Practice-Based Training for Intercultural Mediators in Healthcare Services

Antonio Chiarenza

Azienda Unità Sanitaria Locale – IRCCS di Reggio Emilia

ABSTRACT

The aim of this chapter is to present the role and structure of practice-based training as part of the overall programme for intercultural mediators of the Reggio Emilia Local Health Authority (AUSL RE). The pedagogical approach for this type of training is based on experiential learning geared towards promoting reflection and group discussion in order to generate knowledge and improve performance. Specifically, the trainee is guided to perform those tasks and roles which make up the professional practice of the intercultural mediator by firstly observing and then practicing mediated interactions in healthcare consultation. The aim is to provide practice learning opportunities for trainees through internship and placement activities by engaging them in concrete experiences and stimulating reflection on the problems encountered and the solutions adopted. This chapter presents the organisational structure of practice-based training, the actors involved, the roles and tasks, the methods and tools to facilitate learning and to assess the outcomes.

Keywords: healthcare consultation, intercultural mediation, interpreting, migrant patients, practice-based training, experiential learning, professional development, training assessment.

1 INTRODUCTION

Numerous studies and experience in healthcare provision show that language discordance and cultural differences have adverse effects on accessibility, quality of care, patient satisfaction and health outcomes for refugees and migrants (Norredam 2011; Chiarenza et al. 2017; Bischoff 2003). This is particularly true for communication in clinical encounters (Divi et al. 2007). Due to linguistic and cultural barriers these patients may not receive complete information about their care and at the same time the provider is not able to understand the patients' needs, which leads to communication problems and misunderstanding (Carrasquillo et al. 1999; Karliner et al. 2010). Strategies to ensure language support and mutual understanding between migrant patients and providers have proven effective in decreasing medical errors, reducing utilisation inequalities, improving clinical outcomes and satisfaction for foreign-language speaking patients (Karliner et al. 2007; Jacobs, Sadowski, and Rathouz 2007; Cohen et al. 2005), suggesting that accurate consideration of the communication problem is in fact beneficial to the provision of the service.

Access to well-trained intercultural mediators – as well as healthcare interpreters – is thus crucial to improve communication between migrant patients and healthcare providers. In this chapter, we focus on practice-based training as a learning strategy for the initial preparation of intercultural mediators as well as their professional development. This type of training is problem-based and grounded on reflective observation and discussion to generate knowledge, improve performance and ultimately better define and further develop the specific skills of this profession still in the process of formal recognition. In doing this, reference will be made to the role and structure of practice-based training, drawing on experience from internships and placement schemes, comprised in the overall programme for intercultural mediators of the Reggio Emilia Local Health Authority (AUSL RE).

2 POSITIONING: INTERCULTURAL MEDIATION IN ITALY

This chapter focuses in particular on the training of intercultural mediators, the type of personnel mostly used in Italy to facilitate language understanding and acceptance of cultural differences between migrant patients and healthcare providers (Zorzi 2008; Baraldi 2016; Falbo 2013). Although in Italy the role of this occupation is considered indispensable by both patients and healthcare professionals, its integration into the national healthcare system is still far from being achieved. To date, there is no officially recognised profile of the intercultural mediator; furthermore, mediation activities themselves and how they are carried out from recruitment to training are far from clear and are often taken from

circulars, interpretations and guidelines arranged by different ministries (Ministry of Justice, Education, and Health).[1] The attempt to define a national profile[2] and certification system[3] carried out by the "Institutional working group on intercultural mediation" did not produce the expected results. In the absence of a national framework and common definition of the knowledge and skills needed for this emerging profession, individual regional governments and even local authorities have autonomously defined the areas of intervention, certification and training programmes for intercultural mediators.

Within this broader picture, the AUSL RE in 2005 formally established a coordinated Linguistic and Cultural Mediation (LCM) service based on the experience and results achieved by participating in the European project Migrant-Friendly Hospitals (Chiarenza 2005; Bischoff, Chiarenza, and Loutan 2009), which inspired the organizational structure of the service and the inclusion of this new profession in the routine of health services. In accordance with the 2004 Regional Decree[4], the AUSL RE formally adopted the denomination *mediatore interculturale* for those employed to perform linguistic and cultural mediation in its healthcare services. In this phase, it was decided to hire intercultural mediators provided by external social cooperatives in order to share resources with other services in the community and provide migrants with opportunities for career development as intercultural mediators (Chiarenza and Chiesa 2018).

Since its inception, given the wide geographical dimension of the province, the coordination of the LCM service at a central level has been linked to each health district. The central coordination system encompasses the booking system, the

1 In the *Testo Unico sull'immigrazione* (Consolidation Act on immigration - Legislative Decree 286/1998 and subsequent amendments), both figures that of *mediatore culturale* and of *mediatore interculturale* are cited without specifying the profiles and differences between the two.

2 http://www.integrazionemigranti.gov.it/archiviodocumenti/mediazione-interculturale/Documents/00937_linee_indirizzo_mediatore_interculturale.pdf

3 http://www.integrazionemigranti.gov.it/Documenti-e-ricerche/DOSSIER%20DI%20SINTESI%20QUALIFICA%20MEDIATORI_28_07.pdf

4 In the Italian region of Emilia-Romagna the intercultural mediator is described by Regional Decree 10.11.2004 as a person "*able to accompany relations between migrants and the context of reference, fostering the removal of linguistic and cultural barriers; the understanding and enhancement of one's own culture and the access to public and private services; and able to assist service organisations in the process of making the services offered to migrant users appropriate*". The regional decree places the *mediatore interculturale* in the professional area of "social, health and socio-health care". Four years later, the Regional Council Resolution 26.02.2009 described the four main competences of the intercultural mediator as follow: i) welcoming foreign users; ii) assisting the relationship between foreign users and services; iii) cultural/linguistic mediation; iv) development of social integration interventions. Specific training pathways were recommended in order to gain the qualification of intercultural mediator ranging from 300 to 500 hours, including formal education and practical training.

list of intercultural mediators and the languages available, as well as service evaluation, and the registering of the number of hours per intercultural mediator, per district and per facility. A clear organizational policy was set out to define what interpretation and intercultural mediation actually involve in order to ensure effective communication between health providers and service users. This includes written procedures and guidelines; training courses for intercultural mediators and for healthcare staff about how to work with mediators; and a documentation system to control the budget and the quality of the service. Different types of services have since been available, including onsite, scheduled and urgent interventions, over-the-phone and video-remote interpreting, and written and sight translation (Chiarenza 2019).

3 CONCEPTS: COMPLEXITY, INTERPRETING AND MEDIATION

Ample evidence supports the necessity of using intercultural mediators and/or healthcare interpreters to ensure that clinical information is communicated effectively across language and cultural gaps through the entire care process, from admission to treatment and discharge (Novak-Zezula et al. 2005; Bischoff and Hudelson 2010; Sturman et al. 2018; Verrept 2012). Although the boundaries of the roles of these two professions are still unclear and confusing (Pöchhacker 2008; Wang 2017) – mediating and interpreting are seen as separate roles (Martin and Phelan 2010; Pokorn and Mikolič Južnič 2020), part of a continuum (Aguirre Fernandez Bravo 2019) or overlapping at different degrees (Hsieh 2009, 2016) there is general agreement that their intervention takes place in a complex relational context in which communication difficulties are linked not only to language but also to socio-cultural, health literacy and even institutional issues (Greenhalgh, Robb, and Scambler 2006). Furthermore, work on recorded and transcribed data shows that many problems in interpreting/mediating conversations are connected to features of interactions, like the ability to coordinate participation from the interlocutors, rather than the role of the “language expert” (Baraldi and Gavioli 2017, 2018).

Different expectations relating to the world of medicine of the provider and the world of the patient's life make healthcare consultations complex even without the need for an interpreter or a mediator (Heritage and Maynard 2006). The presence of a third party (the mediator) turns the already complex dyadic interaction between the healthcare provider and the patient into an even more complex situation in which multiple influences come into play often creating tensions and challenges between biomedical-world and life-world; impartiality and advocacy; trust and mistrust; equality and inequality (Greenhalgh, Robb, and Scambler 2006; Hsieh, Ju, and Kong 2010; Robb and Greenhalgh 2006; Chiarenza, Dome-

nig, and Cattacin 2020; Hilfinger Messias, McDowell, and Estrada 2009). Therefore, the need for mediation, in terms of interactional coordination (Wadensjö 1998; Baraldi and Gavioli 2012); decision-making discretion (Skaaden 2013; Wallander and Molander 2014), meaning negotiation (Leanza 2005); culture brokerage (Gustafsson, Norström, and Fioretos 2013); service integration and equality promotion (Bischoff, Kurth, and Henley 2012; Hilfinger Messias, McDowell, and Estrada 2009; Cattacin, Chiarenza, and Domenig 2013) seems to be inseparable from that of interpreting in healthcare consultations.

4 PEDAGOGICAL APPROACH: PRACTICE-BASED LEARNING

Coping with the complexity (Fraser and Greenhalgh 2001) of mediated consultations in which relationships are not predictable or linear and decisions are often negotiated through interactions, requires that "interpreter-mediators" are trained not only on what they should do in principle (e.g. translate accurately) but also on what such principle actually involves in the complexity of real-life situations. That is to say, interpreters/mediators need to observe what leads to an accurate translation in specific situations, and develop their strategies accordingly. Learning through practice (Billet 2010) is ideal for the initial preparation and further professional development of the intercultural mediator, as it focuses on the critical role real-world experiences play in the learning process (Kolb and Kolb 2005). This is a process that provides feedback on the mediation performance to the trainee about the impact of her/his decisions and actions and those of the patient and the provider in the real-life triadic interaction of the healthcare consultation. The information that is fed back to the mediator-trainee allows for meaningful reflections and serves to consolidate or construct professional knowledge and improve performance. By interacting and observing experienced practitioners through processes such as receiving feedback, discussing, responding to questions and being mentored and supervised, the trainee is engaged in her/his personal learning trajectory. It is a learning process that allows the trainee to focus on those professional skills necessary to facilitate linguistic understanding, acceptance of socio-cultural concerns, equal access to interactions and the resolution of misunderstandings that may affect clinical communication between health professionals and migrant patients in the complex care settings. In this learning process it is fundamental that trainees have access to close guidance by a supervisor and expert intercultural mediators as well as to those healthcare settings that may provide activities relevant for the purpose and scope of the training, together with adequate opportunities to observe different participation perspectives on mediated interactions. Finally, the important role that practice-based learning plays in building the professional knowledge of intercultural mediators should be noted. As intercultural mediators lack profession-

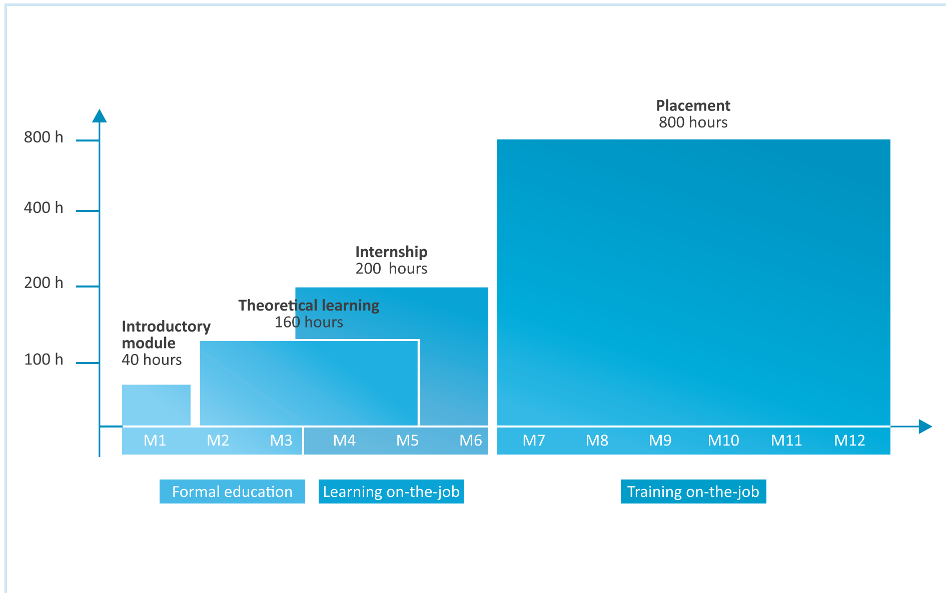
al recognition, hence an institutionalized educational process that would define their professional knowledge, this practice-based learning model goes beyond the traditional goal of consolidating “codified” professional knowledge through its application in practice settings to actually contributing to the construction of this very professional knowledge.

5 THE STRUCTURE OF PRACTICE-BASED TRAINING

In order to ensure quality interpreting and intercultural mediation services, the AUSL RE has developed a broad training programme comprising a theoretical part of formal education[5] as well as a practical part of learning and training on the job. The duration of the practice-based training is usually two thirds of the overall training programme. Although with different intensity, the entire training programme is offered as an initial professional training for new intercultural mediators (entry-to-practice level), as well as a continuing professional training for those who are already working as intercultural mediators. As an example of such training, the structure of the initial professional training offered to new intercultural mediators a few years ago in the AUSL RE is provided in Figure 1. The whole programme lasted 12 months with a 1200-hour training scheme that included 200 hours of formal education (introductory module and theoretical training); 200 hours of learning on the job (internship); and 800 hours of work-based training (placement). After two months of formal education, internship sessions were introduced, so that theory and practice alternated within one month. At the end of the internship, a period of supervised placement of 6 months started aiming at formally introducing intercultural mediators into the routine of the service.

5 The theoretical part of the intercultural mediation programme is divided in two main parts: the first is an introductory module focusing on the local and national context of migration; the second addresses the role and tasks of the intercultural mediator including: professional ethics, communication theory, understanding diversity, linguistic and cultural mediation, interpreting and translation, social and system mediation, and specific healthcare services and target groups. The methodology for delivery is based on classroom lectures and discussions, work group sessions, case scenarios, role play and analysis of transcripts of audio-recorded materials. Trainers are experts on migration, health professionals, sociologists, psychologists, lawyers, researchers from our affiliated university (University of Modena and Reggio Emilia), and intercultural mediators themselves. The methods for evaluation are pre- and post-training survey; questionnaires, or written feedback from trainees.

Fig. 1: Structure of the initial professional training for new intercultural mediators



5.1 INTERNSHIP AND PLACEMENT

After the first step, based on analysing real-life interactions through audio-recorded encounters in healthcare services (see the chapter on authentic mediated interactions for training healthcare mediators in this volume), the trainees enter the more practical part of the training involving internship sessions and work placement. During internship sessions the trainees accompany an expert intercultural mediator in her/his job and observe the mediation strategies used in healthcare consultations, while during work placement the trainees practice the role of intercultural mediator under supervised guidance. Internship and placement are different models of practice-based training: internship is a form of work-based learning that we consider to be still part of the formal education of the intercultural mediator, a form of learning from practice, but still learning. The duration is comparatively short and is addressed to new intercultural mediators enrolled in their initial training. Conversely, placement is a form of work-based training aiming at consolidating professional skills and knowledge through action and direct experience. While placement clearly provides ample opportunities for learning, it requires more mature professionalism. Placement also usually lasts longer and is offered to actual intercultural mediators as part of their continuing training, as well as to new intercultural mediators that have completed internship as part of their initial training.

5.2 SELECTION OF THE HOSTING ORGANISATION

A successful implementation of the practice-based training relies on a careful selection of the hosting organisation, in our case those healthcare services that mostly use intercultural mediators. To this end it is important to identify health services providing activities that are relevant for the purpose and scope of the training, as well as adequate opportunities to observe or experience different participation perspectives of mediated interactions. Moreover, the organisational culture and structure of the hosting organisation should favour the learning activities of internship and placement: for example, they should have healthcare staff capable of working with intercultural mediators, and provide healthcare services that have already integrated intercultural mediation in the routine of their organisation.

5.3 ROLES AND TASKS IN PRACTICE-BASED TRAINING

Various actors are engaged in the training process (e.g., those responsible for training, for the host organisation, the supervisor (trainer), the tutor (expert mediator) and the trainee) and specific tasks are carried out by all the actors involved. The training provider in charge of the training programme makes arrangements, introduces trainees to the host institution and illustrates the scope of the training. The hosting organisation assigns a person responsible for all issues relating to internship or placement. A supervisor, chosen by the training provider, provides for supervision, tools and methods to be used, and participates in the evaluation process. Supervision is particularly important in practice-based learning, as it provides constant assistance to the trainees in practicing the professional skills and adjusting their competences as intercultural mediators. Similarly, the tutor, who is often an expert mediator, provides for coaching and discusses with the trainee in individual sessions the aspects of interpreting and intercultural mediation either observed or experienced by the trainee. Finally, the trainee is expected to comply with the training and evaluation rules and to respect the tasks assigned.

6 LEARNING THROUGH PRACTICE

Through practice-based learning the trainee is expected to consolidate and further develop professional skills and competences, gradually moving from knowledge to ability. Specifically, the trainee is trained to perform those tasks and roles which make up the professional practice of the intercultural mediator. The prime objectives of the practice-based training are to learn how: (i) to facilitate linguistic understanding and acceptance of cultural differences in communication; (ii) to manage the flow of communication in a way as to favour equal access to everything that is said and done for all participants; (iii) to recognise misunderstandings (linguistic and cultural) and to repair them appropriately.

6.1 LEARNING METHODS AND TOOLS

Specific tools and methods to facilitate learning are provided, such as an *observation grid* [6], which is used to collect the impressions the trainee has of the encounter observed during their internship or experienced during work placement; a *diary* which allows the trainee to take notes of individual sessions; a *portfolio*, in which the outcomes of the observations and discussions of cases are collected. Finally, a *Supervision report* is produced to present the overall results of practice-based training, jointly produced by the trainee and the supervisor.

6.2 THE LEARNING PROCESS

The supervisor makes arrangements for the practice-based training session, ensuring that the interaction will be done in the language of the trainee and in a proper setting for the learning objectives. The person identified by the host organisation ensures that both the patient and the provider are informed and agree that a mediator-trainee will participate in the mediated consultation either by following the expert practitioner in charge of the mediation or directly acting as the mediator under appropriate supervision. Before the training session, the trainee briefs with the expert intercultural mediator and the supervisor in order to gather more information on the healthcare setting, the healthcare provider and the patient. The supervisor provides and explains the "observation grid" which will be used by the trainee to identify the key points observed during the internship session or directly experienced during the placement. The capacity to observe and identify key points is achieved by focussing on how the patient, the healthcare provider and the mediator participate in the interactions and finally on the mediator's interpreting activity.

The first section of the observation grid focuses on the patient and aims at defining whether mediation is able to promote the patient's active contribution to the interaction, thus fostering participation, equity and empowerment.

6 The "observation grid" has been produced in collaboration with Claudio Baraldi and Laura Gavioli.

How does the patient participate in the interaction?

	Frequently	Sometimes	Never
The patient gives information			
The patient asks questions			
The patient shows reception/understanding of the mediator's talk			
The patient shows reception/understanding of the provider's talk			
The patient seems relaxed (laughs, smiles)			
The patient speaks Italian occasionally			

The second section focuses on the healthcare provider and aims at observing the healthcare provider's attitude, participation and active contribution to the mediated interaction.

How does the provider participate in the interaction?

	Frequently	Sometimes	Never
The provider is kind and attentive			
The provider is distracted by things around			
The provider is prone to give (long) explanation			
The provider asks questions			
The provider talks directly with the patient			
The provider seems relaxed (laughs, smiles)			
The provider seems annoyed			
The provider does not seem to listen to what is said by the mediator or the patient			

The third section focuses on the mediator and aims at observing the intercultural mediator's decisions, engagement and understanding in the patient-provider interaction.

How does the intercultural mediator participate in the interaction?

	Frequently	Sometimes	Never
The mediator speaks more or less the same amount of time with the provider and with the patient			
The mediator speaks more with the provider			
The mediator speaks more with the patient			
The mediator seems kind and attentive			
The mediator seems relaxed (laughs, smiles, …)			
The mediator does not seem to understand what is said by the provider			
The mediator does not seem to understand what is said by the patient			

The last section of the observation grid focuses on interpreting and looks at the intercultural mediators' interpreting activity, whether they expand, reduce or modify the text of the interactions; and whether they are confident in interpreting.

How does the intercultural mediator perform interpreting?

	Frequently	Sometimes	Never
The mediator renders after the provider's talk			
The mediator renders after the patient's talk			
The mediator says more than the provider			
The mediator says more than the patient			
The mediator says less than the provider			
The mediator says less than the patient			
The mediator seems at ease			

Immediately after the practice-learning session the trainee briefs with the "expert mediator" on the encounter in order to further clarify what has been observed. Trainees look at their observation notes and use them to describe the impressions they had of the encounter observed, giving some details about what seemed to them "strong points" and "weak points". The trainees use a diary to note their observations (internship) or direct experiences (placement). These notes will be

used in the feedback discussion in both individual and group supervision sessions.

When possible, the trainees collect information on the experience the patient and the provider had in the mediated encounter through a brief interview.

1) The trainees ask the patients to rate the support of the mediator.

	Frequently	Sometimes	Never
The mediator introduced her/himself and explained her/his role			
With the mediator's help, all medical information was understood, e.g. what medication to take, when and why to take it.			
The mediator asked for clarification during the encounter to make sure everything that had been said had been understood			
The mediator made sure the message(s) the provider was trying to communicate to you was clear.			
The mediator assisted in identifying further needs (e.g.: related to institutional, economic and socio-cultural factors)			

2) The trainees ask the provider to rate the support of the mediator.

	Frequently	Sometimes	Never
The mediator introduced her/himself and explained her/his role			
The mediator appeared to have transmitted medical information accurately			
The mediator made sure the patient understood everything that had been said			
The mediator made sure everything was clear			
The mediator assisted in identifying further needs for the patients (e.g.: related to institutional, economic and socio-cultural factors)			

6.3 Reflective observations and group discussion

After 2 to 3 practical training sessions, the supervisor discusses with the trainee the difficulties that had arisen and alternatives to better handle similar cases. The outcomes of the discussions on individual cases are collected in the trainee's portfolio. Significant cases are presented and analysed in "problem-solving" group sessions, where each trainee is asked to illustrate to the group the key

points observed, firstly focussing on the role of the patient; secondly on that of the healthcare provider, and thirdly on the mediators and their active interpreting. The whole group critically discusses and reflects on the cases and observations of the trainee. Finally, under the guidance of the supervisor, solutions to the problems encountered are collectively worked out. These case-based discussions allow for a structured reflection on particular ambiguities (what worked and what did not work in the mediation) and make it possible to consolidate the key learning points (what have we learnt?). Practice-learning activities and learning outcomes are registered in the supervision report, which is then used for the evaluation of the entire training process.

7 ASSESSMENT METHODOLOGY FOR PRACTICE-BASED TRAINING

The assessment methodology for practice-based training aims at evaluating; on the one hand, the implementation process of the activities conducted during internship and placement and, on the other hand, the learning outcomes. The evaluation process begins and develops during the practical training itself and is characterized by the active participation of the trainees who, under the guidance of the supervisor, contribute to evaluate both the organizational process and their learning progress through individual and group discussions. As mentioned above, the main assessment points are collected in the final report, compiled jointly by the trainees and the supervisor. At the end of the whole practical training course, the supervisor may undertake the final assessment. The material presented below has been used at the conclusion of the internship and work placement programme in the AUSL RE; I believe that with necessary adaptations it could be used in other contexts as well.

7.1 PROCESS ASSESSMENT

The process assessment aims to account for the extent to which practice-based training was implemented according to the plan and to what extent it was applied by the participants. Data and information collected throughout the whole training process will be used by the supervisor to answer evaluation questions such as:

- What practice-learning model was offered to the trainee? (Internship; placement)
- Were internship and/or placement arrangements conducted as planned?
- Who was involved in the practice-learning activities? (healthcare staff, supervisor, expert mediator)

- Who and how many trainees were involved in internship and/or placement?
- How often were trainees exposed to practice-learning activities?
- How well did trainees respond to practice-learning activities?

Specific tools and methods are used to collect data and information for the process assessment:

- Practical training activity logs – documenting what, when, where and how many mediation sessions were conducted.
- Supervisor assessment form – to identify gaps in planned activities and those actually conducted and the trainee's attendance of training (attitude and behaviour).
- Trainee feedback form – to identify what trainees liked and disliked, what they learned, etc.

7.2 LEARNING OUTCOME ASSESSMENT

The purpose of the assessment of outcomes is to take into account the extent to which the desired learning outcomes, in terms of skills and competences, have been achieved by the trainees the ability to perform the main interpreting and mediation tasks).

The following five components comprise a reasonably comprehensive process for assessing the trainee's learning outcomes:

- *Bilingual skills.* General proficiency in speaking and understanding each of the languages in which the trainee would be expected to work.
- *Ethical issues.* Recognition of ethical issues and ethical-decision making, assessed by evaluating the trainee's response to situations calling for ethical choices.
- *Cultural issues.* Ability to anticipate and recognise misunderstandings that arise from the differing cultural assumptions and expectations of providers and patients and to respond to such issues appropriately.
- *Healthcare terminology.* Knowledge of commonly used terms and concepts related to the human body; symptoms, illnesses, medications, healthcare specialities and treatments in each language, including the ability to interpret or explicate technical expressions.

- *Interactional coordination and agency*[7]. Ability to manage the flow of communication, so that the patient and the provider have equal access to the communication process and to make the best possible decision in mediating challenging and non-standardised interactions.

The following exercises may be used to evaluate achievements in each of the five areas:[8]

7 For a more complete and in-depth explanation of these concepts see the chapter by Baraldi and Gavioli in this volume.

8 Some of the assessment exercises and examples are taken and adapted from the Migrant-friendly Hospital –"Improving interpreting in clinical communication - Resource kit", 2004; and the UNHCR "Interpreting in a Refugee Context - Self-study module 3", 2009.

1) Bilingual skills

Oral skills (speaking and understanding) in both of the languages the trainee-mediator used for interpreting during internship/placement – including her/his "working language(s)" – are required. This means testing the following:

- *Local language oral comprehension*. How well does the trainee understand the spoken local language? This does not include medical terminology or jargon, but only everyday speech.
- *Local language oral production*. How well does the trainee speak the local language?
- *Non-local language oral comprehension*. How well does the trainee understand the other working language(s)?
- *Non-local language oral production*. How well does the trainee speak her/his working language(s)?

The trainee is asked to audio-record a talk of about 10 to 15 minutes in her/his working language (e.g.: Arabic) on the following topics.

- *The place where the trainee lives at the moment*
- *Someone she/he knows (physical appearance, character, etc.)*
- *The healthcare (or political) system of the country she/he lives in or the country she/he came from (if applicable)*

Firstly, the trainees are asked to listen to their recording once and to give an account of what they have heard, including its main points, in the local language (e.g.: Italian).

Secondly, the trainees are asked to listen to the recording again and translate into their second language sentence by sentence, by using PLAY and PAUSE.

The trainees are asked to repeat the exercise, recording their voice in their second language.

Scoring: when scoring this section, consider the following:

- Was the trainee able to convey the main message in the second language?
- Did the trainee come across interpreting difficulties, in terms of memory, vocabulary, fluency, etc.

2) Ethics

A written (or oral) test is the best tool for evaluating the trainee's understanding of ethical principles and choices.

EXAMPLE 1:

At the end of a mediating session during internship/placement, you notice that the intercultural mediator told a young woman that the doctor said she was pregnant. The intercultural mediator walked out of the exam room with the young woman. Her husband was sitting in the waiting room. He approached the intercultural mediator and said: "What did the doctor tell my wife?"

What would you do? Why?

EXAMPLE 2:

Before starting an internship session at the mother care service, while waiting for the doctor, the patient told the intercultural mediator her husband is beating her and asked for her/his advice.

What would you do? Why?

Scoring: when scoring this section, consider the following:

- Was the trainee able to persuasively justify her/his answer?
- Was the trainee able to relate her/his answer to her/his code of ethics?

3) Understanding of cultural issues

The best way to evaluate a trainee's understanding of the role of the intercultural mediator with respect to cultural issues is through the presentation of situations that actually occurred during internship/placement which presented potential cultural barriers. The trainee is asked to respond to these situations by indicating the intervention she/he would make and how the intervention would be carried out. The description of the response can be presented in written or oral form.

An assessment of an intercultural mediator's ability to address cultural issues should require the trainee to demonstrate:

- *an understanding that differences in cultural assumptions and expectations can lead to miscommunication;*
- *the ability to intervene appropriately in order to identify when a cultural barrier to communication may exist;*
- *the ability to frame questions to help the provider and the patient explore what this cultural barrier may be.*

EXAMPLE 1:

During a consultation the doctor was trying to determine whether and how well the patient was complying with the course of treatment. You noticed that the patient was answering "yes" to all the questions that the doctor asked. However, you also noticed that the patient seemed uncomfortable. At the same time, it was clear to you that the doctor was becoming more and more frustrated because the patient's symptoms did not seem to make sense if the patient had been following the course of treatment. You know that in this patient's ethno-cultural group it is considered impolite to say "no."

What do you say and do in this situation?

EXAMPLE 2:

Describe a cultural belief, value, or practice (way of doing things) that is important in the culture of a patient observed in an internship/placement session that you think might have caused misunderstandings with the provider. What kind of misunderstandings do you think these might have caused? What would you do and say, as the intercultural mediator, if you were faced with this situation? What would you say to the provider? What would you say to the patient? Be as specific as you can.

Scoring: when scoring this section, consider the following:

1) Does the trainee show an understanding of the influence of cultural issues in the described encounter?
2) Does the trainee intervene appropriately? Does the trainee indicate in some manner that she/he is now speaking for her/him-self as opposed to interpreting the words of the patient? Does the trainee share her/his observation that there is some miscommunication going on and that she/he is prepared to assist the provider and the patient in exploring where the barrier is? Or does the trainee take over by providing her/his own explanation?

4) Healthcare Terminology

It is critical that trainees be tested for their knowledge of basic medical vocabulary. Intercultural mediators working in healthcare should be familiar with commonly used healthcare terms (such as *bladder, sprain, urine, diabetes*) in both languages, and be able to interpret such terms even if there are no exact equivalents in the other language.

Assessing Knowledge of Healthcare Terms.

Assessing the trainee's knowledge of healthcare terms can be accomplished through many different types of tests. Of course, the trainee must demonstrate knowledge of terminology in both languages. The assessment therefore

usually involves translating individual terms from one language into the other, in both directions, orally or in writing. Listed below are recommendations for the areas to be tested, with sample lexical items:

Symptoms: nauseous, shooting pain down the arm, head spinning

Anatomy: bladder, gall bladder, ankle, thigh, tongue

Disease: tumour, high blood pressure, diabetes, leukaemia

Procedures/tests: X-ray, glucose test, abortion, surgery

E*quipment:* wheelchair, ultrasound, bed, cart, sterilizer, monitor, microscope

Specialists: gynaecologist, cardiologist, paediatrician, dermatologist

Treatment: chemotherapy, physical therapy

Common medications: aspirin, laxative, eye drops, insulin

Hospital departments/clinics: radiology, primary care, in-patient, outpatient, intensive care unit

Notice that such lists of specialized terminology usually include only nouns. It is essential that the knowledge of adjectives, verbs and possibly other parts of speech also be assessed because these words can also express technical concepts.

Verbs: to examine, to elevate, to draw (blood), to intubate

Adjectives: elevated (levels), throbbing (headaches), primary (symptoms), distended

Adverbs: periodically, regularly, normally, intravenously, laterally.

5) Interactional coordination and agency

"Interactional coordination skills" indicate the full complement of skills that a competent intercultural mediator calls upon not only to ensure the accuracy and completeness of each "converted message", but also to facilitate equal access to the communication process and acceptance of cultural differences for both the patient and the provider. Thus, in addition to the central skill of rendering in the two languages, there are other skills that a competent mediator should have in order to ensure a fair balance of discussion (doing as much listening as talking) between the patient and provider and to recognise differences in their cultural assumptions and ways of expressing that may interfere in mutual understanding and trust.

The purpose of this section, therefore, is to allow the trainees the opportunity to demonstrate their performance using all the skills they have acquired in an integrated way. It also provides the assessor with a sense of how well the

trainee is able to use these skills to maintain accuracy and completeness of the conversation without detracting from the patient-provider relationship and the clinical goals of the encounter.

Assessment of coordination and agency.

The best way to assess coordination and agency skills is through the analysis of real-life interactions through audio-recorded encounters in healthcare consultations (see also the chapter by Baraldi and Gavioli in this volume). Examples could be the mediator's choices of rendition to allow coordination of the patient-provider interactions so as to favour equal access to everything that is said and done for all participants.

EXAMPLE 1

The mediator summarises rendition

EXAMPLE 2

The mediator expands rendition

EXAMPLE 3

The mediator modifies rendition

Scoring: The transcripts of authentic mediated interactions should include specific items the intercultural mediator's renditions of which will be tested: 1) reduced or summarised renditions; 2) expanded renditions; 3) multiple renditions.

The examples provided above are only few of the many challenging situations that the trainees have encountered in their training sessions during both internship and placement. Since the assessment is seen here as an instrument to favour professional development rather than to measure individual competence, the supervisor could decide to ask the trainees themselves to list their own priority learning points against which they want to be assessed.

8 CONCLUSION

The inclusion of practice-based learning models in any programme for the initial preparation and further development of intercultural mediators is strongly recommended. This form of experiential learning will provide the mediator-trainee with invaluable opportunities to observe experienced mediators at work, to be observed, to receive feedback, to discuss and reflect upon critical issues concerning

professional knowledge and to practice under appropriate supervision. In the case of intercultural mediators, this learning approach is able to generate deeper understanding of their competence and role in the workplace, hence contributing to the process of professionalization of this occupation. However, to achieve this goal it is desirable that learning experiences with practice settings are integrated in educational programmes. So far, university courses are devoted to general interpreting issues encompassing dialogue as well as conference interpreting. Although active in the research field, the academy has failed, for the moment, to effectively connect with the world of practice, where intercultural mediators are often employed with insufficient education and preparation. This requires coordinated action by the community of intercultural mediators, universities, legislators and employers.

9 ACTIVITY

Mutual learning through exchange of experiences

This activity can be used for the continuing education of mediators already working in healthcare services. It involves a group of 8 to 10 mediator-trainees: 2 to 3 of them present a case; everyone else is involved in the discussion. The supervisor (trainer) leads the discussion and facilitates the identification of learning points.

Phase 1. 2 to 3 mediator-trainees present a case in a narrative form, drawing on their experience related to one of the topics listed below.

Phase 2. The presenters focus on the problems encountered in the triadic interaction between the patient, mediator and provider and on the solution adopted, and explain what they believe worked or did not work in the interaction.

Phase 3. Under the supervision of the trainer the whole group discusses the cases presented, focusing on the impact of decisions and actions of the patient, the provider and the mediator in order to identify the strengths and weaknesses of these decisions and actions.

Phase 4. Finally, the supervisor and the trainees define the main learning outcomes. Together they answer the question: what have we learned?

Themes:

1) How to react if a healthcare provider is distracted by other things and does not pay attention to what is being said by the patient or the mediator.

2) How to react if the healthcare provider talks a lot and does not really listens to what the patient is saying.

3) How to react to disrespectful behaviour on the part of a healthcare provider.

4) How to win the trust of the patient, make patients rely on you as a mediator.

5) How to react if the patient does not seem to understand or seems to misunderstand what is being said by the healthcare provider.

6) How to react if patients refuse treatment although this is clearly not in their best interest.

7) How to deal with differing views on 'truth-telling' and the communication of bad news.

8) Role of the mediator in case of conflicting cultural values between the healthcare provider and patient.

9) How to react if the patient wants to discuss additional needs (e.g. related to socio-cultural, economic, institutional or other health needs not related to the specific consultation).

10 FURTHER READING

As intercultural mediators lack an established body of specialised knowledge, there appear to be very few specifically related studies in the available literature describing training programmes based on the exercise of occupational practice. What is available refers to training practices collected within the scope of international projects, or developed by governmental and non-governmental organizations and educational institutions revealing the considerable variability of these activities as well as the scarce evidence of the effectiveness of these training courses. However, below are some readings that provide practical advice that may be of help to those who want to develop a practice-based training programme for intercultural mediators:

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