element of risk during healthcare interactions; their use may be attributed to time constraints or interpreting-service costs (Estrada, 2014). In general, interpreting research is still in the process of diffusing a culture of empirical research and, thereby, leaving a more credible footprint for policy-altering or policy-making purposes; similar to the established scientific fields. This lag may be due to the relative young age of the academic side of the profession, as technical advancements which allowed for recording, storage and research of interpreting efforts occurred recently when compared, for example, to translated efforts (Schäffner, Kredens, & Fowler, 2013).

This study seeks to gain a preliminary answer to the research questions listed below using a scientific methodology comprising of a non-probabilistic, snowball sample to which a questionnaire was forwarded. 77 healthcare practitioners hailing from different professions participated in the questionnaire. The sample in question is not representative of the whole healthcare-practitioner population. However, efforts were made to compose a questionnaire and build a methodology as valid and reliable as possible in relation to the research questions.

The results provided show 7 statistically significant relationships between a number of important questions which provide potentially pertinent insight into the Maltese healthcare system and the language issues it is facing. Any generalisations are to be considered as preliminary indicators due to the sample constraints. The research questions are quoted below:

"In the context of a multicultural Malta, new challenges and questions arise; Is the healthcare system capable of offering the best service possible?"; "Are local healthcare practitioners witnessing healthcare provision disparities due to language barriers?" In addition, "What do local healthcare practitioners think of the proposition of introducing an interpreting service?"

It is the author's understanding that, given the findings presented in the Data Analysis and Results Section, the preliminary indication is that the Maltese healthcare system may not be offering the best service possible in light of the influx of migrants and the resulting language barriers. In addition, it seems that the questionnaire participants working in Malta are receptive to the healthcare provision disparities unfolding in the healthcare system due to said language barriers. Finally, healthcare practitioners working in Malta are potentially in favour of a healthcare interpreting service, despite possibly not being fully aware of the nature of the healthcare interpreter's role. Generalisations are to be considered tentative due to the limited sample.

Question 1

"Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?"

85.71% of respondents said that they face language barrier issues when providing healthcare in such situations. This may be an indication of a serious problem plaguing our healthcare system. The results warrant further investigation to gain qualitative information of

its implications; important questions such as “How is this phenomenon affecting the practitioner’s workload?” and “How is this affecting long-term outcomes?” need to be asked. The literature clearly shows that language barriers potentially lead to longer hospital stays, higher chances of readmission, incorrect diagnoses and, in rare cases, even death. The possible issue highlighted by question 1 could be presenting itself as a chain reaction in the Maltese healthcare system. If we take the example of secondary care in hospital, the language barrier may lead to resource inefficiencies across all stages; from the administrative procedures (including documentation) upon admission to receiving lengthier healthcare-professional encounters to ascertain a diagnosis, made more difficult by the language barrier, to potentially receiving incorrect treatment, which in turn would lead to a lengthier hospital stay. Outpatients appointments would also require additional resource use and such patients will have a higher change of readmission within the following few months. This scenario is a disadvantage for both the healthcare system and the patient: The healthcare system is potentially wasting additional resources while the typical patient with a language barrier could not be receiving the healthcare necessary to realise the recovery potential. As a result, it is important to identify all the healthcare procedures along the aforementioned “chain” by way of planning strategically for language barriers. For example, administration sheets translated into the most common foreign languages faced in hospital can be a simple and effective solution to process admissions quickly. Once all the procedures have been mapped and addressed strategically, further investigations can be aimed at gauging susceptibility to language barrier. In other words, identifying which healthcare procedure is the most and least pertinent to the quality of healthcare provision for patients or clients and which healthcare encounters are most susceptible to language barriers. Furthermore, streamlining parts of the healthcare procedure chain according to their susceptibility to language barriers may help to better target healthcare interpreting. The latter will help curb issues with identifying patients

who truly require healthcare interpreting; a persisting issue according to Estrada (2014). It creates a system which can anticipate which patients and what healthcare encounters will require interpreting services.

It would also be ideal to initially define what constitutes a “language barrier” as its interpretation is a source of bias which could have undermined the validity of the question 1. The umbrella term “language barrier” was picked for its various interpretations in a bid to extract information about anything which can potentially hinder the healthcare provision however; different types and severity of language barriers may pose different challenges to the healthcare provision. Not all language barriers can be solved or mitigated with the help of a healthcare interpreter. A language barrier due to an organic disorder requires a different set of skills to overcome when compared to one derived from a cultural difference. For example, a healthcare interpreter is not equipped to overcome hearing loss and the language barriers that come with it, but a properly trained professional healthcare interpreter should be more than capable of inferring meaning from gesture cues, or lack of, as exhibited in different cultures. Language barriers beyond healthcare-interpreting capabilities could have made it into the questionnaire, thereby establishing what falls into the remit of a healthcare interpreter in Malta is pertinent to define and streamline the role in question.

This also highlights the importance of medical training for the healthcare interpreter. Medical training is a necessity for the healthcare interpreting to properly infer meaning while interpreting. It prevents omission of seemingly irrelevant information and maintains overall interpreting-accuracy. Terminology is also important to have at hand; it is the interpreter’s job to be as prepared as possible to interpret in any given medical exigency (Crezee, 2013). As discussed in the literature review, you cannot interpret what you cannot understand. A possible future healthcare interpreting service in Malta has to be underpinned by basic

medical training by way of providing a healthcare-overview and fostering a community of competent healthcare interpreters.

Question 2

"Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?"

The second question was aimed at getting further information on the language barriers faced in the Maltese healthcare system after potentially establishing their presence in the previous question. 94.81% of participants answered "Yes". The most evident implication of this is that time-inefficiency may be a persisting hurdle accompanying language barriers faced in the Maltese healthcare system. Similarly to what was discussed in question 1, time-inefficiencies may be pushing the healthcare practitioner's sequence of work-tasks to a later stage. In theory, this may be causing a domino-like effect which directly hinders the timeliness of healthcare provision, and which in turn may harm the quality and long term benefits of it as well. The adverse effect of time-inefficiencies were discussed in Section 2.1 by Hadziabdic *et al*. (2011), who reported incorrect use of time and resources when faced with language barriers; this increased the workload, delayed treatment and caused a chain reaction effect similar to what is being described in this study. Another study conducted by Kravitz *et al*. (2000) uncovered statistically significant time difference in the healthcare provision to English, Spanish and Russian speaking patients. The patients did not differ in present medical conditions, physical functioning, or mental health. In spite of the common factors, Spanish patients required an average of 9.1 minutes of additional physician-encounter time, while Russian patients required an average of 5.6 additional minutes. Moreover, the language barriers had a larger impact of follow-up encounters. Russian patients had more referrals, while Spanish speakers were less likely to follow-up on the recommended way forward.

Quantifying time losses in the Maltese healthcare setting can help achieve baseline readings similar to the study conducted by Kravitz *et al*. (2000) and identify objectives and important manifestations such as the following:

- Average time spent on interactions with patients with language barrier issues and identification of adverse long term effects (such as incorrect treatment repercussions, additional costs, follow-ups, readmissions and long term quality of life);
    - Average time lost from successive patient-visits and their adverse long term effects;
    - Average additional cost of providing healthcare to patients with language barrier issues;
- Average additional time spent on patients with language barrier issues when compared to patient-visits with no language barrier issues.

Additionally, the questionnaire does not take into account a practitioner's and patient's repeated incidences of healthcare interactions featuring language barriers. Crucially, in such cases, future investigations could delve into how the practitioner's and patient's attitudes and general inclination towards the healthcare service can change when continuously exposed to language discordances. Finally, a more coherent long term picture of the practitioner's and patients' potential attitudinal changes and changes to the execution of their role within the Maltese healthcare setting could be attained. Investigations into the long term effects of these incidences may also help to shed light on the need to introduce a healthcare interpreting service and also pinpoint the need to address any challenging attitudinal concerns hindering healthcare provision. A study conducted in Sweden, where a healthcare interpreting service has been operational for decades, concluded that, when dealing with language barriers, time-related stress is a pertinent obstacle to the healthcare provision (Fatahi, Mattsson, Hasanpoor, & Skott, 2004). Fatahi *et al*. (2004) highlighted how

lack of time was found to be stressful for both the doctor and patient and how certain cultural expressions required additional time to explain. The resulting lack of time was also intermittently rendering any healthcare interpreting as a strictly verbal-translation exercise.

Question 3

"Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?"

The majority of participants (90.91%) responded that the healthcare provision suffers in quality when faced with language barrier issues. The preliminary data warrants an investigation into how and why 90.91% responded as such. The implications of this are in line with those presented for question 1. However, the remaining 9.09% may still present valid reasons as to why language barriers did not, in their view, constitute a significant obstacle to the quality of healthcare provision. Consequently, their input in this question may be highlighting specific scenarios in which the quality of healthcare provision is not being lessened, where language barriers are easily dealt with or are not having a detrimental effect. On the other hand, their input may also indicate attitudes akin to a lack of sensitivity to such issues or lacking education on the subject. This, in turn, may translate into a culture whereby language barriers or cultural pitfalls are simply ignored. To this end, in her recommendations, Estrada (2014) discussed the need for nursing staff to receive specific education. Due to their ubiquitous role, the author argued that nurses often find themselves amidst social, political and cultural intricacies while providing healthcare. Therefore, cultural knowledge and specific training is necessary to communicate such intricacies effectively to patients facing language barriers. Similarly, the Maltese healthcare system may be experiencing such issues.

In bid to attribute a reason why 9.09% of participants responded as such, it might be worthwhile to investigate if they invest additional time in their patient encounters with language barriers. Potentially, these practitioners may be either be circumnavigating the

language barrier issues or ticking off their tasks with minimal patient contact. The nature of the profession could also be a valid reason as to why language barriers did not, in their opinion, hinder the quality of healthcare provision. For example, due to the biomechanical nature of physiotherapy, cultural pitfalls could be more limited when compared to a doctor's examination. A doctor usually starts their visit with the patient's file, then proceeds to the patient's bedside, conducts a visual inspection and collects a medical and family history prior to conducting a physical examination. The doctor then concludes the examination with their recommended way forward. In every step described, information crucial to the history-taking, tentative diagnosis and future treatment has to be relayed from the patient to the doctor and vice versa. The outcome of such interactions is wholly dependent on the communication between doctor and patient. Alternatively, the physiotherapist, notwithstanding the history-taking, may find it possible to physically model exercises to the patient; therefore using less verbal communication and more paralinguistics. A speech and language pathologist may also be able to better bypass language barriers as they are equipped to deal with them in the first place. The language or speech impediments speech language pathologists face require remedies that go beyond translational or interpretative activities. For example, they could be focusing on sound drilling in order to neurologically remap the phonemes following an acquired disorder. The phoneme is a sound or a basic unit of every sequence of phonemes which form an information carrying word; therefore, it transcends any language or culture. Ultimately, different professions may have different sensitivities to language barriers.

A statistical correlation between different healthcare professions and question 3[6] could reveal a research scope into their respective strength and weaknesses in overcoming language barrier issues. Nonetheless, data extracted from the cross tabulation tests revealed

[6] Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?

no such relationship. Despite this, it is important to note that a representative sample was not collected, thereby it is not excluded that future studies may reveal this correlation.

Question 4

"Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?"

66.23% of respondents are aware that professional healthcare interpreting is offered in healthcare settings abroad. The results potentially reflect the need for education and training amongst healthcare practitioners with regards to healthcare interpreting. This was shown to be in line with the literature reviewed (Estrada, 2014). Capacity building is being considered as a must by the author; an initiative which could accurately inform the practitioners on the role the interpreter is to assume. To this end, one of the participants in this study, a transcultural nurse, discussed an on-going Training Programme for Cultural Mediators. The course in question has been available since 2010, and was delivered to a total of 103 participants as of the date the questionnaire results were collected. No additional information such as a follow-up report was made available. It constitutes a possible starting point to increase awareness, further train healthcare practitioners and establish an accredited, fully-fledge training programme. It would also be useful to follow up on the 103 participants to ascertain their role in the healthcare sector or indeed any other sector. Furthermore, feedback on the course from the participants could be collected by way of gathering information on what is being taught regarding healthcare interpreting.

The author's understanding is that the results have a deeper implication tied to the healthcare practitioners' formal education. Given the multicultural workload the Maltese healthcare system is currently facing, it would be instrumental for education institutions to cover such issues in their courses. The ever-increasing need to target healthcare provision to patients hailing from different cultures requires efforts at the formative stages of a healthcare

profession. Multicultural interactions are becoming the norm and initiatives to efficiently cater for them are pertinent to the Maltese healthcare system in keeping abreast of constant demographic changes in a globalised world. Thus, the healthcare professional needs to be familiar with interpreting services and its benefits to the healthcare provision in addition to undergoing familiarisation with different cultures. To this end, identification of the most commonly served cultures in our healthcare system would help orient cultural sensitisation efforts in formal education and training. The benefits of such aspirations would lead to a cessation of the adverse chain reaction described in question 1 and question 2. As a result, time and budgetary resources spent on admission procedures, hospital stays, physician encounters, laboratory work and treatment can be mitigated considerably.

The preliminary data suggests that, given the lacking awareness of interpreting services, future endeavours in introducing healthcare interpreting might benefit from promotional and educational campaigns. Raising awareness on healthcare interpreting and the potential issue at hand is the first step in dealing with the issue in question. Finally, question 4[7] may be reflecting the healthcare system's potentially lacking aptitude to deal with a multicultural workload. The lacking awareness of healthcare interpreting abroad could be portraying a profound lack of knowledge in the field of transcultural healthcare provision. This, in turn, could mean that healthcare practitioners sensitive to healthcare provision disparities may be feeling powerless when confronted with the aforementioned multicultural workload. In light of this, an investigation into compensatory techniques employed by practitioners in dealing with such encounters would be useful to include in future studies.

Question 5

"Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For

[7] Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?

example, patients/clients describing cancer as an infection (a cultural norm in certain Middle-Eastern countries).”

Question 5 establishes grounds for gaining insight into the dynamics of healthcare interactions with language barriers in a qualitative fashion. It is preliminary proof that actual misunderstandings or omissions of information (ultimately pertinent to the patient’s health) are occurring due to language barriers. Misunderstandings and omissions can be conducive to unfavourable medical outcomes. As shown in the literature, accuracy of the information transmitted is pivotal to its correctness and effective healthcare provision (Jackson, Nguyen, Hu, Harris, & Terasaki, 2010; Esposito, 2001; Butow, *et al*., 2011). It is important to emphasise that “accuracy” refers to accurate rendering of information to accommodate the target culture, as opposed to linguistic accuracy; which can still be misleading to the interlocutors due to cultural differences. Additionally, a high rate of misunderstandings and omissions outlined by question 5 may justify a follow-up on such instances. A qualitative investigation into these cases would shed light on the complex dyadic relationship between patient and practitioner. This will help uncover adverse medical outcomes and examine precisely under which circumstance communication failed between patient and practitioner. Details from medical encounters with language barriers pertaining to cultural backgrounds, medical circumstance, time invested for healthcare provision and staff involved in the interaction are pertinent to establishing a baseline of what to expect from such interactions.

Studies of the dyadic relationship between patient and practitioners have long been conducted in healthcare systems across the globe (Estrada, 2014). Discourse and situational analysis can be used to examine the role undertaken by the patient and practitioner during a particular healthcare interaction within the sphere of the Maltese healthcare system. From the results of such exploratory studies, linguistic, cultural, social and political issues rife in the Maltese healthcare system can be inferred. Additionally, the way the patient and practitioner

manifest their roles will provide a guideline on targeting capacity building by way of gaining the best outcomes possible. Dyadic investigations in the Maltese healthcare system are the way forward prior to establishing a healthcare interpreting service.

Furthermore, the examination of the relationship between patient and practitioner could reveal a rationale behind the other responses to question 5. 7.79% of participants answered “All the time”, possibly meaning that their workload and/or other specific characteristics, is allowing misunderstandings or omission of medically-relevant information to commonly prevail. Of equal importance to forming a comprehensive picture of the Maltese healthcare system are those who answered “Usually”, “Rarely” and “Never”. The preliminary statistical results of this study potentially show that the type of profession has had no effect on their responses as the cross tabulation between question 5 and question 10 uncovered no statistically significant relationship. However, this cannot be excluded as the participant sample was not representative of the entire population; this justifies further investigation in future studies.

Question 6

“Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese patients/clients?”

94.81% confirmed that a professional interpreter could help medical staff with limited English and/or Maltese patients/clients. The preliminary data suggests that the need for a healthcare interpreter is possibly warranted. Having established in question 5 that misunderstandings and omissions of medically-relevant information were common place among the participant sample, results from this question are potentially a consequence of the previous one. Consequently, the participants could be inclined to think that a solution for the issues outlined in question 5 could be a healthcare interpreting service. To this end, one of the participants expressed their concerns regarding a lack of tools available for interpreting. The

said participant claimed they had to resort to using Google Translate to overcome language discordance, or merely to communicate effectively. The participant also discussed how they are not sure if Google Translate is reliable enough for their needs.

The literature shows that practitioners feel that professional healthcare interpreting helps, however, the literature also stipulates that they tend not to resort to such services or rely on ad hoc interpreting when they do (Crezee, 2013; Butow, *et al*., 2011; Bischoff & Hudelson, 2010). Ad hoc interpreting has been shown to be a riskier option in providing healthcare when compared to professional interpreting. Its persistent use reflects the need for capacity building on healthcare interpreting among practitioners as discussed in question 4. Despite this, it could have been useful to inquire on any availability and use tendencies of ad hoc interpreting, such as family members of patients. In relation to this, another participant explained how some patients are accompanied by an interpreter at the Floriana Health Centre. It could not be ascertained if these were ad hoc or professional interpreters in a freelance capacity. The respondent also expressed her concern at how no interpreting service is available after hours. Sometimes, this meant patients had to return the following day to ensure no urgent medical attention was necessary. What can be inferred from the comments is that, potentially, an interpreting service in a particular form is available during normal hours and that the respondent may be accustomed to its use.

Finally, the high percentage of respondents seemingly in favour of healthcare interpreting adds further weight on understanding when and why professional healthcare interpreting is perceived to be most needed. Additionally, there may be a pattern of sporadic use of a particular healthcare interpreting service in the Maltese healthcare system which warrants further investigation.

Question 7

"What do you think is the interpreter's role?"

The interpreter's role across the decades has been discussed at length in Section 2.1. Ultimately, the current optimal iteration of the interpreter's role according to research is that of a cultural liaison, regardless of the industry in which the service is operating. Providing a word to word interpretation is prone to cultural pitfalls, inaccuracies and misinformation; the consequences of which can have profound adverse effect in the healthcare sector.

64.47% of the respondents think the interpreter's role is to provide a word to word direct translation over acting as a cultural liaison. This is potentially the result of the general lack of knowledge on interpreting in the healthcare sector described in the literature (Crezee, 2013). The response pattern for question 4[8] may also compound to this issue as 33.77% said they are not aware that healthcare settings abroad may offer interpreting services. Education and capacity building for healthcare staff is discussed in this chapter under question 3. However, there may be other reasons 64.47% of participants responded as such. The practitioners' attitude could be a driver for such an inclination towards healthcare interpreting. The practitioner may not want anyone to "dilute" their input during a healthcare encounter. Trust in all components of a triadic system[9] is essential to achieve the best outcome possible.

Accountability is also worth mentioning; a practitioner whose utterances are being rendered and delivered into an unknown language may not trust the interpreting process. They may feel they are losing control of what is being communicated to the patient. Additionally, who is accountable in case of an adverse medical outcome? A solution for such a potential issue lies in education still. It is important to iterate the roles a triadic

[8] Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?

[9] A healthcare encounter featuring the patient, practitioner and interpreter.

communication setup conceptualises: The practitioner is the main driver of the healthcare encounter while the patient listens and provides the appropriate feedback. The healthcare interpreter, despite being responsible for the delivery in the target language, is there to facilitate. Therefore, even eye contact should be maintained between the practitioner and the patient, not the interpreter. Further information on the physical setup of healthcare interpreting is provided in Section 2.2.1.

The practitioners' own personal experience might also have affected their choice for question 7. Practitioners who may have been through certain healthcare provision pitfalls due to cultural differences may conceptualise the interpreter's role as one of a cultural liaison. Having said that, this is not in line with the response pattern for question 5, which shows that 94.81% encountered misunderstandings or omission of medically-relevant information born out of cultural differences at least once. Therefore, it can be assumed that other factors are influencing the respondents' choice for question 7.

A significant relationship between question 7 and question 10[10] was found. Therefore, the relationship between respondents' answer for question 7 and their profession (question 10) cannot be attributed to chance. The relationship between question 7 and question 10 is further discussed in the cross tabulation section below.

Question 8

"Do you know if visiting foreigners/migrants have a private health-insurance policy? (This mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card)."

In Europe, the European Healthcare Insurance Card (EHIC) allows free access or access for a reduced cost to state-funded healthcare (European Commission, 2017). The EHIC does not cover emergency return travel, private healthcare access and other

[10] Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.

entitlements obtained via a private travel insurance policy. It also stipulates that EU Member States have to provide "necessary healthcare" within the aforementioned capacity during a temporary stay in another Member State. A report issued by the European Commission highlights how 19 Member States have difficulties interpreting the scope of providing "necessary healthcare" (Pacolet & De Wispelaere, 2016). The EC Regulations 883/2004 and 987/2009, which pertain to the EHIC, do not cover healthcare interpreting. Having said that, Malta has signed and ratified Treaty 164 of the Council of Europe which stipulates that equitable access to healthcare has to be provided; further details are provided in Section 2.6.2. Legal expertise is necessary to discern if Malta is obliged to provide healthcare interpreting. Additionally, legal expertise can help ascertain if the scope of "necessary healthcare" includes healthcare interpreting by way of providing "equitable access" as stipulated by Treaty 164.

Healthcare insurance providers abroad may cover language services in their health policies. To this end, it is potentially useful to investigate if patients ever requested for healthcare interpreting. A follow-up on such cases could help reveal if any reactions were made in response to failure to provide healthcare interpreting.

With respect to third country nationals, non-governmental organisations constitute a better option to help such individuals. As a result, it would be useful to liaise with NGOs in investigating any language services provided to third country nationals.

Question 9

"Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?"

0.00% of the respondents replied "Neither" to question 9. Despite the lacking awareness and knowledge highlighted in the literature on the benefits of healthcare interpreting, this result is a promising indication for future studies. The participants have

potentially shown receptivity to a healthcare interpreting service. Minimally, it shows a basic understanding of the benefits of interpreting; a positive reception is an advantage to introducing such a service.

On the other hand, 88.31% replied “Yes for both”. What the author infers from the result is a combination of the perceived time inefficiencies and belief that an improvement in healthcare provision can be achieved with interpreting. This is in line with the literature reviewed in Chapter 2.0 (Estrada, 2014; Kravitz, Helms, Azari, Antonius, & Melnikow, 2000; Schäffner, Kredens, & Fowler, 2013). Question 2[11] and question 3[12] address the issues of time inefficiencies and the healthcare provision quality respectively. Their results are also congruent with the output from question 9.

Further to the implications discussed in the other questions, this study makes the assumption of a general loss in time-efficiency and quality of healthcare provision across the Maltese healthcare system due to language barriers. However, realistically, a tangible improvement of these two aspects requires a wider scope into the unexplored healthcare remits fulfilled by practitioners beyond the participant sample. An in depth, qualitative study into the different settings can help to gauge where and how interpreting-intervention is most needed; thereby targeting the service. Certain procedures, such as filling admission documents, can be hastened without the costly service of interpreting but instead with strategic changes which offer a permanent solution. A good example of this is translated documents. Likewise, training for cultural sensitisation for practitioners can deliver fundamental information on the most common cultures serviced by the system. To this end, a practitioner would know beforehand that a lung cancer could be described as a lung infection by members of certain cultures. Consequently, the practitioner would be in a position to

[11] Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?

[12] Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?

revaluate their investigative efforts without the costly intervention of the interpreter. Pursuing the wrong diagnosis could translate to losing precious time, engaging in needless check-ups and laboratory work, and ultimately increase spending and lessen the quality of healthcare provision. A study into the different healthcare provision functions and their language needs will not only target the interpreting service but also shape its delivery and prioritise the patient load.

The remaining 11.68% of respondents answered either for a strictly more time-efficient or a better healthcare provision outcome. The circumstances leading to their choice for question 9 merit an investigation. Their context could justifiably be specific scenarios where improvements gained by an interpreting service are exclusively tied to time efficiency or better healthcare provision. If only limited improvements can be tangibly achieved, the interpreting service can be tweaked for such scenarios by way of streamlining it to preserve resources. On the other hand, considering the limited knowledge on interpreting outlined in the literature, the participants could have missed ample opportunities for eliminating language barriers, which could improve time efficiency and provision of healthcare.

Question 10

"Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments."

A breakdown of the professions involved is provided in Chapter 4, Table 3. A number of the additional comments provided by the participants helped to understand how the healthcare system reacts to language barriers and how healthcare encounters unfold.

Participant 2: "Speech-Language Pathologist. Working with elderly, I often meet patients who find difficulty communicating with foreign staff. Working with children, speech and language intervention with clients who are non-English/Maltese/Italian speaking, is not as effective."

This study is based on the assumption that the practitioner is the competent, bilingual speaker of Maltese and English while the patient or client is the cause of the language discordance. As outlined by participant 2's comment, this may not always be the case. The influx of migrants, economic or otherwise, means that additional foreign workers are joining the workforce. Therefore, the participant's comment highlights a significant limitation and provides a premise for a qualitative study into healthcare encounters. The latter effort introduces fewer participant-biases and investigates healthcare encounters thoroughly as they unfold via valid tools such as situational and discourse analysis. More to the point, the comment is preliminary evidence that therapeutic efforts may be susceptible to language barriers within the Speech and Language Pathology field.

Participant 3: "Speech Language Pathologist. In the case of No.7[13] both options may apply depending on the circumstances. The situation is even more complex when service users may have aphasia or cognitive communication disorders."

This participant highlights a specific instance where the interpreter's capabilities may fall short of addressing language barriers. Additionally, the comment overlaps with the implications of question 3[14] as well. Speech language pathologists were described as being equipped to deal with pathologically induced language barriers. Aphasia and cognitive communication disorders in general are hallmark pathologies requiring specific therapeutic treatment to overcome. This argument further reinforces the potential need to prioritise the patient workload, as interpreting may be not effective across all settings and may not be useful to certain caseloads. Despite this, the respondent argues that the answer for question

[13] What do you think is the interpreter's role?
- To provide a purely linguistic translation in order to convey the practitioner's utterances precisely?
- To act as a cultural liaison?

[14] Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?

7[15] depends on the circumstance, therefore possibly implying that the interpreter can still be of use within the Speech and Language Pathology field.

Participant 52: "podiatry/diabetic foot clinic some questions could be replied both ways esp. num.7"

The respondent's comment is in line with the points made for participant 3.

Participant 37: "Podiatrist. sometimes it is difficult to explain the proper treatment required in a different language."

A podiatrist expressing their concern on effective communication when faced with language barriers.

Participant 64: "Medicine. Sometimes I resort to using google translate. However, I'm not always certain about how reliable this is !"

A doctor trying to deal with language barriers. This further highlights the need for healthcare interpreting.

Participant 21: "Therapy. Interpreters available but need to be booked in advance." Supplemental information is required to this end as no public healthcare interpretation service is available in Malta. The participant may be referring to a private entity. It would be useful to establish a contact in future investigations by way of familiarising one's self with the efforts conducted in the field of healthcare interpreting.

Participant 38: "I am a Transcultural Practice Nurse who has developed a Training Programme for Cultural Mediators in Health Care. in 2010. Since then 15 groups have been trained with just over 103 participants. I would like to invite you visit our webpage where you can also find my email address: http://deputyprimeminister.gov.mt/en/phc/mhlo/Pages/mhlo.aspx"

[15] What do you think is the interpreter's role?
- To provide a purely linguistic translation in order to convey the practitioner's utterances precisely?
- To act as a cultural liaison?

Endeavours in the interpreting field within the public sector were outlined by comment above. Since then, the author of this study has subscribed for the training in question and is waiting for the next recruitment. Extrapolations in this regards were highlighted under question 4.

Participant 69: "GP at Floriana Health Centre Some patients do come accompanied by an interpreter. However, patients present after hours, no interpreter is available. Sometimes this means asking the patient to return in the morning after an examination to make sure that there is no urgent need for medical attention."

The interpreting service mentioned in the comment above could be related to the one outlined by participant 21. The comment identifies a provision failure after normal hours; this can have a detrimental effect on the quality of healthcare provision. Furthermore, it is leading to resource wastage as the patients are being asked to return the following day.

Participant 66: "Specialist in Family Medicine In view of the non appointment based system in primary care, it would be difficult to have an interpreter on standby. I have suggested on other occasions that a specialized clinic for refugees / migrants should be set up to deal with non-urgent cases. This should include a cultural mediator service to aide these vulnerable patients to access the Maltese health services in a more efficient way. Another problem I see is the increase in economic migrants from Italy (Italians and Italian recognized refugees) not able to speak Maltese or English. The latter ones do not have any health care protection status in Malta and are therefore even more at risk."

Participant 66 offered useful insight into the primary care system. The breakdown of issues provided by the respondent is in line with the scope of the discussion and the research questions; from the need for a cultural mediation service to healthcare coverage. Moreover, a prospective solution was also put forward.

Overall, the comments outlined in this section reflect real issues faced on the ground by healthcare practitioners. The comments add an authentic dimension to the growing evidence pertaining to the benefits of healthcare interpreting and the investigations carried out in this study.

Cross Tabulation: Questions 1 & 2

Link to table.

The table affirms that the relationship between those who answered "Yes" to both question 1[16] and 2[17] cannot be attributed to chance. This informs the reader that the practitioners who are facing language barriers also feel that it is taking longer to provide healthcare under said circumstances. Therefore, it can be tentatively said that practitioners facing language barriers are also taking longer to provide healthcare to patients with limited Maltese and/or English skills. This is potentially further confirmed by the participants who do not face language barrier issues, but also feel it takes longer to provide healthcare when patients have limited Maltese and/or English skills. The cross tabulation serves to highlight the importance of addressing language barriers.

In case of a representative sample, the cross tabulation would have served as definitive evidence of the language barriers issues the healthcare system is potentially facing. This means that the Maltese healthcare system is possibly ill-equipped to offer the best service possible in light of the growing multiculturalism and its accompanying cultural-mediation needs.

[16] Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?

[17] Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?

Cross Tabulation: Questions 1 & 6

Link to table.

A statistically significant relationship was found between question 1[18] and 6[19]. The relationship shows a strong link between the practitioners facing language barriers and the perception that professional healthcare interpreting may help in such situations. To a superficial degree, this is a contrast to the main literature consulted in Chapter 1.0. Estrada (2014) and Crezee (2013) both discussed the lack of education and awareness of healthcare interpreting services and training for the use of such services amongst healthcare practitioners. However, in-depth knowledge on healthcare interpreting awareness amongst practitioners working in the Maltese healthcare system is yet to be attained.

The preliminary indication from this cross tabulation potentially shows that local practitioners would think favourably of the introduction of a healthcare interpreting service. This is possibly further confirmed by the 72.7% who do not face language barrier issues but still feel that a professional interpreter may help medical staff in such contexts. Further investigations are needed in assessing qualitatively how the language barriers are affecting the day to day healthcare provision.

Cross Tabulation: Questions 1 & 10

Link to table.

A statistically significant relationship was found between question 1[20] and all the professions listed in question 10[21]. The two respondents who failed to indicate their profession were not included in this table. The table shows that all of the doctors who

[18] Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?

[19] Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese patients/clients?

[20] Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?

[21] Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.

participated in this questionnaire said they face language barrier issues. On the other hand, a relatively lower 60% of nurses answered in line with the doctors. This percentage difference was found to be statistically significant. The discrepancy in question may be a case of language barriers unfolding differently according to the profession as discussed in question 3. However, no statistically significant relationship was found between question 9[22] and the professions listed in question 10; further details are provided below in this section. This could also be a capacity building difference between the two professions. Both cases warrant further investigation since the literature has repeatedly shown lacking capacity building on healthcare interpreting services amongst healthcare practitioners and investigating the needs for different professions would be crucial in targeting a prospective healthcare interpreting service.

The latter arguments may apply to the therapeutic professions as well since 16.7% said they do not face language barriers. The entire Non-Specified Healthcare Profession group said they face language barriers.

Cross Tabulation: Questions 9 & 10

Link to table in Appendix B

Question 9[23] addresses specific benefits gained from healthcare interpreting. 88% of all participants and a high percentage from all participants answered “Yes for both”; meaning that healthcare interpreting would make interactions more time-effective and improve quality. Despite this high percentage and the statistically significant relationship found between all the professions and the language barriers they face (questions 1 and 10), no significant relationship was found in this question pair.

[22] Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?

[23] Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?

This issue is worth re-investigating with a representative sample from all healthcare professions as it can provide an indication into the readiness for acceptance of a healthcare interpreting service uptake and into the need for it per profession.

Cross Tabulation: Questions 3 & 9

Link to table.

The results show that participants who answered "Yes" and "No" to question 3[24] still answered "Yes for both" for question 9[25]. This potentially shows an awareness of the benefits of healthcare interpreting which in turn may prove to be important for future considerations in introducing such a service. This may be applicable even for those who do not feel that the healthcare provision is currently suffering in its provision to patients or clients with limited Maltese and/or English.

Additionally, question 3 is noteworthy as the respondents perceive a lower quality of healthcare provision when dealing with patients with limited Maltese and/or English skills. Similarly to the previous cross tabulation, results from questions 3 and 9 may be reflecting the respondent's positive inclination towards healthcare interpreting and a readiness for such a service.

Cross Tabulation: Questions 4 & 8

Link to table.

The majority of all the participants who did not answer "Usually do" to question 8[26] are aware that healthcare settings abroad may include a professional interpreter. However, 75.0% of those who answered "Usually do" are not aware of this. This can be due to a

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[24] Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?

[25] Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?

[26] Do you know if visiting foreigners/migrants have a private health- insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card).

specific caseload where foreigners or migrants are given healthcare. To this end, a cross tabulation test between the different professions (question 10) and question 8 was run. No statistically significant relationship was found.

This finding could also be tentatively explained by the lacking education on healthcare interpreting amongst healthcare practitioners as discussed in, question 4 and question 6.

Cross Tabulation: Questions 4 & 10

Link to table.

The cross tabulation test revealed a statistically significant relationship between the different healthcare professions and question 4[27]. Nurses seems to be more aware that healthcare interpreting services may be offered abroad as 90.0% answered as such, while the therapeutic professions were the least aware at 50.0%. With a total of 66.3%, the results can possibly be attributed to the aforementioned lacking education on training on healthcare interpreting amongst healthcare practitioners. This issue was covered in question 4 and question 6. Increased awareness of healthcare interpreting services is the first step in establishing such a service.

Cross Tabulation: Questions 7 & 10

Link to table.

The table shows a statistically significant relationship between the different professions and how they replied to question 7[28]. The results displayed in the table show how only the medical profession were more inclined towards the healthcare interpreter working as a cultural liaison as opposed to a strictly linguistic interpreter. According to research, the ideal role is that of a cultural liaison in a bid to convey the meaning of an utterance as

[27] Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?

[28] What do you think is the interpreter's role?

intended for the target culture (Pöchhacker & Shlesinger, 2007). Interpreting in a strictly linguistic capacity is susceptible to inaccuracies. These inaccuracies may very well harm the healthcare provision of any given healthcare system (Estrada, 2014). Further details are given throughout Chapter 2.0.

The salient finding is the discrepancy between the medical professionals' input when compared to the other professions as outlined in the table. The doctors' caseload may be exposing them to more varied scenarios which in turn may be informing the doctors differently. In ideal conditions, future endeavours should be supplied with information from all healthcare sectors and professions. However, this situation may tentatively present a streamlined option from which information pertinent to the field of healthcare interpreting can be collected. Overall, the preliminary indication is that characteristics inherent to the different professions may lead to significantly different responses to the questionnaire and, ultimately, to the outlook on healthcare interpreting. Additional details on professions differences are given in this chapter under question 3.

Furthermore, as discussed in this chapter under question 4 and question 6, the education and training of certain professions may not be covering the field of healthcare interpreting. This, in turn, may be accounting for the differences in their responses. A revaluation of said education and training to include awareness of healthcare interpreting may be warranted. Capacity building for already-established healthcare practitioners on the awareness and use of interpreting services is a must in moving forward.

Chapter 6.0 Conclusion

This chapter will summarise the findings of this study, link the findings to the research questions and present rationales for the proposed hypotheses. Limitations of this study will also be explored and the recommended way forward will be outlined.

6.1 Study Limitations

Limitations of any study are to be recognised by way of judging the findings, their extrapolations and the resulting recommendations appropriately. The following is a list of anything which was: a compromising factor to the internal validity of this study, a source of bias, an issue with the measures, a factor pertaining to the sample size or anything which could have improved the study:

- Language barriers were limited to Maltese and English given the local context;
- The prevalance of healthcare practitioners with limited language proficiency is unknown. This will be pertinent to future investigations;
- Limited sample size made it impossible to infer fully relevant conclusions;

6.2 Study Strengths

- The first investigation into a previously unexplored field in Malta;
- A scientific methodology: this will create a precedent for studies to come. A common methodology will help maintain relevance throughout different studies;
- Provides objective data which warrants future investigations and, ultimately, a possible improvement in the Maltese public healthcare system;
- Additional comments collected provided a supplemental research scope.

6.3 Main Findings: Research Questions

This study sought to answer research questions pertaining to language barriers within the Maltese healthcare system. A scientific methodology was used to collect preliminary data from healthcare practitioners.

"In the context of a multicultural Malta, new challenges and questions arise; is the healthcare system capable of offering the best service possible?"; "Are local healthcare practitioners witnessing healthcare provision disparities due to language barriers?" In addition, "What do local healthcare practitioners think of the proposition of introducing an interpreting service?"

The findings related to the latter two research questions suggest that the Maltese healthcare system may not be equipped to offer the best service possible when faced with language barriers and that healthcare provision disparities may be occurring. Moreover, this is tentatively shown by the feedback collected from questions 1, 2, 3, 5, 6, and 9. Furthermore, the additional comments left by the following participants also indicate a discrepancy in the healthcare provision when faced with language barriers: participants 2, 3, 38, 64, 66, and 69. Both the questions and additional comments are discussed in Chapter 5.0.

In addition, "What do local healthcare practitioners think of the proposition of introducing an interpreting service?" The results indicate that healthcare practitioners may predispose a positive attitude towards healthcare interpreting. The latter is tentatively evidenced by question 6 and participants 38 and 66.

6.4 Secondary Findings

The secondary findings presented below pertain to additional extrapolations from the data collected from the questionnaire and have an influence on future recommendations.

Healthcare practitioners may not be familiar with the interpreter's precise role in the healthcare setting. This is evidenced by questions 4, 7 and 9 and is in line with the literature.

Furthermore, practitioners may expect a dual role from the interpreter (both as a cultural liaison and a strictly linguistic interpreter) as highlighted by participants 3 and 52. Moreover, the supplementary comments in question 10 by participants 21 and 69 categorically indicate that a healthcare interpreting service, possibly private, is at times involved in healthcare interactions at the Floriana Health Centre. Patients are finding it difficult to communicate with foreign staff as outlined by participant 2. A cultural mediation course has been offered since 2010; a total of 103 participants have been trained as of this study.

6.5 Recommendations and Conclusive Comments

The findings of this study potentially reveal a chronic occurrence of language disparities leading to profound adverse effects to both the healthcare system and the patients it services. What is being uncovered is not only a potential need for a change of ideas and attitudes towards language barriers during healthcare interactions, but also a potential need for a widespread public language service to buttress the changes in question.

In light of the preliminary data collected in this study, a qualitative study of the healthcare interactions in the Maltese public healthcare system is warranted by way of further ascertaining a need for healthcare interpreting. A dyadic study into the interaction between patient and practitioner encounters with and without language barriers is the recommended successive study. The study structure in question will permit the researcher to qualitatively compare and contrast healthcare encounters with and without language barriers and document compensatory techniques employed by practitioners in dealing with language barriers. Situational and discourse analyses and qualitative questionnaires are reliable tools to achieve this aim. It will also pave way for cost estimations and map the relevant healthcare procedures for a prospective healthcare interpreting service. Investigations into current healthcare interpreting services, liaison with NGOs to examine any language aid they offer to third country nationals and the cultural mediation course outlined in the previous chapter are

also recommended. The current system is at a possible disadvantage and this is the spur for future studies into healthcare interpreting.

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Appendix A

Consent Form, Questionnaire and FREC Approval

Consent Form.

Thank you for clicking, this is an invitation for a 3-minute online survey. My name is Gary Lee Doublet Meagher. I am currently conducting a study on healthcare interpreting at Masters Level in Interpreting at the University of Malta under the faculty of Translation, Terminology & Interpreting Studies. The study in question requires research.

The current literature outlines a financial gain and an overall improved healthcare provision for patients with limited English in the US and UK when they are offered the help of a professional interpreter. In light of Malta's influx of migrants, the research field in question was never more relevant. I am therefore investigating the need for interpreting services in the Maltese healthcare context.

The 10 question survey is of a subjective nature. You will be asked about any language barrier difficulties you may have faced in interacting with patients or client with limited English and/or Maltese or any language incompatible with the healthcare provider's. No personal data is required aside from qualifying your profession (nurse, doctor or therapist etc..) The research is an initial attempt at penetrating this field and therefore we are still scraping the surface, hopefully, to ultimately trigger a policy reaction. Therefore your participation is immensely appreciated. The data provided will be extracted as a quantitative description in graphical and written form.

In answering the questions, it is not reasonably foreseen that psychological and/or physical discomfort or risks can be incurred.

Benefits

No immediate benefit is to be had with this research, however, you will be contributing to a potential policy change which, according to literature, will definitely benefit patients who have trouble communicating with healthcare practitioners. No remuneration will be given to the participant, nor will they be incur any cost upon participation.

Participation

Participation is voluntary. Refusal to participate will involve no penalty or loss of benefit what so ever.

Withdrawal

Withdrawal from the study is possible at any time. The data you provided will be omitted from the study.

Confidentiality

No personal data will be collected. Any information pertaining to the questionnaire will be tied to the researcher's password-protected account on survey monkey. Only the researcher has access to this information, which he can grant to the supervisor for quality-of-work purposes.

Participant Rights in Accordance with GDRP (Please keep in mind that NO personal data will be collected.

You have the right to:

- information about the processing of your personal data;
- obtain access to the personal data held about you;

- ask for incorrect, inaccurate or incomplete personal data to be corrected;
- request that personal data be erased when it's no longer needed or if processing it is unlawful;
- object to the processing of your personal data for marketing purposes or on grounds relating to your particular situation;
- request the restriction of the processing of your personal data in specific cases;
- receive your personal data in a machine-readable format and send it to another controller ('data portability');
- request that decisions based on automated processing concerning you or significantly affecting you and based on your personal data are made by natural persons, not only by computers. You also have the right in this case to express your point of view and to contest the decision. (https://ec.europa.eu/info/law/law-topic/data-protection/reform/rights-citizens/my-rights/what-are-my-rights_en)

Contact Information

doubletgary@gmail.com – researcher - joseph.eynaud@um.edu.mt – supervisor

_____

Participant Signature

_____

Researcher Signature

_____

Supervisor Signature

Questions

1. Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?
    a. Yes
    b. No
2. Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?
    a. Yes
    b. No
3. Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?
    a. Yes
    b. No
4. Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?
    a. Yes
    b. No
5. Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection (a cultural norm in certain Middle-Eastern countries).
    a. All the time
    b. Usually
    c. Sometimes
    d. Rarely

e. Never

6. Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?
    a. Yes
    b. No
7. What do you think is the interpreter's role?
    a. To provide a purely linguistic translation in order to convey the practitioner's utterances precisely?
    b. To act as a cultural liaison?
8. Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:
    a. Always do
    b. Usually do
    c. Sometimes do
    d. Rarely do
    e. Never do
9. Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?
    a. Yes for both
    b. Neither
    c. More time-efficient
    d. Better healthcare provision
10. Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.

FREC approval.

Charlotte Cucciardi Fava <charlotte.cucciardi@um.edu.mt>
to me

Dear Student,

At its meeting of 8 June 2018, FREC audited and approved your Research Ethics and Data Protection

The form will be filed.

FREC Faculty of Arts

Gary Doublet <doubletgary@gmail.com>
to Charlotte

Dear Ms Cucciardi Fava,

Acknowledged with thanks,

Kind Regards,

Gary

Reply Forward

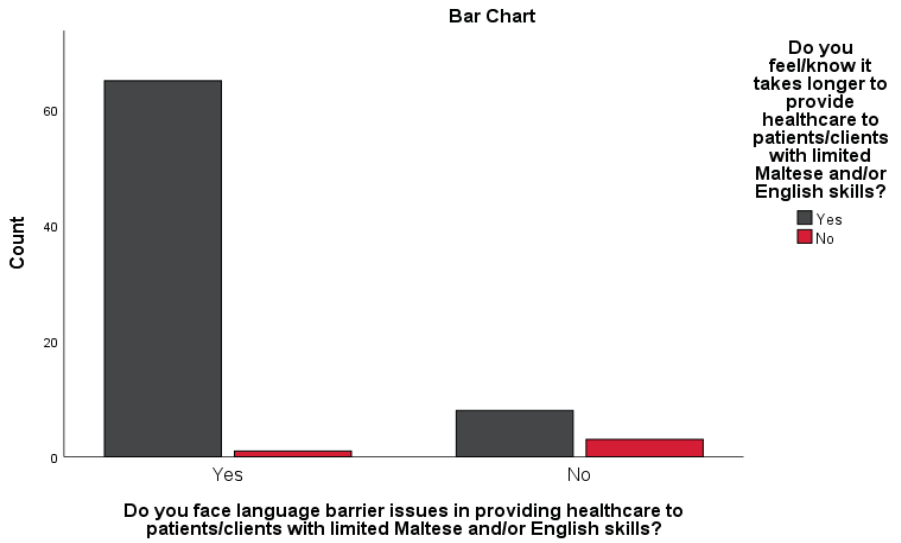
Appendix B

All Results

Question 1 & 2

			Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?		
			Yes	No	Total
Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	65	1	66
		%	89.0%	25.0%	85.7%
	No	Count	8	3	11
		%	11.0%	75.0%	14.3%
Total		Count	73	4	77
		%	100.0%	100.0%	100.0%

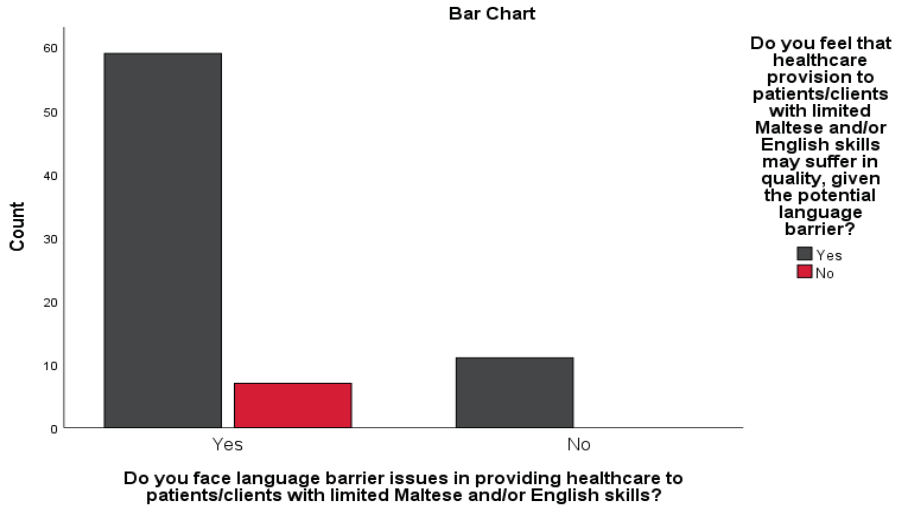
X^2 (1) = 12.701, P = 0.000



Question 1 & 3

			Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?		
			Yes	No	Total
Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	59	7	66
		%	84.3%	100.0%	85.7%
	No	Count	11	0	11
		%	15.7%	0.0%	14.3%
Total		Count	70	7	77
		%	100.0%	100.0%	100.0%

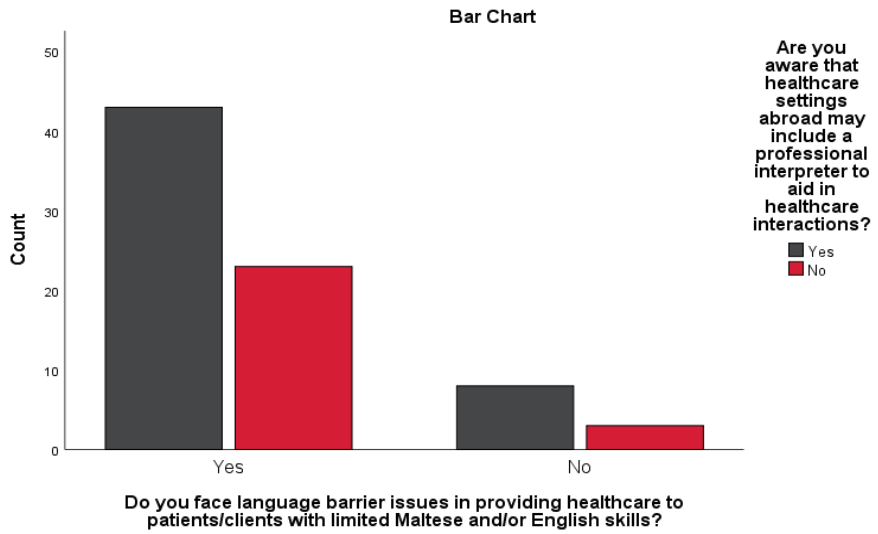
X^2 (1) = 12.701, P = 0.000



Question 1 & 4

			Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?		
			Yes	No	Total
Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	43	23	66
		%	84.3%	88.5%	85.7%
	No	Count	8	3	11
		%	15.7%	11.5%	14.3%
Total		Count	51	26	77
		%	100.0%	100.0%	100.0%

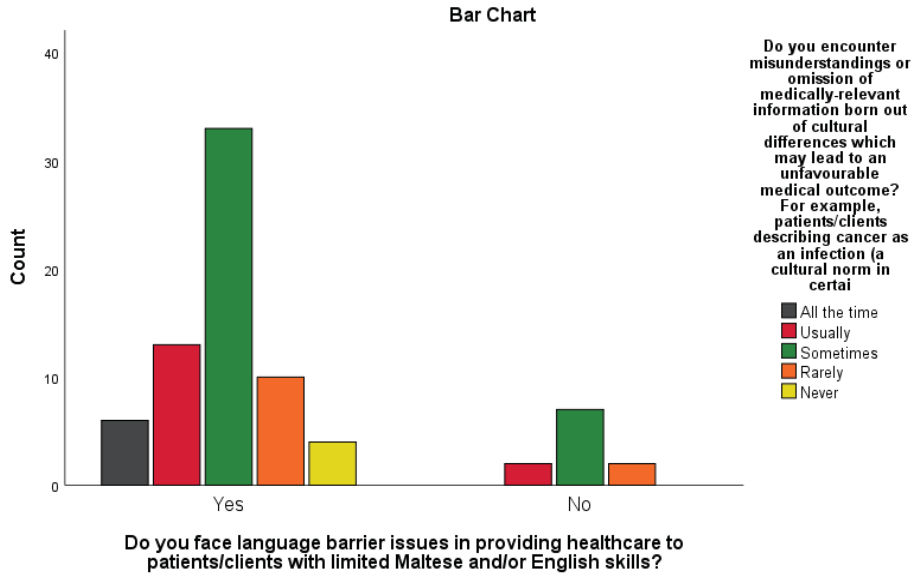
X^2 (1) = 0.242, P = 0.623



Question 1 & 5

			Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection					
			All the time	Usually	Sometimes	Rarely	Never	Total
Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	6	13	33	10	4	66
		%	100.0%	86.7%	82.5%	83.3%	100.0%	85.7%
	No	Count	0	2	7	2	0	11
		%	0.0%	13.3%	17.5%	16.7%	0.0%	14.3%
Total		Count	6	15	40	12	4	77
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

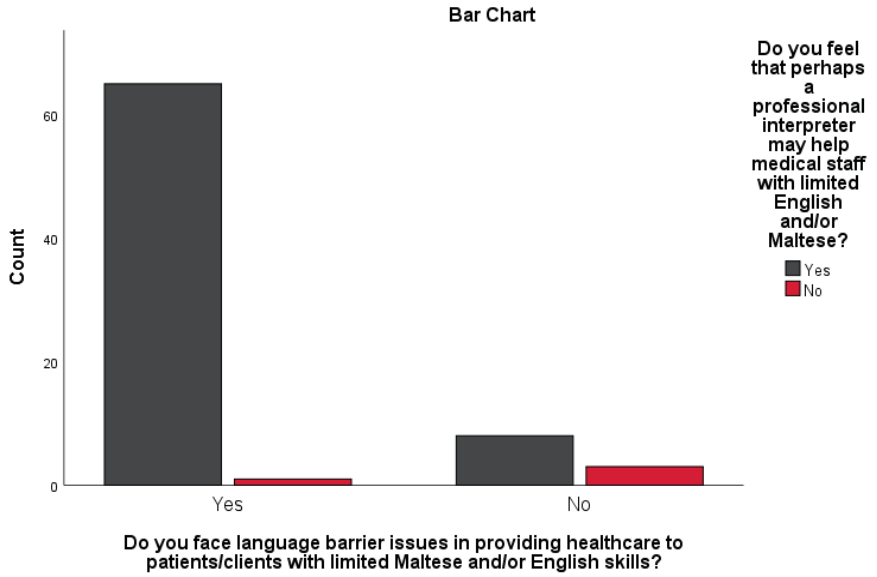
X^2 (4) = 2.071, P = 0.723



Question 1 & 6

			Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?		
			Yes	No	Total
Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	65	1	66
		%	89.0%	25.0%	85.7%
	No	Count	8	3	11
		%	11.0%	75.0%	14.3%
Total		Count	73	4	77
		%	100.0%	100.0%	100.0%

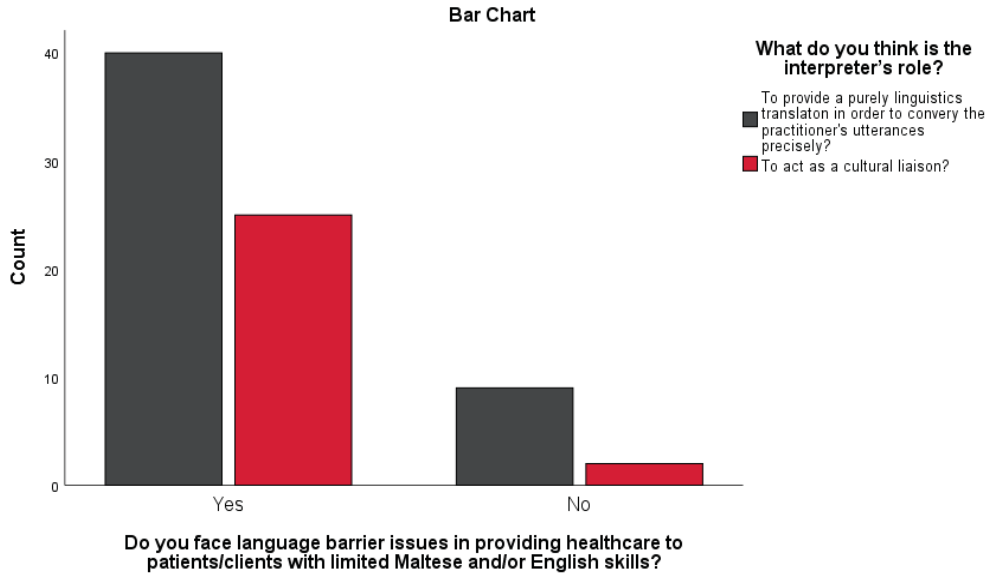
X^2 (1) = 12.701, P = 0.000



Question 1 & 7

			What do you think is the interpreter's role?		
			To provide a purely linguistics translation…	To act as a cultural liaison?	Total
Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	40	25	65
		%	81.6%	92.6%	85.5%
	No	Count	9	2	11
		%	18.4%	7.4%	14.5%
Total		Count	49	27	76
		%	100.0%	100.0%	100.0%

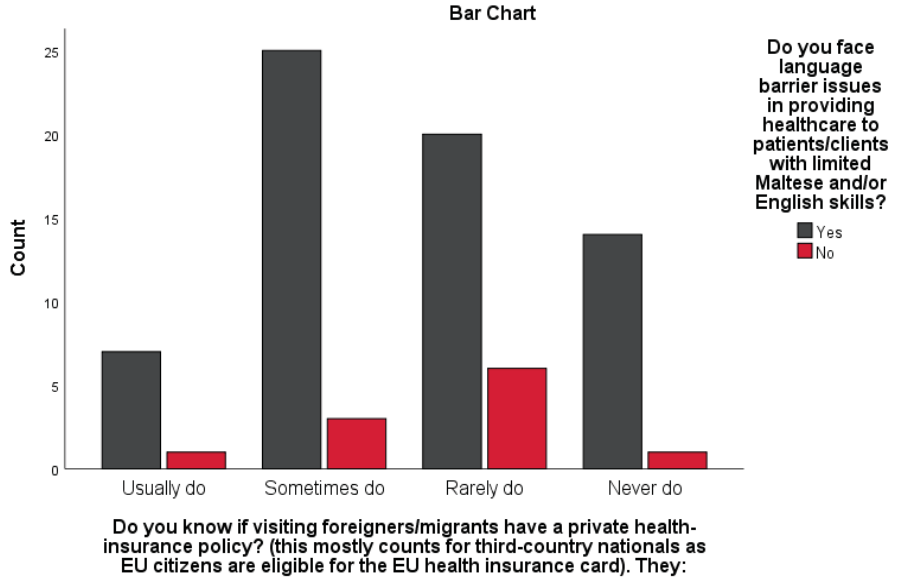
X^2 (1) = 1.689, P = 0.194



Question 1 & 8

			Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?		
			Yes	No	Total
Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:	Usually do	Count	7	1	8
		%	10.6%	9.1%	10.4%
	Sometimes do	Count	25	3	28
		%	37.9%	27.3%	36.4%
	Rarely do	Count	20	6	26
		%	30.3%	54.5%	33.8%
	Never do	Count	14	1	15
		%	21.2%	9.1%	19.5%
Total		Count	66	11	77
		%	100.0%	100.0%	100.0%

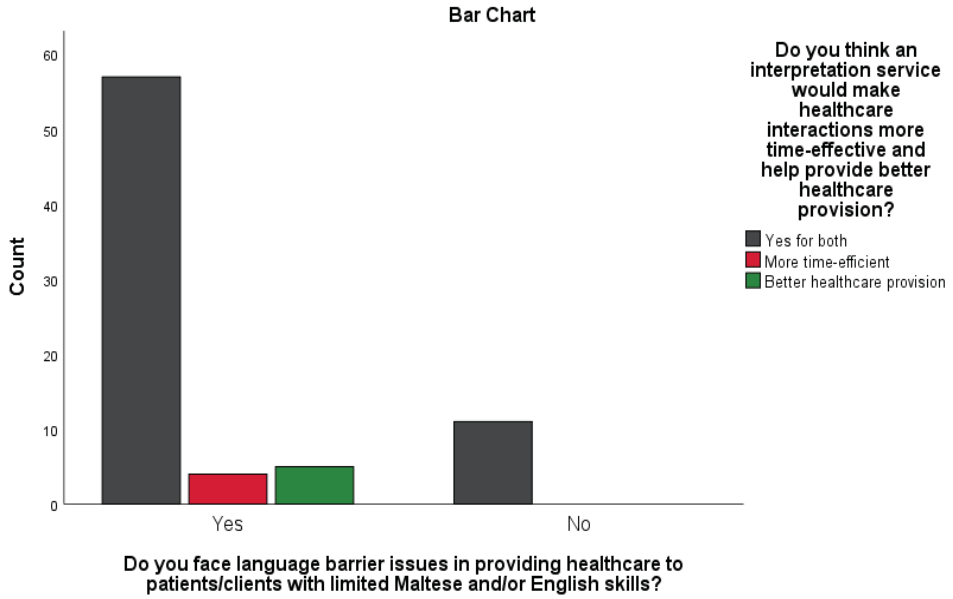
X^2 (3) = 2.665, P = 0.446



Question 1 & 9

			Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?			
			Yes for both	More time-efficient	Better healthcare provision	Total
Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	57	4	5	66
		%	83.8%	100.0%	100.0%	85.7%
	No	Count	11	0	0	11
		%	16.2%	0.0%	0.0%	14.3%
Total		Count	68	4	5	77
		%	100.0%	100.0%	100.0%	100.0%

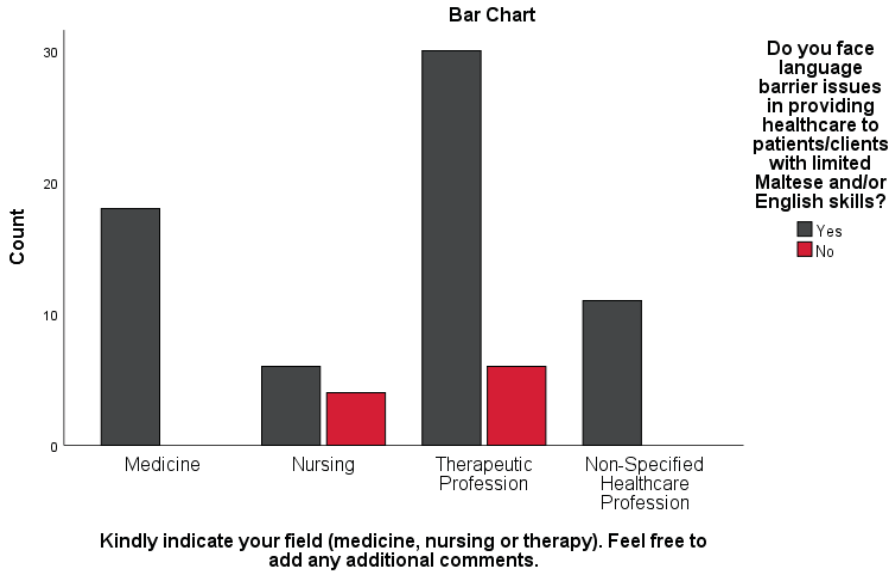
X^2 (2) = 1.699, P = 0.428



Question 1 & 10

			Do you face language barrier issues in providing healthcare to patients/clients with limited Maltese and/or English skills?		
			Yes	No	Total
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	18	0	18
		%	27.7%	0.0%	24.0%
	Nursing	Count	6	4	10
		%	9.2%	40.0%	13.3%
	Therapeutic Profession	Count	30	6	36
		%	46.2%	60.0%	48.0%
	Non-Specified Healthcare Profession	Count	11	0	11
		%	16.9%	0.0%	14.7%
Total		Count	65	10	75
		%	100.0%	100.0%	100.0%

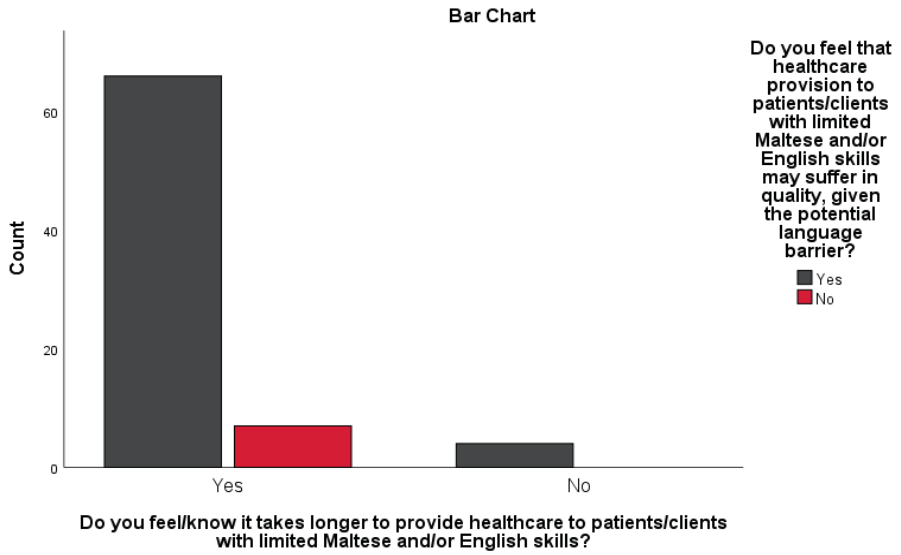
X^2 (3) = 10.962, P = 0.012



Question 2 & 3

			Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?		
			Yes	No	Total
Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	66	7	73
		%	94.3%	100.0%	94.8%
	No	Count	4	0	4
		%	5.7%	0.0%	5.2%
Total		Count	70	7	77
		%	100.0%	100.0%	100.0%

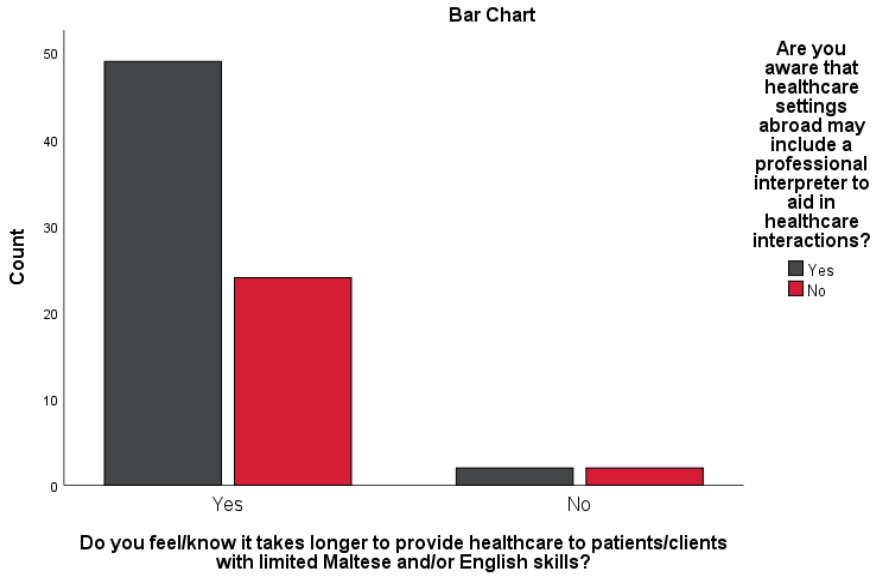
X^2 (1) = 0.422, P = 0.516



Question 2 & 4

			Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?		
			Yes	No	Total
Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	49	24	73
		%	96.1%	92.3%	94.8%
	No	Count	2	2	4
		%	3.9%	7.7%	5.2%
Total		Count	51	26	77
		%	100.0%	100.0%	100.0%

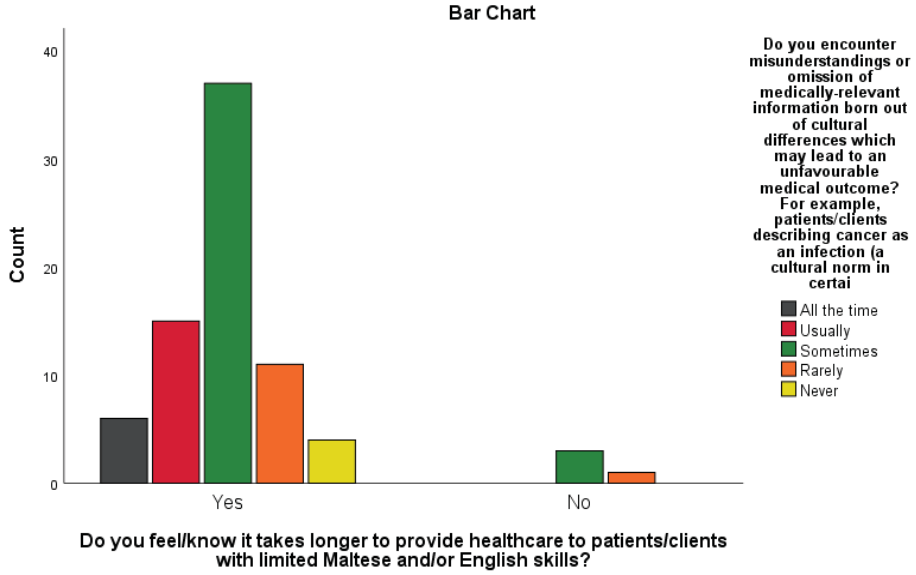
X^2 (1) = 0.497, P = 0.481



Question 2 & 5

			Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection					
			All the time	Usually	Sometimes	Rarely	Never	Total
Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	6	15	37	11	4	73
		%	100.0%	100.0%	92.5%	91.7%	100.0%	94.8%
	No		0	0	3	1	0	4
		Count						
		%	0.0%	0.0%	7.5%	8.3%	0.0%	5.2%
Total		Count	6	15	40	12	4	77
		%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0 %

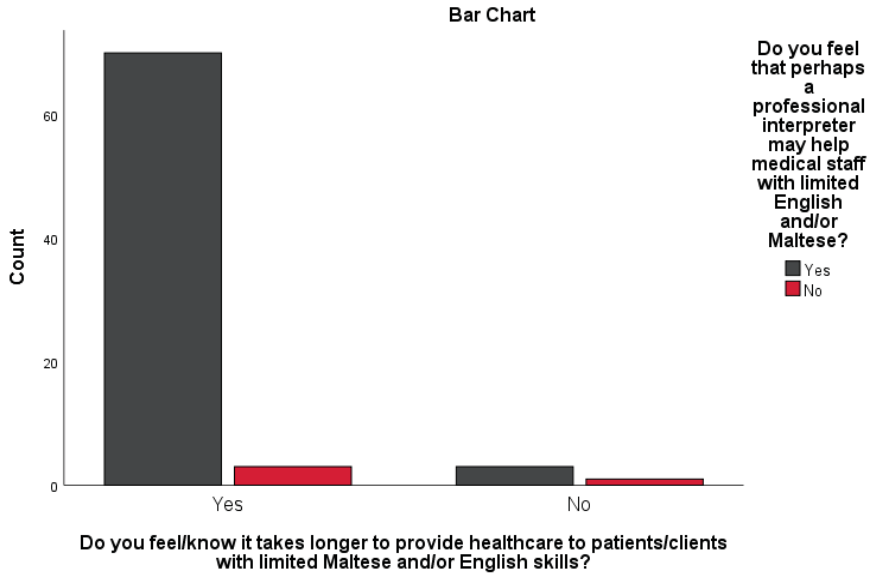
X^2 (4) = 2.041, P = 0.728



Question 2 & 6

			Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?		
			Yes	No	Total
Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	70	3	73
		%	95.9%	75.0%	94.8%
	No	Count	3	1	4
		%	4.1%	25.0%	5.2%
Total		Count	73	4	77
		%	100.0%	100.0%	100.0%

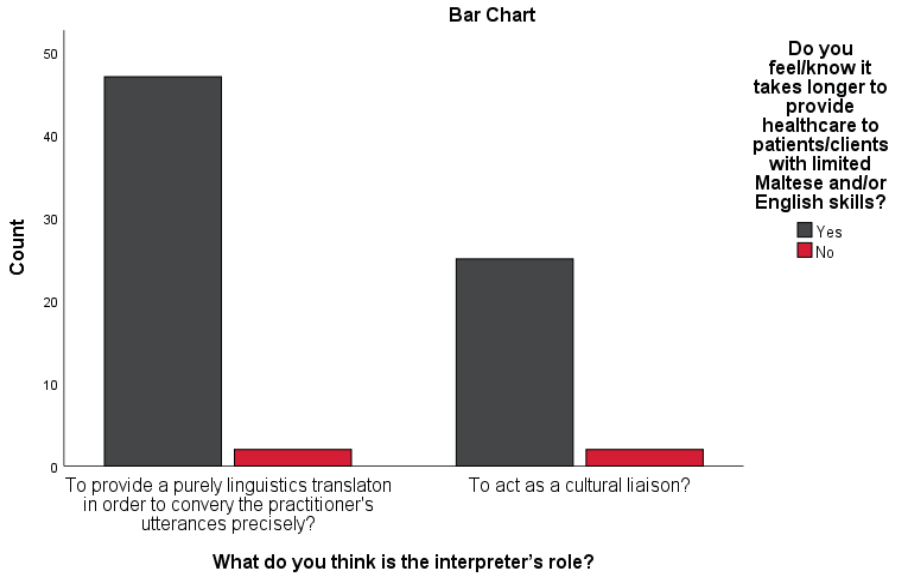
X^2 (1) = 3.360, P = 0.067



Question 2 & 7

			Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?		
			Yes	No	Total
What do you think is the interpreter's role?	To provide a purely linguistics translation …	Count	47	2	49
		%	65.3%	50.0%	64.5%
	To act as a cultural liaison?	Count	25	2	27
		%	34.7%	50.0%	35.5%
Total		Count	72	4	76
		%	100.0%	100.0%	100.0%

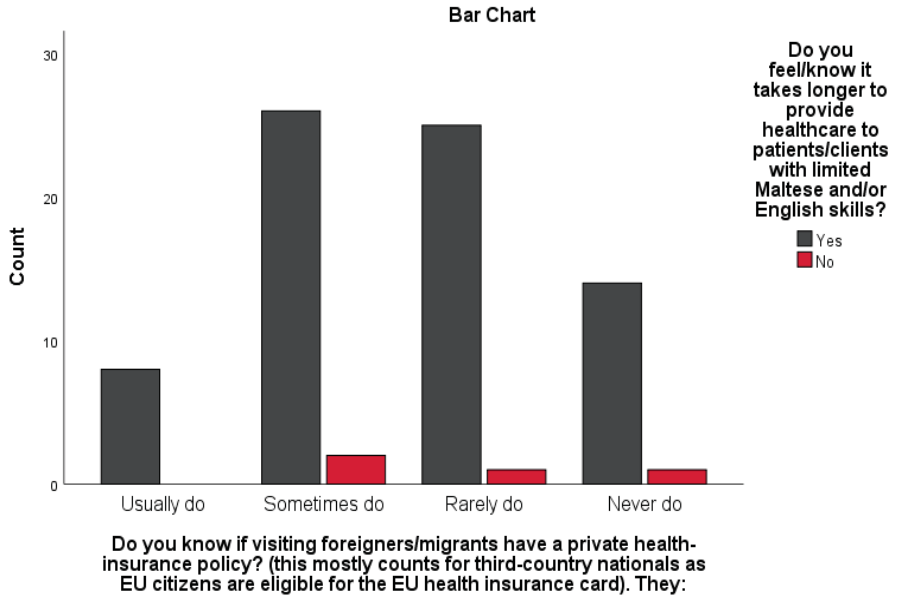
X^2 (1) = 0.386, P = 0.534



Question 2 & 8

			Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?		
			Yes	No	Total
Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:	Usually do	Count	8	0	8
		%	11.0%	0.0%	10.4%
	Sometimes do	Count	26	2	28
		%	35.6%	50.0%	36.4%
	Rarely do	Count	25	1	26
		%	34.2%	25.0%	33.8%
	Never do	Count	14	1	15
		%	19.2%	25.0%	19.5%
Total		Count	73	4	77
		%	100.0%	100.0%	100.0%

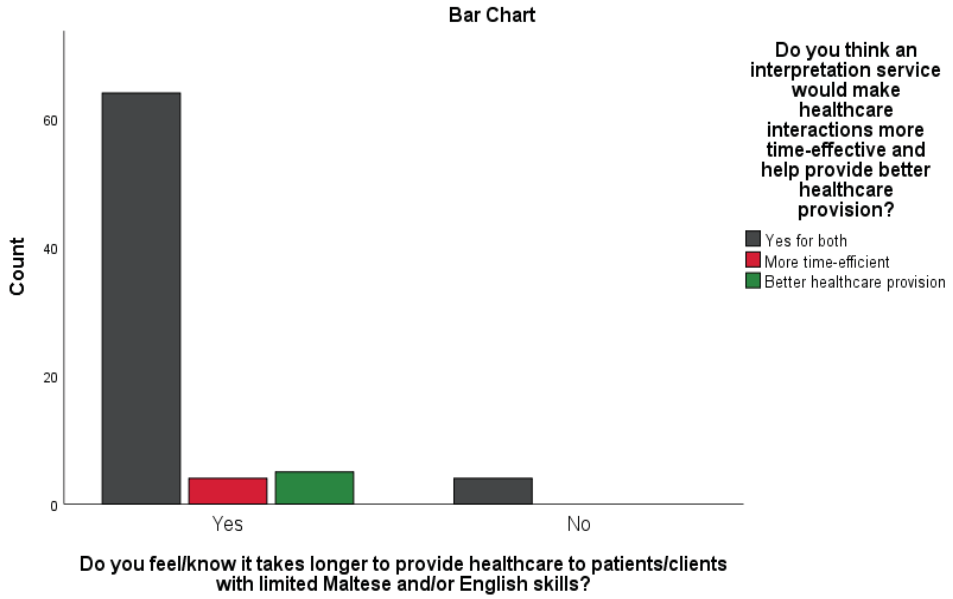
X^2 (3) = 0.816, P = 0.846



Question 2 & 9

			Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?			
			Yes for both	More time-efficient	Better healthcare provision	Total
Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?	Yes	Count	64	4	5	73
		%	94.1%	100.0%	100.0%	94.8%
	No	Count	4	0	0	4
		%	5.9%	0.0%	0.0%	5.2%
Total		Count	68	4	5	77
		%	100.0%	100.0%	100.0%	100.0%

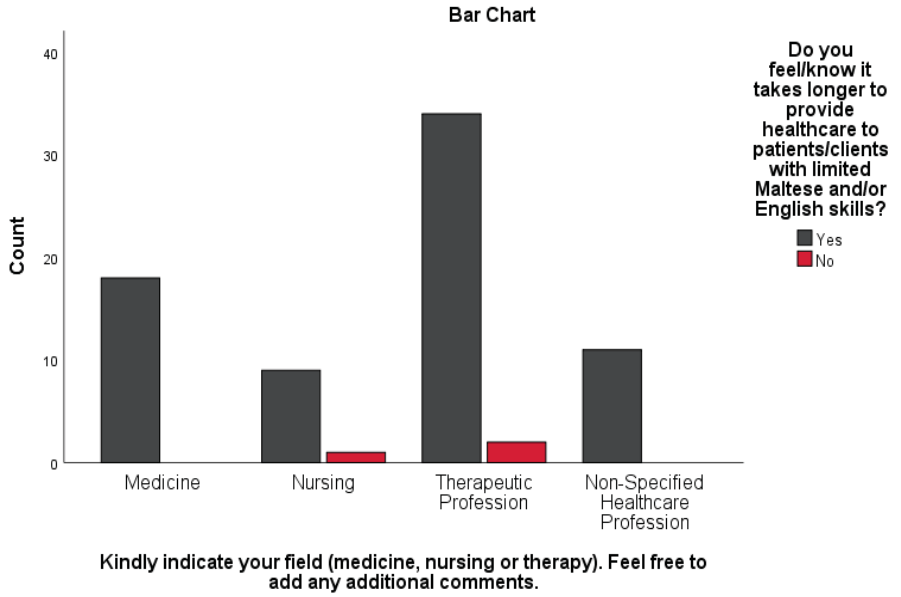
X^2 (2) = 0.558, P = 0.756



Question 2 & 10

			Do you feel/know it takes longer to provide healthcare to patients/clients with limited Maltese and/or English skills?		
			Yes	No	Total
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	18	0	18
		%	25.0%	0.0%	24.0%
	Nursing	Count	9	1	10
		%	12.5%	33.3%	13.3%
	Therapeutic Profession	Count	34	2	36
		%	47.2%	66.7%	48.0%
	Non-Specified Healthcare Profession	Count	11	0	11
		%	15.3%	0.0%	14.7%
Total		Count	72	3	75
		%	100.0%	100.0%	100.0%

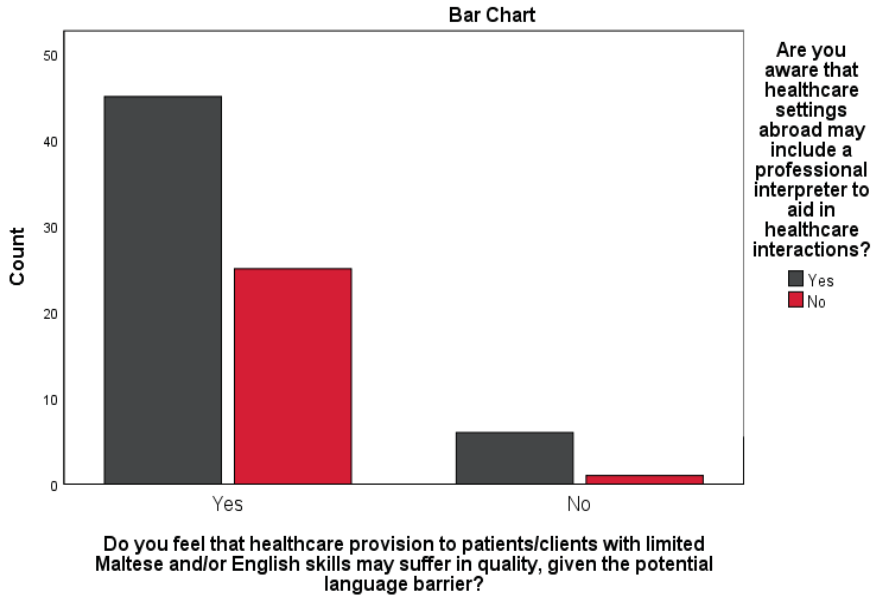
X^2 (3) = 2.373, P = 0.499



Questions 3 & 4

			Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?		
			Yes	No	Total
Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?	Yes	Count	45	25	70
		%	88.2%	96.2%	90.9%
	No	Count	6	1	7
		%	11.8%	3.8%	9.1%
Total		Count	51	26	77
		%	100.0%	100.0%	100.0%

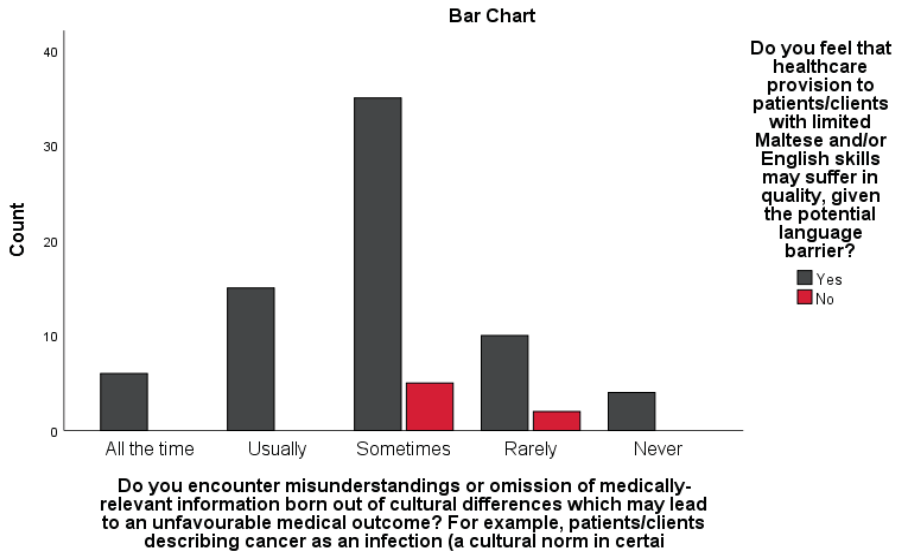
X^2 (1) = 1.307, P = 0.253



Questions 3 & 5

			Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?		
			Yes	No	Total
Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection	All the time	Count	6	0	6
		%	8.6%	0.0%	7.8%
	Usually	Count	15	0	15
		%	21.4%	0.0%	19.5%
	Sometimes	Count	35	5	40
		%	50.0%	71.4%	51.9%
	Rarely	Count	10	2	12
		%	14.3%	28.6%	15.6%
	Never	Count	4	0	4
		%	5.7%	0.0%	5.2%
Total		Count	70	7	77
		%	100.0%	100.0%	100.0%

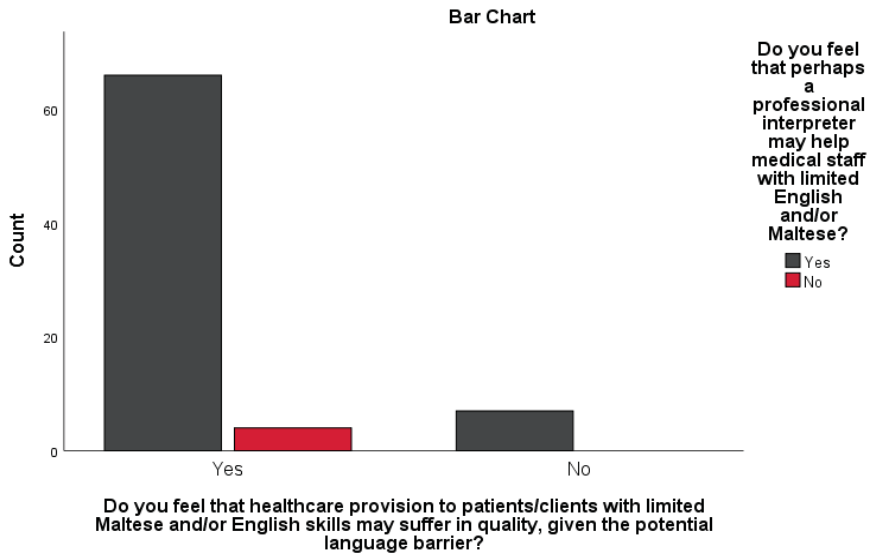
X^2 (1) = 1.307, P = 0.253



Question 3 & 6

			Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?		
			Yes	No	Total
Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?	Yes	Count	66	4	70
		%	90.4%	100.0%	90.9%
	No	Count	7	0	7
		%	9.6%	0.0%	9.1%
Total		Count	73	4	77
		%	100.0%	100.0%	100.0%

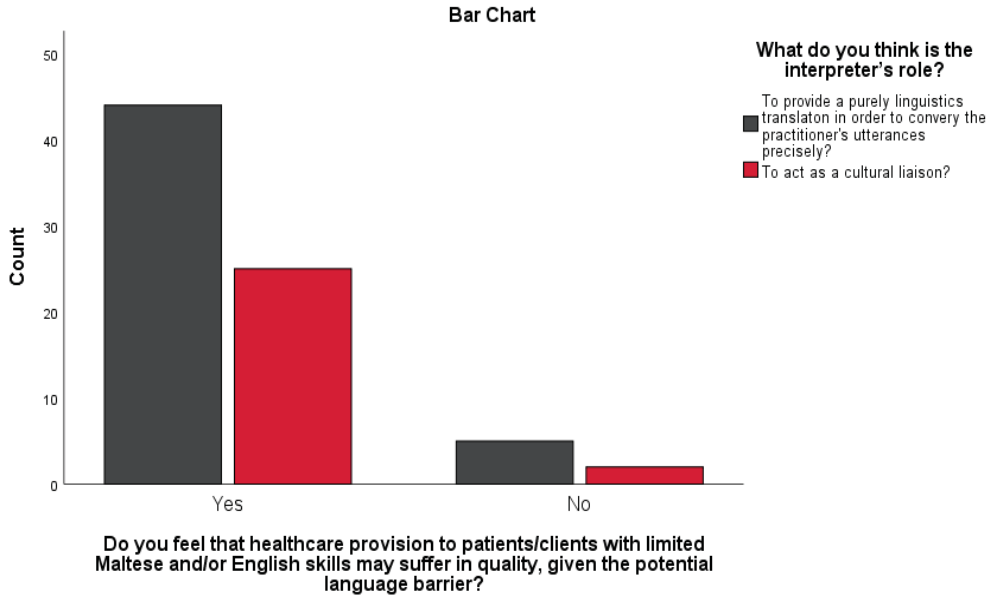
X^2 (1) = 0.422, P = 0.516



Question 3 & 7

			What do you think is the interpreter's role?		
			To provide a purely linguistics translation…	To act as a cultural liaison?	Total
Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?	Yes	Count	44	25	69
		%	89.8%	92.6%	90.8%
	No	Count	5	2	7
		%	10.2%	7.4%	9.2%
Total		Count	49	27	76
		%	100.0%	100.0%	100.0%

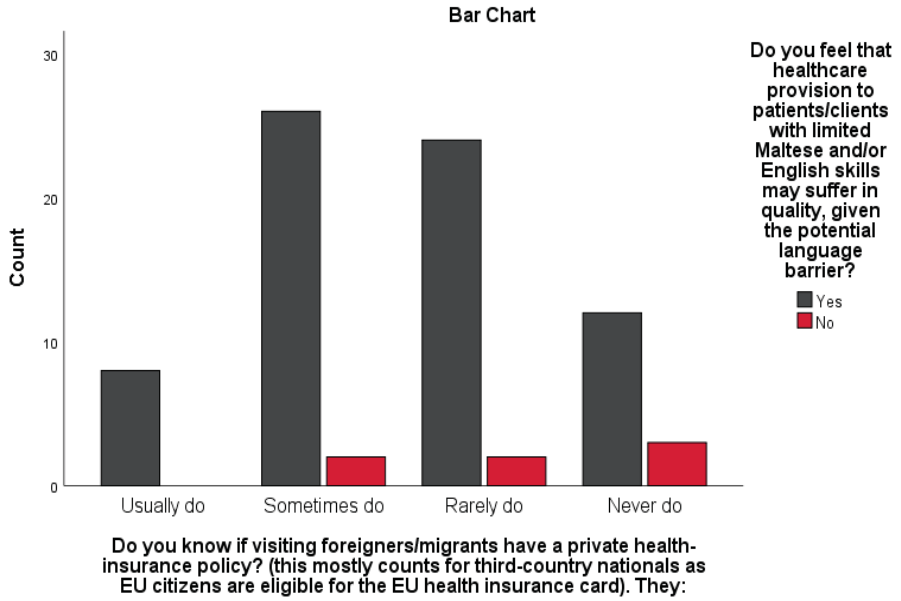
X^2 (1) = 0.163, P = 0.687



Question 3 & 8

			Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?		
			Yes	No	Total
Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:	Usually do	Count	8	0	8
		%	11.4%	0.0%	10.4%
	Sometimes do	Count	26	2	28
		%	37.1%	28.6%	36.4%
	Rarely do	Count	24	2	26
		%	34.3%	28.6%	33.8%
	Never do	Count	12	3	15
		%	17.1%	42.9%	19.5%
Total		Count	70	7	77
		%	100.0%	100.0%	100.0%

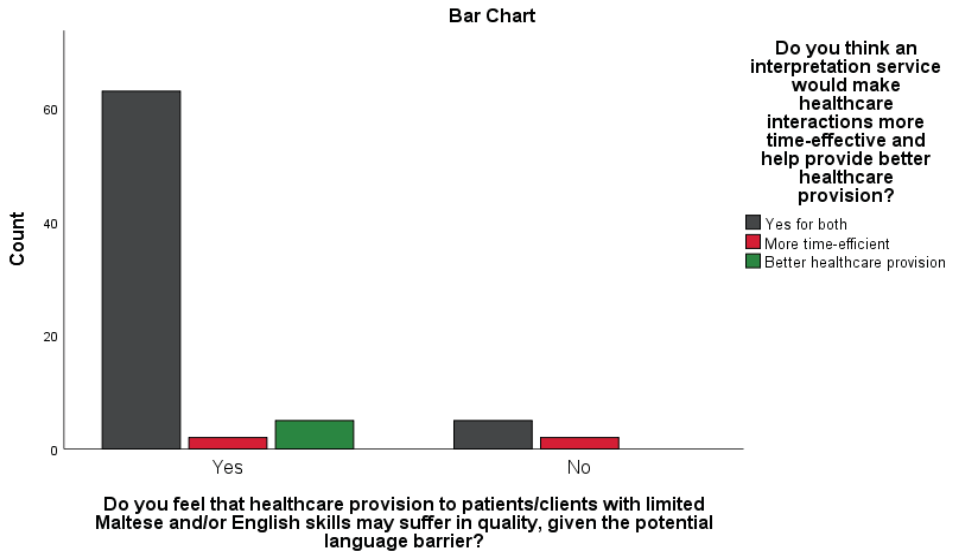
X^2 (3) = 3.150, P = 0.369



Questions 3 & 9

			Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?			
			Yes for both	More time-efficient	Better healthcare provision	Total
Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?	Yes	Count	63	2	5	70
		%	92.6%	50.0%	100.0%	90.9%
	No	Count	5	2	0	7
		%	7.4%	50.0%	0.0%	9.1%
Total		Count	68	4	5	77
		%	100.0%	100.0%	100.0%	100.0%

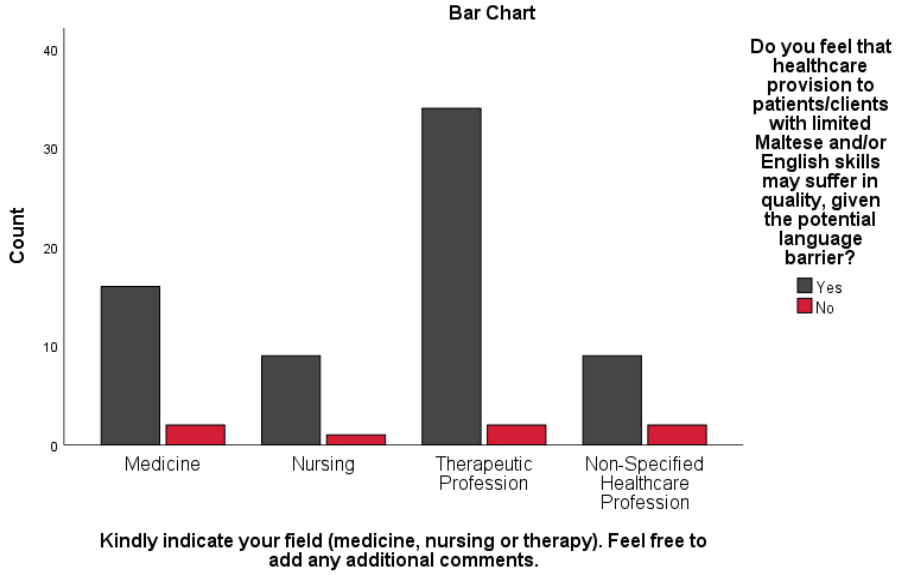
X^2 (1) = 8.849, P = 0.012



Questions 3 & 10

			Do you feel that healthcare provision to patients/clients with limited Maltese and/or English skills may suffer in quality, given the potential language barrier?		
			Yes	No	Total
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	16	2	18
		%	23.5%	28.6%	24.0%
	Nursing	Count	9	1	10
		%	13.2%	14.3%	13.3%
	Therapeutic Profession	Count	34	2	36
		%	50.0%	28.6%	48.0%
	Non-Specified Healthcare Profession	Count	9	2	11
		%	13.2%	28.6%	14.7%
Total		Count	68	7	75
		%	100.0%	100.0%	100.0%

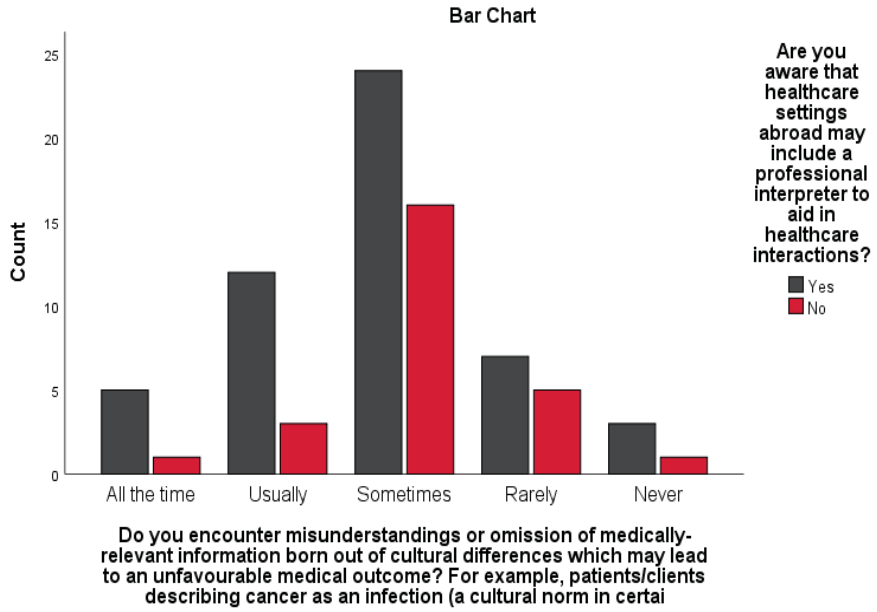
X^2 (1) = 1.697, P = 0.638



Question 4 & 5

			Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?		
			Yes	No	Total
Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection.	All the time	Count	5	1	6
		%	9.8%	3.8%	7.8%
	Usually	Count	12	3	15
		%	23.5%	11.5%	19.5%
	Sometimes	Count	24	16	40
		%	47.1%	61.5%	51.9%
	Rarely	Count	7	5	12
		%	13.7%	19.2%	15.6%
	Never	Count	3	1	4
		%	5.9%	3.8%	5.2%
Total		Count	51	26	77
		%	100.0%	100.0%	100.0%

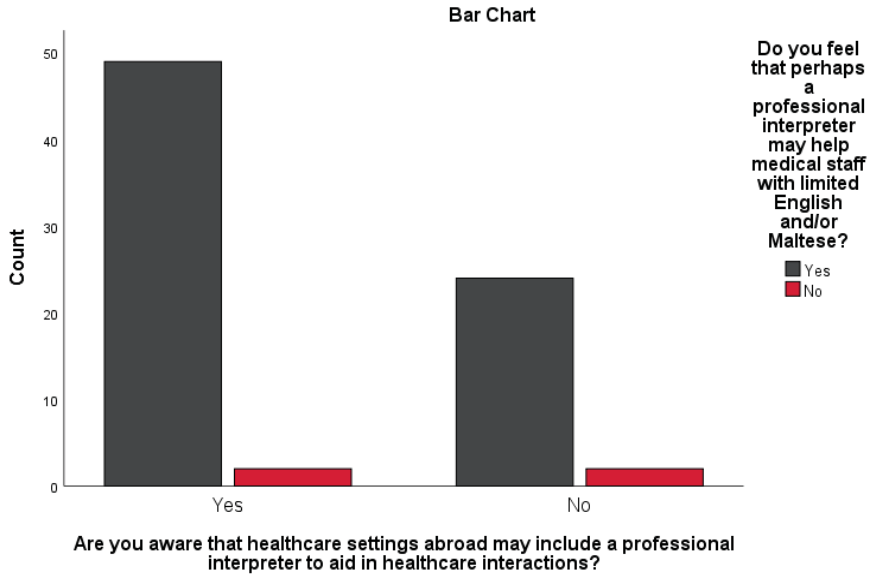
X^2 (4) = 3.223, P = 0.521



Question 4 & 6

			Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?		
			Yes	No	Total
Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?	Yes	Count	49	2	51
		%	67.1%	50.0%	66.2%
	No	Count	24	2	26
		%	32.9%	50.0%	33.8%
Total		Count	73	4	77
		%	100.0%	100.0%	100.0%

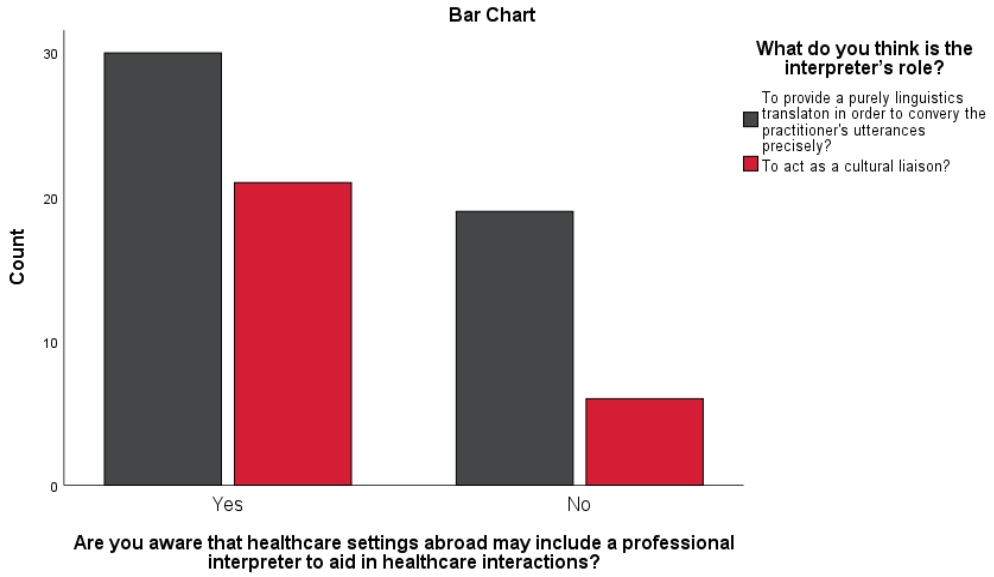
X^2 (1) = 0.497, P = 0.481



Question 4 & 7

			What do you think is the interpreter's role?		
			To provide a purely linguistics translation…	To act as a cultural liaison?	Total
Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?	Yes	Count	30	21	51
		%	61.2%	77.8%	67.1%
	No	Count	19	6	25
		%	38.8%	22.2%	32.9%
Total		Count	49	27	76
		%	100.0%	100.0%	100.0%

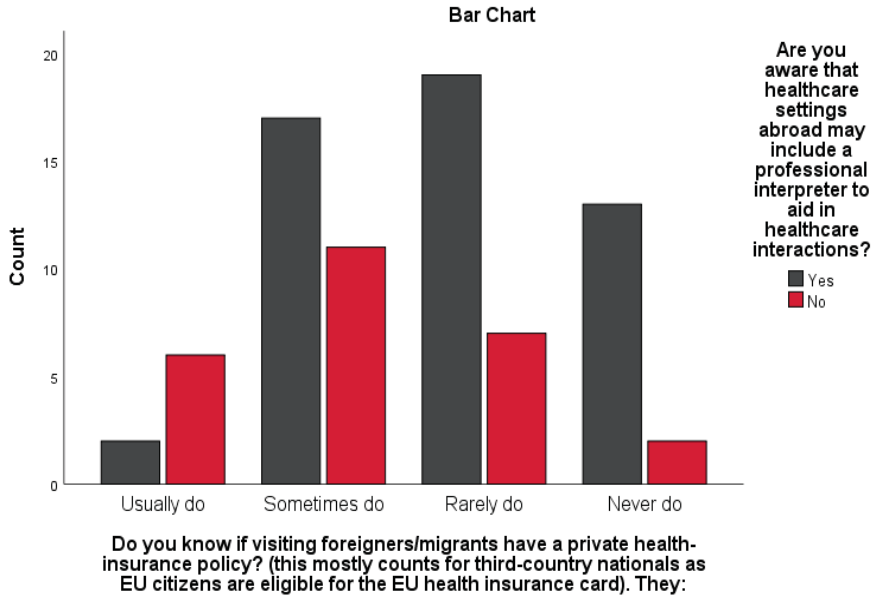
X^2 (1) = 2.161, P = 0.142



Question 4 & 8

			Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?		
			Yes	No	Total
Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:	Usually do	Count	2	6	8
		%	3.9%	23.1%	10.4%
	Sometimes do	Count	17	11	28
		%	33.3%	42.3%	36.4%
	Rarely do	Count	19	7	26
		%	37.3%	26.9%	33.8%
	Never do	Count	13	2	15
		%	25.5%	7.7%	19.5%
Total		Count	51	26	77
		%	100.0%	100.0%	100.0%

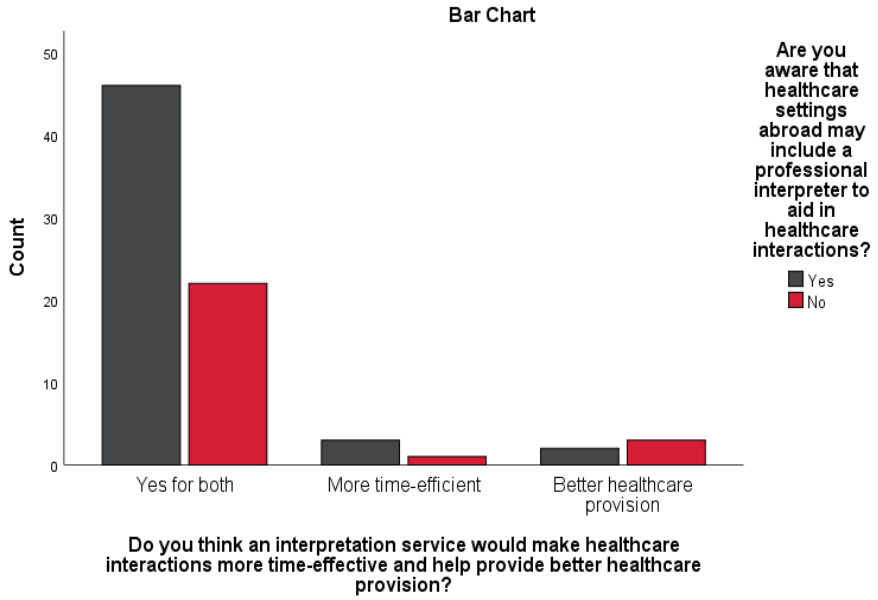
X^2 (3) = 9.808, P = 0.020



Question 4 & 9

			Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?		
			Yes	No	Total
Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?	Yes for both	Count	46	22	68
		%	90.2%	84.6%	88.3%
	More time-efficient	Count	3	1	4
		%	5.9%	3.8%	5.2%
	Better healthcare provision	Count	2	3	5
		%	3.9%	11.5%	6.5%
Total		Count	51	26	77
		%	100.0%	100.0%	100.0 %

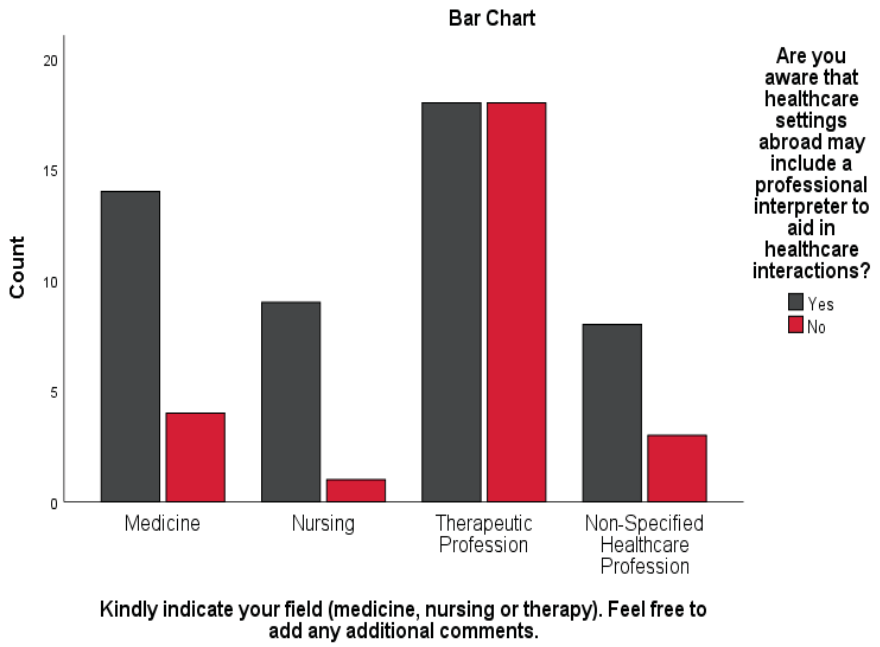
X^2 (3) = 1.737, P = 0.420



Question 4 & 10

			Are you aware that healthcare settings abroad may include a professional interpreter to aid in healthcare interactions?		
			Yes	No	Total
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	14	4	18
		%	28.6%	15.4%	24.0%
	Nursing	Count	9	1	10
		%	18.4%	3.8%	13.3%
	Therapeutic Profession	Count	18	18	36
		%	36.7%	69.2%	48.0%
	Non-Specified Healthcare Profession	Count	8	3	11
		%	16.3%	11.5%	14.7%
Total		Count	49	26	75
		%	100.0%	100.0%	100.0%

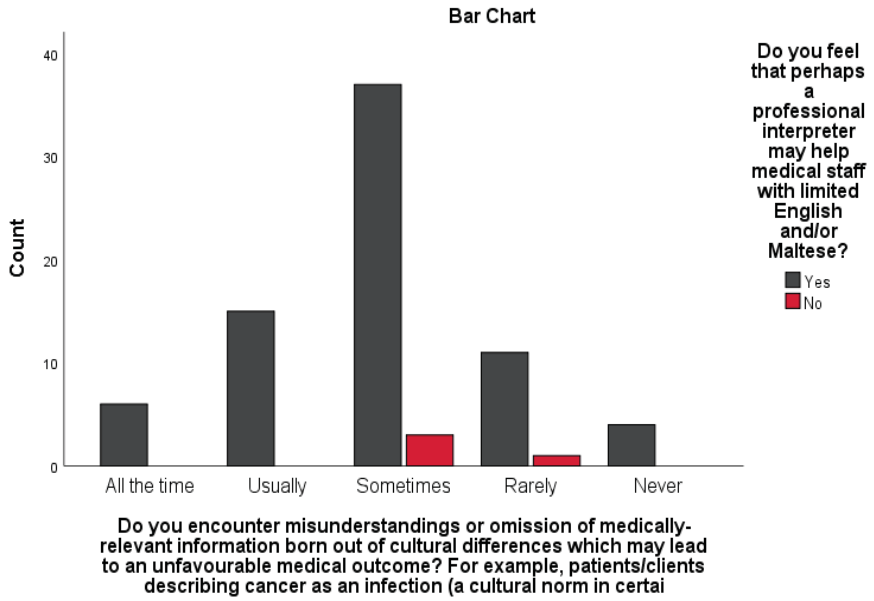
X^2 (3) = 7.920, P = 0.048



Question 5 & 6

			Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?		
			Yes	No	Total
Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection.	All the time	Count	6	0	6
		%	8.2%	0.0%	7.8%
	Usually	Count	15	0	15
		%	20.5%	0.0%	19.5%
	Sometimes	Count	37	3	40
		%	50.7%	75.0%	51.9%
	Rarely	Count	11	1	12
		%	15.1%	25.0%	15.6%
	Never	Count	4	0	4
		%	5.5%	0.0%	5.2%
Total		Count	73	4	77
		%	100.0%	100.0%	100.0%

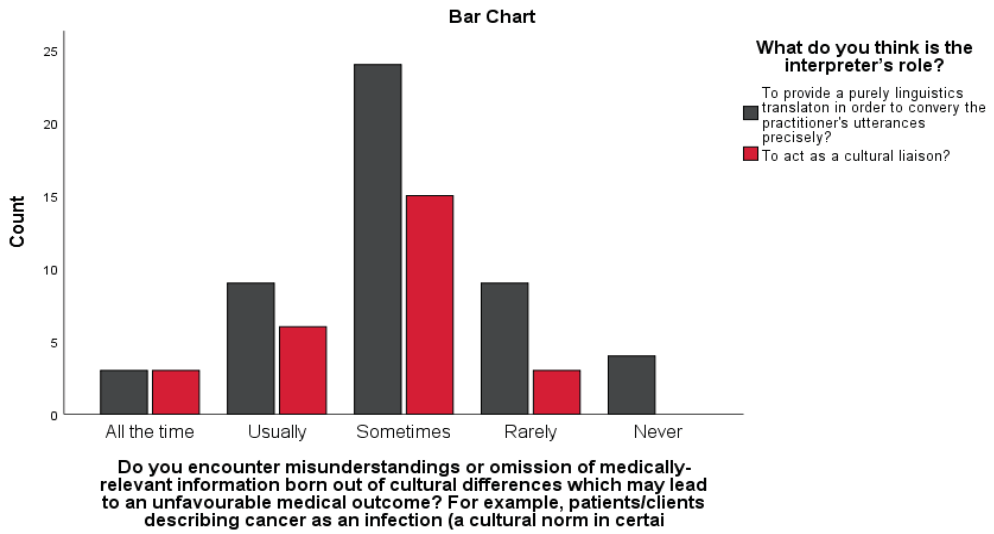
X^2 (4) = 2.041, P = 0.728



Question 5 & 7

			What do you think is the interpreter's role?		
			To provide a purely linguistics translation	To act as a cultural liaison?	Total
Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection.	All the time	Count	3	3	6
		%	6.1%	11.1%	7.9%
	Usually	Count	9	6	15
		%	18.4%	22.2%	19.7%
	Sometimes	Count	24	15	39
		%	49.0%	55.6%	51.3%
	Rarely	Count	9	3	12
		%	18.4%	11.1%	15.8%
	Never	Count	4	0	4
		%	8.2%	0.0%	5.3%
Total		Count	49	27	76
		%	100.0%	100.0%	100.0%

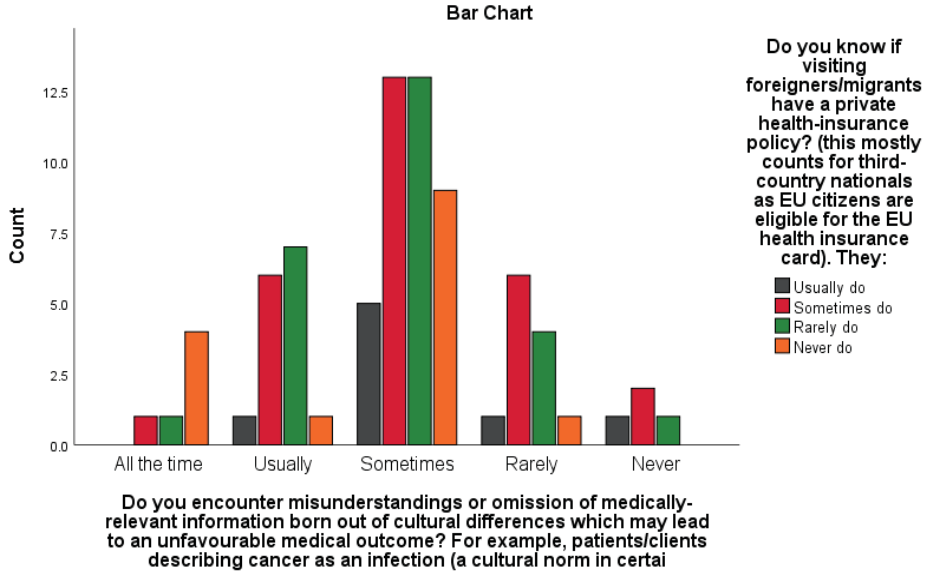
X^2 (4) = 3.611, P = 0.461



Question 5 & 8

			Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:			
			Usually do	Sometimes do	Rarely do	Never do
Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection.	All the time	Count	0	1	1	4
		%	0.0%	3.6%	3.8%	26.7%
	Usually	Count	1	6	7	1
		%	12.5%	21.4%	26.9%	6.7%
	Sometimes	Count	5	13	13	9
		%	62.5%	46.4%	50.0%	60.0%
	Rarely	Count	1	6	4	1
		%	12.5%	21.4%	15.4%	6.7%
	Never	Count	1	2	1	0
		%	12.5%	7.1%	3.8%	0.0%
Total		Count	8	28	26	15
		%	100.0%	100.0%	100.0%	100.0%

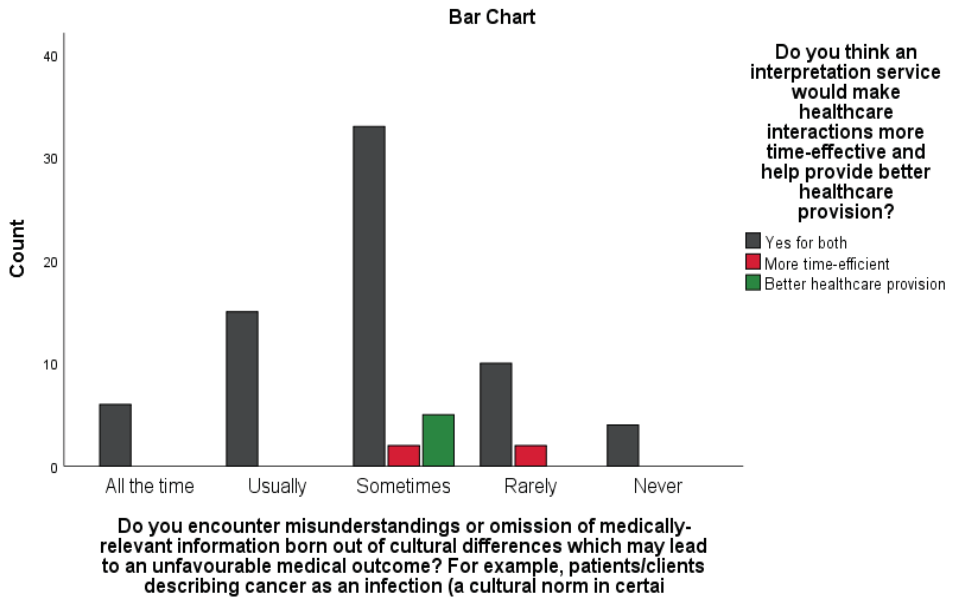
X^2 (12) = 14.766, P = 0.254



Question 5 & 9

			Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?			
			Yes for both	More time-efficient	Better healthcare provision	Total
Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection.	All the time	Count	6	0	0	6
		%	8.8%	0.0%	0.0%	7.8%
	Usually	Count	15	0	0	15
		%	22.1%	0.0%	0.0%	19.5%
	Sometimes	Count	33	2	5	40
		%	48.5%	50.0%	100.0%	51.9%
	Rarely	Count	10	2	0	12
		%	14.7%	50.0%	0.0%	15.6%
	Never	Count	4	0	0	4
		%	5.9%	0.0%	0.0%	5.2%
Total		Count	68	4	5	77
		%	100.0%	100.0%	100.0%	100.0%

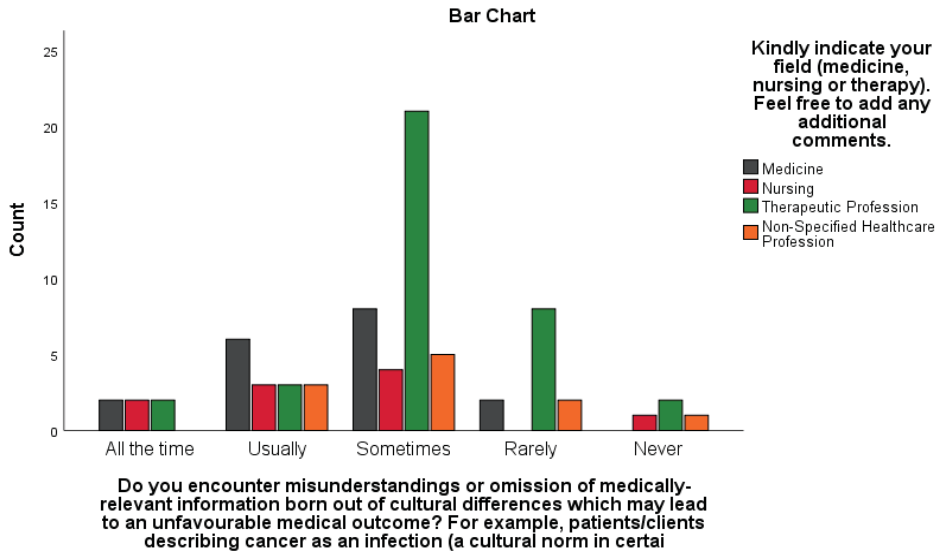
X^2 (8) = 9.540, P = 0.299



Question 5 & 10

			Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.			
			Medicine	Nursing	Therapeutic Profession	Non-Specified Healthcare Profession
Do you encounter misunderstandings or omission of medically-relevant information born out of cultural differences which may lead to an unfavourable medical outcome? For example, patients/clients describing cancer as an infection.	All the time	Count	2	2	2	0
		%	11.1%	20.0%	5.6%	0.0%
	Usually	Count	6	3	3	3
		%	33.3%	30.0%	8.3%	27.3%
	Sometimes	Count	8	4	21	5
		%	44.4%	40.0%	58.3%	45.5%
	Rarely	Count	2	0	8	2
		%	11.1%	0.0%	22.2%	18.2%
	Never	Count	0	1	2	1
		%	0.0%	10.0%	5.6%	9.1%
Total		Count	18	10	36	11
		%	100.0%	100.0%	100.0%	100.0%

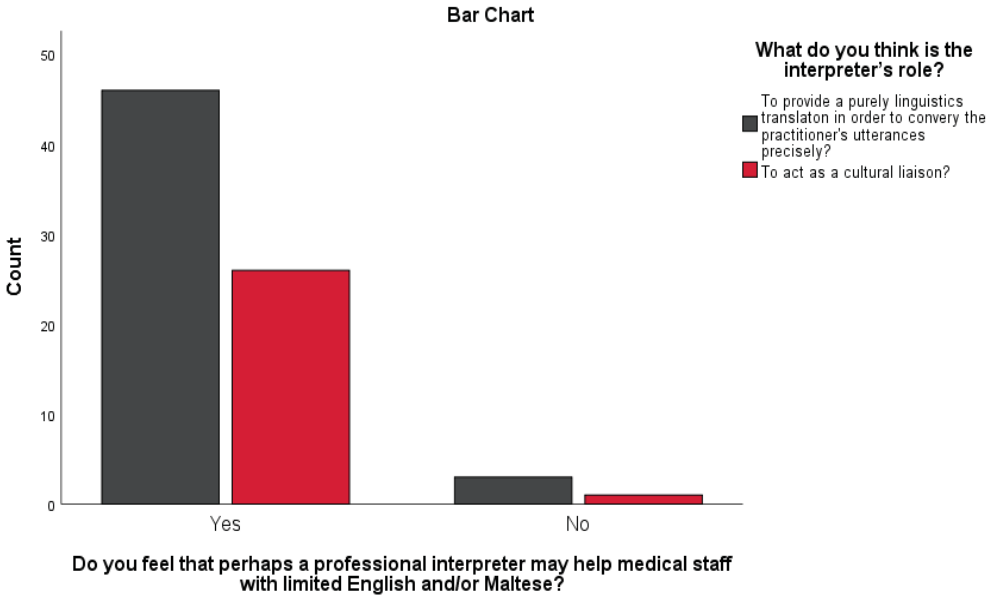
X^2 (12) = 13.282, P = 0.349



Question 6 & 7

			What do you think is the interpreter's role?		
			To provide a purely linguistics translation…	To act as a cultural liaison?	Total
Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?	Yes	Count	46	26	72
		%	93.9%	96.3%	94.7%
	No	Count	3	1	4
		%	6.1%	3.7%	5.3%
Total		Count	49	27	76
		%	100.0%	100.0%	100.0%

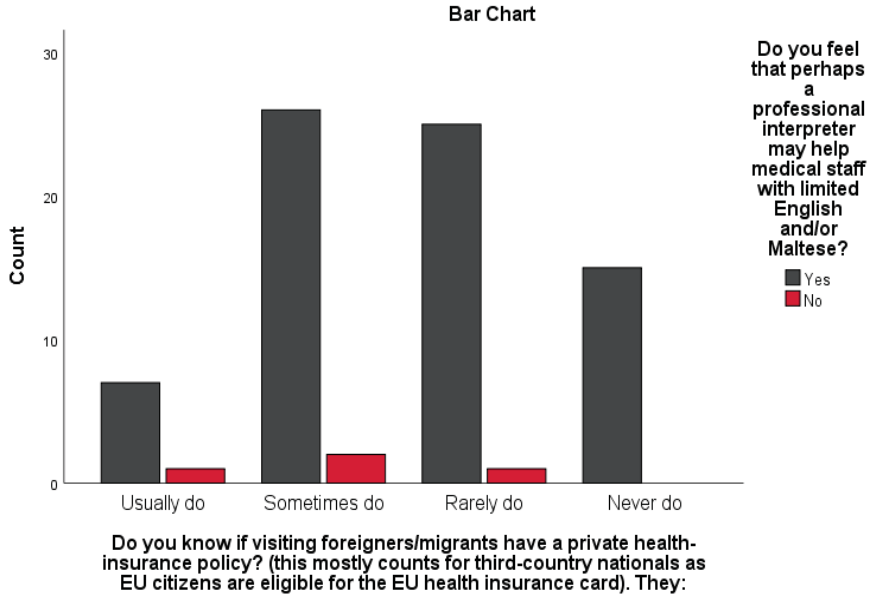
X^2 (1) = 0.204, P = 0.651



Question 6 & 8

			Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?		
			Yes	No	Total
Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:	Usually do	Count	7	1	8
		%	9.6%	25.0%	10.4%
	Sometimes do	Count	26	2	28
		%	35.6%	50.0%	36.4%
	Rarely do	Count	25	1	26
		%	34.2%	25.0%	33.8%
	Never do	Count	15	0	15
		%	20.5%	0.0%	19.5%
Total		Count	73	4	77
		%	100.0%	100.0%	100.0%

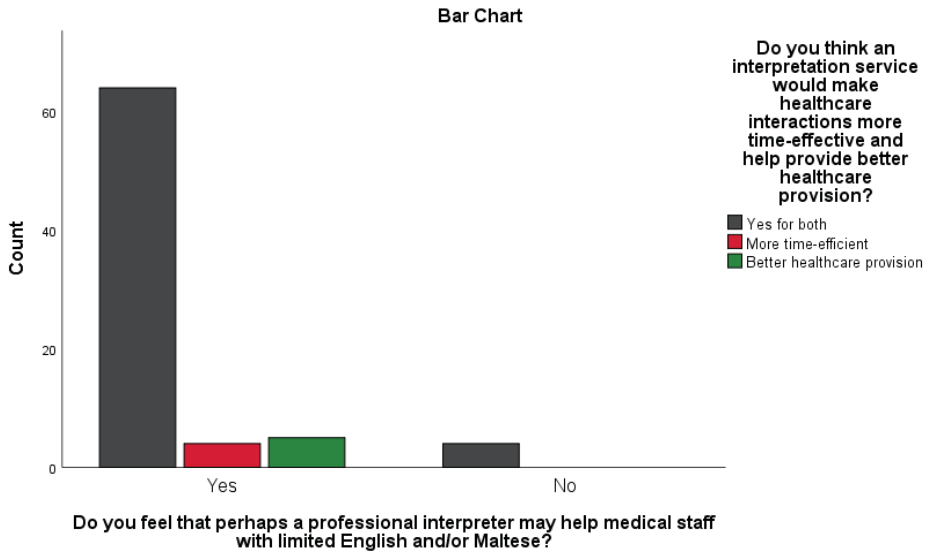
X^2 (3) = 2.001, P = 0.572



Question 6 & 9

			Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?			
			Yes for both	More time-efficient	Better healthcare provision	Total
Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?	Yes	Count	64	4	5	73
		%	94.1%	100.0%	100.0%	94.8%
	No	Count	4	0	0	4
		%	5.9%	0.0%	0.0%	5.2%
Total		Count	68	4	5	77
		%	100.0%	100.0%	100.0%	100.0%

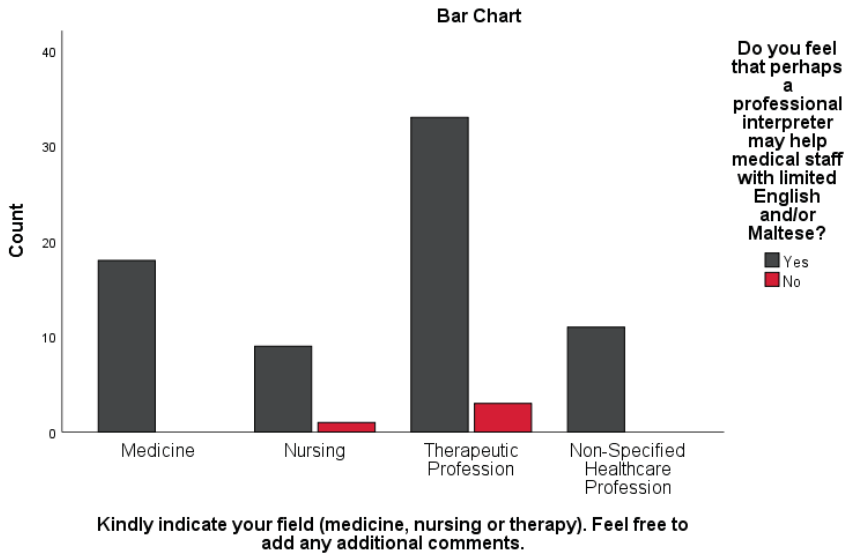
X^2 (2) = 0.558, P = 0.756



Question 6 & 10

			Do you feel that perhaps a professional interpreter may help medical staff with limited English and/or Maltese?		
			Yes	No	Total
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	18	0	18
		%	25.4%	0.0%	24.0%
	Nursing	Count	9	1	10
		%	12.7%	25.0%	13.3%
	Therapeutic Profession	Count	33	3	36
		%	46.5%	75.0%	48.0%
	Non-Specified Healthcare Profession	Count	11	0	11
		%	15.5%	0.0%	14.7%
Total		Count	71	4	75
		%	100.0%	100.0%	100.0%

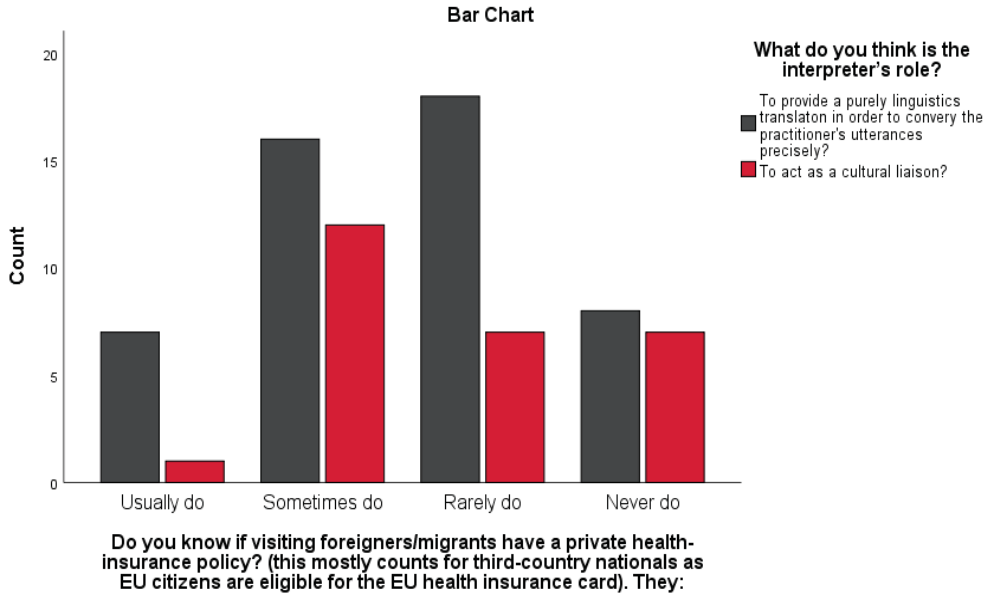
X^2 (3) = 2.707, P = 0.439



Question 7 & 8

			What do you think is the interpreter's role?		
			To provide a purely linguistics translation…	To act as a cultural liaison?	Total
Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:	Usually do	Count	7	1	8
		%	14.3%	3.7%	10.5%
	Sometimes do	Count	16	12	28
		%	32.7%	44.4%	36.8%
	Rarely do	Count	18	7	25
		%	36.7%	25.9%	32.9%
	Never do	Count	8	7	15
		%	16.3%	25.9%	19.7%
Total		Count	49	27	76
		%	100.0%	100.0%	100.0%

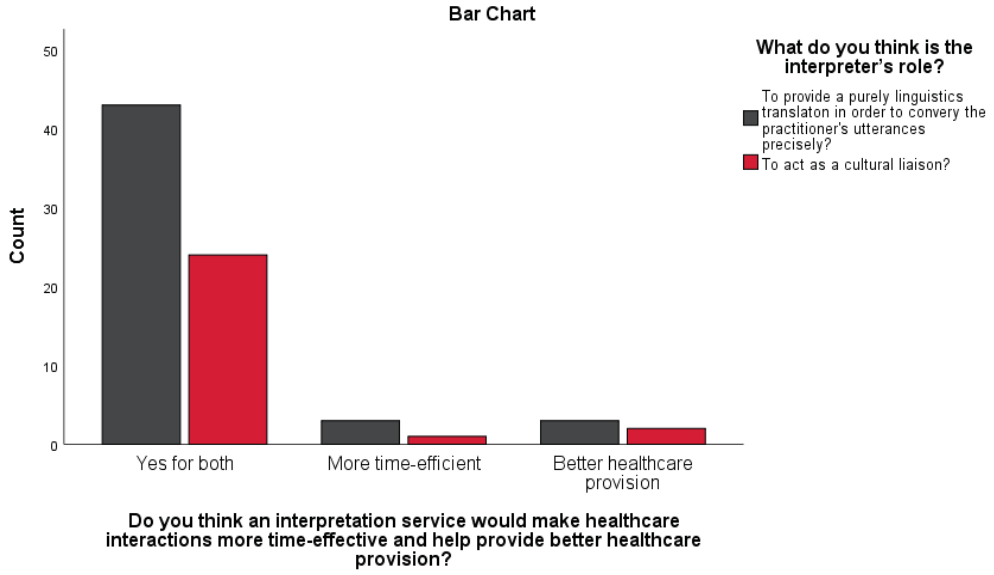
X^2 (3) = 3.940, P = 0.268



Question 7 & 9

			What do you think is the interpreter's role?		
			To provide a purely linguistics translation…	To act as a cultural liaison?	Total
Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?	Yes for both	Count	43	24	67
		%	87.8%	88.9%	88.2%
	More time-efficient	Count	3	1	4
		%	6.1%	3.7%	5.3%
	Better healthcare provision	Count	3	2	5
		%	6.1%	7.4%	6.6%
Total		Count	49	27	76
		%	100.0%	100.0%	100.0%

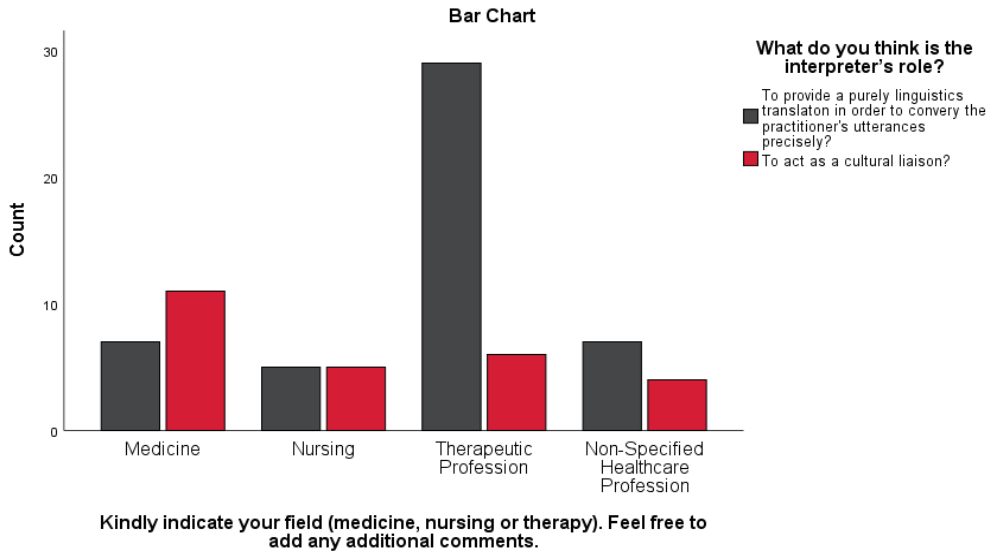
X^2 (2) = 0.240, P = 0.887



Question 7 & 10

			What do you think is the interpreter's role?		
			To provide a purely linguistics translation…	To act as a cultural liaison?	Total
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	7	11	18
		%	14.6%	42.3%	24.3%
	Nursing	Count	5	5	10
		%	10.4%	19.2%	13.5%
	Therapeutic Profession	Count	29	6	35
		%	60.4%	23.1%	47.3%
	Non-Specified Healthcare Profession	Count	7	4	11
		%	14.6%	15.4%	14.9%
Total		Count	48	26	74
		%	100.0%	100.0%	100.0%

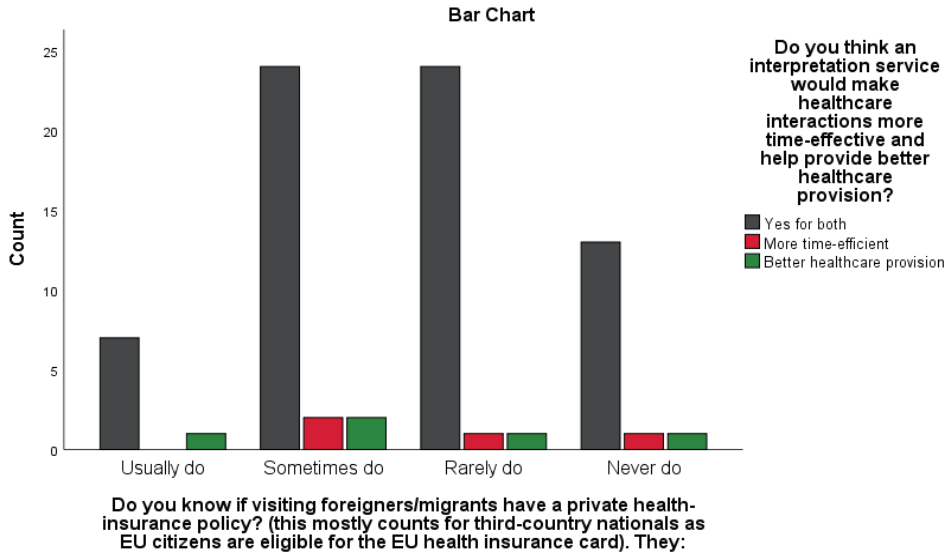
X^2 (3) = 11.278, P = 0.010



Question 8 & 9

			Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?		
			Yes for both	More time-efficient	Better healthcare provision
Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:	Usually do	Count	7	0	1
		%	10.3%	0.0%	20.0%
	Sometimes do	Count	24	2	2
		%	35.3%	50.0%	40.0%
	Rarely do	Count	24	1	1
		%	35.3%	25.0%	20.0%
	Never do	Count	13	1	1
		%	19.1%	25.0%	20.0%
Total		Count	68	4	5
		%	100.0%	100.0%	100.0%

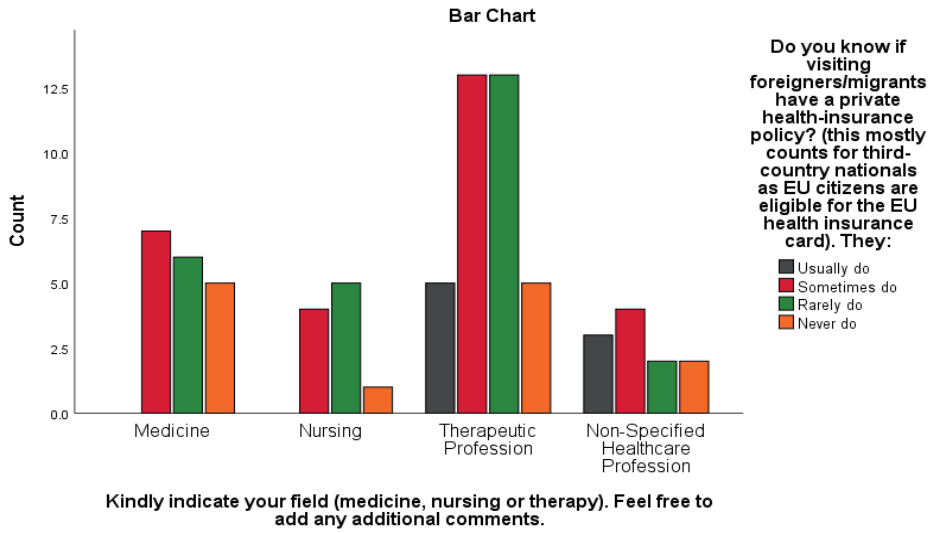
X^2 (6) = 1.591, P = 0.953



Question 8 & 10

			Do you know if visiting foreigners/migrants have a private health-insurance policy? (this mostly counts for third-country nationals as EU citizens are eligible for the EU health insurance card). They:			
			Usually do	Sometimes do	Rarely do	Never do
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	0	7	6	5
		%	0.0%	25.0%	23.1%	38.5%
	Nursing	Count	0	4	5	1
		%	0.0%	14.3%	19.2%	7.7%
	Therapeutic Profession	Count	5	13	13	5
		%	62.5%	46.4%	50.0%	38.5%
	Non-Specified Healthcare Profession	Count	3	4	2	2
		%	37.5%	14.3%	7.7%	15.4%
Total		Count	8	28	26	13
		%	100.0%	100.0%	100.0%	100.0%

X^2 (9) = 9.494, P = 0.393



Question 9 & 10

			Do you think an interpretation service would make healthcare interactions more time-effective and help provide better healthcare provision?		
			Yes for both	More time-efficient	Better healthcare provision
Kindly indicate your field (medicine, nursing or therapy). Feel free to add any additional comments.	Medicine	Count	14	1	3
		%	21.2%	25.0%	60.0%
	Nursing	Count	10	0	0
		%	15.2%	0.0%	0.0%
	Therapeutic Profession	Count	31	3	2
		%	47.0%	75.0%	40.0%
	Non-Specified Healthcare Profession	Count	11	0	0
		%	16.7%	0.0%	0.0%
Total		Count	66	4	5
		%	100.0%	100.0%	100.0%

X^2 (6) = 6.468, P = 0.373