STRUCTURING PUBLIC SERVICE INTERPRETING: THE INTERPRETERS BANK MODEL AS AN ORGANISED RESPONSE TO COMMUNICATION NEEDS[1]. / ESTRUCTURACIÓN DE LA INTERPRETACIÓN EN LOS SERVICIOS PÚBLICOS: EL MODELO DE BANCO DE INTÉRPRETES COMO UNA RESPUESTA ORGANIZADA A LAS NECESIDADES DE COMUNICACIÓN.

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Abstract: Globalisation urges governments to address equality in access to public services. Even though Public Service Interpreting (PSI) helps allophones to overcome the breach in communication, such services need a solid, organised structure to effectively respond to the current linguistic needs. This article presents the results of a comparative study of the healthcare interpreting services provided in Barcelona and Montreal which, by applying an indirect method of observation (interviews) to examine the aforementioned services, describes the existing PSI structures and organisations as narrated by their managers. Our conclusions draw attention to certain aspects of Barcelona's interpreting services which, should they be modified, could be beneficial. Finally, the interpreters bank model settled in Montreal (and throughout Quebec) is suggested as a role model for Barcelona, that could contribute to structuring PSI services in Europe.

Keywords: Public Service Interpreting (PSI); Healthcare interpreting; Multilingualism; Civil rights; Accessibility.

Resumen: La globalización insta a los gobiernos a abordar el problema de la igualdad de acceso a los servicios públicos. Si bien los servicios de Interpretación en los Servicios Públicos (ISP) ayudan a los alófonos a vencer barreras comunicativas, estos necesitan una estructura sólida organizada para responder con eficacia a las necesidades lingüísticas actuales. Este artículo presenta los resultados de un estudio comparativo de los servicios de interpretación médica de Barcelona y Montreal que, mediante la aplicación de un método de observación indirecto (entrevistas), examina los servicios mencionados, describiendo las estructuras y organizaciones existentes tal y como las definen sus propios gestores. Las conclusiones se centran en aspectos de los servicios de interpretación de Barcelona que convendría modificar y sugieren el modelo de banco de intérpretes instaurado en la provincia de Quebec como un ejemplo a seguir en Barcelona, que podría contribuir a la estructuración de servicios de ISP en Europa.

Palabras clave: Interpretación en los Servicios Públicos (ISP); Interpretación médica; Multilingüismo; Derechos civiles; Accesibilidad.

1. Introduction

Linguistic and cultural diversity within a society often leads to language barriers and miscommunication. Although substantial socio-political efforts have unquestionably succeeded at conforming a multicultural European space, miscommunication is still common in the different member states' public services. According to Eurostat (2018), a total of 4.3 million newcomers arrived to the 28 European Union member states in 2016, around 2.4

million arriving from non-EU countries and 1.8 million people migrating from one EU member state to another. The report states that such a trend affects all the 28 member states, even though those hosting more migrants are (up to the last statistics carried out in 2016) Germany (1.03 million), the United Kingdom (589,000), Spain (414,700), France (378,100) and Italy (300,800) – however these data could change after the United Kingdom's imminent departure from the EU. Furthermore, the existing movements of EU citizens to a different member state also need to be considered. Whatever the reason might be (tourism, study, work, immigration or commerce, to name a few), EU citizens have total freedom of movement within the EU's borders, making cross-cultural communication a common reality. Subsequently, miscommunication in a multilingual and multicultural Europe —that needs mutual understanding for economic and socio-political reasons— has become an extended challenge that needs to be faced with the EU's coordination.

As claimed by Malgesini and Giménez (2000), citizens' rights can only serve as a vehicle towards the integration of newcomers if they really get to use such rights —i.e., if host countries' institutions meet the needs raised by ethnic minorities and other allophone individuals. On a higher scale, this is only possible if states' policies favour social equity and strengthen civil participation, in order to attain the necessary social cohesion to allow a real union at a European level. After experiencing the new communication difficulties that such a freedom of commerce and travel implies, several member states, now multicultural, have (successfully or not) tried to face their own communication needs within public services, in order to guarantee allophones' rights. However, the way such intervention is provided is, without a doubt, linked to the way each country's public administration handles immigration. Therefore, the responses provided are highly different from one member state to the other. Nevertheless, member state societies are a part of a wider social European context that recognises the rights of citizenship to all those who live in the European territory and, hence, all European administrations should guarantee their effective protection. Even though a clear interest from the EU policy to face the challenges imposed by Europe's linguistic diversity has been shown – proof of that is the Study on Public Service Translation in Cross-border Healthcare, undertaken upon request from the European Commission's Directorate-General for Translation (DGT, 2015) – no formal decision has yet been taken on how to face such a reality.

Contrary to most research on interpreting, which tends to focus on single realities of a given city, region or country, or to compare related realities (i.e. European countries), this paper describes and compares two distant realities with common features. It describes the solutions adopted in Barcelona (Spain) and compares these with those set up in Montreal (Canada), both of which are known for their long tradition in multicultural and multilinguistic matters.

Barcelona and Montreal are two large bilingual cities (Spanish and Catalan vs. English and French) with a fairly similar population of approximately 1.7 million. They are both immigration targets, which makes multiculturalism one of their distinctive characteristics. As a result, different languages are brought to coexist within public services with each city's pair of local languages. Consequently, those two cities are amongst the most advanced ones in the field of Public Service Interpreting (henceforth PSI) in their respective countries. In addition, given that Canada is among the pioneering countries in the field of PSI worldwide (Pöchhacker, 1999), the results of this study can be very stimulating for the evolution of PSI in Barcelona and can also contribute to the PSI provision debate in the European context.

2. Multilingual needs and the creation and evolution of Public Service Interpreting

As Abril Martí (2006) points out, the evolution of PSI is subject to socio-political and structural issues. It is also strongly linked to the different linguistic and immigration policies applied in

different countries, and, therefore, to each country's institutional system and to the organisation of their public services. In fact, as stated by Ozolins (2000), PSI is an institution-driven reality, rather than a profession-driven one. Other highly influential factors highlighted by Abril Martí (2006) are the degree of regulation of access equality in each country's legislation, as well as migratory flows, which determine the needed languages in PSI services.

Corsellis (2002: 71-90) enumerates the phases through which any society goes, up to the moment when it gets to establish structured PSI services. These phases comprise:

1. lack of recognition of the problem;
2. denial of the problem and attempts to find solutions that are often not very rational —this brings opinions that are not really in line with reality, such as the lack of need of PSI services, motivated by the apparent communication established by other means (i.e., mediation of children or communicating through gestures and drawings);
3. recognition of the problem;
4. analysis and implementation of solutions;
5. formal solutions at a local level, implemented thanks to private initiatives;
6. institutionalisation of solutions at a national level; and
7. regularity at a local level within a national framework after reaching general measures —i.e., codes of ethics, professional PSI services or interpreters' associations.

In Europe, PSI has developed differently in different countries. Sauvêtre (2000) distinguishes three different models of PSI services. First, the English model is focused on multiculturality, recognises ethnic minorities and chooses a differentiated integration; interpreting is therefore seen as a right for communities. Second, the French model rejects differentiation on an ethnic or cultural basis. This model believes in an individual integration, claiming that, since everyone is treated equally and no ethnic or cultural distinctions are done, there is no need to create specific services related to culture or language. PSI services are thus offered by migrant-friendly associations and NGOs. Other countries following this model are Belgium, Spain, Italy or Portugal. Finally, the German model considers immigration as being temporary, even though workers might have settled in the country with their entire families. The need to create linguistic services for them is therefore not perceived as such. Hence, only a few PSI services are available, especially in the healthcare sector. Other countries following this model are Austria and Switzerland.

Unlike in the majority of European countries, countries like Canada, the United States and Australia have achieved a certain level of professionalisation in PSI by establishing regularisations, professional accreditation programs, professional organisations, etc.

3. Methodology

Data collection consisted of interviews with managers of different PSI services providing linguistic services to Barcelona's and Montreal's healthcare sectors. With these interviews, we intended to answer the following research questions:

− What are the goals of PSI services in Barcelona's and Montreal's healthcare sectors?
− How are PSI services organised in hospitals and primary care centres of each city?
− What are the similarities and the existing differences between both cities' healthcare PSI services?
  a) How are PSI provided in Barcelona's and Montreal's healthcare sectors?
  b) How are PSI services integrated into each city's healthcare sector?

c) Were any programs developed for creating the available PSI services? If so, what were the main characteristics of such programs? Of what phases were they composed? What were their budgets?

This study followed a replication-based methodology. In other words, it reproduced the same research process in Barcelona and Montreal. It then compared the data obtained in both cities, which allowed reaching significant conclusions. This paper outlines the main organisational information obtained from those interviews in order to draw a brief image of the structure of both cities' PSI services.

3.1 Participants

A convenience sample was recruited through an open call sent to the coordinators of the existing healthcare interpreting services of Barcelona and Montreal.

Despite the researcher's aim to achieve a comparable volume of data in both cities, this was unattainable due to the characteristics of each city's PSI service structures: as will be described further on in this paper, Montreal's healthcare interpreting services are quite centralised, whereas Barcelona's are managed by a reference person in each healthcare centre.

Barcelona's informants were public employees of the healthcare sector (N = 9) (mainly healthcare providers or social workers) in charge of coordinating the PSI services available in their healthcare centre (and sometimes also in some adjacent centre). They represented a total of 10 healthcare centres, of which 4 primary care centres (*CAP Sagrada Familia, CAP Collblanc, CAP Drassanes, CAP Trinitat Vella and CAP Fondo*) and 6 hospitals (*Hospital Vall d'Hebrón, Hospital Sant Pau, Hospital Can Ruti, Hospital del Mar, Hospital General de l'Hospitalet and Hospital Dos de Maig*).

On the other hand, Montreal's informants (N = 2) were the coordinators of the two main healthcare PSI services: Montreal's Interregional Interpreters Bank (IIB) and Montreal Children's Hospital's Sociocultural Consultation and Interpretation Services (SCIS).

3.2 Data collection procedure

This study being a multiple case study, data collection was undertaken in two phases: the first phase took place between September 2011 and June 2012 in Barcelona, while the second was between September 2012 and May 2013 in Montreal. However, little progress has been made since then regarding the organisation of the analysed PSI services.

Provided the characteristics of each analysed reality, the steps followed to enter each culture of study are different. Given the lack of an organised structure of PSI services in Barcelona, the first step was to contact Barcelona's healthcare region authorities requesting which healthcare centres provided PSI services. Those centres were then invited to participate in this study. This was done via e-mail, phone call or through face-to-face meetings with each centre's patient service department representative or, alternatively, their directors. In those exchanges, the study was briefly presented, describing the main goals and methodology, as well as what part participants would be expected to play. After getting a positive response from the participant centres' spokespersons, managers from their PSI services were contacted to schedule an interview, for which they gave a verbal consent. The director of the IIB and the Professional Coordinator of the SCIS were contacted via e-mail. A meeting was scheduled with each institution's manager to briefly present the project and invite them to participate. Once they had given their verbal consent, interviews were scheduled.

3.3 Research instruments

A semi-structured interview protocol (Appendix 1), based on a model from a previous study (Burdeus-Domingo, 2010), was approved by an extraordinary scientific board created to that end at the *Centre d'Études Ethniques des Universités Montréalaises*, and applied to all interviews. It had 31 questions covering a wide range of topics concerning PSI services, including the description of PSI needs, the procedure of implementing PSI services, the exploitation of these services, or their hierarchic relation inside the healthcare system.

3.4 Corpus

The data of this study comes from the set of recordings obtained in the observation phase. A total of 11 recorded interviews were compiled.

The data management methodology was optimised as the project progressed. The initial methodological strategy was to transcribe the interviews and compile them into the qualitative analysis software Atlas.ti, together with their corresponding recordings. This was done for the entire set of interviews describing Barcelona's PSI services. However, provided that the study's goal was to undertake a content analysis (rather than a discourse analysis), the decision was taken later on to directly annotate and code the interviews of Montreal's informants on the audio documents themselves. This decision was based on Strauss (1987), who suggested that transcriptions should be done with the accuracy imposed by the research question and the study goals. This new strategy, previously used and proven effective by other researchers in the field of PSI (Nappier and Kidd, 2013; Napier and Sabolcec, 2012), seemed thus more appropriate, as it allowed the researcher to reach the same goals in a more efficient way, preventing an unnecessary duplication of data as well as the risk of bias that a change of code could entail.

3.5 Analysis procedure

Thematic analysis techniques were used to analyse the data obtained through interviews with the qualitative analysis software Atlas.ti. This was achieved by categorising the data into thematic groups (or codes) in order to understand, describe and analyse the creation and implementation of existing PSI services. Firstly, the information shared in informants' responses was segmented – i.e. divided into units fitting into specific "boxes" of the codification frame; secondly, the resulting segments were coded; and thirdly, codes were assembled into categories, structuring data into a codification framework conforming to a thematic network organised at several levels. This allowed us to draw concrete and accurate conclusions from the results and reduced the potential risk of subjectivity by comparing data of diverse origin.

4. Results

This section presents a brief overview of the main findings drawn from our analysis. It aims to answer the research questions exposed in section 3.

4.1 PSI services' objectives

4.1.1 Overall objectives

The overall objective of Barcelona's and Montreal's healthcare PSI services is to improve the quality of communication between healthcare professionals and their allophone users, in order to improve the quality of the services provided.

Barcelona seems to pay special attention to ethnocultural differences. PSI services are seen in the Catalan capital as a tool to comprehend allophone users' cultures in order to adapt healthcare services to their traditions and cultural needs. Even though Montreal's IIB interpreters also do cultural clarifications when proven necessary – following their code of ethics – this does not seem relevant enough to mention it among their main objectives. However, cultural mediation seems to be also a main concern for SCIS's services.

4.1.2 Specific objectives

There is an observable discrepancy between the analysed PSI services when it comes to deeply analysing their specific objectives. Such discrepancy seems to have political foundations and affect the services delivered by PSI providers.

Unlike the rest of the studied PSI services, Montreal's IIB has just one main objective: to give a voice to allophones in the local languages through interpreting (without altering their messages: not adding nor omitting information). Focused on facilitating communication, the IIB leaves integration matters to the competent bodies on the matter. By contrast, the SCIS and Barcelona's healthcare settings include managing inequality in healthcare as an objective to be reached by their PSI services, leaving the door open for advocacy practices in interpreting (which may contravene the ethical principle of impartiality).

Among their achieved objectives, Barcelona's PSI managers point to those of an early stage. They include the insertion of intercultural mediators and community health agents[2] – rather than interpreters – as new professional profiles within the healthcare sector; the optimisation of healthcare resources use; and the establishment of communication between healthcare providers and allophone users.

Montreal's PSI services managers, by contrast, do not even refer to the above-mentioned objectives (even though they have been achieved), as they have gone beyond the initial stage by also introducing intercultural interpreters into the healthcare system and by normalising their services through the city's healthcare centres. Montreal's informants thus state that PSI have been recognised as necessary and have been the subject of study of renowned researchers. They insist that healthcare professionals consider them essential for their professional practice, whereas Barcelona's informants state that the Catalan city's practitioners consider PSI services only useful.

On the other hand, pending objectives in Barcelona include: raising awareness amongst healthcare providers, increasing PSI service availability (a wider range of languages and extended PSI availability hours would be needed), cultural mediation, healthcare professional training on multiculturality, normalisation of PSI services, and total integration of interpreters as professionals of the healthcare sector.

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[2] Intercultural mediators and community health agents share the common task of interpreting between healthcare providers and allophone patients in Barcelona' public healthcare sector. Their services are thus considered PSI services for the purposes of this study (and all those undertaken by the *Universitat Autònoma de Barcelona's* research group MIRAS, to which the author belongs).

In Montreal, the only pending goals highlighted were the expansion of PSI services (in order to entirely cover the needs) and the optimisation of the assignment managing system (which was being dealt with at the time of the interview).

Despite the discrepancies, the need for improvement of interpreters' working conditions was emphasised in both contexts —even though Barcelona has more room for improvement. Also, both cities' respondents agreed on the need for standardised PSI training and accreditation.

4.2 PSI services' organisation

4.2.1 Organisation of PSI services in Barcelona

In the absence of regulations focusing on how to provide language access services, Barcelona lacks an organised and centralised structure for its PSI services. In this city, only those healthcare centres that receive a high immigrant population have interpreting services, with a limited number of workers.

Such disorganisation has generated different responses to the same need within the Catalan metropolis. As a result of this lack of common work undertaken on this matter, different linguistic services have emerged: while most on-site interpreting is provided by intercultural mediation services, there are also community health services offering on-site interpreting, while remote interpreting is offered by remote interpreting services (not included in this study).

Regardless of their professional profile, both intercultural mediators and community health agents work only in the healthcare sector, providing their services to one or several healthcare centres but – with rare exceptions – contracted by external entities.

Most of the PSI providers actively working in Barcelona when this study was undertaken were conducting an internship as part of a training program on intercultural mediation offered as a result of an agreement between the Catalan Health Institute (ICS) and the *la Caixa* Foundation. However, when this agreement came to an end, the lack of funding led to the end of such services, leaving healthcare services with high rates on migrant patients with no interpreting services at all. Even though a few healthcare centres (such as *Hospital del Mar*) have developed their own intercultural mediation projects, thanks to the collaboration of migrant-friendly associations (such as *Salud y familia*), these kinds of agreements are scarce. The *CAP Drassanes*, for its part, has community health agents devoted to its Tropical Medicine and International Health Unit. The incorporation of such intercultural communication workers was instigated by the *Secretaria per a la Immigracio de la Generalitat de Catalunya* (the Catalan government office which deals with integration issues), thanks to the development of the *Programa integral d'acollida* (PIA) [Hosting Comprehensive Program]. However, their services are quite unstable, as they depend financially on public subsidies and allocations.

4.2.2 Organisation of PSI services in Montreal

Having a greater tradition in multiculturalism, Montreal also has more structured PSI services. The main PSI services provider is Montreal's IIB, funded in 1993 as a result of an initiative taken by the *Agence de la Santé et les Services Sociaux de Montreal* (ASSSM, the local healthcare authority). This initiative was motivated by the ASSSM's determination to respect the obligations imposed by several legal frameworks and jurisprudence, e.g. the Act respecting health services and social services (chapter s-4.2), requiring to provide services in English to English-speaking users and to adapt its services to the needs of the members of cultural communities.

Ever since its foundation, the IIB has had a vast group of interpreters that, working as freelance interpreters inscribed to its list of PSI service providers, serve all the healthcare centres of Montreal healthcare region, covering a wide range of languages. Notwithstanding that the bank was created within the healthcare system, IIB's interpreters also serve public services in other domains (e.g. education). Interpreters provide the bank with their availabilities – including emergency hours – and the IIB subsequently confers interpreting assignments to them. It has a limited office staff in its headquarters located in the *Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal* (CSSMTL). However, this does not interfere with the bank's administration, since assignment management is done telematically. The members of the IIB's office staff are therefore committed to: ensuring proper request management, by solving problems that can be originated with the request procedure via *Jérôme+* (a web application conceived to this end); dealing with invoices; supervising the quality of their services; ensuring interpreters respect PSI code of ethics; guaranteeing quality in their interpreters' training; and ensuring interpreters' appropriate working conditions.

Even though this governmental body is well structured and serves all healthcare centres in the area —regardless of its vehicular language (i.e. it serves French-speaking as well as English-speaking centres)—, alternative interpreting services to those offered by the IIB have been rising in Montreal's healthcare context. The most outstanding of these is the SCIS at the Montreal Children's Hospital, that, established as a private bank of interpreters, provides interpreting services to all the healthcare centres linked to McGill's University Centre.

4.3 Similarities and differences between Barcelona's and Montreal's healthcare PSI services

4.3.1 Service provision

PSI services are provided following different steps in each healthcare context analysed.

On the one hand, Barcelona's services are managed by each centre's social work or user service department. Those are usually the departments in charge of receiving healthcare practitioners' requests (usually through the phone) and pass them on to their on-site interpreters (when available). When interpreting services are not available, they usually schedule new appointments for allophone users to be treated during the times when the needed language interpreting services operate. On the other hand, Montreal's practitioners send their requests to the IIB online through the web application *Jérôme+*. Interpreters get a notification when receiving practitioner's requests for their services. They can then either accept or decline the request through the application. A notification is subsequently sent to the practitioner. If declined, the request is sent to another interpreter with the requested language combination.

While access to PSI services seems to be quite satisfactory in Montreal, many of Barcelona's informants highlight their services' scarcity of time and language coverage. However, they add that the most important difficulty regarding access to those services is institutional. In fact, since the services depend on subsidies and allocations, and are often provided by trainee cultural mediators covering internships, they are not constant in time, leaving Barcelona's healthcare centres with gaps of time where there is no PSI provision – especially between internships of different years. Moreover, due to the withdrawal of the available funding, most of the PSI interpreting services that participated in this study were wound down. Montreal, however, did not experience such budgetary problems as the IIB serves healthcare centres on the basis of the user pay principle (the user being the healthcare centre that needs an interpreter to tend an allophone patient). After each interpreting session, interpreters present a detailed, duly signed service sheet to the IIB. The IIB pays the interpreter and sends a detailed invoice to the healthcare centre at the end of each month with information regarding all the interpreting services delivered. However, it is worth stating that, being a public

service professional working directly for the ASSS, the IIB's director's salary is covered by the local healthcare authority. The manager of the IIB insists that even though healthcare centres tend to complain about the cost generated by PSI services, a study conducted by the IIB proves that such costs represent only around 0.002 % of the annual budget allocated to healthcare.

In addition, when a need for interpreting services arises outside interpreting hours (especially at night time and during weekends or bank holidays), remote interpreting services are used in both cities. Barcelona's needs are covered by *Sanitat Respon*, service belonging to the Health Department of the Government of Catalonia. In Montreal, by contrast, remote interpreting services are offered by interpreters of the IIB.

Whereas Montreal's PSI services are offered both in English and French, and between those two languages (amongst many others), Barcelonan interpreters only work from and into Spanish. This is due to their language skills: being foreigners residing in Barcelona, they often have a certain level of Spanish language skills but lack of Catalan language command. Moreover, only a few healthcare centres offer PSI services to Spanish speaking users (mostly Latin-Americans), and those are more dedicated to the cultural transfer rather than to the linguistic transfer.

4.3.2 Integration into healthcare sector

As previously explained, Barcelona's PSI services are not officially linked to any healthcare institution. Their relation with the different healthcare centres' departments is restricted to the fact that they collaborate with them to serve patients. PSI services are considered to provide support during the medical assistance process. These services depend generally on the patient service or social work departments of most centres, serving allophone users with linguistic needs. Even though there is no actual PSI service network in the Catalan metropolis, most of the services participating in this study are related, in the sense that, at the moment of the interviews, their interpreters were conducting internships as part of *la Caixa* Foundation' training course on intercultural mediation.

Additionally, an informal network of PSI services spontaneously emerged. This was originated by healthcare professionals' needs to communicate with allophone users outside the interpreting hours of their healthcare centre. Sometimes aware of interpreters' working hours in other healthcare centres, healthcare professionals tend to contact them in the other centre and ask them to interpret for them. When their workload allows them to, interpreters leave the healthcare centre where they are meant to be working to attend that specific need. The same procedure is sometimes followed when a healthcare centre needs interpretation in a language not available for them.

4.3.3 Programs developed for creating the available PSI services

Having a multicultural tradition and being a pioneer in the field of PSI, Montreal has benefited from difference-sensitive legislation that has increased efforts to promote and facilitate the establishment and normalisation of PSI services over the years. Even if Barcelona could also benefit from public initiatives, due to the Catalonian government's lack of experience in the matter, its services are undoubtedly less integrated and demonstrate poorer organisation.

Even though migratory flows started to increase in Barcelona at the end of the 80s, it was only during the 90s that the city started to take action on this matter. Healthcare community services started in 1994, meanwhile cultural mediation services took longer to arise. As stated by the study's informants, most of the Barcelonan services (as they are described in this paper) started functioning between 2008 and 2010.

The first governmental Catalan initiative considering language provision services in healthcare came in 2006, with the *Pla Director d'Immigració en l'Àmbit de la Salut* [Immigration in Healthcare Settings Master Plan], elaborated by the *Departament de Salut* (the Catalan Health Department). This Master Plan was based on three main hubs of activity: hosting, training and mediation. Even though there were already scarce language access services in certain healthcare settings before this Master Plan, this was the first initiative undertaken with the intention of harmonising the different solutions proposed to fight language-related barriers in allophones' access to healthcare. However, its success is questionable, since, even though it foresaw the implementation of intercultural mediation services, it left the management, financing and provision of such services to external agencies. As a result, several entities started collaborating in a new intercultural mediation project (viz. *Institut d'Estudis de la Salut* [Institute for Health Studies], *la Caixa* Foundation and the Service of Psychiatry of the University Hospital Vall d'Hebrón) and some others joined their efforts later on. The latter include migrant-friendly associations (*Probens, Salud y Família, Equip de treball sobre Immigració i Salut, Ibn Batuta...*), foundations (*Bayt Al-Thaquafa...*), organisations (*Barcelona Activa*) and even companies (EULEN). Thus, the *Departament de Salut* facilitates the access to intercultural mediation services to Barcelonan healthcare centres, which benefit from such services despite the lack of any contractual relationship, by only offering mediators a physical space to work at, office resources and a person of reference to turn to in case of need.

Mostly depending on subsidies, competitive biddings and projects with private funding often coming from non-profit organisations like *la Caixa* Foundation, Barcelona's PSI services appear to be strongly influenced by the aforementioned external agencies. Providing funding and/or training, such agencies play an important role describing the professional profile established (and therefore their roles and functions). As a result of the different viewpoints on what PSI should consist of, we find intercultural mediators and community health agents serving the Catalan metropolis's on-site linguistic services. The main difference between these two professional profiles is due to their main functions: while the former focuses on facilitating communication between healthcare professionals and users, interpreting the different cultural codes without interfering in the conversation, the latter facilitates communication between the parts of the triadic conversation in the healthcare sector, but also develops health promotion activities and provides healthcare advice.

In Montreal, the right for allophone healthcare system users to be treated in their own language was first included in legislation in 1986. Later, in 1989, the *Ministère de la Santé et des Services Sociaux* (Quebec's Healthcare and Social Service Ministry) created a structure to safeguard the adjustment and adequacy of healthcare services to the needs of their multicultural society. In this first action plan, which was followed by a second plan in 1993, the creation of interpreters banks to solve communication problems was foreseen. This adjustment process produced its first results in 1993, with the creation of the IIB, whose first official service was offered in April 1993 —even though some emergency PSI services were already made for exceptional cases in 1992. Whilst local interpreters banks were implemented in other cities, the decision concerning Montreal was to establish an interregional bank, provided that, due to its geographical position, this bank would supply PSI services to allophone users of nearby municipalities.

A unique professional profile was therefore introduced to Montreal's healthcare sector: the cultural interpreter, with the clear function of facilitating communication between professionals and users, interpreting both verbal and non-verbal language, as well as the different cultural contents, without interfering in the conversation.

Until around 2003, the IIB delivered the totality of its income to its interpreters, as the ASSS was assuming the IIB's coordination expenses, its equipment and the costs of designing

a request-managing software (*Jérôme+*). However, due to the need to extend its office staff, the IIB started using 10 % of its income to pay its new members of staff, which also made the price of their services increase by 10 %.

It is worth highlighting that, besides Montreal's public initiatives, significant private initiatives were also taken by the Canadian city's private healthcare institutions —i.e., SCIS of the MCH, which began in 1986, under the label of "Multiculturalism" and provided multicultural services to newcomers and ethnic minorities (especially allophone aboriginal communities), dedicating much effort to facilitating intercultural communication. The creation of the SCIS was therefore a mere extension of such a service.

5. Discussion

When comparing the evolution of the examined PSI services it is evident that their origins are quite similar. Both cities follow the PSI service implementation phases enumerated by Corsellis (2002): when the miscommunication problem is recognised, it is analysed and first solutions are implemented, those then become formal locally thanks to private initiatives, after which some governmental initiatives arise in order to harmonise the existing solutions. It is at this stage that we start perceiving some differences. While the action of Quebec's Healthcare and Social Service Ministry was to create an action plan inciting Montreal's local healthcare authority to create an interpreters bank centralising the management of all PSI needs in the city and surrounding areas, the Catalan Health Department's master plan claims for the establishment of intercultural mediation services without getting involved in further actions to help such decision thrive (such as describing appropriate PSI service management and provision initiatives or funding). This ratifies the observation made by Baixauli Olmos (2012) that Spanish PSI services are characterised as the result of entities' improvisation and are constituted mainly by *ad hoc* solutions lacking a permanent organisation and structure. As described in the present study, in the absence of clearer regulations describing how to serve allophone patients or a unifying PSI body, Barcelona's PSI services have been evolving irregularly in different healthcare centres – with service interruptions, different languages according to the interpreters available during each intercultural mediation internship period, altering the interpreting times, etc. The results of this study also confirm the statements made by authors like Toledano Buendia (2010) or Vargas-Urpí (2013) highlighting the influence that hiring entities exert on PSI services, as their viewpoints condition the professional profile to engage in PSI services (intercultural mediators and community health agents vs. interpreters) as well as their role in interpreting assignments.

By contrast, Montreal has benefited from the IIB's good administration that allowed offering PSI services uniformly and uninterruptedly. The IIB also managed the fluctuations promoted by each moment's migratory flows which determine the languages of immigration, providing (unlike Barcelona) PSI services to cover all the city's linguistic needs. Moreover, its interpreters can rely on the support and collaboration of their hierarchic superiors inside the bank. In contrast, Barcelona's intercultural mediators and community health agents cannot really count on their managers to face any PSI-related problem or difficulty, as they admit to being unfamiliar with PSI, which makes them unable to respond to such queries. This makes us start considering the convenience of changing the way PSI services are managed in Barcelona. Establishing an interpreters bank adapted to the distinctive characteristics of Barcelona's society as well as to its administrative structure and economic situation seems a suitable option. For so doing, it would be convenient to bear in mind the deficiencies that Montreal's IIB might present, in order to advance towards an improved model.

The present paper is merely theoretical. It is therefore limited to outlining the solutions adopted in two similar contexts to overcome the communication barriers encountered by allophone users of public healthcare services and subsequently compare them. It is not the author's aim to list the steps to undertake to set up an interpreters bank. In fact, this paper draws attention to some structural aspects of the interpreting services analysed, which, should they be modified, could be beneficial. Further research would be needed to describe the ideal ways to implement the application of such modifications. Nonetheless, based on the comparison of both analysed realities, suggestions include to create an interpreters bank counting on the support of local healthcare and immigration administrations. In the case of Barcelona, it would be pertinent to create an interpreters bank with the joint efforts of the *Departament de Salut* and the *Secretaria per a la Immigracio de la Generalitat de Catalunya*, as both entities have already made efforts regarding healthcare interpreting issues. It would be convenient to keep the already involved institutions taking part in the new structure, by participating in managing (*Institut d'Estudis de la Salut*) or co-funding (*la Caixa* Foundation) the bank. However, a prior consensus would be needed to clearly define interpreters' roles and functions as well as clear shared criteria regarding the access to the profession (required education, language skills, professional values…). Instead of having a person in each healthcare centre manage the services of a few interpreters, this new structure would only need to count on a reduced number of staff devoted to managing and coordinating a large group of freelance interpreters. The management of the proposed bank could be a shared task between two members of staff: a political-administrative one —a public service employee, in charge of the bank's administrative work— and an operative one —a PSI specialist, in charge of PSI-related issues. Thanks to the creation of an interpreters bank, assignment could be conferred to interpreters telematically, as is done in Montreal. A possible collaboration with the IIB could be considered in order to contemplate the possibility of using the assignment-managing software *Jérôme+*. PSI services could be paid, as in Montreal, by the different healthcare centres. In Barcelona, healthcare centres could allocate, to this end, the funding received from the different subsidies financing linguistic services.

The implementation of an interpreters bank following Montreal's example would centralise assignments and allow for a more adequate response to the PSI needs in Barcelona's metropolitan region. Centralising PSI services would also reduce ambiguity and disparity of the roles and functions of interpreters, as this would contribute to the clear description of a single professional profile. This would, over time, facilitate public service providers' and patients' comprehension of PSI, which would promote more realistic expectations, leading to a better use of such services. This would also help to improve interpreters' working conditions since, being paid for every offered service, they would be able to make a living out of interpreting, and would be able to stay in the profession. Of greater importance: the increased availability of accessible interpreting services would avoid not serving allophone users due to miscommunication. In any event, to further strengthen this proposal, awareness-raising is needed, not only in Barcelona's society, but also amongst its authorities. The described PSI initiatives need to count on governmental support to be able to get unification and thrive. This requires regional as well as national policies, in accordance with European guidelines.

It has been observed by several authors that this situation repeats itself in many other European countries. As shown by a study analysing healthcare PSI services in different areas of Germany, Greece, Italy, Spain and the United Kingdom (DGT, 2015), some member states do not even provide PSI services at all. According to DGT (2015), *ad hoc* interpreters are frequently used, as are family members or friends of the person trying to communicate with public service providers. The document also highlights that language services are often limited. Sadly, this situation is generally extended to PSI in any context —i.e., education, justice, etc. The idea of creating a European network of interpreters banks based on the described Canadian

model could hence be studied, as this has been proven to work in a territory that, like the EU's, promotes and supports multiculturalism. Proposals could include the creation of a stratified network with different hierarchical figures, acting together for the coordination and unification of interpreting services in any kind of public service (healthcare, education, justice, etc.). This would ensure that PSI is provided following accorded norms and regulations in every member state, guaranteeing citizens' rights across Europe.

6. Conclusion

This approximation to the reality of PSI services in Montreal's and Barcelona's healthcare regions shows that Barcelonan healthcare centres have been working to face the communicative challenges of a modern multicultural and multilinguistic society. It has also been observed that Montreal's centres faced such difficulties with decades of anticipation. It is therefore not surprising that the latter proved to have a highly normalised structured service, which adapts better to the city's communication needs. Quebec's practices of good governance on immigration and multiculturality allowed the creation of PSI services that, despite the room for improvement, have worked and made allophone users' egalitarian access to healthcare possible. This study confirms Sauvêtre's (2000) assertion that the way PSI services are implemented is strongly related to the way countries handle immigration, the place that newcomers occupy on a national scale and their distance to the host society. According to the author, integration policies as well as the recognition of ethnic communities' rights – or the lack thereof – affect the communication model established. It is important to remember, however, that Barcelona's relatively newly multicultural society is part of a wider European social context, in which citizens' rights are recognised for all those who inhabit the European territory. Europe, just like Canada, has openly promoted multiculturalism. Based on this idea, freedom of circulation of people and goods was promised within its borders. Even though a large number of immigration, trade and even healthcare policies have been implemented – to name a few fields in which the EU has made such freedom possible – linguistic policies are still lagging behind. Yet, as stated by Sasso and Malli (2014:42), "lack of public policy on access to health, legal and civil services for the minority language speakers impedes equity, and inhibits the delivery of effective public services". Even though access to public services is guaranteed by the EU Charter of Fundamental Rights, it has to be remembered that this implies, to begin with, understanding and being understood to eliminate communicative obstacles that may interfere in the proper provision of such services. Thus, this still remains a challenge for the EU and many of its member states (see also Pöchhacker, 1999; Abril Martí, 2006; Ozolins, 2010; DGT, 2015). The interpreters bank model (extended throughout Quebec) has advantages over other implementations of translation and interpretation services (like the Barcelonan, described in this paper). It can therefore be considered as a role model (yet not the only valid one) to improve PSI services that lack an organised structure.

After having widely analysed the need for PSI service provision in the EU and described the heterogeneous services offered in its member states —or the lack thereof— (DGT, 2015), the moment has come for the EU to include in its legislation a description of the language services that should be available to ensure access to public services to all those European citizens or newcomers hosted by member states that, due to a lack of language proficiency, are unable to communicate by themselves in the member state where they are, either temporally or permanently.

The findings of this study have to be seen in light of its primary limitation, which is strictly linked to its sample. It should therefore be stressed that, even though this study was limited to analysing the services provided in specific contexts in 2012 and 2013, its results still

reflect the current situation. In fact, little change has been made since then in the organisation of the described services. Meanwhile, in Montréal, PSI services continue to be ensured by the IIB, whose organisation has been slightly improved by the upgrades to its assignment-managing web application *Jérôme+,* the opposite is true of Barcelona, as several PSI services have been fading since this research was undertaken, mostly due to organisational issues. However, the study presented in this paper opens up new avenues for research. On the one hand, a new study should be conducted to deeply illustrate the sociopolitical obstacles impeding Barcelona's linguistic services to progress, considering its funding, the lack of a detailed description of professional requirements to join the profession, the lack of consensus regarding interpreters' required education, etc. Likewise, a study focusing on the actual incentives for setting up such an organised structure should be undertaken, considering healthcare providers' motivations and satisfaction regarding communication, the improvement that such a structure would entail within healthcare settings, the benefits it would bring to Barcelona's society, etc. Finally, a pan-European study considering the advantages, disadvantages and challenges of creating a coordinated PSI European network could nourish the debate of how to best implement PSI services to respond to a multilingual Europe's linguistic needs.

References

Abril Martí, M. I. 2006. *La interpretacion en los Servicios Públicos: Caracterización como Género, Contextualización y Modelos de Formacion. Hacia unas Bases para el Diseño Curricular*. PhD dissertation. Universidad de Granada.

Baixauli Olmos, L. 2012. *La interpretació als serveis públics des d'una perspectiva ètica. La deontologia professional i l'aplicació al context penitenciari*. PhD dissertation. Universitat Jaume I.

Burdeus-Domingo, N. 2010. *Interpretación en los servicios públicos en el ámbito sanitario en la provincia de Barcelona*. Masters dissertation. Universidad Autónoma de Barcelona.

Corsellis, A. 2002. "Interpreting and Translation in the UK Public Service. The pursuit of Excellence versus, and via, expediency". Anderman, G. and Rogers, M. (eds.) *Translation Today. Trends and Perspectives*. Clevedon: Multilingual Matters: 71-90.

DGT (Directorate-General for Translation of the European Comission). 2015. "Studies on translation and multilingualism. Public service translation in cross-border healthcare 1/2015". Luxembourg: Publications Office of the European Union. [Available at: https://publications.europa.eu/en/publication-detail/-/publication/0d038be5-9a52-11e5-b3b7-01aa75ed71a1/language-en].

Eurostat. 2018. "Migration and migrant population statistics". [Available at: https://ec.europa.eu/eurostat/statistics-explained/pdfscache/1275.pdf].

Malgesini, G. and Giménez, C. 2000. *Guía de conceptos sobre migraciones, racismo e interculturalidad*. Madrid: Catarata.

Napier, J. and Kidd, M. 2013. "English literacy as a barrier to healthcare information for deaf people who use Auslan". *Australian Family Physician*, 42 (12): 896–899.

Napier, J. and Sabolcec, J. 2012. *Access to preventative and ongoing healthcare information for deaf Auslan users: A qualitative study*. Sydney: Macquarie University.

OJEU (Official Journal of the European Union). 2012. "Charter of Fundamental Rights of the European Union". European Union (ed.) Luxembourg: Publications Office of the European Union. [Available at: https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:12012P/TXT].

Ozolins, U. 2000. "Communication Needs and Interpreting. In Multilingual Settings: the International Spectrum of Response". Roberts, R. P.; Carr, S. E.; Abraham, D. and Dufour , A. (eds.) *The Critical Link 2: Interpreters in the Community : Selected Papers from the Second International Conference on Interpreting in Legal, Health, and Social Service Settings*. Amsterdam/Filadelfia: John Benjamins Publishing Co: 21–33.

Ozolins, U. 2010. "Factors that determine the provision of Public Service Interpreting: Comparative perspectives on government motivation and language service implementation". *Journal of Specialised Translation*, 14: 194-215. [Available at: https://www.jostrans.org/issue14/art_ozolins.pdf].

Pöchhacker, F. 1999. "Getting Organized: The Evolution of Community Interpreting". *Interpreting*, 4 (1): 125–140.

RSQ, Chapter S-4.2, *Act respecting health services and social services*, Section 2, subsections 5 and 7, and Section 15. [Available at: http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/S-4.2].

Sasso, A. and Malli, K. 2014. "Trying to fit a square peg in a round hole: Is community interpreting just too big for public policy? The Canadian experience a provocation". *FITISPos-International Journal,*1 (1): 42-50.
[Available at: http://www3.uah.es/fitispos_ij/OJS/ojs-2.4.5/index.php/fitispos/article/view/10/6].

Sauvêtre, M. 2000. "De l'interprétariat au dialogue à trois. Pratiques européennes de l'interprétariat en milieu social". Roberts, R. P.; Carr, S. E.; Abraham, D. and Dufour, A. (eds.) *The Critical Link 2: Interpreters in the Community : Selected Papers from the Second International Conference on Interpreting in Legal, Health, and Social Service Settings*. Amsterdam/Filadelfia: John Benjamins Publishing Co: 35-45.

Strauss, A. 1987. *Qualitative analysis for social scientists*. Cambridge: University Press.

Toledano Buendía, C. 2010. "Community interpreting: breaking with the "norm" through normalization". *JoSTrans The Journal of Specialised Translation*, (14): 11-25.

Vargas-Urpí, M. 2013. "ISP y/o mediación intercultural: La realidad de los profesionales que trabajan en el contexto catalán". *Cuadernos de ALDEEU*, 15: 131–164.

Appendices

Appendix 1

Semi-structured interview guide managers of community interpreting services

1. On which date began the service of community interpreting/intercultural mediation?
2. What languages was the service originally created with? Why?
3. Which is the variety of the profile of its users?
4. What goals have been obtained and which ones are due to be obtained?
5. Has the service been developing uninterruptedly?
6. What difficulties has the service had in accomplishing the program up until now?
7. What professional qualification does it take to be employed in this service?
8. Which is their professional category inside the hospital/healthcare centre?
9. Which healthcare providers does this service cooperate with? 19.
10. How was the need or the convenience of the incorporation of community interpreting/mediation services to the hospital/medical centre detected?
11. Which were the goals and purposes of the centre in the moment of the creation of the service of community interpreting/intercultural mediation?
12. What type of community interpreters/intercultural mediators did this service begin with? Were they translation and interpreting professionals or "accidental" interpreters?

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13. How many people integrated the hospital's/centre's service of community interpreting/intercultural mediation in its origins? How many hours did they dedicate to this job?

14. Which is the relation of this service with the rest of the departments of the hospital/healthcare centre? (Is it a relationship of cooperation, of subordination, etc.?)

15. Is this centre's interpreting service related to that one of other centres or other public institutions? Is it part of a network of services of community interpreting/intercultural mediation inside the network of healthcare services?

16. Has the service been developing, expanding or improving? In what sense? (More people, more hours, more languages, it serves to more areas, etc.).

17. The community interpreters/intercultural mediators are part of the hospital's/healthcare centre's staff or is this service provided by an external company?

18. Which are the specific medical services of this centre that have required more the services of an interpreter and which ones require them more nowadays?

19. Which are the functions of the community interpreters/intercultural mediators in the different services of the hospital/healthcare centre? (For what it concerns to whether translations or interpretations are realized and in which modality). Do they do any jobs non-related to patients' assistance, such as conference interpreting for doctors or translation of scientific literature, medication instructions, treatments, medical equipment...?

20. Have the interpreters had any previous training related to community interpreting or intercultural mediation?

21. What personal and technical resources has the service of community interpretation/intercultural mediation of this centre?

22. Have they got a specific working space?

23. In your opinion, what benefits do you think the establishment of this service has brought...?

... to the healthcare providers?

... to the users?

... to the healthcare centre?

... to society in general?

24. Do you consider the access to this service to be satisfactory?

25. Do you believe that the demand of these services has increased?

26. How do you believe that the quality of the service is perceived by...

... the healthcare staff?

... the Administration of the hospital?

... the users?

... the community interpreters/mediators themselves?

27. Do you believe that the implementation of the service is satisfactory for the patients who use it?

28. What aspects do you think this service has improved in the healthcare provider-user relationship?

29. Is any evaluation or feed-back of the quality of the service being made, in terms of usefulness, efficiency, etc.?

30. Would you consider necessary to hire external community interpreters/intercultural mediators according to the needs of every single department?

31. Would you consider necessary to have a group of community interpreters/intercultural mediators in the hospital's staff 24 hours a day?