

Intercultural Mediation at Belgian Hospitals

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INTRODUCTION

Since 1999, Belgian hospitals can apply for funding of intercultural mediators at the Federal Public Service of Public Health, Food Chain Security and Environment. The total budget spent on intercultural mediation in the hospitals in 2004 roughly corresponds to 1.240.000 €. At this moment, 50 hospitals are involved (40 general hospitals, 10 psychiatric ones). 50 intercultural mediators are being employed (totalling 40 full time positions). Seventeen different languages are represented in the group. Together they intervened 62.000 times in 2004.

The aim of the intercultural mediation program is to improve access and quality of care delivered to ethnic minority patients at the hospitals. Intercultural mediators are employed to improve the quality of communication between health care providers and ethnic minority patients, as well as to increase the responsiveness of the hospital environment to the socio-cultural and health care needs of ethnic minority patients.

Intercultural mediators have to fulfil certain requirements to be eligible for funding by the administration. They should either have a degree in the domain of intercultural mediation in health care, or have a degree in a social or (para)medical discipline, or have a degree in philology or interpreting. From 2005 onwards, intercultural mediators are normally only eligible for funding when they have either completed a theoretical course on intercultural mediation or have two years of experience in a similar function (and in a professional environment where they have been coached).

THE TASKS OF THE INTERCULTURAL MEDIATOR

Many different terms are being used to refer to persons who are employed in health care institutions to cross the language and culture barrier and to increase responsiveness to the needs of ethnic minority patients. In English such different terms as 'link worker', 'health advocate', 'health care interpreter', 'intercultural mediator' and 'culture broker' are used. In addition, these terms are often used in an inconsistent way (e.g. the tasks of health care interpreters vary considerably between different projects, going from pure language interpreting to other tasks such as culture brokering, providing health education). For this reason, we briefly present the task description of the intercultural mediators at Belgian hospitals.

Intercultural mediators at Belgian hospitals:

- interpret;
- function as culture brokers ('explaining the world of the physician to the patient and the world of the patient to the physician', Kaufert 1984). We want to stress that we do not expect or consider them to have ethnographic knowledge such as cultural anthropologists may have. Still, we are convinced that their relative familiarity with the world of the physician and that of members of their own community may be extremely useful to increase the culture competence of the health care team;

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- provide practical help to patients as well as emotional support. However, they do not act as amateur psychotherapists;
- may be involved in conflict mediation when linguistic or cultural misunderstandings are the cause of the conflict;
- may act as advocates for ethnic minority patients when they are being confronted with racism or discrimination or when the patient's well-being or dignity is at risk
- visit ethnic minority patients in their room to check whether they need help (which will then be provided in collaboration with health providers);
- point out problems experienced by ethnic minority patients to health care providers and the hospital administration;
- provide health education to patients.

In the following paragraphs, we first briefly present the results of 2 evaluation studies conducted at the hospitals. After that, we describe the quality assurance and improvement program that we designed and implemented to remedy a number of problems identified in the evaluation studies. Finally, we present and briefly discuss the effects of the quality assurance and improvement program.

INTERCULTURAL MEDIATION: RESULTS OF TWO EVALUATION STUDIES

A first - qualitative evaluation study - was carried out from 1993-1995. Intercultural mediation had – at that time – not yet been incorporated in the normal funding system for hospitals. This first study mainly focussed on the effects of intercultural mediation on the quality of care and the problems associated with the introduction of intercultural mediators in the hospitals.²

A second study was carried out from 1997-2000. Both qualitative (participant observation, interviews, focus group discussions) and quantitative (survey) methods were used to collect data this time. In this second study, we focused more on the problems associated with the introduction of the program at the hospitals and the quality of the interventions of the mediators. To assess the quality of the interpreting, we used the standards for medical interpreting developed by the Massachusetts Medical Interpreters Association).³

Intercultural mediation: its effects on the quality of care

Health professionals, patients and intercultural mediators confirm that the introduction of intercultural mediators led to an important increase in the quality of care, if adequate use is made of their services. All of the health professionals state that the intercultural mediation program should be continued and become a regular service available to ethnic minority patients and health staff.

Most important of all the improvements is the fact that intercultural mediators facilitate the exchange of correct and detailed information between health staff and patients. This a consequence not only of the presence of an intercultural mediators but also of the fact that

² . For more information see: Verrept H, Louckx , 1997 (exists in English and Spanish). For those who read Dutch : Verrept H, Interculturele bemiddeling in de gezondheidszorg. Cultuur & Migratie 2000/2001: 18 (2): iv + 163.

³ . For more information see: Verrept H, Perissino A, Herscovici A., 2000.

patients are less inhibited about telling their stories in the presence of the intercultural mediator (and/or the absence of an informal interpreter, e.g. child or spouse). In addition, our data suggested that adaptations at the level of communication strategies and style contribute to the effectiveness of communications with ethnic minority patients. These improvements had far-reaching effects.

Improved communication. Health professionals point out that the program increased their ability to diagnose certain conditions and to differentiate between them (e.g., finding clues as to whether continuing feelings of discomfort are related to somatic or psychosocial problems). Taking a detailed illness-history (in the way it is taken from indigenous patients) had become possible with some patients only since the introduction of the intercultural mediator. Health professionals and patients alike point out that the interventions of the intercultural mediators make smoother health care delivery possible because, as a result of the improved communication, they can now cooperate better.

In addition, we find systematic evidence that many patients find it easier to talk to the intercultural mediator about a whole range of topics than to Belgian health professionals. Patients state that intercultural mediators are able to understand certain messages better because “things are different in our community and the intercultural mediator knows what they are like”. Health professionals point out that many problems, especially in the domains of family relationships, marital problems and family planning, were not easily discussed before the intercultural mediators started working and consequently remained hidden from them.

Intercultural mediators and their clients tell us that clients are supported and encouraged to ask questions of health professionals when they are hesitating to do so. Health professionals state that many questions were not asked before, either because of the language barrier or because of patients’ inhibitions. Some patients report that certain topics could not be discussed with health professionals in the past because discussing them in the presence of an informal interpreter would have embarrassed both the patient and interpreter. Folk illnesses, such as possession by spirits (*jnun*), and traditional remedies, such as consulting a Koranic teacher (*fqih*) in the Moroccan community, are also more readily discussed with the intercultural mediator, as are emotions and mental states. In a number of cases, health professionals point out that this had far-reaching (sometimes even life-saving) effects on the health and well being of the patients involved. Patients’ readiness to reveal their mental states to the intercultural mediator makes it possible to meet their need for psychological support of help. This is felt to be one of the major benefits of the program.

Patients’ assumption that intercultural mediators will understand their problems better is not the only reason they are more willing to talk about certain subject with them. Intercultural mediators describe how they adapt to the communication style of their patients. They use specific communication strategies to correct clients’ misconceptions and to convince them of taking their medication regularly, for example. Evidence from our data suggests that intercultural mediators are much more effective in convincing patients to undergo surgery, to stick to certain therapeutic regimens, and to consult specialists or paramedics. Many health professionals recount interventions with considerable clinical impact, adding to the life expectancy or the quality of life of the patients involved. Part of the intercultural mediators’ greater persuasiveness is no doubt associated with their greater ability to assess their patients’ non-verbal clues. They have less trouble assessing the atmosphere during an intervention and are more easily aware of the fact that patients do not understand what is being explained to them, or that they are unwilling to accept a piece of advice. This makes it possible to take patients’ reactions into account.

Providing Culturally Sensitive Care. In some hospitals, the intercultural mediators suggested ways to adapt the hospital environment better to the presence of a culturally diverse clientele. E.g., several hospitals provided a room for Muslim patients to make it possible for them to pray without being disturbed. Also, certain hospital procedures were adapted in ways that make them more acceptable to the ethnic minority patients. Diets were adapted to the eating habits of ethnic minority patients. Intercultural mediators were able to resolve a number of conflicts between health staff and ethnic minority patients and sometimes successfully defended their clients against insensitive and racist practices

Effects on patient satisfaction. Especially at the hospitals, the presence and the interventions of the intercultural mediators contribute tremendously to patient satisfaction. This also holds true for patients for whom the intercultural mediator has never interpreted. They feel less isolated and lonely. Patients very often explicitly express their gratitude to the mediators. They also stress this aspect during the interviews with the researchers stating e.g. “that meeting someone of your own country at the hospital gives you a feeling as if your heart is opening up”. The feelings associated with the presence of someone of their own ethnic group seem to be more important to them than the fact whether these persons have helped them to cross the language and culture barrier. The fact that the hospital is funding an intercultural mediation program is experienced by many of them as a sign that the hospital really wants to help them. This is not unimportant in a country where the growing success of an explicitly racist, extreme right party throws a shadow over interethnic relations in general.

Problems associated with the introduction of intercultural mediation at the hospitals (2000)

Low number and type of interventions carried out by the intercultural mediators. In 2000 most intercultural mediators saw only 4 patients a day. This might have been less of a problem if this number would be enough to cover the need for intercultural mediation. Unfortunately, our research made clear that this was not the case. During our participant observation, we were systematically confronted with the fact that health professionals had not relied upon the services of the intercultural mediators when they were confronted with a language and culture barrier.

Our qualitative data (collected mainly through participant observation) clearly indicated that a high number of interventions initiated by the intercultural mediators themselves or by the patients (or their family), were related to the fact that no intercultural mediator had been present when the patient and the health professional met. Most of these were attempts to remedy communication problems that had developed at that moment. As in many similar projects, it turned out to be very hard to convince health professionals of the importance of the role of the intercultural mediator, as well as of the unacceptability of working with informal interpreters.

Intercultural mediators were aware of the fact that health professionals often did not rely upon their services. This is one of the reasons why most of them systematically visited patients of their own group in their rooms to ask them whether they had understood everything the physician or the nurse had explained to them. At the same time, they also informed patients that they could call them whenever they needed them (e.g. when the physician would be seeing them). Although this method is far from ideal, it turned out to be a pragmatic and often effective strategy to fight the consequences of the phenomenon that health professionals did not systematically rely upon intercultural mediators. One of the negative consequences of this approach was that only in about 40 % of the interventions the health professional, the intercultural mediator and the patient were simultaneously present in the same room, thus rendering direct communication possible.

One important (and undesirable) outcome of the fact that health professionals, patients and intercultural mediators were often not simultaneously present in the same room, was that the language barrier was frequently not resolved when the physician is e.g. taking an illness history of the patient. As a matter of fact, only 25 % of the interventions of the intercultural mediators were related to the taking of an illness history or the execution of an examination. This is far from ideal, as a growing body of research suggests that the presence of language barriers may seriously affect provider effectiveness (e.g. limiting their ability to diagnose certain conditions, poorer pain management, less adequate management of chronic diseases such as asthma and diabetes) (Bowen, 2001; Jacobs & Agger-Gupta, 2003; Saldov & Chow, 1994). Our data suggested that the effectiveness of our program was indeed very seriously hampered by the relatively low number of interventions where health professionals, patients and intercultural mediators met in the context of a triadic intervention.

Interpreting skills. The quality of the interpreting done by the mediators was often poor. As mediators in many other programs, they had clearly been insufficiently prepared to perform this task in an adequate way. In addition, most health professionals had received no training whatsoever to cooperate with intercultural mediators. Both factors made that the interventions of the intercultural mediators and the communication process between health professionals and their patients lacked transparency.

Health professionals insufficiently aware of the tasks of the intercultural mediator. Some health professionals asked intercultural mediators to perform tasks that should normally be performed by themselves with the aid and assistance of an intercultural mediator. This was the case for about 30% of the interventions. This may not be without risks for the patient and the mediator. The integration of the intercultural mediators in the teams of health care professionals was a major problem faced by our program

'Culturalisation' of problems of ethnic minority patients. Many health professionals tended to attribute ethnic minority patients' health problems and problems experienced during the health care delivery process too quickly and falsely to the culture of the patients involved. In our program, we refer to this phenomenon with the neologism 'culturalisation' (see also Kaufert, 1990). Once they believe the problem to be associated with the culture of the patient, they have tendency to shift the responsibility to find a solution to it to the intercultural mediator. This proved to be very stressful for the mediator, and often led to a dead end in the health care delivery process. This phenomenon was most commonly observed in the treatment of patients with psychosocial problems and with non-compliers.

Advocacy. Due to the low status of intercultural mediators at the hospitals, it was very hard for them to defend patients' rights or to intervene when the patient's well-being or dignity were at stake.

QUALITY IMPROVEMENT AND ASSURANCE PROGRAM

To improve the quality, effectiveness and efficiency of intercultural mediation at the hospitals, it was decided to develop a quality improvement and assurance program. It relies on three pillars:

Monitoring of intercultural mediation at the hospitals

To remain well informed on the strengths and weaknesses of intercultural mediation, as well as to assess the possible impact of the quality improvement and assurance program, we decided to monitor the program as closely as possible. To do this we make use of a specially designed questionnaire to register the activities of the intercultural mediators. These are registered every year during the month of March. In addition, we observe the activities of the intercultural mediators (through participant observation), and organise meetings with representatives of the hospitals involved as well as with the mediators who are working for them. During these meetings, feedback is given to the hospitals on the data collected by the intercultural mediation unit. Representatives of the hospitals get the opportunity to provide essential additional information on the functioning of intercultural mediators at their hospitals and to suggest strategies for improvement.

Additional training and supervision for the intercultural mediators

As it had become clear that most intercultural mediators lacked appropriate interpreting skills, we organised a 50 hrs course on interpreting techniques. For this course we hired lecturers who are also involved in the training of conference and community interpreters from the Interpreting Schools.

A lot of attention was also given to the MMIA Interpreting Standards (1995) that are now used as a code of practice for the interpreting done by the intercultural mediators.

Starting from the literature, our own research and the experience of intercultural mediators and health professionals, a new and more detailed task description was developed and discussed with the mediators and representatives of the hospitals.

A number of sessions were organised concerning the role of the intercultural mediators as culture brokers (mainly based on the work of R.Putsch, and J.Kaufert). It was decided to stress that information given on the world of the patient (to the health professional) should be always be presented and regarded as a hypothesis on possible behaviour etc. rather than as unquestionable facts.

Finally, intercultural mediators are regularly invited to participate in supervision sessions where 'trouble-cases' can be discussed. The idea behind these meetings is to create room for exchange between intercultural mediators – and in some cases also external experts – and ourselves. The ultimate goal is to gradually construct a knowledge base that can be used by all mediators when they encounter a similar problem.

Training sessions for health professionals

During their training, most health professionals have never heard of the negative effects of language and culture barriers on the quality of care. In addition, many of them are convinced that working with informal interpreters (e.g. family members, cleaners who belong to an ethnic minority etc.) is an acceptable strategy to overcome linguistic barriers. Finally, hardly any Belgian health professionals have been trained to work together with intercultural mediators or interpreters.

For these reasons we developed two training units for health professionals. The first one has as its aim to convince health professionals of the necessity to rely on an intercultural mediator when they encounter a language or culture barrier. This sessions concentrates on the literature on the effects of language barriers on the quality of care and on the risks associated with working untrained interpreters. A few suggestions are also advanced to make working with an intercultural mediator more effective and efficient.

The second training unit has as its aim to teach health professionals how to collaborate with an intercultural mediator. After a short theoretical introduction and the viewing and discussion of a number of videotaped interventions, health professionals get information on how to work effectively with an intercultural mediator. At the end of the session, one or two health professionals get a chance to role-play an intervention where they rely on the intercultural mediator of their hospital to communicate with a fictitious patient (mostly played by an intercultural mediator form another hospital).

INDICATORS OF CHANGE ...

The most striking change over the years is no doubt the continuing increase of the average number of interventions by the mediators per working day. In 2000, an intercultural mediator would typically intervene 4.6 times a day (this represented about 2,5 hours of work). In 2004, intercultural mediators intervene much more frequently, about 7.7 interventions per day. Still, it is not sure that this dramatic improvement is (only) related to the implementation of our program. It might also be an effect of time (with time the chances increase that a health professional encounters a situation where intercultural mediation can't be done without, and this may make him or her rely on the mediators in the future as well). It is not related to a similar increase in the number of ethnic minority patients relying on the hospitals involved.

As regards the type of interventions carried out by the mediators, we find that mediators interpret a lot more than they used to 4 years ago. In 2000, intercultural mediators interpreted during 40% of their interventions, in 2004 this number had risen to more than 60%. This is a positive evolution, as the literature suggests that especially unresolved language barriers may seriously affect the quality of care. We also find that intercultural mediators are working in closer collaboration with the health professionals than before.

Evidence collected through participant observation and observations by the lecturers during the training sessions on interpreting techniques, suggest that the quality of interpreting is improving. In the second half of this year, all intercultural mediators will be tested to assess their interpreting skills. At that time, we will have more information on the effectiveness of the interpreting training. We have to point out, however, that many of the mediators experience difficulties translating medical terminology into their mother tongue. For this reason, a number of medical terminology working groups will start working this year.

Intercultural mediators argue that – as a result of the training and supervision sessions – they have become more like other professionals (one important aspect is that they can refer to a clear task description and a code of practice to explain why they are doing what they are doing).

A number of problems remain unresolved, however. Although the number of interventions has dramatically increased, a large number of health professionals still fail to rely systematically on

intercultural mediators when they encounter a language or culture barrier. Part of this problem is no doubt caused by the fact that many intercultural mediators only work part-time, and as such are not always available when there is a need. Under such circumstances, health professionals may be forced to rely on informal interpreters and may easily continue to work in this way.

Also, it turns out to be very hard to reach MD's during the training sessions for health professionals. As MD's hold a lot of power in Belgian hospitals, it is very important to reach and convince them of the necessity to work with intercultural mediators. Their point of view may often decide whether an intercultural mediator is being called for a certain patient. Closer collaboration with the structures representing the MD's at the hospital seems to be necessary to reach this group.

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<http://www.health.fgov.be/vesalius/devnew/FR/prof/thema/intercult/index.htm> (in French)

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