Path to Professionalization

The Emerging Role of Intercultural Mediators in Health

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A women’s organization in Barcelona called SURT has collaborated with Vall d’Hebron Hospital to run a mediation program specifically designed for a health context. The participants are called Socio-sanitary Intercultural Mediators. The program has been in existence for less than two years and is therefore still in the process of shaping the mediator’s role. This research project was designed to explore the perspectives of hospital staff and mediators on the role of intercultural mediation at Vall d’Hebron. The analysis compares those perspectives to each other and to what the mediators do in practice. The process of developing a mediation program and incorporating it into a health setting has rarely been documented and the experiences of the mediators at Vall d’Hebron will be interesting for the program that is studied, for institutions who wish to start a mediation program in the future, for policy planners and for community health advocates.

This research project is a qualitative, small scale, exploratory study. The methodology includes observation and semi-structured interviews, focus groups, and document review. The results are based on casual conversations and participant observation in the hospital as well as interviews with nine staff and six mediators, and observation of seven mediations.

There are some differences of opinion between staff and mediators surrounding whether mediators should be in the hospital at all, whether they should act as students or professionals while they are in training, whether their primary role is to translate or to explain and whether they should aim to be neutral in their interactions with patients and providers.

Diffusion of information about the program has been slow, and without a clear definition of and agreement about the mediator’s roles and responsibilities, information reaching health professionals has been inconsistent. This has created differences between how the mediators have been taught to do a mediation and the way that they sometimes work. In their broker role between patients and providers the mediators have to balance multiple identities in order to assist both groups and improve health outcomes without threatening the power of the more established health professionals. Their personal histories as well as medical professionals’ use of alternatives to mediation to communicate with patients also contribute to differences between the program’s vision of mediation in the hospital and reality. In order to facilitate the acceptance and the use of mediation, program coordinators, mediators and hospital staff should come to a joint agreement on the limits of the mediator’s role and the specific duties within it.

The future of mediation is not clear. The participants in this year’s training program would like to continue to work in mediation, but they are concerned that the profession has not been officially recognized and certification has not been standardized. They believe that the chances of formalizing the profession are slim because intercultural mediation in health threatens doctors and politicians by highlighting weaknesses in the health system’s ability to respond to the needs of immigrants. But the mediators also address such weaknesses and reduce them. They support other health professionals and they have raised awareness of the need for culturally and linguistically appropriate interventions in the hospital where they are working.
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Introduction

I was fortunate to stumble upon my first medical anthropology class while studying biology during my undergraduate degree, and I found it fascinating. It raised my awareness of the cultural aspects of health and illness and was one of the topics that convinced me to become involved in the field of public health. Both in the United States and abroad, I have worked in resource-poor settings with populations that had trouble accessing health services. I became interested in how to improve access for these communities from two directions, by improving the community’s knowledge of resources and by improving the health system’s provision of culturally appropriate care.

While working with the Latino population in Boston, Massachusetts in the United States I heard many stories of difficulties in accessing care. Teenagers told me about being terribly uncomfortable when they had to translate personal information for their parents at the doctor’s office, and adults who were afraid that they would be deported if they gave their name at the hospital suffered with illnesses that could easily have been prevented. The need for a more accessible and culturally responsive healthcare system was clear. I was given the opportunity to attend an introductory course for medical interpreters, and for a number of weekends I joined Bostonians from different language groups in learning about the practical and ethical sides of interpreting in a hospital setting. Many of my classmates were already working as formal or informal interpreters, and they complained that although the hospital saw them only as interpreters, their work included a lot of cultural mediation. Because they were hired as medical interpreters, they were not expected to step beyond the bounds of translation to provide mediation or explanation.

I entered the Amsterdam Masters in Medical Anthropology (AMMA) course with the intention of learning about medical anthropology and how it could be applied to public health. During the course I happened upon a book called ‘Health for All, All in Health, European experiences on Health Care for Migrants’ (Vulpiani, Comelles & Van Dongen, 2000) that mentioned the existence of intercultural mediator programs in hospitals in Spain. Remembering the comment that the medical interpreters in Boston had made about the limits that their title imposed, and thinking that such programs might be an answer to broader questions of improving health access for immigrants, I contacted a new intercultural mediation program in
Barcelona to see whether they would let me investigate the emerging role of the mediators.

My goal throughout the year has been to find ways to put anthropology into practice in health programming, to define the border zone where issues of culture intersect with health and the medical setting. The mediator program turned out to be a phenomenal example of how the two can and should be combined, and the work that the mediators are doing touches on many of the topics that we had covered in our medical anthropology course at AMMA, from cultural variations in health beliefs and explanatory models to the existence of a culture of biomedicine, identity and ethnocentrism, brokerage, agency and power. And finally, their work touches on how to apply the conversations that we have been having all year in class to real-life situations.

The mediators are practicing the most pure and simple applied medical anthropology that I have yet seen. They are using many of the concepts that medical anthropologists study, such as medical culture, explanatory models and health beliefs to mediate between immigrant cultures and Spanish cultures, between hospital culture and lay culture, between one immigrant culture and another, and they do so in order to improve health services that are provided to marginalized populations. Each case that they were called for during my six weeks of fieldwork would have provided material for at least three medical anthropology classes, and I was privileged to hear about each one, to listen to their discussions, and in some cases, even to observe the mediation itself. Many of the issues that were raised in their supervisions and conversations are debates that are still relevant in academic medical anthropology circles, such as the advantages and disadvantages of challenging the hegemonic position of western biomedicine, the power that doctors exercise over their patients, and the healing power of belief. Yet their debates had an immediacy that is missing from many academic discussions because they would go directly from the discussion to another mediation where they would put their decisions into practice.

The mediators are in the necessary but uncomfortable position of still unrecognized professionals, but they are being described as ‘pioneers’ in their field. They struggle as any pioneer who stakes a new claim, but whatever the conclusions that they come to in their debates, they are doing necessary and impressive work now. The more conclusions they can reach about the nature of cultural conflicts in a medical setting and how best to address them, the closer we are to finding ways to
bring medical anthropology into practice and to improve medical care for marginalized populations.

In this paper I will present the research that I carried out in Barcelona in the spring of 2005. I will begin by explaining why I will be exploring the issue of role definition for the mediators and providing a short description of the environment in which the program is being developed. I will then explain the methodology that I employed in the research. The results of the research will be presented next, beginning with a series of short case studies that raise issues related to the definition of the mediators’ role. They will be followed by a more detailed exploration of the hospital staff’s and the mediators’ perspectives on some of the debates surrounding the mediators’ role and tasks. I will then provide a general discussion of the implications of the data. The discussion will be framed by a series of questions that come up repeatedly. These are: what falls into the mediator’s role? is the mediator’s role unique? what are the appropriate limits to their position? is it possible to separate ethnic culture from medical culture in a hospital setting? and how does the mediator’s role relate to her level of professionalization? I will explore the mediators’ efforts to balance multiple identities and work within an established power structure. I will conclude with a presentation of the central results and recommendations for how the mediator program could proceed in defining and professionalizing the mediator’s role. The results will be interesting for the program that is studied, for institutions that have considered initiating a mediator program in the future, for policy planners and for community health advocates.
Background

The problem

Cultural mediators, interpreters, and bilingual and bicultural staff are now being trained and utilized in a number of health institutions around the world. They have been introduced to improve “cultural and linguistic competence in health care… to eliminate racial and ethnic disparities in health.” (NCCC 2004) As the use of such staff increases, standards for their training and for their work are being created (Partners for Health 2004, California Healthcare Interpreters Association 2002, MMIA 1995). These standards provide a vision of what someone in the position of facilitating communication between healthcare providers and patients of different cultures should do, but there is no universal standard for what their role should and should not include. There is also very little documentation of how to achieve the standards. Few people have written about the process of training mediators and trying to incorporate them into a health setting to work alongside other health professionals. If new programs for intercultural mediators begin, they do not have a model for the steps in the process of incorporation and the challenges that they might face in defining the mediator’s role for their particular setting.

The Vall d’Hebron Hospital in Barcelona is running a new type of intercultural mediator program specifically designed for a health context. The participants are called Socio-sanitary Intercultural Mediators. As an emerging program in a relatively new field in Spain, the program is interesting and innovative. By looking at the point of incorporation and development that the program has reached after almost two years of existence, I hope to indicate their tremendous successes as well as point out some of the challenges that they have faced in shaping the mediator’s role.

A central challenge for cultural mediators around the world has been delimiting their roles, and that process at Vall d’Hebron is only partially complete. There are differences between an initial version of their role that has been developed by program coordinators of the mediation program (Qureshi & Collazos, in press) and that way that the role has been adapted for the specific setting in which it is practiced. Some of these are based on differences between the perspectives of staff and the perspectives of the mediators as to what it is that the mediators should be doing in the
hospital. The role of mediator is new and the profession is not yet officially recognized (Cohen-Emerique and Fayman 2005:11), so differences in perspective are to be expected. The possible reasons for any discrepancies will be examined to better understand the process of incorporating the mediators into the hospital and defining the role of intercultural mediators both within the hospital and outside. The objective of the research is to explore the perspectives of staff and mediators on the role of intercultural mediator in a hospital setting and to compare those perspectives to each other and to the mediators’ roles in practice.

**Literature Review and Theoretical Framework**

I approached my investigation with four assumptions. These are

1) that the process of defining the mediator’s role is difficult and fits into a larger process of professionalizing what has until now been an unofficial position,

2) that mediation in the hospital was created in response to a wish to improve cultural competence,

3) that patient-provider communication is key to improving culturally competent care, and

4) that mediators improve communication by acting in a broker role between the patients and the providers.

Below I will elaborate on each of these points.

**Role Definition and Becoming a Professional**

As a new member of the medical team, mediators in the health professions must create a place for themselves (Llevot Calvet 2004) and must struggle to maintain that place. The mediator’s roles are not fixed and vary greatly from one program to another. Their titles differ also, from medical interpreter to intercultural mediator to culture broker, but their role, of bridging a distance between healthcare systems and patients from other cultures, is similar. In some places the mediators limit their work to translating for appointments within health centers or hospitals (MMIA 1995). In others they do home visits and help patients access social services (Jackson-Carrol et al. 1998). In other cases the mediators become therapists or co-therapists for mental health practitioners (Boehnlein and Kinzie 1996). In still others, the mediator’s role may be limited initially, but mediation acts as a stepping-stone into the more established health professions (Van Dijk, personal communication). The definition of
the specific roles that they will take on must be determined as the need for their services are defined.

Many cultural mediation programs around the world have faced challenges during their development related to the difficulty of defining the mediator’s role. Two of the many countries that have experimented with cultural mediation in health are Belgium and Canada. In each country, at least one program has described difficulties that were caused by the multiple and sometimes conflicting tasks of the mediators and by not having a clear definition of what their role should include.

In Belgium there has been a culture-brokering program since 1991, and the mediators have been involved in over 62,000 interventions (Verrept 2004:2). In 2000 a report was published to evaluate the success of the mediator programs. A number of difficulties were noted, including that many healthcare providers did not understand the mediator’s role, and the low position of mediators on the professional hierarchy. They also noted the potentially risky tendency of mediators to provide emotional support to patients without adequate professional training, and the fact that mediators were sometimes asked to resolve what providers see as the cultural problems of patients that interfere with treatment. The authors also observed that there is risk of burn out for mediators due to a lack of standards for evaluating the mediator’s performance. (Verrept et al 2000) These particular conclusions have been chosen from among a longer list of challenges because they all relate to the need to carefully define the mediator’s role and to adhere to the definition that is established, to have agreement and cooperation as to the mediator’s role from all participants in the process (doctors, patients and the mediators themselves), and to limit evaluation of the mediator’s performance to the tasks defined as part of the established role. They also indicate that even in a successful and long-running mediation program, the process of defining the mediator’s role is slow.

A medical interpreter program for native interpreters in Canada existed as early as 1984. The mediators in the program had four different types of responsibilities. They were expected to translate, advocate for the patients, explain native culture to healthcare providers, and explain biomedical concepts to native patients (Kaufert and Koolage 1984: 283). The authors who described the program noted that some tension arose from medical providers thinking that the interpreters

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1 translation and summary by Van Dijk
were just translators (284). They also noted that as brokers, the medical system and medical providers are the interpreters’ ‘patrons’, while in advocacy, it is patients who are their ‘patrons’ (285). Thus, the allegiance of the mediator shifts or is believed to shift as his or her role shifts from advocate to broker for the health center. This conflict speaks to the need to define the mediators’ role not only in terms of tasks, but also in terms of allegiance and professional status.

The definition of the mediator’s role falls within a larger process of professionalization. As immigration in Spain increased, a phenomenon called ‘natural’ mediation began. Members of minority communities assisted friends and family in accessing institutions, advocated for the rights of new arrivals, and acted as go-betweens for the community members who didn’t yet speak Spanish² or the regional languages. This role of intercultural mediation has become more common and slightly more official over the years, and now intercultural mediators are trained in a number of NGOs and are hired by the city council or called on directly to resolve intercultural conflicts in legal, educational, health or community settings. Some intercultural mediators are paid and others are not. Some are trained and others are not. The term is broad and encompasses a large number of different responsibilities. Recently, health institutions and other interested parties have begun to think about training intercultural mediators specifically for the health setting. Vall d’Hebron hospital, in collaboration with an employment training program called SURT, have started the first training program for socio-sanitary intercultural mediators in Barcelona.

The existing model of community mediation has to be adapted to fit into a health context, for example by limiting the mediators’ work in advocacy so as not to anger the health professionals and specializing the vocabulary that the mediators should know to do their work as translators. The roles and responsibilities of the hospital-based intercultural mediator have to be discussed and defined. This process is happening at the same time that the mediators are learning about the health system and the health system is learning about them. Throughout the process situations arise that challenge the old definition of mediation and push the limits of the mediator’s role. At each of these points the mediators and the staff have to decide whether to maintain or modify the image that they have of intercultural mediation.

² The word ‘Spanish’ will refer to Castilian, the common language of Spain. Catalan is the regional language in Catalonia and will be called Catalan.
One of the ways to measure the process of professionalization is by looking at the stages through which the professionals-in-training have to pass. An important factor is the clarity of the stages, both in terms of how clear it is that a person has reached a particular stage and also how clear an understanding there is of what they have to do to reach that stage (Bucher and Stelling 1977:182). In the case of doctors and nurses, the stages are clear and the requirements for passing from one to another are clear. They are not only understood within the hospital, but have been standardized in biomedical institutions throughout the world. For the mediators though, the stages through which they will have to pass and the requirements to get there are not clear, and there is no standardization. As a result, if someone calls themselves an ‘intercultural mediator’ no one knows precisely what their training and experience are.

**Mediation and Cultural Competency**

The position of intercultural mediator has been created in response to an increase in cultural diversity as a way to increase cultural competency of healthcare professionals and the health system’s ability to respond to the needs of a multicultural patient base. Culturally competent healthcare systems are “those that provide culturally and linguistically appropriate services” (Anderson et al. 2003) but ‘culture’ is both a contested concept and a contested term (Harrison 1999). Debates about the value of culture as a concept tend to centre on whether viewing groups of people as bounded entities is useful for descriptive and practical purposes and/or whether doing so devalues the varied characteristics of the individuals who make up the groups. The debate about definition generally centres on which characteristics determine culture, particularly in a more globalized world where geographical and social boundaries are not fixed. Through migration and integration, through exposure to new places and new things, an individual’s culture changes and group cultures shift. This process is natural even without moving to a new country, but the process of migration has the potential to strongly affect cultural identities and practices, either by accelerating change or by slowing it. Culture is not fixed and is not always shared. It is also not a quality only of ‘other’ groups. All groups, native and non-native to a region have culture, and institutions like hospitals and health centers within those groups also have their own specific cultures. Despite these blurred divisions, the concept of culture is useful as a means of naming the belief systems and traditions held by both patients
and medical staff that underlie conflicts that can arise between doctors and patients. Within this document ‘culture’ refers to the practices and beliefs that are shared by a group of people.

An ethnic group “is a group of people who identify with one another, or are so identified by others, on the basis of a boundary that distinguishes them from other groups.” and “the collectivity of immigrants from a region of the world and their descendants are called "ethnic groups" despite their lack of internal cohesion and common institutions”(Wikipedia 2005). In this document ‘Ethnic culture’ will be used to refer to the assumed or actual shared culture of groups of people from the same geographical region or, in the case of Spanish Gypsy culture, who self-identify as members of a group with a shared history. ‘Spanish medical culture’ will refer to the shared belief systems and practices of Western biomedical institutions in Spain.

Immigration in Spain has increased tremendously in the last decades. More than 8 percent of the Spanish population is now non-Spanish (National Statistical Institute 2005). Over 2 million people are living in the country with either a residence card or permanent residence status (Boletín Estadístico de Extranjería e Inmigración 2005). The largest group of immigrants has settled in the province of Catalonia, where Barcelona is located. In Catalonia, by 2003 almost 5 percent of the workforce was made up of immigrants while in 1999 it was only 2 percent (BBVA foundation 2005). Immigrants have arrived from Europe, Asia, the Americas and Africa, but the majority of the African and Latin American immigrants have chosen to live in Catalonia. These groups are primarily from Morocco, Ecuador and Peru. Despite the fact that Europe is in need of workers and immigrants to boost its aging population, the transition to an immigrant society has not been easy. The atmosphere in much of Europe is one of xenophobia and fear (Ponteniere 2005), and Spain is no exception. But Spain has a strong system of social services available for anyone living in the country. These services, including hospitals, have to serve the new immigrant population.

Healthcare in Spain is provided for those immigrants who are in the country legally, and emergency, maternal and pediatric care is available to anyone regardless of legal status (Llacer et al 2001, Newby 2004), but there are a number of barriers to providing quality care to immigrants that have confounded hospitals in Spain as in many other parts of the world (Partners for Health 2004:5). There are practical barriers and also more elusive psychological barriers. It is generally agreed that
racism and discrimination are present in any setting, but they can manifest themselves in a medical encounter and have significant consequences. One of the times when discrimination is most marked is during hospitalization (7).

A publication called Unequal Access (Smedley et al 2002) defines cultural competency as, “the ability of individuals to establish interpersonal relationships that supersede cultural differences” (554). The authors go on to explain how it works in practice in a doctor-patient relationship. In this case it is “a process in which the healthcare provider continuously strives to work effectively within the cultural context of a client” (554). The definition is important because it makes it clear that the concept of cultural competency places the primary responsibility for successful interactions on the provider. Although patients’ expectations and prejudices are factors that can negatively affect doctor-patient communication (Campinha-Bacote 2003), many policies and programs are now created under the assumption that it is doctors and medical institutions that should find ways to become culturally competent. The term has become a buzzword and is a stated goal of many medical institutions (Betancourt et al. 2003), but very rarely is it achieved or even defined to the satisfaction of providers, consumers and observers (Betancourt et. al. 2003, Van Dijk 1998). By any definition though, cultural competency requires recognition of barriers to effective care and the development and implementation of changes to reduce those barriers.

**Provider-Patient Communication**

In a practical sense, the first barrier to effective healthcare is often language. If the doctor and the patient speak different languages, it is very difficult for successful diagnosis or treatment to occur, but language is not the most difficult barrier to overcome. Further complicating the encounter, doctors and patients tend to approach health and illness from different perspectives. Their different perspectives affect their ability to work together because communication is both linguistic and cultural (Sales Salvador 2005). To generalize, doctors view illness through a biomedical lens, and patients through a personal one (Helman 2001). Patients bring many personal elements to the clinical encounter, including prior experience with healthcare in other settings, their own multiple health beliefs, explanatory models for disease aetiology, and established health behaviours that can include seeking care in different ways simultaneously (Vall Mayans et.al. 2002, Helman 2001, Foster 1998). They are also
likely to have their own ways of expressing distress. Many of these elements are culturally mediated.

Culture defines how health care information is received, how rights and protections are exercised, what is considered to be a health problem, how symptoms and concerns about the problem are expressed, who should provide treatment for the problem, and what type of treatment should be given. (Stinson 2000)

For some patients and some doctors, the clash of different health beliefs and cultural expectations can make a clinical encounter extremely difficult (Kuipers 1998). Although conflicts may exist in any encounter, whether or not it is intercultural, the difficulties are magnified in an intercultural one. It is the discrepancies in these encounters that the position of cultural mediator has been created to reduce. The presence of good doctor-patient communication has been cited as explanation for clinical success from successful diagnosis to patient satisfaction and good compliance with treatment regimes (Heszen-Klemens & Lapinska1984, Makoul et al 1995, Ong et al 1995, Sanz 1999 & 2003, Sleath et al 2001). Clearly it is beneficial to improve doctor-patient communication and the quality of care for patients of many cultures, and for this the intercultural mediators are expected to play a key role.

Identity and Brokerage

The mediator is in a broker role, in which her multiple identities provide her with the tools of her trade. One definition of culture brokering is “the act of bridging, linking, or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change” (NCCC 2004). The mediator role is designed as a way to bridge the cognitive distance between healthcare professionals and patients. To be chosen for the position, each woman has to demonstrate in a way that satisfies her employers that she belongs to a culture other than mainstream Spanish culture and knows enough about it to explain it to healthcare providers. She also has to speak the language of her adopted country and understand both its culture and the medical culture within it to be able to function as a health professional and explain elements of health and local Spanish culture to the patients.

3 Because all of the mediators in the hospital are women, I will refer to mediators as ‘she’ despite that fact that anyone can act as an intercultural mediator.
4 Citing Jezewski1990
She mediates between language groups, between lay and biomedical health cultures, and between professional and client needs, and she practices on the margin of both medical and ethnic communities (Delcroix 1996). Mediators throughout the world walk a fine line between belonging to the medical culture and belonging to the culture of the patients for whom they mediate. Their professional identity, and their job, depends on their membership in an ‘other’ group, that of the patients for whom they mediate, yet they are expected to be able to represent concepts and expectations of the medical professionals with whom they work. Although both parties, patients and providers, want the allegiance and support of the mediators, if the mediator steps too far in one direction, his or her job is at stake. The mediators’ professional identity depends on the balance of their multiple identities.

**Research context**

Vall d’Hebron Hospital is a third level teaching hospital connected to the Autonomous University of Barcelona. It is composed of three hospitals: General, Trauma, and Maternal and Child. There are more than 6000 employees and it is often described as being like a small city. The hospital does not keep records of the ethnicities of patients, but staff explained anecdotally that the number of immigrants at the hospital has increased significantly in the last few years.

The work that the staff in the hospital do seems noble and important, and there is a sense of limited time that drives everyone to move more quickly than they do on the street and to look straight ahead. But there is also a slow paced, relaxed atmosphere in some halls, in the cafeterias and in the offices. There is a casual disregard of no smoking signs, a tendency to sit for a full hour eating lunch and drinking wine before going back to work, and an assumption that ‘now’ means ‘in a little while’ that balances the urgency of medical emergencies.
Methodology

Overview

This research project is a qualitative, small scale, exploratory study of the Intercultural Mediation program at Vall d’Hebron Hospital in Barcelona. The initial problem description aimed to compare doctors’ patients’ and mediators’ perspectives on the role of the intercultural mediator in a hospital setting (see appendix for initial problem diagram) but was amended during the research period to focus on the perspectives of staff and mediators. The research methodology centers on participant observation and semi-structured interviews, with an emergent design framework that provided the flexibility to change elements of the proposed approach according to unexpected details of the research process. The results are presented so as to provide the context and the participants’ perspectives as accurately and as completely as possible.

During a six-week period, intercultural mediators trained as part of the mediation training program organized by SURT as well as interested doctors and other staff who make use of the mediators were asked to share their perspectives on the role of cultural mediators within the hospital setting. Patients who have used the mediation service were also asked to participate. Data was collected through observation, analysis of program records, semi-structured interviews, and formal and informal focus groups. Many of the interviews were recorded and later transcribed, and the others were transcribed from notes and memory as soon after their completion as possible. There is no hospital-initiated tracking method for the mediations that are held. I therefore depended on program documents and the mediators’ written and verbal accounts of each case to compliment my observations and conversations as I collected data.

The research process

The week before my research began I met with two Transcultural Psychiatrists who coordinate the mediation program. They gave me permission to observe supervisions and other program activities, and to look through the case histories that are produced after each intervention. On the first day of my research they introduced me to the 8 mediators and the woman who coordinates the program’s daily activities.
During the next few days I began to hold formal individual interviews with the mediators when they were not very busy. I was able to conduct individual interviews with six of the eight mediators, and follow-up interviews with one of them. I was present in their classroom and with them at lunch or other parts of the day for almost 40 hours each week for 6 weeks, so there was ample time to explore issues in more detail, to finish conversations, and to speak to the two mediators who did not find time to participate in formal interviews. Many of the topics that I had hoped to discuss in a focus group setting were discussed in the classroom or at group lunches, and I decided that by observing the conversations and recording relevant portions, I was gaining more information than I would have by scheduling and running an official focus group. This flexibility in changing and adapting the methodology to the reality of the fieldwork situation was anticipated, and allowed me to best accommodate the time and other constraints of my informants.

I had two opportunities to observe meetings between the program coordinators and the social workers who work closely with the mediators. Similarly to my conversations with the mediators, these replaced formal, planned focus groups. They discussed many of the topics that I had hoped to discuss in a focus group. Their conversations provided me with contextual information and with ideas for some topics to explore in individual interviews. I ran one rather informal but enlightening focus group over lunch with three nurses who have not worked with mediators. I carried out individual interviews with 9 staff members (see appendix for a more detailed list), including two social workers who work with the mediators, two nursing supervisors, one of whom has worked with mediators and one who has not, an administrator for the social work department, and four program coordinators, one who is a staff person of the agency that funds and runs the mediator program, one who oversees all daily activities of the mediators and two of whom are also doctors who have worked with the mediators. I also spoke briefly to one doctor who had just completed his first intervention with a mediator.

I observed almost all program activities in the classroom, including the arrival of demands by phone and in person, speakers, lessons, discussions, case supervisions and work that the mediators were doing on a document describing their own role. I also accompanied the mediators to ten mediations, although in one case the doctor didn’t arrive before I needed to leave, in one the nurse said that it had been scheduled for a different day, and in one the doctor said we weren’t needed and we were sent
away. The seven full mediations that I did observe were with five different mediators from five different countries. The observation of mediations allowed me to gain greater insight into the dynamics of the hospital, to compare the mediations themselves to the way that they were presented in supervisions and on paper, and to create opportunities to speak to the mediators about their performance of specific actions.

I spent almost all of my time with the group, and slowly they came to accept me in some activities as one of them. They soon stopped paying attention to all of the notes that I was taking and they were comfortable in the classroom even while I was there. I knew that they had accepted me when during the second week a psychiatrist came to hold a group session with them and she asked me to leave because they would be discussing cases and personal issues. All of them protested and later told me that they didn’t know why I couldn’t be there. But yet there were moments when I was conscious of my difference from them, such as when we all introduced ourselves to visiting speakers, or when I would leave to accompany the coordinators to meetings that they were not allowed to attend.

I arranged most of my interviews through snowball sampling, beginning with connections from the meetings that I attended, from casual meetings with social workers in the cafeteria, and through information provided to me by the program coordinators and mediators. I was conscious that this method would tend to include people who are already more involved or familiar with the mediator program, and I therefore actively sought out a nurse who was rumored to dislike the mediator program and I took advantage of personal connections to a nurse and a patient who had less experience with mediation. This process was an effort to make my sample as varied as possible but to work within the limited timeframe available.

When I asked to go with the mediators to observe mediations they all agreed. They seemed to appreciate the company and didn’t seem to feel threatened that I was watching. They did seem slightly uncomfortable with the process of me introducing myself to the professionals and asking for permission to be there, but once it was granted they relaxed. Although I have no way of knowing whether the mediations were conducted more carefully or differently because I was there, I did speak to the mediators after each one, and we discussed the way it had gone. I asked them about some differences that I noticed between what I had heard them learn in class and what had happened. They were open about the differences. They seemed pleased to have
someone to share their frustrations and successes with. In one case a mediator did say that she acted differently because I was there. After we had spoken about the fact that the doctor almost never looked at the patient and some of the conversation was not translated for the patient, she said that it had been hard for her to say anything about it because she felt like the doctor had been doing her a favor by letting me be there.

When I observed mediations I wore a lab coat that I borrowed from one of the mediators or the program coordinator. I felt strange and powerful in the lab coat, as if I were in disguise as someone important. I even used the staff elevator. The medical professionals and the patients, after they had agreed to let me observe, seemed to ignore my presence completely, as they did with all of the other white coats who hovered, came in or out to change medicines, or stood nearby. Although I don’t know whether the professionals acted differently with me observing, I felt like they were accustomed to ignoring extra students or nurses, so they ignored me until I thanked them and said goodbye.

On the last day of my research I met with two of the program coordinators and they were unhappy with a preliminary document that I had produced because, among other reasons, they thought that I had taken unfair advantage of the access that they had given me and that I had overstepped the bounds of my research proposal. The document in question was based purely on my observations and was only for their interest, but I believe that all of the issues raised were in fact related to what I had set out to study; multiple perspectives on the role of intercultural mediators in a hospital setting. Although I hated to leave on such a sour note and I hope that all of the issues that they raised can be resolved, the event was a reminder for me that I had indeed had privileged access to the program. I think that there were many times that everyone forgot that I was a researcher and that they forgot to edit their behavior and their comments. I will try my best to balance the interests of the program and my goals set out in the proposal with my need to present a realistic and potentially useful documentation of the perspectives on the new role of intercultural mediator in a hospital.

**Ethical considerations**

Before I was able to conduct the study, I was required to have the proposal approved by the Hospital’s ethics committee. The program coordinator attached an informed consent sheet and a patient information sheet (see appendix) that explained
the purpose of the project and patient rights. I submitted the proposal to the hospital months before the research began. A few days after my arrival I was informed that it had been approved, but that we were waiting for the official letter of approval to be delivered. One of the program coordinators advised me to wait until the letter arrived to begin to speak to both patients and staff, but that as long as the mediators consented to participate, they could be interviewed and observed before the letter arrived.

All conversations and interviews were conducted outside the clinical encounter so as not to interfere with patients’ treatment and to make it clear that participation or the decision not to participate are not linked in any way to the provision of care by the hospital. During the research process I always presented myself as a researcher and asked each participant for permission to observe, interview them and use the retrieved information. Names and identifying features of all participants will remain confidential.

All participants were over 18 and were fully informed about the project and consented to participate. Confidentiality was discussed with all participants, but it is particularly difficult to guarantee for the mediators. I explained to them that I would not include their names in what I write, and they were told that no one other than I will read my field notes or listen to the tapes of our interviews. We discussed the difficulty of keeping their identities from the program coordinators who know them well, and although they were not concerned about anyone reading what they have said and were clear that they would not say anything that could put them or their reputation at risk, I will make every effort to maintain their confidentiality while presenting the data in an understandable way. The mediators will only be part of the program for another month and a half, and the program coordinators have promised not to allow any information from the research to affect the mediators’ job security. Some details of the cases presented in the text have been changed in order to protect the patients’ anonymity.
Results and Analysis

In this section I will begin by describing four case studies that illustrate the range of activities in which the mediators are involved and touch on some important questions about what activities should be included in the mediator’s role. I will then provide a more textual introduction to the role of the mediator, including perspectives of both mediators and staff on the need for mediation, the details of the program, the role of the mediator as it its understood now, debates about the nature of mediation in a hospital setting, and the process of incorporating the mediator into the hospital structure. I will then describe the primary elements of the mediator’s role as understood by the mediators and the hospital staff and their thoughts about appropriate limits for the mediator’s role. Following that discussion will be a presentation of factors that make it difficult for the mediators to carry out their job exactly as they are taught in the classroom. The job of the mediators depends on their being brokers between patients and the health system, and I will present staff’s and mediators’ reflections about this challenging position. I will conclude the section by presenting their ideas about the possible future of mediation for the mediators themselves, for the mediation program at the hospital, and for mediation as a profession.

Short case studies

Below are a series of short case studies that touch on each of the parts of the mediator’s role and raise some important questions about what health professionals and patients should expect from mediators. Each one is a description of a case that one of the mediators faced, although certain details may have been changed to maintain anonymity. Despite the fact that each case is from a different ethnic group, the roles that the mediators play in these examples and the issues that they raise can be applied to many different cases.

Case 1:

One of the mediators came into the classroom after a mediation and explained to us that she had been called to mediate a case with a young East-Asian couple. The father of a new baby was angry because the medical staff had performed a cesarean section on his wife before her water broke. They had given her an epidural and he...
didn’t understand why. He said it was because “no estoy en mi país”, I’m not in my country\(^5\). The staff explained that the baby had the umbilical cord around his neck and they had to perform the cesarean to save him.

The nurses wanted the mother to breastfeed but she had been refusing the baby for a few days and seemed like she didn’t want to have him by her side. The nurses thought that she was rejecting the child. The mediator spoke to the father and found out that he had been keeping the child from the mother because “the hospital is to rest, not to breastfeed, to work.” She explained this to the nurses and also told them that in her country it is common to wait two or three days before beginning to breastfeed because the first milk is dirty. She then explained to the father what the nurses wanted him to know, that the first milk is not dirty, and that it is an antibiotic that will help the baby be healthy.

According to the mediator, the father had been making sure that his wife could rest and he had been taking care of the baby. The nurses had decided that the father keeping the baby from the mother was a case of abuse. The mediator said that she explained to the doctor and the nurse why the man was acting the way that he was, and that everything had become peaceful. The nurses and the patient agreed that the baby would be given bottles during the night to let the mother rest, but that she would breastfeed during the day.

This case demonstrates a number of the mediator’s roles: to translate, to explain cultural beliefs to the patient and to the provider, to facilitate communication and to provide support to the two parties. It raises questions about what causes conflicts and about how much of an active role the mediator should take in resolving them.

Case 2:

One evening a mediator was called after she had left work to come to the hospital to resolve a conflict. A young boy from the Gypsy community had been in the car that his brother was driving, and he jumped out of the car and got run over by another one. The family took him to the hospital right away, where he was soon pronounced dead. The boy was 23 years old. His whole family came to the hospital.

\(^5\) All quotes that were originally in Spanish have been translated into English by the author. The original Spanish will be included only for emphasis or when there is no direct translation for Spanish terms used.
Even before they knew that he was dead the family was grieving in the waiting room, banging their heads against the wall and creating a loud scene. When the mediator arrived there were security guards and "about 50 policemen" blocking the door. When she arrived, from home without her lab coat, they didn’t want to let her in, but when she told them that she was a mediator they let her pass. She spoke to the family and figured out whom to tell about the boy’s death. The mediator explained that in this case it was his uncle, as the older male and the patriarch, who was responsible for the situation.

The next day a nurse who had been there during the conflict thanked the mediator profusely for what she had done for them. She said that before the mediator arrived she hadn’t even known that mediators existed. The nursing supervisor also thanked the mediator and said that they had been so impressed by her work that they were going to have the hospital send her a thank you card. She explained that they were worried that the brother would do something, that he was hitting the door and they were scared. They had stopped all visits. The security guards had called the police. The nurse explained that when the mediator arrived she explained a lot of things to them, things they would have had no idea about, like notifying the patriarch that the boy had died.

This case highlights a few roles of the mediator, conflict resolution, educating the healthcare professionals about cultural dynamics, and facilitating communication. It raises questions about what scale conflicts the mediators should be expected to handle, about who should be expected to be culturally competent, and also, because one of the nurses said that she didn’t know that the mediators even existed, about dissemination of information within the hospital.

Case 3:

One of the mediators described a case that had affected her deeply. She told me that it had been with a 74 year old African woman, who had had part of her liver removed because of a cyst. The second time that she met the woman she accompanied her through a painful procedure. She had to pass brief, concise information to her, such as when to breathe and when to stop breathing. She said the procedure took less than two hours, less than half the time that it had taken when they had done it the year before without a mediator.
She told me that before the test she asked that woman to tell her what she does to relax. The woman told her that she reads the Koran. The mediator said to her “cualando entran lees aqui (indica la cabeza) tranquil, y imaginate asi, con el sol y con el mar y todo lo bonito que puedes”, ‘when you go in there read here (points to her head) a little bit of the Koran calmly and imagine yourself with the sun and the ocean and everything beautiful that you can.” She told me that the woman’s tension didn’t go up at all. She was relaxed and she got through the whole procedure well even though sometimes she was suffering.

The mediator told me, “The woman was very thin and very weak, and she spoke in a very educated way, and she looked a lot like my grandmother, and she had delicate hands just like her and when she spoke she held me and hugged me and my grandmother used to do the same.” She said, “She moved a lot of things inside me, first that I hadn’t seen my grandmother die and she had asked for me and I wasn’t there.” Her eyes teared up as she told me about the case, and she had to pause before continuing. She told me that because of her training she went outside and cried and worked with herself for three days to understand that even though she seemed like her grandmother she wasn’t her grandmother and that crying wouldn’t help. The next time she had an interview with the woman it didn’t affect her as much. She said that beyond the success of the procedure, for her it was an accomplishment that she didn’t cry during the second meeting and that she was able to see the woman leave without being upset.

The mediator in this case translated and she also supported both the patient and the hospital, by calming the patient and making the procedure go faster. The example raises issues of the effects of emotion and personal experience on the mediators’ work and also of whether it is always important to respect the established limits of the mediator role, because in this example the mediator spoke to the patient without the doctor to help her enter the procedure calmly. It also indicates one way in which mediation can help the hospital work more smoothly and quickly.

Case 4:

During the last week of my fieldwork, one of the mediators described a mediation that she had done with a doctor, a Central Asian man and his sick young daughter. The father has been in Spain for 5 years, but he spoke very little Spanish. The doctor asked the father to act out his daughter’s symptoms and how they began
because he couldn’t describe them in Spanish. She provided some translation. The mediator explained that the doctor “in the end wasn’t very satisfied and asked how long the father had been in Spain. When he said 5 years, the doctor asked ‘and why don’t you speak Spanish, how are you going to talk to us next time?’” This part of the conversation happened between the doctor and the patient without the mediator translating. The doctor asked the father to bring his son with him next time because the son studies in Spain, but the father said no, his son is only eight years old, and he knows the language but he does not know very much about other things.

The mediator in this case translated and watched the father and the doctor disagree. The case raises debates about the appropriateness of alternatives to mediation, such as using family as translators and also about how involved a mediator should become in resolving conflict.

**Introduction to the position of intercultural mediator**

The cases above are examples of what happens when a medical professional calls a mediator to assist with a case, but there is still debate about whether the mediators are necessary in the hospital and exactly what mediation means. Below I will summarize the mediators’ and the staffs’ perspectives on some of the questions surrounding the introduction of mediators to the hospital, beginning with whether mediation is even necessary. I will then describe the mediation training program, and introduce the role that they play in the hospital. I will then briefly present some of the debates surrounding the definition of the mediator’s position.

**The Need**

Staff, patients and mediators alike see the need for mediation as a response to the increase in immigration to Spain and to Barcelona. The mediators, in a draft of a document that they are producing to explain their role in the hospital, list a number of barriers that immigrants face in accessing the health system⁶. The barriers highlight the need for intercultural mediators. They are; lack of local language skills, lack of knowledge of the health system, legal status, differences in culture and health beliefs, fear, shame and rejection by the health professionals, and socio-economic factors. They explain in more detail that,

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⁶ “Modelo de Mediación Intercultural en el ámbito Socio-Sanitario en el Hospital Vall d’Hebron”
Often when an immigrant comes to a hospital health professionals can’t contact the patient because he doesn’t give his name or his address for fear or insecurity… the lack of language makes it take longer to diagnose him, and the medical professional doesn’t have time. Also, misunderstanding can cause a misdiagnosis and an incorrect treatment that has side effects… which causes the patient to have less confidence in his doctor. The doctor, faced with different cultural behaviors finds himself unable to manage because of his limited cultural knowledge.

Like the mediators, some staff also mentioned things that can make it hard for new immigrants to access the health services, including fear and unstable work situations.

Both patients and staff think that the immigrants who most need mediation are those who have recently arrived, who don’t have social or family support and who don’t speak very much Spanish. They agree for example that South American patients don’t need mediation services as much as other immigrants because they can express themselves well. They point out some exceptions to the rule that recent immigrants with poor Spanish skills are those who require mediation. One that they mention often is the Gypsy community. Staff people admit that there are problems between Gypsies and other groups of Spaniards, and they complain repeatedly about the way that Gypsy families behave when they have a relative in the hospital.

Despite the needs recognized above, there are also staff who don’t see a need for mediation. One nurse in the general hospital believes that mediation isn’t necessary because nurses can communicate with patients from all cultures. Her perspective is that nursing education includes training in cultural competency and that if a patient really needs or wants something he will be able to communicate well enough for her to provide it. She says that if mediation is done at all, it should be done outside the hospital to teach immigrants about the resources that are available.

Mediators tend to take the need for mediation for granted, and are sometimes frustrated that other professionals within the hospital don’t recognize the importance of their services or put them on an equal level with other health professionals. They say that it is the immigrants themselves and the ‘little hernias’ in the health system that has made problems with minority patients visible. By ‘little hernias’, the mediators are referring to the conflicts, omissions and discrimination that they and others have noticed. Specifically, they criticize health treatment for being technical, cold and short, and imply that these are shortcomings that mediation can help to improve.

Mediation has the potential to change not only the way that individual medical encounters are conducted, but also the way that the health system in general responds
Intercultural mediation was created in response to an increasing diversity in the local community, and both staff and mediators see a need for mediation as a way to increase cultural competency on an individual and a procedural level. Nonetheless, their perspectives on the level of cultural competency that they already have and on the need for improvement vary.

Program staff explained that cultural competency is the ability to do one’s job successfully with anyone, regardless of their culture. They have designed the mediators’ training program to focus heavily on identity and interculturality to prepare them to be culturally competent. But they explain that even culturally competent professionals cannot be expected to know about every culture. Instead, they should be able to ask for help from others when they need it. Other professionals in the hospital echoed their explanation, saying that cultural competence is an important achievement but that even once you are culturally competent you will need help from someone who knows more than you do. They also pointed out that regardless of their level of cultural competency, they do not know how to communicate with patients who speak other languages, so they believe that mediators are necessary.

Staff mentioned a number of issues that make multiculturalism problematic, including prejudices, discrimination and ethnocentrism. One social worker gave an example of why ethnocentrism is dangerous when dealing with patients of other cultures. She explained that in a case of abuse, where the line is between discipline and abuse is cultural. Some staff, like her, are far more able to recognize their weaknesses or shortcomings in dealing with issues raised by the confluence of multiple cultures than others. Staff with her level of awareness are generally more open to the idea of using the mediator as a tool to help them improve their own cultural competency.

When the mediators explain their understanding of the term ‘interculturality’, they touch on aspects of cultural competency. They define the term more broadly than the program staff, as a respect for culture and a recognition that all cultures have things in common. They mention that some staff in the hospital are better able to work with patients from their cultures than others. They said that some are not willing to admit that they need help and think that they can communicate with
anyone, and others “know their abilities and want to learn more”. This last group has gained the mediators’ approval.

The Program

Over the last few years the number of immigrant patients in the hospital has increased. In response to the changing patient base and a recognition that they needed support to serve the new patients adequately, social workers and nurses from at least two of the three units of the hospital had requested that cultural mediators be hired. Concurrently, a women’s organization for workforce development called SURT that teaches job skills to ‘disfavored’ women decided that it would be useful to run a training program for intercultural mediators in the health sector. They approached Vall d’Hebron Hospital about working with them, and eventually the two agencies signed an agreement that SURT would run the program at Vall d’Hebron. The mediators would complete one-year trainings and practicum at the hospital, paid by SURT with funds from the government’s department of labor. The first program ran in 2004, administered by the hospital’s Department of Transcultural Psychiatry with the collaboration of the department of Social Work and Client Services. The first year’s mediators were from Spain, Morocco, Algeria, Russia, Gambia, Senegal and Uruguay.

A second group of mediators has been working since September of 2004 and will complete their training course in September of 2005. The mediators in this group, who were working during my research, are from Spain, Morocco (2), Gambia, China, Russia, Romania and Pakistan. Between them they speak 15 languages. There are patients from each of these countries in the hospital, and there are demands for each of the mediators, but the Moroccan mediators are called most often and the Chinese mediator is called least often. As mentioned earlier, the hospital does not keep records of the ethnicity of its patients, so it’s hard to determine how representative the mediators are of the hospital’s patient population. In addition to their linguistic and ethnic diversity, the mediators are from a variety of professional and religious backgrounds. Four of the eight have experience in health or biological professions, and three of the eight had previous experience with intercultural mediation in a community or school setting.

The mediators spent the first six months of their year-long training program taking classes related to mediation and working in the hospital only as translators.
They are now completing a practicum in which they do mediation. While they are in
the hospital they spend most of their time in the classroom or in a library down the
hall, working on group projects and presentations, documenting their cases or
participating in supervision sessions. Often classes or speakers are scheduled and/or
run by the coordinators, and all mediators who are not providing mediations attend.

When a case that needs mediation is identified by a professional in the
hospital, someone contacts one of the program coordinators by cell phone and he or
she contacts the mediator who is needed, either by cell phone or in person, and tells
her the location and the details of the case. The mediator puts on her lab coat and
goes to find the doctor, nurse or social worker who has made the demand. After
conducting the mediation she tries to conduct or schedule an interview with the
professional, and she returns to the classroom to join the activities that are going on
and to wait for another call.

The nature of the mediations, the subjects that are covered and the location of
the mediations vary tremendously. As an example, of the mediations that I observed,
one was conducted in an office, four by the hospital beds of patients, one in an
emergency room exam room, and one in a hallway. The number of mediations that
each woman does each week also varies. Some might do two and others might do
five or six, but in the months since they completed their initial 6-month training
period, the group of eight mediators has conducted more than 80 mediations and
follow-ups.

The work of intercultural mediation has not been officially recognized by the
government or the hospital as a profession (Cohen-Emerique and Fayman 2005), and
socio-sanitary intercultural mediation, the health-specific mediation that the mediators
in the hospital are being trained for, is even newer and therefore has even less
recognition. Although mediators from a local NGO are being subcontracted at a
number of health centers and hospitals, there is no certification required for them to
be hired and most of them have no specific health training. The training program at
the hospital is new and therefore few people know how thorough their training is. The
coordinators at SURT and at Vall d’Hebron have created internal standards for
training and for progression from classes to conducting mediations, but the standards
are not yet shared by all mediators in the city, and the requirements for moving from
one stage to another are not yet universally understood.
Because of this and because there is no standardized certification process for intercultural mediation, the diploma that the mediators will receive at the end of their training may not be very valuable. The mediators believe that their work is important and that they should be recognized and added to the government’s list of official professions. But before that can happen, the importance of mediation must be demonstrated and the role of the mediator must be defined.

The Role

There is some level of disagreement among staff about what the role of the mediator is and what it should be. The program coordinators explain that the primary role of the mediator is to improve communication between patient and provider through translation and other strategies that they have learned during their training, while other staff tends to think of the mediators primarily as translators. On two separate occasions nurses who spoke to other staff about the mediator referred to her as ‘the translator’ and the only service that the doctors and nurses appeared to expect during the mediations was translation. They were not opposed to the mediator participating in other ways in the encounter, but they did not seem to expect that she would. During interviews the medical staff that have worked for months with the mediators explained that their primary function is not translation, and pointed out that if it were, they could use a free phone translation service. It appears that the staff who work most closely with the mediators recognize the mediator’s role to be broader than merely translation, but that those with less exposure do not.

When describing the mediator’s duties, after translation, medical staff tends to focus on the mediator’s ability to calm both the patients and the providers during the encounter and to support each of them. In the cases that I observed, the patients who had been agitated or visibly in pain when we entered did calm down once they were able to speak to the mediator in their own language and able to have their questions answered. The providers seemed relieved to be able to tell the patient what they needed to tell them and ask the patient questions. Medical staff mention two other roles for the mediators, which are to explain a patient’s reaction to them or explain the hospital’s norms to patients.

The mediators’ explanation of their own role focuses very heavily on their job of improving communication and understanding between providers and patients. They describe themselves as a bridge or as a thread, as a point of contact between the
two parties, and explain that they can observe communication to make sure that everything is being understood and find a way to re-establish communication if it breaks down. Some of them also mention that their position is mute, one of passing information without participating actively in the communication. They note that communication is not just verbal, but also non-verbal, and that to transmit ideas correctly they must choose words very carefully and sometimes interpret metaphors and cultural ideas.

The mediators’ official title is “Estudiante del Taller Ocupacional de Mediación Intercultural Sociosanitario de SURT, haciendo la práctica en el Hospital Universitari Vall d’Hebron”. (Students of SURTs’ occupational workshop in socio-sanitary intercultural mediation, completing a practicum at the Vall d’Hebron Hospital) This is long and complex, and is often shortened for the sake of convenience. This can become problematic because some of the individual parts of the title are either still debated or have their own connotations. For example, mediation often refers to pure conflict resolution, so those who hear that the socio-sanitary intercultural mediators are mediators might expect them to be trained extensively in conflict resolution. Some people refer to them as intercultural mediators and others as students. The title of ‘students’ is important because, as will be discussed in the following section, the question of when they are seen as students and when they are seen as professional is complicated. Additionally, calling them ‘students of the workshop’ might be confusing for those who see them in the halls or in consultations and think that they are staff of the hospital. A clarification of their role would help not only for the sake of the mediators and their coordinator’s peace of mind, but also to explain their status, their position, and the expectations that go along with them to the rest of the hospital staff.

**Debates about the mediator’s role**

**Staff vs. Student**

The mediators who I worked with are students in a year-long occupational training program being run in the hospital. They are the only mediators in the hospital. When asked about the fact that the mediators are referred to as both professionals and students, program staff explained that the mediators are working as
professionals, with all the rights and responsibilities of professionals, but that they are students because they are still being trained. They explain that being clear about their student status is a way to protect them from the full responsibilities of professional status. They also explain that at the beginning of the year the mediators have no training and cannot be expected to mediate well. They believe that the rest of the staff has to understand that the mediators are students so that they won’t have unreasonable expectations of them, and so they will understand when the program ends and begins again with a new group of students. Other staff seem to have picked up the discourse of the coordinators or developed the same perspective and explain that they can’t expect too much of the mediators because they’re still students.

Surprisingly though, a paper that was used as part of the mediators’ training suggests that they introduce themselves to patients as professionals. It says, “La mediadora se presenta (nombre y función como profesional del Servicio de Mediación) ‘Soy…… y soy del servicio de mediación cultural del Hospital...’” “The mediator presents herself (name and function as a professional of the Mediation Service) ‘I am _____ and I’m from the Hospital’s cultural mediation service.’” Even to the professionals, the paper suggests that they present themselves by name and say that they are from the mediation service. It does not suggest that they say they’re students. As the hospital does not have its own mediation service, and the only mediators are from the training program, this can be hard to understand. Staff knows that the distinction between student and professional can sometimes be confusing. They also admit that some aspects of it, such as who would have legal responsibility in the case of a problem with a patient if the patient blamed the mediator, and fundamental questions such as when and how they will pass from being students to being professional have not yet been clarified.

The mediators refer to all other hospital staff, including doctors in residence, as professionals but do not refer to themselves as professionals unless their status is being challenged. Among themselves ‘professionals’ means everyone else, but they complain that the professionals don’t recognize them as equals and that they need to present themselves as professionals in order to gain respect. They still see themselves as students in many ways. They talk about mistakes that they make or things that they think they should improve. For example, one mediator says that she wishes her Spanish were better, and another explains that she needed to work with herself for days after the case described in case study 3 to learn to control her emotions and be
less affected the next time. They explain that at the beginning of the year that were only allowed to do direct translation, but now, as they learn more, they are allowed to do mediation. They seem to appreciate the excuse that being students gives them. One of them requested that on a flyer for an event outside the hospital they be listed as students of mediation, and they are careful to sign documents as ‘students in an occupational workshop for mediation’.

In some ways the mediators are not given the same rights and responsibilities as the other professionals in training. At the beginning of the year they were not allowed to eat in the cafeteria, and even now they are not given the same subsidized lunch as all of the hospital employees. They wear lab coats, they deal with patients, they ride the staff elevator, but their behavior is reviewed in meetings not only by their supervisor but also by social workers who would be their ‘peers’ if they were also professionals. I also observed that the supervisor is available to step in to smooth any conflict that arises over their behavior, apologizing and claiming that they are students.

**New Profession or a New Take on an Old Idea?**

Positions similar to that of the intercultural mediators exist in different parts of the world and in many institutions, with different titles. In the United States for example, members of ethnic minority communities who are hired to work in hospitals to facilitate communication with health professionals are most often called medical interpreters. In other places they are called culture brokers and in others still, cultural mediators. Often their job includes translation, yet translation is in many countries now a recognized profession with official training and certification procedures. The mediators often complain that they are seen as translators, and one of the program coordinators admits that on paper, the job of a socio-sanitary intercultural mediator is not very different from that of a medical interpreter. But as part of an emerging profession, it is important for the mediators to clearly differentiate their title from those that already exist. There is still much debate about the meaning of each title. The Intercultural Mediators at Vall d’Hebron are trying to determine where intercultural mediation ends and the other professions, of translator or medical interpreter begin, or whether the titles all mean the same thing in practice. Much time was spent in the classroom discussing whether there is in fact a difference and just what the difference is.
Some medical professionals in the hospital seem to recognize that there are differences between mediation and translation because they see aspects of mediation that are unique, such as explaining cultural beliefs and resolving conflicts with groups that speak Spanish. Program staff is aware of even finer distinctions. One program coordinator explained that although they might do almost the same job, the final objective of translation is different than that of mediation. She says that for an translator or interpreter, the final goal is to remain true to the message being transmitted, while for a mediator, the final goal is to facilitate and maintain good communication between patient and provider. She says mediators might be more conscious than translators of how the messages that they transmit are received. Medical and program staff mentioned that mediators are also different from translators in that they relieve tensions between the patient and the provider by their mere presence, and don’t necessarily need to speak to do their job well.

Mediators are even more concerned than program staff with the distinction between mediation and interpretation or translation. One explained that there’s ‘something more’ to mediation than translation, but she was not able to articulate the difference. Another explained that

The [mediator] also has to look for points to resolve conflicts that come from culture or from the health system…in an interdisciplinary way…it’s much deeper than a translator. The translator has to pass things without getting very involved, but the mediator also has to know something about the culture

A woman who works with community mediators came to speak to the class at the hospital and I attended her presentation. The mediators worried aloud about tension that could exist between mediators and translators in a hospital because they do almost the same job. The speaker explained that in general, mediation education does not include a solid training in direct translation skills, and that the training that professional translators or interpreters complete does not include very much practice in understanding the socio-cultural aspects of situations. She challenged them to decide whether it’s better to train in one or the other or to combine the two sets of skills in one professional. They agreed that it would be best to combine the two skill-sets in their position as mediators.

Socio-sanitary mediation is a new form of mediation that happens specifically in a health setting, done by mediators who are knowledgeable about the health system. As such, it has to differentiate itself not only from translation and mediation,
but also from community mediation with which people in Barcelona might be more familiar. Mediators and staff agree that although socio-sanitary mediation was developed from the base of community mediation, there are some significant differences between them. One mediator who has experience with mediation in a school setting explains that the health setting has its own set of concerns, and that the approach as well as the feeling are completely different in the two settings. Another mediator explains that the health setting brings with it people’s understandings of health and disease, and that it carries more suffering and pain. Staff and mediators both explain that in community mediation the mediator is involved in a different way, with more ability to affect the situation directly, and they also explain that community mediation is centered on conflict resolution whereas health mediation is centered on communication.

**Advocate vs. Neutral Participant**

An important debate that directly affects the definition of the mediator’s role is what constitutes the ideal stance for the mediator; that of advocate, for one or both parties, or that of an objective, neutral participant with equal alliances. Staff has a number of ideas about the mediator’s alliance and neutrality. They tend to believe that the mediator will identify most easily with the patient. A social worker used an interesting metaphor to describe the ideal position of the mediator. She said that they should be like a judge, who belongs to the legal system, but is not in favor of either the defendant or the prosecution.

One staff member describes the ideal role less as that of neutrality than a double fidelity or balanced allegiance:

Especially at the beginning there’s so much identification with the immigrant, they identify with the immigrant because they’re immigrants themselves…they have to feel that they’re immigrants but they’re also part of the health system, so they have to play a double game. At the beginning of their training the other part of identifying with the health personnel isn’t there…when they do translation…it’s true that neutrality does have to play an important part, but I wouldn’t really talk about neutrality in this case, but rather staying true to the message. This is different than neutrality because in the end neutrality puts you in a position, of objectivity, of neutrality…the concept that they have to incorporate is that of double fidelity.

Issues of allegiance become tricky when the mediator is a member of the professional community and also a member of the patient’s community. One program coordinator explained that although it’s dangerous for the mediator to speak to the patient outside
the medical interview, it is all right for her to speak to the provider. In fact, the mediators are encouraged to have pre and post interviews with the providers where they discuss the case and talk about how the mediation will be conducted and how it went. They are also encouraged to enter and leave a medical consultation with the professional and not to spend time alone with the patient.

One program coordinator believes that advocating for the patients will alienate and anger the health professionals. He says, “Some will say that one of the roles of the cultural mediator is to be a patient advocate…that’s the last thing we need at this stage in the game, is to irritate medical personnel.” He seems to believe that being aligned with the professionals is acceptable because the mediators are their colleagues, He explains,

If we start from the basis that the mediators are part of the medical team, there’s no reason why there shouldn’t be any kind of engagement…maybe the ideal is that the mediators are really 100% neutral, and they come in as a service, and they leave, and they don’t have that kind of pre-existing relationship, although I would tend to believe that the better they understand social workers or nurses, the better they’ll be able to facilitate communication

but having this position of collegial status with the providers and no connection to the patient may challenge the ideal of balanced allegiances.

The mediators are also conscious of the need for balance, but they point out some inconsistencies in the double allegiance that they are required to maintain. They seem uncomfortable with the difference between how they are expected to relate with the patients and how they relate with the providers. For example, one asks whether they can negotiate with the patient the same way that they can negotiate with the professional, and they point out that their relationship with the patient is different because it’s more social. They say another reason that the relations are not the same is that it’s the professional who makes the demand for their services.

**Incorporation into the Hospital**

Both program staff and medical staff admits that the figure of the mediator is not yet fully accepted by the hospital. One person describes the situation thus

The cultural mediator doesn’t exist. It’s a curious thing. You have this person who’s in the hospital, who’s participating as part of the medical team, who has an absolutely tremendous amount of influence over the patient, they have no legal recognition, they have no formal recognition…there’s an appreciation of this role, but as a formal recognition, it isn’t there.
The situation is complicated because the figure is new and also because the issue of immigration is sensitive. One social worker explains this sensitivity and also warns about the way in which the mediators are introduced. She says,

It’s always hard to adapt ourselves to new things…because the topic of immigration is a hard topic, it could have detractors, it’s not a light thing, it’s very important theme that could have a lot of connotations. If we put all of this together, introducing this professional has to be done very carefully because at first it’s already difficult and then you have to be very careful about how to introduce the figure, how, at what moment, you have to have a lot of things in mind, its’ very complicated.

Program staff explain that although the mediators at first didn’t see themselves as part of the hospital team, now that they wear lab coats and attend meetings they feel more integrated. One coordinator believes that the difficulties in integration are not from the mediators themselves, but rather that the hospital has not learned to utilize them as frequently as they should. He says,

I think they’ve integrated well, without big problems. The critique is from the other side, the students have shown their willingness to integrate, but the hospital hasn’t shown, almost two years later, a willingness to call in the mediation services. I’m the same, in most of my appointments I don’t call a mediator because I think I can understand well enough, but in other specialties even more, and this makes integration harder.

Unlike this coordinator, many staff people believe that much of the work of integration depends on the mediators themselves and how well they can assert themselves.

The Mediators program was introduced last year, and although at first the coordinators expected it to be run in close collaboration with that hospital’s nurses, in the end it was connected to Social work and client services. Two reasons that they gave for this were that the work of the mediators would have a social nature and that all of the social workers and the mediators are women.

Demands for the mediators generally pass through social work before reaching the mediator program. The social work administrator receives demands from doctors, nurses and even from some patients, and she calls the program coordinator asking for particular mediators. She says that they decide on who to ask for based on what language they think the patient speaks, and if the patient is black, they call the black mediator. The social workers contact the mediators directly. The program coordinators are trying to formalize both the channels for demands and the demands
themselves, by creating schemes and by using a form to ask for mediation, but there is some resistance from the social workers who say that it will make the mediators seem less like part of the team.

The mediators explain that it is very seldom that a doctor makes a demand, but that they can, and that it is even more seldom that a patient initiates the demand. They question the value of all demands passing through social work. They say that some groups of patients don’t even know about the mediators, but others who do can only ask social workers, and if the social workers don’t contact the mediator the patient can end up wandering the halls looking for one of them. They suggest finding a way for the patients to reach the mediators directly, by posting signs for patients or even creating a box where patients could drop their requests for mediation. One of the mediators says that this is important because mediation is a service for both professionals and for patients.

Officially, all of the mediator’s cases should be either carried out or discussed with a social worker. Some social workers are pleased with this situation, but program staff explained that others have chosen not to work with them this year because they were forced to take responsibility for the mediators last year and were frustrated with the arrangement. Some nurses, including one that I spoke to, are not pleased with the way that the program was introduced and particularly with the fact that the social workers and not the nurses were given responsibility for the mediators. The social workers that continue to work with the mediators recognize many similarities between their own work and that of the mediators and they believe that the connection between them is logical. One social worker explains that they too passed through a process of integrating and professionalizing a new role in the hospital, and that they are still given less respect and resources than the more established and medicalized professions. But they say there has been a shift within the hospital context from a purely biological perspective to a more global view of the patient that has been to their benefit.

Mediators and program staff raised the possibility that social workers and nurses see the mediators as impinging on their space or their responsibilities. When they were asked directly about this, two social workers said that they are not threatened by the mediators, and in fact, even though there are elements of their work that are very similar, they see the mediators as complimentary, as a tool that they can use to improve patient care. Specifically, one social worker said,
The mediators can’t step in on the work of the social workers because we’re social workers and we have very concrete functions… anything that lets you develop, in the sense of bringing knowledge or health education, no one can understand it as stepping on our turf, it’s a tool. Every one of us within a multidisciplinary team is a tool, coming together at a determined point, the patient.

Most nurses who have not worked with the mediators were extremely pleased to hear about the program and they said that if there were elements of the role that overlapped with theirs, the presence of the mediators would still be a support because they have more work than they can handle right now. Almost all staff agreed that mediation is different than their own profession and helpful.

The mediators say that if the professionals are sure about their work they should not feel threatened, but they understand that people have had to work hard to gain the terrain that they have, so they say it’s natural to worry about invaders. One says that,

There are some who see you as one more person who’ll help them and who’s part of the team…I still haven’t found any who think you’re trespassing or that they don’t need the mediators because they can solve everything themselves, I haven’t heard any but I think they exist, that think you’re stepping on their ground or trying to do their job. I don’t think we’ve ever tried to take anyone’s job or do anyone’s work, everyone has their role within the work.

The mediators are generally much less optimistic about their status in the hospital than staff. One says that the professionals see them as extraterrestrials. Another says that when she’s not called for mediations she feels like she doesn’t exist. A third says that they are nobody in the hospital, and a fourth says that even if they complain about how the hospital is run nobody will care because “we are like a line of ants in a big forest.”

They give various explanations for why they are not recognized like the other staff, ranging from the idea that the staff are threatened by the power that they have when translating, to the idea that they are not being presented well. One mediator explains,

If you work in an ugly disgusting office you won’t have credibility. If it’s a very pretty office with flowers and other things, with everything ultra-modern, you have lots of space to work and you go along presenting yourself well, you give yourself more credibility. But if we’re below, in a little classroom, alone, with a computer that doesn’t work and another that’s broken, there’s no telephone to connect…
She implies that the physical location and the resources allocated to the program affect the way that they are seen or not seen by the rest of the hospital. Another says that they should do publicity and find strategies to make themselves needed within the hospital. They say that the process of professionalization is still missing a lot and they hope for some kind of recognition and for the medical staff to value them, but they also admit that it’s hard to develop a good relationship with staff before working with them directly.

**Elements of the mediators’ role**

The different elements of the mediator’s role can never be fully separated from one another. It is through translation that mediators can make patients feel more comfortable and through facilitating communication that they can sometimes resolve conflict, but the process of defining their role is one of including, excluding and defining tasks. Below I will present hospital staff and mediators’ thoughts about the tasks of translating, facilitating communication, supporting the patient and the hospital, and resolving conflict and how they fit into the mediator’s role.

**Translating**

A key portion of the mediator’s role is that of translating between the patient and the provider. Medical staff explained that this task is extremely important because not knowing the language and not being able to express what they’re feeling is an added stressor for many immigrants. One social worker described it as “the spark that could set off the detonator for other conflicts”.

One of the program coordinators describes the mediators’ translation as having two components, literal and metaphorical, “with the mediator saying ‘the patient said’… and ‘normally in my culture that means’”. The literal translation that he describes is direct translation from one language to another. One of the mediators describes their translation work similarly. She says that they begin with translation, and then move on to clarification. But the program coordinator cautioned that in reality, there is no literal translation, but that all translation is interpretation once it is spoken. He believes that language is key to the mediator’s role but that language and culture are closely bound to the point that they cannot be fully separated. This implies that translation is not as simple a task as it might appear; it is both linguistic and cultural. Some staff mentioned that they hesitate to use the mediators as translators.
This is because there is no way to check the quality of her translation. One staff person explained, “When there’s someone who speaks another language and you don’t know it you have to put all your trust in the person to translate correctly, if you see that things are being said outside of the translation or that the translation is much shorter, then it goes against your confidence”.

The mediators mention a number of problems that they have faced in providing literal and metaphorical translations. They explain that patients sometimes use metaphors or cultural expressions that are difficult to explain to the doctors. For example, one mediator mentioned that during one of her first mediations a patient wanted to thank the doctor for doing a good job, and used an expression from his culture, literally that he wanted to ‘kiss her vagina’. She said that in Spanish the phrase would have been very rude. She didn’t feel comfortable translating it literally for the doctor because she thought that it would be misunderstood, so she just told the doctor that the patient thanked him very much. Other metaphors can be translated literally, but then need to be explained. For example, the same mediator mentioned that in another mediation a patient used the expression that people are like eggs, and the doctor thought that he was comparing people to chickens, but she explained to the doctor that the patient was referring to the fragility of life, that like an egg, life can break at any moment.

Unlike the doctors, the mediators mention translation not only from the language of one country to that of another, but also from technical medical terminology to words that the patients can understand. The mediators talked about how difficult it is to learn all of the medical vocabulary that they need to translate, and many of them believe that if their own Spanish skills were better, they would be able to do a better job at mediations. They often ask the doctors or nurses to explain what medical terms means in simpler words. The mediators are creative in their approaches to resolving situations in which the professional will not or can not explain the term more simply. In one case a mediator had to explain the valves in the veins that stop blood from flowing in the wrong direction to the family of a baby girl with a blood problem. She did not know the word in Chinese, but she came up with a culturally appropriate explanation of the technical medical term by comparing the valves to the valves along a bamboo stalk, and the family understood.
Facilitating Communication

The mediators have been taught that the best way to improve communication between provider and patient is to carry out their functions in a triangular interview, with the patient, the mediator and a medical professional. Staff explain that during this interview the mediator should transmit every piece of information that is said in either direction. Ideally, the primary relationship should be between the provider and the patient, and they should look at each other when they speak even though the mediator is translating. The mediator should do direct translation and be as unobtrusive as possible, and should sometimes insert comments to clarify issues. Her goal is to assure a smooth communication between patient and provider without lapses or misunderstandings.

Mediators often describe their role in facilitating communication as being a bridge between the patient and the provider, but they also have to contribute to the conversation when they see that there is something missing or when they note miscommunication. One mediator explains that,

An intercultural mediator is a mute person, a person who has to pass the information. It’s a person who’s in between. You know we talk about a triangle, it’s the person who’s below the triangle, no, not below, but in the middle, they’re between two parts, the professional and the user…you also have to look for a point to resolve the conflict.

Others go beyond her explanation to say that they try to make sure that both parties really understand what’s being transmitted. In case 3 the mediator described how during a long and painful test that a patient was undergoing, she was able to very clearly pass the instructions from the medical staff to the patient, about when to breathe, when to stop breathing and when to move, and that this transmission facilitated the communication and made the whole process go much faster.

But mediators do sometimes contribute to the conversation. For example, one mediator explained that during an interview the doctor told a patient who had had part of his digestive tract removed that he could eat anything when he got home. The mediator, knowing that the family of the man probably all eats from the same pot of food and that the food would be very greasy, explained the situation to the doctor and the doctor, with the extra information, explained more clearly what kind of food the man should eat and wrote out a special diet. In another case, a mediator was working with a woman with a heart condition who had recently had a second abortion. When
the doctor was sending the woman home, the mediator was concerned that the woman had not received any information about contraception, and she was worried that the woman would find herself in the same situation again. She explained to me that each time it would be more dangerous. During their last meeting before the woman was discharged, the mediator asked the doctor to give the woman some information about how to prevent pregnancy, and the doctor was surprised. He said that he had thought that in her culture the topic of contraception was not discussed, but after the mediator raised the issue he gave the woman information about using condoms. In both cases the mediator noticed that information was missing from the exchange and added what she thought was necessary.

Supporting the Patient

Staff mentioned many times that a mediator can make a patient feel more comfortable because she speaks the same language and lets the patient explain what’s wrong. A patient who had worked with a mediator confirmed the idea that the mediator can help to calm tension. She said that the mediator’s presence helped because it made her family “feel more serene”. Mediators agree that their presence relaxes the patient, makes him or her feel like there’s an ally in the room, and facilitates his or her access to the professionals. Although they said that just being in the room and speaking the patient’s language helped to make them feel more secure, there are also other ways that they calmed the patients. One example is the case of a young woman who had a tumor on her hand and was worried because the surgeons were going to cut it off. The mediator explained to the surgical team how important it was for the girl to keep her hand and they agreed to take off only a portion of it. The mediator explained to me that the girl kept asking whether they were going to cut off her hand, and she kept asking the doctors and explaining that no, they were only going to take off a piece. She continued to transmit the girl’s questions and the doctor’s answers for hours. In case number 3 described above, the mediator used her knowledge of the patient’s culture and her ability to speak the patient’s language to calm her down. Her suggestion that the woman read Koran in her head and imagine herself in a happy place helped the woman stay calm through a painful procedure. In case 1 the mediator calmed the patient’s husband by explaining that a cesarean had been performed on his wife not because she was a foreigner, but because the baby had been in danger.
Staff mention another way that the mediators support patients, by explaining things to the professional that the patient might not be willing or able to discuss. For example, one social worker worked with a mediator on the case of a man who had been robbed and beaten. She mentioned that at one point the man came to an appointment drunk, and although she would have told him not to come after drinking, the mediator explained that she should not mention it because it would make the man feel ashamed. In another case a mediator mentioned that one of her patients felt ashamed to discuss the details of a gypsy tribunal in his country because the professionals hadn’t seemed receptive the first time that he mentioned it. The mediator encouraged him to speak and supported him in explaining it to them.

The mediators told me that often conflicts arise because the parties don’t understand what’s being transmitted. They give many examples of when and how they explain things to patients. These include explaining when to take pills and what the side effects might be, explaining what a treatment will consist of, explaining why the professionals are doing what they’re doing, explaining how the health system works and explaining pathology in less technical terms.

**Supporting the Professional**

The mediator’s work and her presence not only support and calm the patient, but also the provider. Staff mentioned that mediators support them in very tangible ways, like helping them to get information from patients if they can’t do it themselves and they also support them in more emotional ways. The mediators explain that sometimes their presence makes staff more comfortable working with patients from cultures that they don’t generally feel comfortable with. They also mention situations where they help the hospital with its work of providing the patient with good care. In case number 2 above, with the mediator’s help, a treatment lasted less than two hours instead of four hours as it had the time before. In case 1, the mediator explained that in her country it’s normal to wait a few days before beginning to breastfeed, and she calmed the nurses’ fears that the mother was rejecting her baby. In case 3 the mediator explained to the nursing supervisor that before informing anyone of the boy’s death they should find out who the patriarch is and give the information to him. In another case, a social worker brought a mediator to a meeting because the medical team working on the case had to make a delicate decision about whether what they
had seen was abuse, and the mediator was able to provide relevant information about the culture that the patient’s family came from.

Within their role of supporting the hospital, the mediators tend to focus on their job of explaining culture and cultural values to the professionals, and they describe a number of situations in which they have done so. They talk about explaining gestures and metaphors, explaining to a group of nurses that when a young patient doesn’t look them in the eyes it’s out of respect, not disrespect, and explaining the cultural meanings of having a family member in the hospital. They often offer explanations in order to improve the professionals’ view of their culture both during medical encounters and outside them. One mediator complains that because of their professional pride, the doctors don’t recognize the help that they’re getting from the mediators but they hope that eventually their work will make them more open towards immigrants.

**Resolving Conflict**

Case 2 described above was a clear case of conflict. A family was mourning loudly in the trauma hospital, all visits stopped and the security guards and the police were called in. The mediator was able to calm the disturbance and return service to normal. But the definition of conflict and the scale at which a disturbance or tension is considered conflict is debatable. The program staff and the mediators discuss the fact that the definition of conflict varies from culture to culture and from person to person within a culture. For example, one of the program coordinators thinks that a disagreement only reaches the scale of conflict when emotions are so high that there is no communication, but another thinks that conflict can even be as minor as internal debate. Some of the mediators’ definitions of conflict are even more extreme. One thinks that a conflict is a disagreement that becomes a war, and others think of it as a battle or violence.

There is disagreement about what types of conflict the mediators should resolve. On one hand, program staff mentions that although the mediators are not trained specifically in conflict resolution, it does enter into their responsibilities. They say that the mediators are not called on to resolve conflicts, but to translate, and they question whether what the mediators do is really conflict resolution or approximation. On the other hand, both agree that the mediators should not get involved when the two parties do not want to resolve the conflict, and they think that
they can not be expected to resolve a conflict when there is a complete break-down of communication. They say that what they can do is bring parties closer together when communication weakens. Staff also questions the mediators’ capacity to resolve conflicts that are not culturally based.

The mediators mention a number of cultural conflicts that arise, such as a woman not being willing to get undressed in front of a male doctor because she doesn’t see him as a man who will cure her, but merely as a man, and a gypsy family wanting to take the body of a loved one who has died home until the burial. They also describe a number of factors that can cause conflict. One is lack of cultural or linguistic understanding and one is lack of information. Another mediator adds that a lot of conflicts come from overly rigid reactions on the part of the hospital or the patient. She explains for example that the hospital believes that technical and spiritual approaches to health are incompatible while she thinks that the two can be complimentary. She also explained that patients hold tightly to their practices when they don’t need to. She says that in the hospital,

It’s all chemical and biomedical and it ignores the spiritual as if they’re not compatible, and sometimes they are compatible because everything spiritual affects us and makes us react differently and can benefit us too, there are probably things that aren’t compatible with medicines, but if you put, I don’t know, a piece of the Koran under your pillow or a bracelet it can help the people who believe in it but without having a bad effect. They’re things that the hospital doesn’t have to be rigid about, and other things are the culture…There are people who don’t do what you give them, like the question of Ramadan for diabetics and all that, there are even people who think they can’t take pills during the day and then the imam himself gives them permission to do it…these are things that mediation can fix, both sides, when they’re in doubt because their reactions are very rigid.

In response to these conflicts the mediators use a number of different strategies. They try to find points in common and make both parties see that theirs is not the only answer, they teach the professionals about the patient’s culture and cultural values. They try to find ways to make each person question their own rigid reactions.

A couple from South America described difficulties they faced at the hospital and the tension that they felt. The young couple explained that everything at the hospital has its norms and regulations, and even if you don’t want to do something at a particular time you have to because it’s scheduled. The mother explained that while giving birth they had hooked her up to a lot of different monitors for the baby’s heartbeat and she didn’t want them all, but she had no choice. They also gave her anesthetic and used forceps, which she did not understand. Although these conflicts
never reached the point where a mediator was needed, they make it clear that even in
a ‘conflict free’ hospital stay for people who speak fluent Spanish, there are things
that are frightening or frustrating for the patient and that could or should be clarified.

In case number 1 above, the father was angry and frightened because a
procedure had been performed on his wife without being fully explained. In another
case a patient described the conflict that caused the doctor to call a mediator. She said
that the baby who had been admitted to the hospital had a high fever and had been in
the hospital for a long time but was not getting better. The hospital wanted to do more
tests, but the baby’s father was frustrated and wanted to take her out and take her to
another hospital. She said that the mediator was called to convince them to leave the
baby there and allow the tests to be done. In this case too, the patient’s family was
frustrated and frightened and the hospital did not explain all of the details of what was
being done and why. In these cases the same type of confusion led to situations that
required mediation. As the mediators mentioned, the conflicts arose from a lack of
understanding or a lack of information, and were resolved by improving
communication between the professionals and the patients.

These discussions are relevant to all of the mediators, but they are particularly
important in the case of the Gypsy mediator. When staff discusses conflicts during
interviews they almost always use the example of Gypsies and their unwillingness to
follow the rules of the hospital. They talk about the disturbances that they cause by
bringing their large extended families to the hospital and smoking or cooking or
mourning loudly. Unlike the rest of the mediators, the Gypsy mediator is Spanish by
birth, and as Spaniards for hundreds of years; the group that she works with is not a
language minority but solely an ethnic minority. The majority of the mediators
complain that they are called most often for translation, but the gypsy mediator
explains that in her case, “it’s not translation or information they want, they call me
for conflict resolution.” But she, like the other mediators, has not completed a
specific training in conflict resolution, and although the conflicts that she mediates are
generally cultural, there are sometimes other elements contributing to the conflict that
the mediators’ interculturally-focused training did not address. For example, one
mediation was between a doctor and the family of a small baby who was going to be
transferred to another hospital. The family didn’t want to move the baby from where
he was and didn’t understand why he would be moved. The doctor called for the
mediator’s help. In this case there seemed to be an existing personal conflict between
the doctor and the baby’s father. If the conflict that she was called to mediate was cultural at all, it was a conflict caused by the complex technical medical culture that the doctor hadn’t clarified and that the patients had not understood rather than by differences of ethnic culture.

**Role Limits**

The limits of the mediator’s role are hotly debated. The process of defining what elements belong within the mediators’ role runs parallel to the process of defining what elements do not belong. Each limit that is set serves to further specify what it is that the mediators do. But as the mediators try to make themselves useful in the hospital, the limits that they and other staff place on them can sometimes be seen as impositions. The limits change and are clarified over time, as new situations arise and the limits are tested. For example, program coordinators mentioned that professionals sometimes call the mediators outside of their work schedule and expect them to do things that they would never expect of other colleagues.

Program staff repeatedly mention how important it is to respect the limits of the mediator’s role. These include limits in the mediator’s abilities, ethical limits, limits that they should keep in mind to maintain their professional image, and limits for their own comfort. One example of professional and ethical limits comes up in a hypothetical example that one of the coordinators offered. He explains that if a mediator is translating and a patient says that he has demons the phrase “could indicate…something that all of us could agree with at some level, or it could indicate a psychotic state.” He says that the mediator should translate literally and then explain what that phrase usually means in the patient’s culture, so that the doctor has the information available to make the decision about whether the patient is psychotic. He makes it clear that it should not be the mediator who makes this type of medical decision.

The program coordinators specify that conflict resolution only falls within the mediator’s role if the conflict is culture-based, and both staff members and mediators suggested that conflicts should only be their responsibility if they are related to health issues. But one program coordinator cautions that the mediators should only approach issues related to ethnic culture, and not issues based on “problematic hospital culture that affects all patients equally”, such as scheduling practices or the need for accompaniment.
In a more practical arena, program staff warn the mediators to be aware of the limits of their own language abilities when they are asked to translate documents. This touches on legal issues as well. Although the mediators’ legal responsibility within the hospital has not been clearly established, the program coordinators warn them not to sign documents with their own name unless they add that they are students of mediation and that they are signing in that capacity.

Ethical dilemmas that came up in conversation with the staff included the fact that the mediators should not spend time alone with the patients so that they will not hear information that medical professionals don’t know about a case. They also mention that the mediators should not censor what the doctor says to the patient as they translate, and they should try not to visit patients in the hospital. Situations such as these did arise during my research. Patients stopped mediators in the halls to tell them about their situations or ask them questions, and the mediators had to decide whether to visit members of their community who were in the hospital. In the case of visiting, program staff stress the importance of going without a lab coat to make it clear that the patient should not expect them to act in the role of mediator. They seem concerned about the mediators acting unprofessionally by visiting patients from their community in the hospital and taking care of patients who they feel connected to.

One of the program coordinators explained to the mediators that the limits themselves are not as important as recognizing when you go beyond them and why. She says,

Think in every mediation to what point can I suggest or help, to what point the task has to do with the job of a mediator. It’ll depend on the case, but always keep in mind the clear objectives, but without fooling yourselves. The point is to realize when you’re doing something outside the job description and to recognize why, such as ‘the doctor scared me’ or ‘I don’t’ know what to do with the kid if I don’t watch him’…

The mediators provide a number of different reasons why they do respect the limits of their position. One explains that the hospital has norms and you can’t break them no matter what. Another says that in one case when a doctor asked her to talk to the patient without him she said no because she didn’t want to get involved in his personal life. Another said that even though the hospital called her to do a phone mediation on a Saturday she didn’t because they haven’t been trained for that. But at other times they consciously overstep the bounds that their program coordinators have suggested. One mediator explained that “when they ask you to do something in a
mediation you do it just because they’re asking” and another explained that when she’s working with a social worker and the social workers gets hysterical, she has to make decisions. One mediator explained that she even spoke to a patient about the importance of eating a variety of different foods during her pregnancy after the triangular interview with the doctor had ended, something that the program coordinators have warned the mediators against. Another said that although she knows it shouldn’t be part of the mediation, she told one patient that she would pray for her.

The limits that the coordinators set and the importance that they place on staying within the bounds of the job description are taken very seriously and very literally by some of the mediators, although they can sometimes be in direct conflict with the responsibilities that the mediators have to their communities. For example, one mediator described what happened when she didn’t visit the members of her community who were in the hospital. She says they were offended and decided that she “thought she was something in the hospital”, but she was scared to visit people because it wasn’t part of her work. Now she’s decided that as long as she goes without a lab coat and after work, it’s ok to visit.

**Barriers to the ideal mediation**

As part of their training, the mediators are taught how a mediation should ideally be run and what its goals are. They are even given a sample script for how to introduce themselves to the patients and to the professionals\(^7\). The presentation to professionals is (translated) as follows:

I am ________ from the mediation service. I’d like to explain how we work in mediation and I’d like you to explain the reason for your demand and the objective of the visit with the patient. If it seems to me that there are cultural or linguistic aspects that could make the visit difficult I will mention them.

How we work:

a) Please speak directly to the patient to maintain a helping relation with him.
b) If it’s necessary to do translation, make sentences short and simple...
c) Give [the patient] time to respond
d) I will be true to the translation, if the patient uses a complicated metaphor I will do a literal translation and the possible cultural significance of it
e) It’s better if we don’t talk about the patient in the interview; we can discuss it later
f) Agree with the professional about who will explain the mediators’ presence to the patient (in case you haven’t spoken to the patient).

\(^7\) From a paper used as training material for the mediators entitled “Protocolo de presentacion de la actuacion de Mediadoras Interculturales”
The ideal mediation assumes that a patient, a mediator and a professional will all be in the room together, that the professional will by that point know how the mediation will be conducted and that the mediator will know the details of the case. It also assumes that the mediator will transmit every phrase that is said, that she will be neutral and equally aligned with both parties, and that she will contribute cultural information as necessary to facilitate communication. This ‘perfect mediation’ is extremely difficult to achieve. When they hold supervisions, mediators and program coordinators often comment on the ways that the mediations should have been closer to the ideal, but they all seem to recognize that differences between the reality and the ideal of mediation are to be expected. The ideal is presented as a guideline for action, not as an answer to every situation that the mediators might encounter.

The mediators are very conscious of the differences between what they learn in the classroom and what happens in the hospital. One explains that “when it’s time to do a mediation what you learned in class doesn’t even come out”. The mediators complain that doctors almost never look patients in the eyes when they speak and sometimes don’t seem to want to hear what they try to tell them about their cultures. They explain that in these situations they can’t always act as they should. They can’t force doctors to listen or to change their behavior. My observations of mediations confirmed much of what the mediators complained about; that the doctors were always in a rush, that they didn’t take the time to sit down to discuss cases before or after mediations, and that many of them had never worked with a mediator before. I noticed that the professionals seemed to feel much more comfortable looking at and addressing comments to the mediator than to the patient, and that it was not easy to find a way to break into the conversation with clarification for either party.

There was a large variety in the way that the professionals treated the mediator and the patients and there was also variation in their patience, their timeliness, and their interest in learning about other cultures. Many of the professionals seemed interested only in finding out the details of the patient’s case but others seemed to want very much to be able to hold deeper conversations with the patients and their families. Two of the doctors even asked the mediator how to say goodbye in the patient’s language. During my observations the mediators did try to adhere to the guidelines for an ideal mediation, but the professionals did not always have the time or the interest to change their standard approach. One mediator explained that, “in the
end you have to do what the doctor says”. Clearly they know the theory, but they also work with the reality.

Below I will discuss four factors that may contribute to the differences between what the mediators learn in the classroom and what they find in the hospital wards. I will present the perspectives of both the staff and the mediators about each factor. These factors are: the way that information about the mediator program has been disseminated within the hospital, the resources available to resolve communication problems without using mediators, the effects that the mediators’ personal experiences can have on her work and the effect that her membership in a minority community can have on her work.

**Dissemination of Information**

One of the issues that makes it most difficult for the mediators to act in the ‘ideal’ way is that many people within the hospital don’t know what that ideal is, so when they find themselves working with a mediator, they have to juggle learning about mediation and treating the patient during the short time that they have allocated for an appointment. Others don’t even reach the point of working with a mediator because they don’t know that the program exists or how to get in touch with the program coordinators. Medical professionals have received information about the mediator program from a variety of sources, but this information is sometimes incomplete or hard to understand, and is not always consistent. For example, a group of nurses who knew nothing about the mediation program saw a flyer that listed the program coordinator’s name and phone number with a message that said “do you need cultural mediation?” They understood from it that the program coordinator’s name was the name of the hospital’s one cultural mediator and they did not know exactly what cultural mediation was or why to call. Another nurse thought that the program had been stopped after a provisional period and that it had then been started again. She didn’t understand that the program is an occupational workshop that will stop and start each year.

Staff complained about the fact that they have not met the mediators in person, that they don’t have a chance to ask questions directly. Many staff people seemed eager to learn about the program. They asked me questions as I spoke to them, and were pleased to hear more about the details of the program. They asked for presentations from the mediators and for more information. Medical staff are
surprised when they hear that the program has been running for so long, and a few of them told me during interviews that now that they know more about it they will call the mediators more often. Many of the staff that work with the mediators now have actively sought extra information. I saw that one of the nursing supervisors had added notes about the mediator’s hours in pencil at the bottom of her contact information sheet, and another supervisor said that she had gone outside the hospital to find information. They suggested a number of diffusion techniques, such as holding information sessions and sending an email with the program information to all hospital staff. Some of the suggestions that they made for how to share information have already been tried, but with little success.

The staff of the mediator program explained that in fact they have done a lot of diffusion within the hospital. They gave a presentation to the staff last year and they have sent informational emails. They have explained the program and left their own flyers with their contact information for the nursing supervisor on every floor, and they have organized for the mediators to do rotations with the social workers in order to be presented in every unit. But they say that little education has been done for the professionals because it’s hard to get people to attend a meeting. They recognize that there are weaknesses in the way that the program was introduced in its first year and that many professionals in the hospital still don’t know what a mediator is and how to work with one.

The mediators talk about the fact that they have gone to each floor of the hospital to present themselves, but they say that it is difficult to spread information in such a large hospital. They say that it would be good for people to know about the program before a conflict arises, referring to the fact that some people, such as the nurse mentioned in case 2, find out about them only when they arrive to resolve a conflict. One mediator mentions that when you talk to other staff they ask what you do, and this is an opportunity to teach them about the program.

Two of the mediators complained that the people from their cultures don’t know about the program. One said that in her culture there is not a strong network, and the patients don’t know about mediation because it’s still not recognized by the state. Another said that patients know about the service once they’ve been involved in a mediation, but that it would be good to have notices posted on the announcement boards telling others about the service.
The information that has been spread in the hospital has certainly had some effect. The nurses who I spoke to knew that the program existed because of the sign that was posted in their area, and one nursing supervisor learned about mediation at a meeting held by the program last year. Even though they had misconceptions about mediation and did not know the details, some said that their awareness of cultural differences had been raised, and a clear sign that people are learning about the program is that the demands for mediation are increasing. Many of the mediators would like to be called even more often, so there is still work to be done.

One social worker mentions that the openness of staff to education about mediation and cultural issues varies, but that things are improving; the newer doctors tend to be more open. To explain why more people are opening up to mediation, she says that sometimes awareness of the need is raised by the presence of the program itself. She explains,

Maybe we’re a little more sensitive now. You become aware, you don’t know up to what point you notice and then they offer things or if it’s that by offering them they open your eyes more to the possibilities, the fact that there’s the possibility of mediation makes you more likely to be aware.

She compares the process of introducing the mediators and educating other professionals about them to a similar process that the social workers went through. She says, “It’s like when we got here they call you for very concrete things and then realize you can do other things, I think this case is the same”

**Alternatives to Mediation**

There have only been mediators in the hospital for two years, but there have been immigrants and ethnic minorities coming to the hospital for much longer than that. Medical professionals and patients have found ways to communicate, from gestures to a phone translation service and many things in between. With few exceptions, hospital staff seem comfortable using other ways to communicate but mediators feel that they are the best option for improving communication. Case number 4 above highlights one common option, that of using the patient’s relatives as translators. In such cases, the relatives who know enough Spanish to translate are often the youngest children in the family, those who are attending school in Spain and have therefore learned more Spanish.
Staff explained that before calling a mediator, their first option is to try to communicate with the patient alone. If they can’t, they try to find colleagues who can, and if that doesn’t work, they call a mediator. Thus the mediators are only called in as a last-resort option. Sometimes they have residents, nurses or other doctors translate for them. There are resources that they have always depended on: those of the phone translation service, colleagues who speak the person’s language, or friends and family who accompany the patient. Some also mentioned that they can call the consulates of a patient’s country or his or her travel agency to arrange to have a translator sent over. In the emergency room conflict described in case 2, police and security guards were called in before the mediator.

Some of the staff think that these alternatives are sufficient, but others think that using a professional mediator is better. They give a number of explanations for why. For example, nurses complained that the consulates and travel agencies take a long time to send translators and one social worker explained that mediators are better than the phone translation service because they know about different cultures and not just different languages. One staff member says that there are cases where things should be explained by the hospital and he also says that the mediators are more professional. Even though staff are beginning to use mediators more often, they don’t seem concerned about having to fall back on their old techniques when the mediators aren’t available. The administrator of social work doesn’t seem worried about the mediators leaving for the summer and said they can go back to using the phone translation service, and in case 4 it is clear that despite the doctor’s awareness of the mediation service, he feels most comfortable using the patient’s older brother as a translator despite the fact that the boy is young and the topic of his sister’s illness is serious.

The mediators recognize point out that not only professionals but patients also have other resources for communication. They explain that patients from their cultures compensate for their lack of knowledge of Spanish by learning a few words related to their illness, by bringing translators or by having a friend translate on the phone. The mediators believe very strongly that they are in a better position to mediate and to translate than are the other people who the professionals depend on. They explain that relatives or friends who translate might not know enough technical medical vocabulary and they might not feel comfortable asking the doctors to explain again. They say that the patients also might not be able to discuss personal matters in
front of their families or their friends. One mediator gave the example that in her culture a man would never discuss a reproductive problem with a friend in the room. They also point out that their mediation is more helpful than communicating through gestures as many staff say they can. They say that the meaning of gestures varies from culture to culture and that even if people can communicate through signs, it will take longer than using the mediator to translate.

In the case of cultural conflicts, the mediator who has most experience with conflict resolution explains that if they only consider the other point of view, they might not have to call a security guard. They are frustrated by the difficulty of making the professionals understand how important it is to call them instead of depending on friends and family and security guards. They say that “the way it’s always been is that if the communication works, great, but if not, the patients will come back, and no one bothers to look more deeply at the communication between providers and patients.”

**Personal Experience and Emotion**

In case number 3 presented above, the mediator’s associations between the patient and her grandmother and her ideas about how elders should be respected made it very hard for her to maintain her composure during the mediation. Personal experience can affect the way that a case is handled, both positively and negatively. Staff mentioned that this is not only true for the mediators, but for every professional. Everyone is shaped by their previous experiences and they enter medical encounters with their own perspective, beliefs, positive and negative biases, and expectations. In terms of the mediators’ work, both staff and mediators brought up cases where past experience may have influenced the way that the case was handled.

Program staff often talks about the mediators’ personal experiences affecting their reactions to the situations that they mediate. These include such things as their experiences of discrimination in Spain, their previous experiences with or exposure to genital mutilation or child abuse and their maintenance of taboos from their cultures of origin. For example, in one case cultural taboos kept a mediator from being able to facilitate communication. She had to explain to a woman that she should collect her partner’s semen, but she couldn’t because she couldn’t bring herself to say the word semen.
One of the social workers who has worked with the mediators said that at first she hadn’t even thought about the effects of the mediators’ personal experience on what they said, but that the program coordinator told her be cautious in taking all of what the mediators say as truth. She said that now that she thinks about it, it must be very hard to make generalizations about your own culture and to separate your own experience from the norm, or even to articulate a norm. The program coordinators are strongly aware of the importance of the mediators’ own experiences, and they provide much time during supervisions of each case to discuss the case, the mediator’s relevant experiences and the reactions that the mediator had to it. All three of the program coordinators are psychiatrists, and their own training may contribute to their awareness of issues of transference and countertransference. They assured social workers that they are working hard to make the mediators aware of countertransference during each case and also to control the mediators’ tendency to defend the immigrant patients.

Social workers and other medical staff recognize that the mediators are affected by the emotional weight of the cases that they mediate, and they know from their own experience that the work can be very difficult. One of the social workers thinks that because of the time that it takes to learn to handle emotion in the hospital setting, a one-year course for mediation is short. Some staff mentioned that for personal reasons such as having children of their own, the mediators will be moved by the patients’ situations.

The mediators mentioned many times that it can be difficult and highly emotional to see the patients suffering, especially during their first few cases, and some of the examples that they gave made it clear that their personal experiences can make situations harder. During the mediation described in case 3, the patient brought back such powerful memories and associations for the mediator that she cried after the encounter and had to work with herself to control her emotions the next time she was called. In other cases though, their personal experiences and histories can actually help them do their job of mediation more successfully. One mediator explained that she works especially well with Muslims. She explains that she is a Christian, and in her country Christians are discriminated against, but when she had to work in the hospitals with Muslims at home, they praised her way of nursing and her human spirit. She is proud of the way that her work can “bear witness for Christ” and says that this motivates her to continue to work well with Muslims in the future.
The mediators make it clear that they experience the greatest emotional burden with their first cases. One mediator who was a nurse and a social worker explained that because of her previous positions she is able to see the patient as the object of her work and doesn’t get as emotional as some of her colleagues. There are some emotionally charged tasks that the mediators say will always be hard, like talking to patients about diseases such as cancer, but emotional burdens are not always negative. In certain cases even positive emotions can be overwhelming. One mediator described a surgical case that she had mediated and said that after meeting with the patient, the surgeon and the doctor for the first time she left the room and cried. At first she couldn’t figure out why she was crying, but then she realized that it was out of gratitude that she had had the opportunity to be in a surgical theater and gratitude that they had done so much for her compatriot.

Minority and Immigrant Status

An important element of the mediators’ personal experience is their experience with immigration or their minority status in Spain. For some, their experiences have made them more interested in becoming mediators, and others mention that their shared experiences of discrimination might make them more empathetic towards the patients. For example, one of the mediators who received her residence papers while I was doing my research mentioned that perhaps going through the whole ordeal of not being legal and having to get papers made her understand better what the immigrant patients are experiencing. In general though, the mediators did not often connect their experiences as minorities to how they worked in the hospital, while staff often mentioned that the mediators’ experiences made them feel closer to the patients.

One of the program coordinators knows that the mediators have experienced and continue to experience discrimination in their personal and professional lives; having their degrees discounted and struggling with the language, being stopped by the police and having to work in cleaning or other undervalued professions. The mediators are divided about whether they have experienced discrimination in Spain. One says that no, she does not feel marginalized, and another says yes, it’s very hard to find a job when you don’t have Spanish nationality and you’re over 35. Another talked about her experience arriving in Spain and how difficult it was. She says,
When I entered Spain I started cleaning houses and all, and I always cried, a lot, because my parents spent so much money so that I could do that career and here I can’t practice because the people don’t recognize my degree and it isn’t worth anything here. And they told me I have to do the course again and I’m not in a position to do it.

One of the reasons that she found it so hard to do the coursework again is that the classes are given in Catalan, and the local language that she has learned is Castilian. This is a struggle for most of the mediators. Even though they have become bilingual in their native language and Spanish, they will be marginalized in the workforce if they do not also speak Catalan. Another mediator mentioned that she had taken some computer classes in Barcelona, but she understood very little because they were given in Catalan.

The mediators also discussed the difficulties that patients face because of their immigrant status. They talked about how some patients might not even come to the doctor because they don’t have anyone to accompany them, they might be afraid because they are in the country illegally and they worry that they will be forced to leave. They don’t have a support network and they work hard and don’t have time to see a doctor. In general they don’t mention the patient’s difficulties in the same context as their own, but at one point one of the mediators wondered about whether having minority status in your country of origin makes a person more humble in their work in Spain.

Community Membership and Responsibilities

Staff often describe the mediator’s community membership and sense of community responsibility as a barrier to achieving the neutrality or double fidelity that they would like to see. They believe that if the mediators feel a strong sense of social responsibility they find themselves in a dilemma because they are required to help their community even if it is not the professional choice. A program coordinator explains the situation, saying, “we all want to conserve our identity, but on the level of health services here in the hospital, if I can’t maintain a double fidelity I’m going to act like a defender of immigrants and the professionals see you as one more barrier.” The same program coordinator mentions that some of the mediators have a stronger sense of community than others, and worries about one mediator in particular whose community expects her to share confidential information about what happens at the hospital.
Some of the mediators are aware of and open about their community membership than others. One mediator mentioned that initially she did not feel strongly connected to her collective, but now that she is doing mediation she feels a lot closer. Echoing some of her colleagues, she says that as she does the work of mediation and learns more about her own culture and the variations within it, and has started to feel more social responsibility.

Sometimes in [your country] you don’t have to justify…you don’t reflect on anything, because that’s the way it is and everyone does it the same way, but when you get here you start to see differences within the same collective and…you see other customs that are also from my country but aren’t mine, they’re not ours, because culture is also of the family, of the city. You see clearly that there’s not one truth but many truths…and then you start to think about the humility that is in these things and think that other ways are also good, and that they’re the reality of immigrants here, it incites you and you have this connection that we have here of social responsibility, even when they’re not my family, but for me before I didn’t’ think that.

Other mediators mentioned how the patient’s perception of their membership in the same community helps make patients feel more comfortable. They said, “the patients identify your presence in the room as something of theirs.”

The level of the mediators’ public identification with her ethnic community varies from moment to moment, and can be accepted or rejected as appropriate. One mediator mentioned that although within the group she is not the gypsy mediator, she also has gypsy blood, and sometimes patients notice that she has knowledge of their culture and they identify her, and that makes her very happy. Another mediator explained that when she arrived in Spain her father told her that she would have to be a representative of her culture, but that she did not want to be. But, she said, “Even if I don’t identify normally, when I see my group being attacked, I defend them”. In the same vein, one of the program coordinators mentioned that she feels more Argentinean in Spain than she did in Argentina. The mediators agree, saying that they have to explain things about their culture that they always took for granted before.

**Brokerage**

This task of explaining things about their culture raises the issue of the mediators’ position as culture brokers. Being in a broker role creates tension that one of the social workers alluded to, of having to negotiate between groups of doctors and patients who don’t agree, but on a deeper level a broker must struggle with respecting
or changing power dynamics and maintaining an appearance of being dually aligned, with the patients and with the providers. There are a number of definitions for culture brokering (2001). One is “the act of bridging, linking, or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change.” A second is that “a cultural broker acts as a go-between, one who advocates on behalf of another individual or group (NCCC 2004).” The position of broker is one of being an intermediary, and the position of advocate, as mentioned in the second definition, naturally accompanies it. But it is advocacy that would make the mediator appear to be aligned with and supportive of one party’s interests to the detriment of the other party’s needs, which could threaten her position.

In a more standard definition of brokerage, a broker is “One that acts as an agent for others, as in negotiating contracts, purchases, or sales in return for a fee or commission” (Websters 2005). This definition points out that the broker is negotiating in return for a fee. If the two parties are required to pay a fee to the broker, they will only ask for his or her services if they really need them. Like all professionals, the intercultural mediators are being paid for their services in the hospital. Their job exists because a need has been noted and will cease to exist if the need disappears. Thus the mediators’ job security depends not only on the balancing of two cultural identities, but also on the need that each cultural group has for his or her services. If the medical professionals become too culturally aware and competent, they will no longer need the mediator to resolve conflicts. Similarly, if an immigrant community learns how to speak the local language, access health services, and advocate successfully for their needs to be met, they will no longer need the help of an intercultural mediator. The mediator is thus in a broker role (Bailey 1970). She profits from the distance between the two groups, and from her close relationship with each. Her professional success depends on her ability to bridge or narrow the gap between the two groups, but her power depends on the maintenance of the distance. Paradoxically, if she does her job too well and too quickly, she will make herself obsolete.

One mediator describes her position in the hospital, and it eerily echoes the problems inherent in a broker role. She says that even though there is no recognition of the position or any public and visible power accorded to it, there is power inherent

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8 citing Jezewski 1990 and Jezewski & Sotnik, 2001
in mediation because when she translates she’s the only one who knows everything that’s going on and no one can know how she’s translating. She says,

> What power can we talk about here?... but of course you have a power because imagine, you’re the only one in this case, you’re the bridge, you’re passing the information, but only you know what you’re saying, you know what’s happening, it’s that it seems like you don’t have power but of course you have it, and it’s of this power that the professionals are scared. That’s why [mediation is] still not recognized.”

Her statement makes it clear that she thinks the power that she has because she is the only one who knows exactly what is going on threatens the professionals and she connects the lack of prestige that the mediators have in the hospital to the professionals’ fear.

Not only the mediators’ power, but also their perceived alliance with the patients threatens some professionals. Many professionals mentioned the danger or the sense that the mediators are not fully neutral in their role and that they tend to identify with and defend their communities and not support the staff. They complain that the mediator expects the hospital to accommodate the patient. They stress the importance of impartiality as distinct from judgment or being a conductor of information, and they mention that the hospital is a neutral space, where the topic should be physical health and not social problems or ethnic conflict.

One of the social workers described the difficulty in her own work of being put in the position of bringing the patient’s and the doctor’s perspective to the rest of the medical team and of negotiating with the doctor and the patient. When she thought about the parallel between this and what the mediators do, she explained that in the case of the mediators’ work the job is even more difficult because it’s complicated by the effects of the personal opinions and prejudices of the professionals towards the foreign patients.

**The future of mediation**

As the newest branch of the young field of intercultural mediation, Socio-sanitary Intercultural Mediation is still breaking ground and establishing itself. It is not clear how the program at Vall d’Hebron’s success will be measured or whether the program will continue, and the individual mediators who will complete their training in September of this year will either begin new careers as mediators or will
try to find other work. If they choose to work in mediation some of their success will depend on the future of the field; whether the government officially recognizes the profession, whether a certification process is put into place and whether health centers in the area decide to contract intercultural mediators. Below I will present the thoughts that mediators and staff shared with me about the future of mediation at a personal and programmatic level and as a profession.

**Personal**

Almost all of the mediators hope to find work in mediation after the program. Some want to work particularly in a health setting and others in any type of mediation. One mediator says that she will do almost anything to continue to work in health. She says, “I like to work in the hospital setting, I’d like to be a nurse or a mediator or anything to the point of cleaning the hospital, but to be inside the hospital.” Some of the mediators plan to distribute their CVs to hospitals and health centers, others are planning to ask their communities to help them find work, and others are planning to use connections from previous jobs to either return to or hear about positions. One of the mediators said that she does not like working in health and that she will not look for work in a hospital. For the mediators who do hope to work in health, there is only one agency that contracts health mediators in Barcelona, and many of the mediators have already gone there to introduce themselves and to find out who they are hoping to hire. The agency offered a temporary position to one mediator for the summer, and there is a possibility that they will offer positions to others as well. Two of the mediators have been doing part of their internship at a drug addiction program, and the center where it is run has mentioned the possibility of hiring them to work part-time. Vall d’Hebron is not likely to contract any mediators. One of them says that the hospital has “asked us to pack our bags” at the end of the year.

Despite the steps that the group has taken to distribute their CVs and to contact other agencies, all of the mediators still express fear about finding work. They are concerned not only about finding work in mediation, but about finding a full time contract so that they can maintain their legal status in the country and support their families. Some are extremely concerned about their language abilities, and others are more concerned about whether the certificate that they get in mediation will be recognized or useful. One of the responsibilities of SURT is to help the mediators
find jobs. They have helped them create resumes, discussed job search techniques and talked about interview skills. They have computers and a job list available for the mediators to use during their free time.

Program staff is aware of how important it is for the mediators to find work after the program ends, and they say that they have been talking about how hard insertion would be since the beginning of the year. They know that there are very few places that will contract mediators and they say that they don’t have the status within the hospital to convince the administration to contract mediators directly.

Programmatic

Staff of the mediation program explained that although they hope in the future the hospital will contract mediators and take advantage of the fact that they are doing training there, at the moment the mediation solution is just provisional. They say that this is in part because the program was not initiated directly by the hospital, and they allude to economic and political reasons. Other staff wonder about who will decide whether the program will continue, and assume that for as long as the program is running and providing free mediators, there will be no reason for the hospital to contract mediators. One of the social workers says this is a shame because it’s a complicated job and it takes more than one year to learn it. She also laments that sometimes a patient is with a mediator for a while, but “when the contract ends the string breaks.” The mediators also see it as a waste that the hospital will not be contracting any of them. One of them explains, “If you’re going to train someone, and we’ve had a lot of experience and training, and we’re here, at least take advantage of the service to improve your service. I think that’s the most logical, even other jobs… do training, and then they recruit the people”. But they know that it is unlikely that the hospital will choose to contract anyone soon.

General

Program staff, medical staff at the hospital and the staff at SURT all have visions of a future for mediation. They believe that the ideal would be for mediators to be contracted directly by hospitals and not subcontracted from NGOs as they are now, and they would like to introduce the figure of mediator to other hospitals, to primary care centers, to drug dependency programs and to other locations. At SURT they talk about the goal of consolidating the figure and reaching agreements with
other organizations for internships and of eventually having the figure be widely recognized. A staff person at the hospital says that the ideal would be for the figure of mediator to, “become habitual”. She says,

> We’ll always have new immigrants, logically, obviously, and mediation will have to form part of our cultural context because some will pass on to not need mediation because we’ll understand each other. I hope we turn into a tower of Babel where we can even speak in all native tongues, but...when a person comes here he’s afraid because he doesn’t have family, social support, he doesn’t have anything, he’s afraid. When this person develops ties and loses the fear...I think he won’t need the mediation, but it will always be needed for the new arrivals...I think the problem is that we don’t know how to take advantage of [mediation].

Almost all staff mention that even if in the future staff are fully culturally competent, there will still be a need for mediators because no one can know everything about every culture, and there will still be language differences between staff and patients. One social worker says, “culture is something that you learn little by little and what you have to do is that no matter how much you know, work in the light of someone who knows more than you. I can know details that the mediators taught me, but that doesn’t mean that I don’t need their presence...because the person who comes with a problem, I still can’t communicate with that person.” Perhaps in response to this, one staff person explains that the ideal would be for the figure to eventually “take on other aspects, other jobs and functions.” Program staff are conscious that the process of gaining recognition and status would require a lot of resources and a system for officially certifying the mediators.

The mediators hope that eventually socio-sanitary intercultural mediation will be added to the list of official professions and that it will be valued and recognized in general and by the government. Within the health setting they hope that it will be recognized as equal to the rest of the medical team. There is disagreement among them about whether this will ever happen. Some say that it will. They say there are people working to improve the image of the mediator now, and that it will be much easier if another type of mediation is added to the list of professions first. Others doubt that the profession will ever be recognized. One of the more doubtful of the group believes that the government won’t ever recognize mediation as a profession because it would be a public admission of failings on the part of the health system and also of the existence of problems of interculturality. She also thinks that it would be hard to justify spending government funds on it. She attends meetings of a group of
people involved with mediation in Barcelona and she says that at the meetings they talk about whether the profession will ever be recognized, but also whether if they do their jobs too well the patients won’t need them.

Despite the worries about recognition and the question of whether the profession will be recognized, even she agrees that mediation should be done today, but that it should be seen as a temporary measure. She and other mediators believe that mediation will be necessary for as long as there is immigration, and that the government will never be able to stop immigration. One mediator mentioned that perhaps in ten years they might be doing a different kind of mediation, possibly with the children of immigrants. The mediators are realistic about the future of their new profession. They hope that it will develop but they are not overly optimistic.
Discussion

What’s at stake

In analyzing the data it became clear that the informants can be divided into three different groups, each with their own agenda that informs their perspectives on the role of the mediator. These three groups are the mediators, the program staff and the medical staff. All three groups are motivated to keep their jobs and gain professional respect. All three groups are also interested, directly or indirectly, in improving health outcomes for patients. But how this can be achieved varies by group. In order for the mediators to succeed they have to maintain alliances with their communities, with their supervisors and with the medical staff. In order to achieve their goals the program staff have to make sure that the mediator program succeeds, by assuring that the rest of the hospital recognizes the need for mediation and by having the mediators act ‘professionally’, in keeping with the way that the mediator role was presented and approved, in a way that improves health outcomes and in a way that does not threaten the other health professionals. For medical staff, success means not having their competency challenged and keeping their job means not having anyone take over their responsibilities.

Although each group shares the ultimate goal of improving health outcomes for patients, the other goals are often in conflict, and the conflicts between them affect the way that the mediator’s role develops. The medical professionals have the most power and prestige of the three groups. They are well entrenched in the medical system, and as one of the social workers explained, the hospital administration remains very biomedically focused. They tend to allocate funds and resources to the medical professionals and their causes more than to social issues. It is in the interest of the medical professionals to maintain their prestige and to keep the attention of the administration in their camp. The intercultural mediator program is tied to the social work department and has more of a social focus than a medical focus. Additionally, the program’s existence highlights the medical system’s faults. To call in a mediator, each individual doctor has to publicly admit his inability to handle a situation that might arise with a patient. To facilitate communication between patients and providers the mediators judge the adequacy, the quality and the appropriateness of the professionals’ interventions and compensate when they feel it is necessary. By their
compensation they point out the flaws in the professionals’ actions and the gaps in their knowledge. This dynamic makes it particularly hard for the medical professionals to accept the mediators in the hospital without feeling threatened.

The program coordinators have committed themselves to creating a successful mediation program, and they must now prove to a doubting hospital community and to their funders that the mediator training program is adequate and that having mediators in the hospital is a good idea. One way that they can do so is by encouraging professionals to use mediators often, but as mentioned above, the professionals have an understandable aversion to calling on the mediators. If the program coordinators impose the program on unwilling staff or make strong arguments in favor of the program that are too critical of the hospital’s practices, the program is likely to be shut down. “La dimensión intercultural funciona como una lente de aumento de las disfunciones institucionales existente fuera de esta problemática. [the intercultural dimension acts as a magnifying glass for the institutional dysfunction that exists beyond it]” (Cohen-Emerique and Hohl 2003:6). In fear of what such a magnification could mean, they are forced to run the program without making waves. Another way they can gain approval for the program is by having the mediator’s ‘professional’ behavior be such that it does not anger the health professionals. Thus they encourage the mediators to align themselves with the professionals and not to appear too connected to their communities. They limit the mediators’ contact with patients outside the medical encounter, and they discourage the mediators from becoming patient advocates so that the professionals will not feel threatened.

In the midst of this power dynamic, the mediators must find a place for themselves. They have to justify their position in the hospital, which means finding and addressing the gaps in service, and they must support the professionals while not alienating their communities. If they refuse to support the members of their communities or if they offend them by not visiting while they’re in the hospital, the patients from their communities could begin to refuse mediations and their jobs would be in danger. They have to decide in such case whether to act ‘unprofessionally’ by visiting the patient outside the medical encounter which could cause other medical professionals to distrust them and their alliances, or whether to risk the distrust of their communities. They have to maintain good relations with both groups, without challenging or threatening the power of the medical professionals, without upsetting
the program coordinators by acting in an ‘unprofessional’ way, and without angering their communities.

A successful way forward will have to take the needs of all three groups into consideration. The mediation program is a response to common goals and has already begun to benefit every group. If the health of immigrant patients improves, then medical staff will be successful in their work and will be considered competent. Mediators will help both their communities and the hospital, and will prove the value of their work. The mediation program will gain recognition, thus improving respect and longevity for the program and its coordinators.

The interests of each group contribute to shaping the role of the mediator at this early stage in the program’s development. The program staff crafts the initial practical version of the mediator’s role through what they teach to the mediators and crafts the preliminary official version by designing the program on paper. Through their actions, mediators determine what their role will be in practice. The medical professionals shape the role by creating an atmosphere of acceptance or rejection of the mediator’s position that either allows the mediators to work as they had planned or forces them to amend their role.

The role debate continues

There are many different negotiations surrounding the way that the mediator’s role should be defined. Some are discussed openly and some are less public or less conscious. These negotiations surround the purpose of mediation, what issues the mediators should address, the appropriate limits to their role, and the uniqueness of their position. Some of them will be explored below.

Is mediation for explanation or translation?

As mentioned in the introduction, cultural competency requires recognition of barriers to effective care and the development and implementation of changes to reduce those barriers. In the hospital almost everyone recognizes that there are barriers, and many have called for mediation to break them down, but what exactly they see as the relevant barriers is different for staff than for mediators. Staff seems to focus on language barriers and the lack of a support network for recent immigrants. They see both as barriers that require mediators to be translators because the patients don’t have family or friends who can translate for them during an appointment.
Mediators tend to see barriers much more broadly, as cultural difference, lack of knowledge of the health system, and discrimination that would require cultural explanation, support and accompaniment. They tend to see the lack of a support structure as a reason that immigrant patients would need the mediators to provide more information about how the health system works, accompaniment and facilitation of access because they don’t have anyone else to do it for them. The distinctions between the perspectives are not hard and fast, but they are indicated by the fact that the mediators tend to describe their role as ‘explaining’ to staff and to patients while the professionals tend to describe it as ‘translating’ even when they are talking about the same process.

The mediators use the terms translation and explanation almost interchangeably. For example, they talk about explaining how many pills to take, explaining treatments, and explaining to a girl with a tumor on her hand what the treatment would be, “every time [she asked] I asked them… and I’d explain it to her again.”(emphasis added). It could be that the two jobs are really the same for them, that as one of the program coordinators mentioned, there is no such thing as literal translation because as soon as something is spoken it is an interpretation, and culture cannot be separated from language. Thus the mediators, by choosing the words that they choose, are explaining to the patient. In practice I observed the way that many short conversations happen between the doctor or nurse and the mediator, and then the mediator explains briefly to the patient what they had just talked about. Or the patient and the mediator discuss something and then she translates it, explaining to the doctor what the patient had said. When translation is done in such a way, without the formality of simultaneous translation or precise consecutive translation where the speaker knows that he or she has to pause often, there really is a fine line between translation and explanation. This places a lot of responsibility on the mediator to transmit the message completely and accurately and to interpret the parts correctly. The fact that the mediators use the word explanation rather than translation seems to imply that they do indeed feel this responsibility, not just for facilitating communication of information, but for actually communicating the information.

The mediators are constantly working as explainers, or as ‘cultural clarifiers’ (California Healthcare Interpreters Association 2002:45). Reducing their duties to translation damages their image as they try to be recognized as skilled professionals. It ignores their knowledge of multiple cultures and that mediation requires a unique
set of skills. It also hinders the process of teaching health professionals that they should be aware of potential cultural barriers even with patients who appear fully integrated into the local society or who speak fluent Spanish.

**Can culture be separated from medicine in the hospital?**

The shaping of the mediator’s role is subject to the needs of the three different interest groups mentioned above. One way that this has expressed itself is through a contradictory limit that has been placed on them. They have been advised to limit themselves to addressing issues and conflicts that are based in cultural differences and that they should not address problems of medical culture that affect all patients equally. It is possible that the program coordinator who made this statement was concerned that addressing issues of medical culture would be too direct a critique of the way that the hospital is run, or it could be a way to limit the mediators’ duties to make sure that they use their time most wisely. The warning sounds reasonable, but the lines between issues related to ethnic culture, medical culture and Spanish culture are not always clear. The distinction between problematic medical culture and issues that are based on differences between ethnic cultures is particularly unclear because in the hospital setting the dominant Spanish culture is actually medical culture, with its own vocabulary and belief structures, and immigrant culture in comparison becomes lay or traditional (not biomedical) culture. In the hospital there is the medical/lay dichotomy, and also the Spanish/immigrant dichotomy. This puts the mediators in the position of mediating between three cultures, the ethnic, Spanish and medical cultures in order to mediate between the provider and the ethnically ‘other’ patient.

The mediators’ task of translating from medical language to lay language beautifully illustrates this point. The process of asking a doctor to explain a term in simpler language and then translating the simpler explanation to the patient could be seen merely as the ‘clarification’ that they should do after they translate a statement literally, but it also crosses into a gray area of conflict or misunderstanding that is not necessarily based in differences of ethnic culture. The use of over-medicalized terminology and unnecessarily complex explanations is something that complicates doctor-patient communication throughout the world (Gailly 2004:3, Vecchiato 1997:186). But if translating is necessary only for patients who do not speak Spanish but explaining medical terminology is necessary for all patients, then where is the line between translating and explaining, and to what extent is the mediator responsible, as
part of facilitating communication, for making sure that she uses words that the patient understands? The line between clarifying because the patient speaks a language other than Spanish and clarifying because the medical professional is using words that are too technical is blurry.

Program staff think that cultural conflicts can be separated from those that are due to ‘problematic medical culture and affect all patients equally’. Mediators think that any issues that make it difficult for patients of their communities to access care should be addressed. While it is dangerous to ascribe too many difficulties to ‘culture’ (El Kadaoui Moussaoui 2005), it is also dangerous to ignore the fact that while ‘problematic medical culture’ does potentially affect every patient equally, when it is compounded by the barriers to care for minorities listed by the mediators, it has a tendency to disproportionately affect immigrants and minorities. It is almost impossible to separate problems that arise from ethnic cultural differences from those that arise from the nature of Spanish medical culture.

**What are the limits to the mediator’s role?**

Beyond the debate about whether ethnic culture can be separated from medical culture, there are a number of other questions about which tasks should fall within the mediator’s role and which should not. One task that falls into the gray area between the mediator’s role and overstepping her bounds is that of contributing unsolicited information to the provider or to the patient. For example, in one case mentioned above a mediator asked the doctor to speak to a woman about contraception before she was sent home from an abortion. In another a mediator explained to a group of nurses that in her country it is normal for a woman to wait a few days before beginning to breastfeed. There are a number of contradictions inherent in the mediator’s role as it is being practiced at the hospital. One is that the mediators are taught during their training to be as unnoticed as possible during the interview, transmitting information between the patient and the provider, but participating only minimally. One mediator describes their ideal position as ‘mute’, just a bridge between the patient and provider. This is in accordance with the role of message converter as it is described in the California Standards for Healthcare Interpreters (2002:44) where a mediator is expected to be almost unnoticed during the interaction. But they are also supposed to contribute to the discussion when they note a cultural conflict or misunderstanding in accordance with the ‘culture broker model’ (NCCC
or being a cultural clarifier (California Healthcare Interpreters Association 2002:46). Even one of the program coordinators notes the bind that the mediators are in this respect. He says it’s hard to facilitate the doctor patient relationship because, “during the interview, you can’t be saying well, here I see a cultural [issue] so it has to be somehow inserted into the flow of the conversation with the pre and the post interview alerting to some of these issues” The mediators find ways to balance the two expectations during the interviews, but the negotiation can be difficult.

The mediator’s decisions in these cases are therefore personal. The specific situations in which they do go beyond direct translation in the triangular interview are those in which her own personal knowledge and experience motivate her to make a contribution. When she contributes information that has not been solicited she is in one sense doing what is expected of her by explaining cultural practices and clarifying cultural misconceptions. In another sense the mediator is speaking for the patient in a way that takes away his agency. In the case of a mediator who asked the doctor to mention birth control methods to a woman who was about to be discharged after an abortion and in the case of a mediator who explained breastfeeding practices in her country to the nurses, the mediators’ additions were based on a knowledge of medicine that the patient did not have and on her knowledge of the patient’s culture that the doctor did not have. They facilitated communication about topics that would not have been raised or understood otherwise. The question is whether it is her place to decide that the topic is important or whether it should be the doctor who learns to ask about these issues. The mediators’ involvement in each case might serve to alert the doctors to the need and the ability to raise the issues in future encounters.

There is also some debate surrounding other aspects of the mediator’s role, such as conflict resolution. Program coordinators discussed whether the mediators should be expected to resolve conflicts or whether what they do is actually approximation, bringing two parties who already want to resolve the conflict closer together. Whether they are called conflicts or difficult situations, cases that mediators are called to participate in arise from many different causes and reach many different scales. The mediators explain that they most often arise from the overly rigid stance of either the hospital or the patient and are connected to the patients’ frustration with the hospital’s rules and norms. It can be frustrating for both patients and staff to be faced with a requirement that they don’t understand or to have their own demand ignored without explanation. Whether the demand is to take a particular medicine, to
use anesthetic to deliver a baby or to send a dead body home with a family before it passes through the normal hospital procedure, frustrations can, as one mediator explained, arise from a lack of understanding. Without understanding why a patient is acting a certain way it is easy to fall back on hospital regulations in some cases and personal preferences in others and to be unwilling to change their mind. In the case of the hospital’s rigid stance, it is possible that “by treating people equally according to apparently neutral procedures, rules, concepts and arguments, we are ignoring the Western values inherent to the health care’s processes and structure and inherent to the implicit image of the patient that is steering health care practice.” (Gailly et al 2004:12). The mediator’s job as I observed it is to avoid such inadvertent discrimination by unearthing the unanswered questions for patients and providers and having them answered so that the two parties can understand, if not respect, each other’s perspectives.

In many ways, the mediator’s jobs of communication facilitation and conflict resolution are strongly linked. By facilitating communication they are preventing or resolving conflicts. A general practitioner in the Netherlands found that even if it is not possible for doctors and patients to reach a shared solution, they should attempt to achieve “clarity about each others views and opinions” (Harmsen 2003:125). This responds to the program coordinator’s questions of whether what the mediators do is approximation or conflict resolution. Approximation is part of facilitating communication, which can resolve or prevent conflict. For example, in the case of the conflict with a Gypsy family’s mourning described in case 2, although the conflict was large, what the mediator provided for the hospital and the family could be called either conflict resolution or approximation. She brought the two parties together by transmitting information from one side to the other and educating each group about the other’s norms in order to make the situation more understandable and therefore bearable. The process of approximation can, of course, also uncover latent conflicts, but by uncovering them they can be recognized or addressed before they become unmanageable. In such cases the results of facilitating communication can be either conflict resolution or conflict prevention. How the role of the mediator in such cases would be defined and whether this type of work falls within her job description depends on the definition of both conflict and conflict resolution.

As the coordinator recommended, the mediators seem to be aware of when they are stepping beyond the bounds of their position and conscious of why they are
doing so. But an important question in terms of boundaries is who should set them. Should it be the hospital, a larger body responsible for making mediation official, the program coordinators or the mediators themselves? At this point it seems to be a combination of the coordinators and the mediators, with both groups being conscious of the expectations of the medical staff and the hospital. It may be that different groups should set different types of limits. For example, ethical limits could be set by the hospital, legal limits by a larger board, professional limits by the program coordinators and personal limits by the mediators themselves. Without being articulated, these last two sets of limits are already being established by the mediators and the coordinators. Disagreements arise when there are discrepancies between what one thinks should be the limit and what the other thinks should be the limit because they have not divided up the responsibility for setting and maintaining them. In fact, this is the type of disagreement that one of the coordinators alludes to when she says that the mediators sometimes make unprofessional decisions.

Is the role of a socio-sanitary mediator unique?

Some of the mediators at the hospital have worked in community mediation and some continue to work in it now. The distinction between their mediation work inside and outside the hospital is important because people in Barcelona are far more familiar with the figure and the role of community intercultural mediators than they are with the newer figure of socio-sanitary intercultural mediator. But even community mediation is not very well entrenched. There is no official title, training program, or accreditation (Sales Salvador 2005:2). There are a number of agencies that train mediators and at least one that contracts them, but it is by no means a widespread profession. The mediators seemed intent on defining the difference both to move away from community mediation’s focus on conflict resolution and also to validate the uniqueness of their own branch of mediation.

The secondary role that conflict resolution takes in a socio-sanitary setting appears to be what differentiates them from community intercultural mediators. While for the community mediators, conflict resolution is the primary focus of their role, for the socio-sanitary mediators it is merely one element among many, and is not the focus. The conflict resolution and translation elements of socio-sanitary mediation can be applied in any setting where a cultural conflict arises, but the other aspects of their role, supporting the patients and supporting the provider, are far more
important in a hospital setting that is, as one mediator pointed out, a context of suffering. The way that they facilitate communication is also different than in other contexts because they have to deal with medical terminology, the power and structural elements of a medical encounter, and a heavy emotional burden.

The challenge of becoming professional

How will the mediators become professionals?

The mediators refer to all other hospital staff as professionals, but they rarely call themselves professional. Though important for clarifying their role and limiting expectations, their student title accentuates the newcomer status that they are trying so hard to overcome. It also poses less of a threat to the established order. The mediators completed an intensive training course and were not allowed to do mediations for 6 months. But now they are working as part of the medical team, and when they work they have full responsibility for their actions.

It is difficult to determine at what point they will pass from being students to professionals, particularly because there is no standardization for mediation training programs and mediation is not an officially recognized profession. When they complete their year of training, the mediators will be given a certificate. Unlike a degree from a university, the certificate may not be recognized and signifies no more than that they have completed SURT’s requirements. Will the certificate symbolize the passage to professional status or will they need to eventually complete an official certification? Will they become professionals when they are hired directly by a health care institution instead of being placed by SURT? Are they professionals now because when working with patients their responsibilities are comparable to those of the other hospital staff? These questions can be discussed further, and should be clarified not only for the mediator’s sake, but also so that there is consistency in the message being delivered to the professionals and to the patients about the mediator’s role. The fact that the staff encourages them to present themselves as professionals to the patients and as students to the other professionals creates a blurred identity that was confusing for me when I first arrived and was never fully clarified.

There is a learning process that accompanies any new job, whether you are hired as a professional or brought on as a student doing a practicum like the mediators. In any new situation you have to learn the context, find a place for
yourself, learn to do the specific tasks required by the job, and figure out how to apply the knowledge that you arrived with. The difference in the case of the mediators is that there is no role waiting for them to fill. They have to go through the process of learning and gaining respect that every new professional goes through, but they have to do it while also carving out a space for themselves within the hospital. They have to look for gaps in the health providers’ knowledge, identify weaknesses of the health system and find needs that are not being adequately met in order to build a role for themselves. As mentioned above, this type of scrutiny can be difficult for the hospital and health providers. It exacerbates the normal tension that exists between the established and the newcomers in any setting. They face a difficult process of convincing the professionals that they should be working and of teaching them what their role really is. They have to articulate their strengths and to explain to hospital staff that have already established comfortable ways of doing their work why they are a new and useful addition to the team.

The mediators want professionals to begin to see them as more than translators, to learn how a triangular interview should be held, to call them for more mediations, and to understand that they are better suited to be the third party in a medical interview than a patient’s family or friend. But there is a fine line between educating the professionals about the ideal encounter and creating overly high or confusing expectations. They must make themselves useful to be recognized and appreciated, but if the mediators are to stay within their competencies they may not be able to deliver all that the professionals want them to. This year’s mediators are well trained and have hospital experience and professionals who have worked with them are beginning to understand that they can be called not just for translation but to address cultural conflicts. The next group of mediators that will be trained in the fall will spend their first 6 months working only as translators before they begin ‘real mediations’. Will the professionals understand that their expectations have to change? If it has taken two years for the hospital of 6000 to begin to understand what a mediator is, will they be able to keep up with changes every 6 months? This speaks to the need to define the mediator’s role very clearly before information is disseminated and to be complete and clear on all of the information that is shared. It will also be important to clarify not only the ideal role for the mediator, but also the role that she will play at each stage of her training within the hospital. These
clarifications could be shared with the professionals as part of the process of educating them about the program.

One issue that the mediators alluded to that makes this education and integration harder is the lack of infrastructure for the program. The classroom where they spend most of their time serves as an office for the program where they wait to be called for mediations. There is no landline telephone in the room, so the professionals who call them have to reach them through the coordinators’ cell phones. The hospital phone system is not always able to reach cell phones, so sometimes the staff has to come in person to the basement room or pass the message through other channels. The room also has no Internet connection, so regular updates to hospital staff and diffusion of information is difficult. This lack of infrastructure makes the process of alerting the staff to their presence more difficult, and limits access hospital staff’s access to them. It slows their process of integrating and being recognized as equal professionals. As one of the mediators mentioned, the situation that they are working in might damage their credibility.

Unlike doctors and nurses and other hospital staff who pass through carefully defined stages of training on the road to official professional status, the mediators are working without a secure end goal, and the respect that they receive from other professionals suffers as a result. With professionalism comes respect, job security, power within the professional hierarchy and status within the larger community. Two different elements affect the mediators’ lack of prestige. One is the lack of government certification for mediation as a profession, but the other is the lack of visible support for the program from the hospital. If the hospital provided resources and contracted mediators or publicly stated their commitment to the mediation effort it would be easier for the mediators to establish themselves among the other health professionals. As it is they are forced to struggle against the hospital’s established order instead of being accepted into it. This tension makes their efforts seem like a challenge to the hospital’s integrity instead of helpful collaboration in improving health outcomes for patients.

**Teaching the staff and patients about mediation**

Staff and mediators agree that there should be more information about the mediation program available for professionals. The way that they describe the information though, is different. Medical staff tends to ask for very concrete flyers,
emails and presentations about mediation, and not for such things as pre and post interviews. This may be for lack of information or because of time constraints. The mediators talk about ‘sensibilizacion’ of the professionals, literally ‘sensitizing’ them to the issues that need mediation and to how to conduct a mediated encounter. These two are not mutually exclusive, but the mediators will have to conduct their sensitizing efforts in a way that respects the professional’s time constraints and their expectations. It is possible that, as one of the social workers mentioned, the sensitizing is already underway, and that the existence of the mediation program is helping it along, but the process is slow and hard to measure. Considering that one nurse had a strong reaction to the fact that the program was introduced without involving the nursing staff directly, publicity material should be carefully checked to be sure that it is inclusive of all medical professionals. If the mediation program wants to avoid alienating anyone they will have to be careful about what information is distributed and how.

When discussing dissemination of information, staff focused on their own and other professionals’ knowledge of the program, but mediators mentioned ways to raise awareness among both staff and patients. The mediators seem more interested than staff in giving staff and patients equal access to their services. Program staff are making efforts to build alliances between the mediators and the other medical staff, and to share information about the program with staff. They are simultaneously trying to limit the mediator’s contact with the patients beyond the medical encounter. There seem to be two goals to this behavior. One is to build legitimacy for the mediator’s role within the hospital setting and the other is to try to counterbalance what they see as a tendency for the mediators to over-identify with the patients.

The two goals are connected, because the way that the mediator role is defined, the most professional and legitimate stance for the mediator is neutral, or that of a double, balanced allegiance. But increasing allegiance for one group should not decrease it for the other. One of the mediators mentioned that she can’t be completely neutral because it is the professional who makes the demand for her to be there. This implies that by making the demand the professional has some level of power over the mediator. If this difference in power over the mediator comes partly from the fact that the professional places the demand, then it is possible that equalizing the access routes to the mediators for patients and providers might help to equalize the power relationships and thus the mediators’ allegiance.
If the diffusion of information about the mediation program is aimed at the professionals within the hospital and not at patients as the mediators suggested, it could create an interesting dilemma for mediation in general. If only providers know how to access the mediation system and patients do not, the mediators might become part of the system to such an extent that they no longer help to relieve tensions for the immigrant patients. It is possible that if patients identify the mediator too strongly with the provider they will reject her out of envy of her ‘success’ or out of shame (Gailly 2004:11). They would have come full circle from identifying strongly with the patients to over-identifying with the professionals. Professionalization seems to be a process of taking away one identity and a putting on another, and might lose sight of the goal of having the two be strong and useful for the mediation itself.

**The process of incorporation**

Incorporating the mediators fully into the hospital would raise awareness of the mediation program, increase demands for mediation and allow their work to have a greater impact on health outcomes. It would also increase the level of respect that they are given by their colleagues. One of the ways that the mediators are being incorporated into the medical team is by working directly with the social workers. The mediators’ collaboration with them is interesting. The social workers are one of the newest professions in the hospital, and as one of the social workers explained, it has been difficult to make headway as a primarily social service in a medically-focused institution. Because of their similar situations and because in some sense the mediators are following in their footsteps, the alliance between the two new professions is logical and enriching. It is a tremendous asset because it creates learning opportunities for the mediators, exposes them to many different situations, models social services provision, and opens doors in the whole hospital. But from another angle, it is possible that the association between the mediators and social workers makes it even harder for the mediators to gain professional respect from doctors and nurses. Their alliance with a newer, less medically trained profession might serve them well as a learning opportunity but less well as a tool for incorporating themselves into the medical hierarchy because they will be identified with other ‘marginal’ professions by doctors, nurses and the administration.

Two authors who have written about intercultural mediation in France explain that social workers are some of the most hesitant to accept mediators because they
seem to see the mediators as competition and to think that they are deforming the social workers’ own work (Cohen-Emerique & Fayman 2005:12). They explain that that the mediators have to learn about the context in which they are working and have to allow the professionals to maintain their own status without challenging them. The mediators that I studied are struggling to do just that, to work with the other professionals, recognizing and compensating for their weaknesses, but without challenging their authority. The position is difficult, but in the case of Vall d’Hebron the direct alliance that they have established with the social workers helps them to sensitize the group who could feel most threatened by their presence, which helps them incorporate into the hospital with less tension.

The fact that the mediators’ incorporation is still incomplete is clear because professionals don’t always choose them over using relatives and friends as translators. When I asked the nurses and doctors if using mediators would be better than using family members as translators they all said yes, but many admitted that they still don’t call the mediators as often as they could. One explained that the mediators are the better option because they are more professional, and another said that there are certain messages that should be transmitted by someone from the hospital. All agree in theory that the mediators are a better alternative to using friends and family to translate. The mediators must now try to make a final push in their education of the professionals, convincing them to act on the fact that they are the best option for improving communication with patients. One argument that they don’t often use with the professionals is that not only are they better than family and friends, but they are also better than translators for this kind of work. The mediators have been through a process of thinking about and becoming conscious of their own experiences of immigration and their strategies for becoming bicultural. This conscious process, facilitated by their training, is what prepares them to work with the patients in a way that another translator could not. They provide role models and reflection for the immigrant patients (Cohen-Emerique and Fayman 2005:7) The mediators themselves leave their cultural competence out of this discussion, short-changing themselves as they try to sensitize the professionals to the need for mediation.

There seem to be a number of separate discourses going on, one about the mediator’s double allegiance and ability to help both the professional and the patients and a separate one about mediators being the best option for translation in the hospital. Only some of the staff members are combining them by arguing that the
mediators are the best option precisely because they are knowledgeable about both Spanish-medical culture and the patient’s culture. If staff continue to think of communication as purely translation, then the mediators’ other role, of facilitating cultural communication and clarifying cultural issues, is ignored. Combining the parallel discourses might strengthen their arguments within the hospital and help their insertion. One way to do so would be for the mediators, who understand that communication is, as one mediator explains, ‘deeper than what translators do’ to make that explanation part of their publicity program.

**Negotiating Identities**

As interpreters and explainers of language and culture, the mediators transmit not only messages, but also identities. They are expected to be bicultural, belonging to at least two different cultural groups, and they negotiate between different interest groups by balancing their multiple identities. When they are hired, the two groups that they must belong to are the Spanish culture and another ethnic culture. As they move along in the process of professionalization, they are expected to also belong almost exclusively to the professional medical culture. But they also have to maintain their membership in an ‘other’ group in order to communicate well with patients. These multiple identities are necessary for them to do each part of their job successfully. To translate both literal and metaphorical meanings they have to know two languages and cultures. To resolve conflicts and facilitate communication they have to be able to understand the basis of the conflict, find the parts that are being misunderstood, and find ways for each party to understand the other’s perspective. They do this by providing information or by creating the space for them to explain things to each other. Without a deep knowledge of the two cultures that are in conflict it’s difficult to understand the basis of the misunderstanding, and without personal experience with the topics being discussed, it is difficult to provide information that could clarify the situation. The mediators support patients and the hospital by being part of each culture and making each person feel like they have an ally in the room. If the goal in terms of the mediators position is truly just to have an equal knowledge and an equal allegiance to Spanish culture and to an ethnic culture, then it would be logical to hire a Spaniard who has learned another language and lived in another country, but the mediators are chosen for their immigrant or minority status. Their
role of making the patient feel more comfortable and normalizing their immigrant or minority status is often more difficult for an ethnic majority Spaniard to achieve.

The mediators’ knowledge of lay, biomedical, Spanish and ethnic cultures must be strong, but they must not appear to be more aligned with one of the cultures than with another. It seems from the comments of the staff at the hospital that they feel threatened whenever it appears that the mediators are more closely aligned with the patients than with them. The mediators have to find a way to maintain their multiple identities and bring each one out when it is appropriate and in ways that will not threaten either the patients or the providers. Working in a triangle, as the mediators are expected to do, has the potential to throw off the power balance that normally exists in a medical encounter. Staff and mediators agree that the doctors normally have more power than the patients, and that patients themselves describe feeling powerless. So to add another player to the mix who seems like a second medical professional could make the patient feel even more insecure, unless the new person also makes it clear that she is supporting the patient. Adding another person who seems aligned with the patient could make the new person and the patient seem like a team challenging the power of the medical professional unless the third person, in this case the mediator, makes it clear that she is also supporting the professional. These power games make it necessary for the mediator to be clear about her own identities, but to be very careful about how and when she expresses each one.

Emotions and personal experience affect the mediators’ ability to act in a way that is considered professional. Any emotion that the mediators can empathize with affects them. The social workers discussed the fact that when a mediator can identify with a patient because they have something in common, like having children, the mediator’s reaction to her case will be stronger. But by the very nature of their job, the mediators work with people with whom they have something in common. They share either a language or a cultural history and often a history of discrimination, so the emotional burden of every case will affect them more than it might affect another health professional. This has two potential effects. One is that it might contribute to or reinforce the feeling that staff seems to have that the mediators will over-identify with the patients, and another is that it might make the mediators seem less professional. If controlling your emotions and finding ways to distance yourself from the strong emotions of the hospital are seen as part of the professionalization process, then it might be harder for the mediators to reach a state of acceptable control. They
have accomplished a tremendous amount on this front already, and many of them mentioned that in the time since their first cases they have learned to control their emotions, but as one of the social workers said, a one-year course might be short because of the emotional burden of the work. They have to find ways to balance all of their identities while acting professionally, and what is considered professional depends on how the role of the mediator is defined. What is professional is that which falls within the role, and unprofessional is that which falls outside.

The issue of the mediator’s identification with the patients brings us to the questions of whether the ideal position for a mediator is objective neutrality, or whether the goal is to support both the patient and the provider equally. If the goal is to support the patient and the provider, then empathy will help them in supporting the patients, and having had similar experiences to those of the patients will allow them to better explain the patient’s predicaments to the providers. As Margalit Cohen explains, even though it might appear that there is complicity between the mediator and the patients, and the professionals might be suspicious at first, the complicity is not a loss of neutrality if the mediator doesn’t extend it beyond the encounter and uses it to explain the situation to those who don’t understand it (2005:5). The experience of discrimination and minority status makes the mediator more open to the patient’s experience and also might make the patient more open to the mediator. In some communities it is clearly stated by the mediators that people from their group will only listen to someone else form the group. This means that even if the mediator just repeats what the doctor said, the statement will have more effect because it came from a member of the patient’s community. In all cases, the minority status of the mediator normalizes the minority status of the patient for both the patient and the provider, as mentioned earlier, helping to make everyone more comfortable.

In terms of the effects that personal experience might have on the mediators’ work or on the health system in general, one concern is that cultural mediators may unintentionally strengthen or create cultural stereotypes within the health setting. Mediators are expected to explain elements of the culture of patients to doctors and other health professionals. In going beyond direct translation, it is possible that the mediator’s individual identity or his or her own cultural stereotypes will be over-represented and become generalized. Every person, regardless of how many cultures she has lived within and how many languages she speaks, brings her biases and experiences to the medical encounter. Much as for anthropologists who practice in
their own culture, questions can be raised about whether any individual can distance herself enough from her experiences to articulate the nuances of her own culture. Other questions are whether that person’s experience is the ‘real’ culture of her homeland, if such a culture exists, or whether it has been changed and mediated by so many factors in the new country that it can no longer be generalized. It is also likely that the mediation situation itself affects the mediator’s representation of her culture. She responds to the expectations of the professional, the patient and the patient’s family. Avoiding simplified representations of cultures is one way to avoid the stereotyping that can contribute to health disparities in healthcare (Smedley et al 2000), yet mediators might tend to provide a static picture of a unified culture, ignoring individual adaptations and motives as well as changes in cultural practice that many immigrants experience as they settle in a new country.

Culture and identity are flexible and dependant on the situation in which a person finds himself. In the case of the group of mediators, one person has been hired as the ‘Gypsy’ mediator, so the other person who could identify as Gypsy creates another public identity for herself. Despite this shift, she still maintains her connection to her Gypsy heritage, and when it would be helpful for her work with a particular patient, she brings it out. Identities also change over time. A speaker warned at a conference on diversity and cohesion, “when speaking of the culturally different other, one must contrive to speak of the other without ever taking a definitive view of him because both he and the person speaking of him are evolving” (Bennegadi 2000). Identities are flexible and multiple, and the women who applied to be intercultural mediators may have found ways to be seen as more representative of the cultural ‘other’ in order to be hired.

The mediators are now re-creating their own identities, both personal and professional. They practice on the margin of both medical and ethnic communities (Delcroix 1996). Mediators are expected to be bicultural, belonging in some sense to the culture of the health setting where they work, and also to the community of the language group with whom they mediate. Their professional identity depends on the balance of their two identities. It is this balance, and initially the clear membership in an ‘other’ group that earns them a job, but as soon as they are identified too strongly with one of the two cultures to which they belong, they begin to pose a threat to the power of the other culture group. It is the same cultural membership that earned them
the job that can threaten their position. One mediator explains that for her work as a mediator what she has to learn is not neutrality or double allegiance, but diplomacy.

**Culture-brokering**

Culture-brokering works in a health setting because both patients and providers are working toward a beneficial, effective, healthcare plan. The results of my research indicate that the mediators are very clearly in a broker role, capitalizing on their position between and their membership in two groups who need to access one another. They benefit from the distance between the professionals and the patients, and they act as a bridge between the two. They have power over the patients because they know the language and the health system better, and they have power over the professionals because they know the patient’s language and culture and can decide exactly what to translate and how to interpret what is said. Professionals and patients are both dependent on the mediators to translate completely and accurately and to bridge the gaps in communication.

Unlike traditional brokers in fields like law or stocks though, the goal of mediation is not just to capitalize on the distance between groups, but to bring the two parties together to the point where they can communicate without help. Even if the mediators approach each individual case with the goal of the patient’s health in mind, their professional power will remain, because deeper structural issues of cultural competency will remain, but if they approach mediation as a way to improve the cultural competency of the health system overall, their figure will become less necessary.

The mediator’s role in the short term is to bring individual patients and providers closer together, to facilitate communication and resolve conflict. As the role is defined now, she is put in the difficult position of trying to stand between the two parties, helping both simultaneously. But yet her hands are tied when it comes to advocating for the patient’s needs because she is acting ‘unprofessionally’ if she feels too strongly for her community, and her hands are also tied when it comes to helping the professional because her voice is still weak in the medical encounter and because in the end it is the health professional who will make final decisions about the case. She can do her best to pass information between the two parties to improve understanding, but she cannot act on her own opinions. What she does is to encourage compromises between the two points of view. In the case of the couple
who had given birth and did not want to breastfeed, the mediator’s explanation of the customs in her country and her explanation of the benefits of breastfeeding allowed the couple and the nurses to reach a compromise, that the woman would breastfeed during the day and the baby would be given bottles during the night. In every case, the mediators are negotiating not only between the wishes of each party, but also between the physical and psychological needs of the patient and the norms of Spanish medical culture.

**Improving cultural competency and communication**

A psychiatrist came to speak to the mediators and they asked him what he thinks of mediation. He hesitated for a moment and said that if it’s planted well, it’s a useful tool, but what worries him is that the problems may become chronic, and that mediation could normalize problems instead of pointing them out and he warned them to keep in mind that the goal is for each person to be able to think for himself. If, as Antoine Gailly suggests, referring a patient to a provider who speaks the patient’s language or belongs to his culture is a form of rejection (2003:3), then an over-dependence on the intercultural mediators by the doctors would also be a form of subtle discrimination and indicate a lack of cultural competency. Thus the hospital staff must learn to use the mediators as a tool, to facilitate each interaction with a patient and to make them more confident and competent in dealing with patient from cultures that they are less familiar with. It may be dangerous to provide a mechanism through which medical professionals can displace the responsibility for cultural competency. It is possible that the presence of a cultural mediator in the hospital or in a medical encounter will actually relieve some of the pressure on medical professionals to become culturally competent. If someone is available to translate, explain and resolve conflicts for patients from other cultures, there is little need for doctors to learn to do those things for themselves. If this is the case then mediators will become entrenched in the medical system and will become a permanent crutch rather than a temporary solution to a temporary situation of cultural incompetence.

This should, however, not become an excuse to eliminate the funding or support for cultural mediator programs. Although they may phase themselves out of a job by doing their job well, their experiences as cultural mediators may be a stepping-stone into or back into the health professions. One explanation for the poor overall cultural competency of health systems in some countries is the small number of
ethnic, racial and language minorities who work in the health professions. Perhaps cultural mediation programs can provide short-term assistance for groups who have difficulty accessing quality health care through translation and education, and in the long-term they can improve the inherent cultural competency of health systems by teaching health professional about their cultures, by modeling cultural competency, and by eventually joining the ranks of the permanent health professions. It has been noted recently that integration, which puts people in direct contact with colleagues of other races, might be the best way to overcome the unconscious fear of those of other races (Gardner 2005). By being in the hospital and working with the other health professionals, the mediators are helping with the process of normalizing minority status on a larger scale. Additionally, and not paradoxically, they are also raising awareness of cultural difference and the fact that the health system may need to adjust to the needs of a diverse client base.

One mediator mentioned that doctors are taking classes so that they will not need to use mediators, and patients are developing their own resources and language skills as they spend more time in Spain. She implied the two groups will eventually be able to respect each other’s cultures and medical expectations to the point where they don’t need the assistance of a mediator. A study carried out in Belgium in 2002 found that even after years of educating healthcare professionals about other cultures, immigrants still had trouble accessing the health system, and that the number of problems that immigrants had did not necessarily decrease with the amount of time that they lived in the country (Nierkens et al 2002:257). The mediators continued to be useful. For now, most people at Vall d’Hebron agree that there is a need for socio-sanitary mediation, and that the need will exist for quite some time. They hope that resources will continue to be allocated by the department of labor and that health institutions will begin to invest directly in such programs. Like staff, the mediators are open to the idea of the mediators’ role changing in the future to fit a changing culture and new immigration patterns, but exactly what the role should consist of, both now and in the future, is still not fully defined.

The mediators’ presence improves the quality of care that individual minority patients receive, and if the model works they also teach the community of providers and the community of patients how to deal with each other in the future. They can help with communication until the immigrant patients learn to speak Spanish and develop resources of their own and they also model culturally competent behavior.
They make the professionals more aware of cultural differences in every medical encounter, normalize the presence of minorities on staff, and teach the patients and their communities what to expect from health services.

Whether they are seen as stop-gaps or permanent additions to the health professions would create two very different futures for mediation. If the mediator program is truly to increase cultural competency and cultural responsiveness on a systemic level, the final goals of the program and the roles that the mediators can expect to take on in the future should be clearly articulated. If they are not, the mediators will be put in the position of deciding between assuring a future for themselves and increasing cultural competency within the health system.

Arthur Kleinman suggests that a way to provide better care is to increase communication and negotiation between doctors and patients of all ethnicities (Kleinman et al 1978). Instead of addressing the system’s response to all ethnicities, cultural mediation may merely address the needs of the specific groups for whom mediators have been trained. During the research it seemed that each case being mediated was culture-specific and the problems could not be generalized, but as I stripped the ethnicities from the case studies for this research it became clear that with few exceptions, the underlying issues are similar for all of the cases. A case that happened with a Chinese woman could just as easily have been with a Russian one, a case with a Moroccan woman could have been with an Indian one, and a case with a Spanish Gypsy could have been with a Romanian one. The basic questions of cultural competency that were addressed in each one apply to so many others that if the professionals who work with the mediators learn from their experiences, the lessons can be applied in many more cases. The hospital is still not perfectly able to meet the needs of all of it’s patients but the mediators, by improving communication, by normalizing minority status within the hospital and by sensitizing the professionals to the cultural differences that they might encounter with any immigrant patient, are helping to increase the hospital’s overall cultural competency. In the meantime, they are helping to translate, interpret and explain in individual cases to improve the physical and psychological outcome for each immigrant or minority patient that they see.
Conclusions: Achievements and potential

In two years, the mediation program at Vall d’Hebron has trained 16 intercultural mediators and provided them with valuable hospital experience. The mediators have been involved in hundreds of cases, they have resolved conflicts and clarified cultural misconceptions for patients and providers. They have raised awareness of the need for culturally and linguistically appropriate responses to conflicts with patients, and they have provided a professional development resource for other hospital staff. Staff members who have worked closely with the mediators have been extremely impressed by their work, and report that they are now better able to deal with patients of other cultures. Staff that have not yet worked with the mediators but have heard about the program believe that it is an important resource for the hospital, and they expect to call on the mediators in the future.

Even Belgium’s health mediation that has been running for more than a decade struggles with issues of role definition and competing interests, so it is natural that there is still some clarification of the mediator’s role necessary in Barcelona. The differences that exist between the perspectives of the staff and the mediators regarding the mediator’s role are enlightening and could be useful for determining how best to continue the process of professionalizing the mediators and incorporating them into the hospital.

The first striking difference between the staff’s and the mediators’ perspectives is that while the mediators are interested in making their program equally accessible to both staff and patients, the staff are worried about the mediators’ allegiance to and identification with the patients and therefore make efforts to bring the mediators closer to the medical professionals and farther from the patients. This difference should be discussed and a joint conclusion should be reached about the ideal relationship for the mediator to have with each party in the mediation triangle before the mediator’s place within the hospital can be clarified. They must be careful that the mediators’ specialization in the health sector doesn’t bring them so close to the other health professionals that they lose their connection to the other communities to which they belong. If they do, they will lose their ability to successfully broker between the health professionals and their ethnic communities.
A second difference is in the way that the staff and the mediators describe the mediator’s primary duties. In practice if not in word, the medical staff often understands translation to be the mediator’s primary responsibility, while the mediators describe their duties as resting on explanation, of language and of culture. This difference is one that the mediators and the program staff agree on, so the next logical step is to bring all three interest groups into agreement by continuing to educate medical professionals about the details of the mediator’s role. For this education to be most useful though, certain aspects of the role, such as the nature of the conflicts that the mediators should be expected to resolve should also be clarified.

During this period of incorporation and professionalization, it is necessary for the mediators and their program staff to clearly differentiate the socio-sanitary intercultural mediator’s role from the other professions that it might be confused with, such as translators, community mediators or medical interpreters. They also have to agree about what the long-term goal of mediation is. They have to define the elements and the limits of the mediator’s role at each stage in her training and determine, provisionally or permanently, how and when she will pass from being a student to being a professional.

At this point, many people within the hospital don’t have any idea of who the mediators are or what they do. Once they have established a clear definition of the mediator’s role at each stage of her training, the mediators have to expand their strategy for disseminating information. They must be clear and consistent about the mediator’s role. They must respect the time and resource constraints of the other health professionals, and they must be inclusive of every profession with which they hope to work in the future so that no one feels alienated by the process. Diffusion of information about the program and education of health professionals about why and how mediation works could increase the impact of the mediation program, but must be done very carefully. Their role is being defined according to the needs and interests of mediators, program coordinators and medical professionals, and the way that information is distributed and to whom the program is publicized must take into consideration the needs of each group.

Although placing mediators in the hospital can highlight some of the weaknesses in the way that service is provided to minority communities, it also addresses those weaknesses and improves service. Instead of being afraid to publicize the health system’s faults, it would be fruitful for local politicians to professionalize
socio-sanitary intercultural mediation and incorporate mediators into all of the health institutions as a way to improve the quality of service that they can offer. This process would not be easy. As mentioned in a recent publication on culture-brokering,

A systematic approach is necessary to fully implement and sustain a cultural brokering program in health care settings. This approach will require vision and commitment of leadership, buy-in or acceptance of both the community and health care setting personnel, development of a logic model or framework for the cultural broker program, and identification and allocation of resources. (NCCC 2004:23)

Such an accomplishment in Barcelona will require time, resources, and also the proven success of programs like the one being run at Vall d’Hebron. The hospital administration could improve the program’s image and help it succeed by allocating more resources to it and by contracting mediators to compliment the training program that is being run on their premises. Contracting mediators would increase the consistency of the program, smoothing over the periods when new mediators are being trained, and it would provide experienced role models for the new trainees. Mediators who have already been through a practicum at the hospital could be hired to take advantage of the thorough training that the mediation students have already had in their institution.

Some questions were answered through this research but many more were raised. These include whether mediation should be introduced as a temporary or permanent measure in the health sector and whether the position should be legally recognized as a profession, whether it is possible to separate problematic medical culture from differences in ethnic culture when providing targeted support for immigrants, and how to build cultural competency on an individual and structural level. Beginning to answer these questions would be fruitful for many health settings and policy debates. It will be interesting to see whether mediators achieve their goal of becoming a certified, recognized profession. Until then, the lessons learned from Vall d’Hebron’s efforts, including both successes and challenges, are useful for addressing increased diversity and immigration around the world.
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Appendices

A. Strengths and limitations

Certain factors made my research smooth and others made it difficult, but I was able to compile the necessary data during my time in Spain. My research period was short. The timing of the project’s approval and the schedules of the mediators and staff made it difficult to carry out all of the interviews and focus groups that I had planned. Nevertheless, I built a strong relationship with the mediators and with many of the staff who work closely with them. Because of my Spanish skills and my outsider status, staff and mediators seemed comfortable speaking to me openly about the mediators and their work.

Although my goal was to explore and compare the perspectives of mediators, patients and staff regarding the emerging role of the mediator, a number of factors made it difficult for me to speak to patients. Official permission to conduct the study from the ethics committee of the hospital did not arrive until almost halfway through my research period, and this, combined with the difficulty of communicating with patients from other cultures without using the mediators as translators, made it difficult to speak to the number of patients that I had planned. I was able to speak to one patient who had been involved in a mediation and two patients who are from South America and who had been in the hospital without mediation, but their opinions can not be generalized and are difficult to compare with those of the mediators and the other staff. Thus, I will focus my data presentation and discussion on the perspectives of mediators and of other staff within the hospital, and will include the perspectives of patients only when they are relevant.

This comparison between staff and mediators’ perspectives is still useful without including patients’ perspectives because the mediators are emerging professionals who are working closely and repeatedly with the other staff, and differences in perspective between these two groups could have long-lasting repercussions and also can affect the work in the short-term. Patients tend to have less prolonged contact with the hospital and also, as my observation and interviews indicate, are presently even less aware of the existence of the role of mediators than medical professionals. This in itself is interesting, and will be discussed further, but the perspective of patients on the role of mediator might be more interesting in a few
years when the program or health mediation is more established and more heavily utilized.

I was concerned that my presence might affect the activities of the mediators (Holt 2002), but I spoke to my informants about my concerns and was able to get a sense of what, if anything, had changed because of by presence. I had been asked to help the mediators prepare and edit a paper that they were writing, and I was asked to present classes to them as well. When I arrived in the mediators’ classroom for the first time one of the program coordinators said, jokingly, that the mediators had to help me with my project. Even though I told them very clearly that they were not at all required to participate in the project they may have felt obligated by the way I was presented and by my status as a ‘teacher’. Despite the limitations in time and circumstance I collected rich data and was able to triangulate using a number of sources. I also presented preliminary observations to a group of mediators at a feedback session during my last week to confirm and adjust my findings. If I had more time in the hospital I would have liked to observe unmediated appointments with minority or immigrant patients, and I would have liked to continue to speak to patients about their perspective on the mediator’s role.
B. Preliminary problem analysis diagram

Multiple perspectives on the role of cultural mediators in a hospital setting

- Mediators understanding of own role
- Individual motivation for becoming a mediator
- Mediator's self-identification, ethnic and professional

Hospital Structure
- Who initiates mediator's involvement in medical encounter
- Training, type and level
- Level of pay
- Position within professional hierarchy

Time/ Scheduling
- Level of cultural awareness
- Culture: Medical beliefs, ethnicity, language etc.
- Immigration status

Doctors' Expectations
- Doctors' Needs
- Patients' Needs
- Patients' Expectations
C. Images of the hospital

View of the General Hospital

Map of the Hospital Grounds (Only in Catalan)
Entry to the basement of the Maternity and Children’s Unit where the mediator program is located

View of Barcelona from the General Hospital
D. Semi-structured Interview Questions

Tell me a little bit about yourself.
If someone were going to describe you in the neighborhood where you live how would they describe you?
If someone were going to describe you here at the hospital how would they describe you?
Do you think that you’re a member of a particular cultural group? Which? Why?

Why did you decide to be come a cultural mediator?
Do you think having mediators in the hospital is a good idea? Why?
Can you tell me about one particular case where you worked as/with an intercultural mediator?
Is that typical? Are there differences in other cases?
If you could create the position from scratch, what do you think they should do?

What do you do in your job here?/ What do the mediators do?
Can you explain the term Intercultural Mediator to me?
What does intercultural mean?
Between whom do you/they mediate?
Do you/they gain anything from what you/they do?
Do you think a culture barrier exists between doctors and patients? Can you explain it to me?
How does it happen that you/the mediators get involved in a patient’s case?
Why do people involve you/them in a consultation?
Why do they decide not to involve you/them in a consultation?
What kind of training should a mediator have?

Can you place yourself on this line, if this end means that you have no power in the hospital and this end means that you have complete power.
Why did you place yourself there?
Can you place doctors and nurses and mediators on the same line?
Can you place patients on the same line?
Why have you placed them there?

What are the hospital’s ideas for cultural mediators after this year?
Did anyone do a job like mediation before you got here?
Who?
What did they do?
E. List of Interviews and Focus Groups

Individual interviews were carried out with the following staff and mediators:

One mediator from Russia
One mediator from Morocco
One mediator from China
One mediator from Pakistan
One mediator from Romania
One mediator from Spain who is a member of the Gypsy community
Two program coordinators and doctors from the Department of Transcultural Psychiatry
One program coordinator employed by SURT
One SURT employee who gives employment skills training to the mediators
Two social workers who work closely with the mediators
One nurse who has never worked with a mediator
One nursing supervisor who has worked with mediators
One nursing supervisor who has never worked with a mediator
One doctor who had worked with a mediator once
One social work administrator who channels many of the demands for mediation
One woman from the gypsy community who had been involved in a mediation
One couple from Peru who had given birth recently in the hospital

Focus groups were held with the following groups:

Once with three nurses who had never worked with mediators
Many times with groups of mediators
F. Ethics committee Permission, Informed consent and Patient Information Sheet