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Intercultural Mediation and its Conflicting Allegiances in Slovenia

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The article examines intercultural mediation which is a relatively new profession aimed at assuring equity in access to various institutions, including those in the field of healthcare. Based on qualitative research with intercultural mediators in Slovenia, the article analyses the power relations that arise in the triadic interactions in healthcare worker–patient–intercultural mediator relationships. We explore the role of intercultural mediators in relation to the two sides that they are supposed to connect: the side of the patients and the side of healthcare workers. Paying attention to power relations, we show how intercultural mediators' shifting allegiances between patient and healthcare workers considerably shape their practice.

Intercultural Mediation as an Emerging Profession in Healthcare

> I first saw this woman on the Slovenian border. She was a refugee from Africa and had her three-year-old child in a bag, who weighed only three and a half kilos. The child could not talk or walk, and the only thing he was eating was his mother's milk. As an intercultural mediator I followed them for several years… until he started to walk, talk, and eat normally. You can imagine the satisfaction! I went with his mother to the hospital for every single check-up where I interpreted what the doctor was asking and what the mother was answering. One day the doctor called me and said: "This mother doesn't know how to feed her child!" I asked the doctor if he had tried to find out why the mother had this problem. He answered: ´´I told her that she must tell a fairy-tale to the child while she is feeding him, but she is incapable of doing this since she has no imagination." I knew about her traumatic past experiences, and I explained to her – slowly, step by step – how to sing a song or tell a simple fairy-tale to her child. The fact is that she did not know what a fairy-tale was since she had never been told one. So, I asked the doctor: "How can you say that she lacks imagination? What do you know about her and her past? She doesn't know what a fairy-tale is and you cannot expect her to be able to tell one." (Intercultural mediator, 45 years)

This passage describes the everyday experience of an intercultural mediator (IM). This and similar job titles have been introduced in the last few decades throughout Europe, under various names such as "language and cultural mediator", "cultural mediator", "community interpreter", and "cultural broker". In some European countries (Italy, Belgium, France, Switzerland, Greece, and Portugal), intercultural mediation is seen as a distinct profession, where the IMs are mostly of migrant background and their role is to facilitate communication in everyday migrant relations with public services and therefore help overcome misunderstandings in communication (Theodosiou & Aspioti 2015: 65–66). Intercultural mediation also transforms communication. In the field of healthcare, it turns the dyadic doctor–patient relationship into a triadic one (where the IM is the third party) and thereby changes the power relations within the setting.

This article explores these changes by asking: what are the power relations that arise in the triadic situation between doctor, patient, and intercultural mediator? What challenges do IMs face in their role as the nexus of this triad? To explore this, we analyse the role of IMs in relation to the two parties that they are supposed to connect: patients and healthcare workers. We explore how IMs are pressured to show allegiances to both sides. In answering these questions, we draw upon a multi-year engagement with the process of implementation of intercultural mediation in healthcare in Slovenia

that took place from 2014 onwards, within the framework of projects carried out by the Slovenian National Institute of Public Health ("Health for All" [2013–2016] and "Health Promotion for All" [2018–2019]). In the latter project, in which the research for the present article was conducted, we – both anthropologists – had different roles. Even though we were both engaged in conceptualising and coordinating the research process, Juš Škraban was employed by the National Institute of Public Health and therefore was in everyday contact with intercultural mediators, while Uršula Lipovec Čebron was collaborating as an external expert.[1]

To make the case for the importance of power relations in intercultural mediation, we must examine the core of why intercultural mediation is needed: namely, misunderstandings between healthcare workers and patients. Misunderstandings have been a special focus of medical anthropologists for many decades. The discipline of medical anthropology has shown that numerous misinterpretations and misjudgements in clinical settings arise as a result of systematic neglect of the socio-cultural dimensions of health and healthcare (Good 1994; Napier et al. 2014). In recent decades, medical anthropologists have presented evidence that biomedicine is not universal or culturally neutral but is embedded in the environment in which it exists, and therefore the socio-cultural dimensions upon which every encounter between patient and healthcare professionals is structured cannot be disregarded. Moreover, the extensive academic literature shows how the differences between healthcare workers and their patients become significantly larger when they come from diverse socio-cultural backgrounds, speak different languages, and when the patients have migrant backgrounds (e.g. Ingleby et al. 2012; Chiarenza 2014; Calavita 2015). These patients face large and frequent barriers to accessing healthcare institutions, as documented in the works of contemporary scholars (e.g. Goldade 2009; Rechel et al. 2013; Castañeda et al. 2015).

Similar to other EU countries, research in Slovenia (Bofulin & Bešter 2010; Rajgelj 2012; Lipovec Čebron & Pistotnik 2015, 2018; Kocijančič Pokorn 2019; Huber et al. 2020) has demonstrated the existence of various barriers to healthcare for patients with migrant backgrounds. The findings of a nationwide survey (Kocijančič Pokorn 2019) among 564 healthcare workers in Slovenia indicated that as many as 94 percent of the respondents had reported having had contact with patients who did not speak or understand any Slovene. The official statistics demonstrate that the majority

[1] This work is based on the research within the project of the National Institute of Public Health of Slovenia Health Promotion for All (2018–2019) and has been supported in part by the Croatian Science Foundation under the project The European Irregularized Migration Regime at the Periphery of the EU: From Ethnography to Keywords (IP-2019-04-6642).

of foreign-born residents in Slovenia are from the territory of former Yugoslavia (Directorate for Administrative Internal Affairs, Migration and Naturalization 2018, 2019). This is also reflected in the aforementioned survey in which healthcare workers reported to be in frequent contact with patients who spoke languages from ex-Yugoslav republics, and they experienced encounters with Albanian-speaking patients as the most challenging (Kocijančič Pokorn 2019: 34). This is probably due to the fact that unlike the other languages of former Yugoslavia, Albanian is not Slavic, and also the fact that the number of Albanian migrants from Kosovo is increasing (Huber et al. 2020). In recent decades, however, refugees and migrants who speak Arabic, Farsi, Chinese, Russian and other languages have also been present in Slovenia, and healthcare workers have reported persistent language and other barriers in communication with these patients (Kocijančič Pokorn & Lipovec Čebron 2019). Research in Slovenia has also shown that language barriers experienced by migrants are usually associated with various socio-cultural, legal and administrative barriers (Bofulin & Bešter 2010; Rajgelj 2012; Lipovec Čebron & Pistotnik 2015, 2018; Huber, Lipovec Čebron & Pistotnik 2020). These barriers are connected to legal restrictions that severely limit or deny access to health insurance to many immigrants with precarious legal statuses.[2] As a result, some of them can access healthcare institutions only for urgent care, while some others avoid visits to the doctor due to the fear of paying for out-of-pocket sums for treatment (Pistotnik 2020).

These linguistic, socio-cultural, legal and administrative barriers pose a great challenge to equity in healthcare and can have many negative consequences, including multiple misunderstandings between healthcare workers and patients, poorer patient compliance, dissatisfaction with medical treatment, costly and unnecessary medical tests, and potentially serious medical errors (Martínez 2010: 59; Kocijančič Pokorn 2019; Lipovec Čebron 2021). Moreover, patients and healthcare workers receive no systemic support in solving language and socio-cultural-related problems. Unlike in some European countries such as Norway, Italy, and Belgium, the Slovenian healthcare system does not provide professional interpreting services in healthcare institutions at the national level. Although there are many professional interpreters, they lack the training for interpreting in healthcare settings, they are often difficult to reach, and

[2] There are two types of health insurance in Slovenia: compulsory health insurance, which is obligatory for all persons with Slovenian citizenship and/or permanent residence in Slovenia but which does not cover all costs of treatment; and supplementary health insurance, which is voluntary and covers the difference between the full price of health services and the amount covered by the compulsory health insurance. Thus, a person who lacks supplementary health insurance must pay an additional out-of-pocket fee for most healthcare services. To acquire supplementary health insurance, the person must first have compulsory health insurance – a major obstacle for many immigrants and other residents who do not have access to it (Pistotnik 2020).

their services are too expensive for the average patient (MIPEX 2015; Kocijančič Pokorn & Lipovec Čebron 2019).

In response to the absence of systemic measures, various project-based approaches have been attempted in recent years. Some of them have been oriented towards institutional transformation while trying to introduce more migrant-friendly policies at the level of local healthcare organisations (Farkaš Lainščak & Lipovec Čebron 2016) as well as legislative changes at the national level (Pistotnik & Lipovec Čebron 2015). Others have promoted the importance of the socio-cultural and linguistic dimensions of healthcare as well as a more migrant-sensitive approach among healthcare workers in the form of various training programmes (Rotar Pavlič 2018; Lipovec Čebron et al. 2019).

At the same time, various initiatives have introduced intercultural mediation in institutions across Slovenia. The most rapid advances have occurred in the healthcare sector, starting with a pilot project in 2015 in which an IM was experimentally placed at one community health centre[3] (Škraban et al. 2020). The evaluation of this pilot project showed that "service users perceived the presence of an intercultural mediator at health education workshops[4] as extremely important and expressed satisfaction with the mediator's work" (Lipovec Čebron et al. 2017: 117). This positive evaluation led to a further upscaling of IMs, placing them at 14 other community health centres across Slovenia from December 2018 (Škraban & Lipovec Čebron 2021). All these initiatives contributed to the present state in which intercultural mediation has become recognised as a distinct profession, and a national occupational standard for IMs has been approved.

IMs in Slovenia have reported that their tasks encompass language interpreting, facilitation (including culture brokerage), and advocacy (see Škraban & Lipovec Čebron 2021). Moreover, the introduction of IMs in Slovenia is marked by close attention to the concept of equity in access to healthcare and other public services (Cattacin, Chiarenza & Domenig 2013). However, since the process of this profession being recognised is quite recent, intercultural mediation is still not a fully institutionalised service in healthcare institutions and has not received systemic funding in Slovenia, which contributes to the precarious position of IMs.

[3] Community health centres are the main providers of primary health care in Slovenia. They provide preventive services and treatment covered mainly by compulsory health insurance. Community health centres employ GPs, gynaecologists, paediatricians, community nurses, midwives, dentists, pharmacists, physical therapists, psychologists, and others.

[4] These workshops are part of prevention programmes that include parenting classes, educational programmes promoting healthy food/nutrition, healthy sexuality among adolescents, lectures on dental health for children and adolescents, etc.

Based on our fieldwork material, in the following sections we discuss the role of IMs through the lens of power relations in the intercultural mediation process. We argue that when power relations are considered, it becomes clear that IMs are under pressure with regard to their allegiances. After the data and methodology section, we address the question of allegiances by first exploring IMs' allegiances towards patients and then towards healthcare workers. We demonstrate that IMs' practices are significantly influenced by the need to shift allegiances between patient and healthcare workers.

Methodology

There has been increasing scientific interest in various professionals such as IMs and interpreters who respond to language, socio-cultural and other barriers in healthcare. A major part of this research is based on transcriptions of interpreter-mediated clinical encounters and conversation analysis (cf. Hsieh 2007; Pöllabauer 2004; Baraldi & Gavioli 2015). Although IMs had received a certain amount of anthropological interest by the end of the millennium (Kaufert 1999; Verrept & Louckx 1997), the field has not recently been addressed by anthropologists (for an exception see Vargas 2015), but instead by scholars from other disciplines (especially interpreting and translation studies) using ethnographic methods or a mixture of interviews and participant observation (Agustí-Panareda 2006; Davidson 2000; Hsieh 2007; Leanza 2005). These researchers' use of the concept of culture often differs fundamentally from the anthropological understanding of the term: the former often rely on a reductionist, oversimplified and essentialised notion of culture in which the concept is understood only in terms of language differences (Farini 2008).

Approaches involving the intersection of basic and applied research projects are especially promising but underrepresented. There are only few cases in which scientific research has been conducted simultaneously with the intercultural mediation process but carried out by professionals external to it.[5] Research conducted by those who are themselves engaged in the intercultural mediation process is even less common (see Verrept 2008; Verrept & Louckx 1997). Consequently, not much is known about the incremental processes through which intercultural mediation has developed as a profession, and therefore the dilemmas, problems and pitfalls of these processes are left unexplored and concealed from the academic community.

Our research was carried out at 25 community health centres in Slovenia. The project coordinator was the National Institute of Public Health of Slovenia, which

[5] For example, the University of Modena and Reggio Emilia in Italy has conducted extensive research in collaboration with the local public health authority, AUSL Reggio Emilia (see Baraldi & Gavioli 2015).

provided professional support for all project activities, including those relating to the field of intercultural mediation. In addition, from December 2018 onward, a group of 25 IMs, who had been contracted by community health centres or had previously acted as IMs elsewhere, began to gather monthly. Bearing in mind the lack of support for IMs in Slovenia, the intention was to create an inclusive group which would serve as both a peer-support group and as a group receiving professional training. Since we were actively engaged in the process of forming and coordinating this group, we had the opportunity to closely observe the group dynamics and meanwhile conduct 15 semi-structured individual interviews as well as 15 focus group interviews on topics such as the role of IMs in healthcare settings, ethical issues in intercultural mediation, medicalisation and intercultural mediation, IMs in relation to healthcare workers and in relation to the immigrant community, intercultural mediation and gender roles, and patients' use of complementary and traditional medicines. This article is thus based on the participant observation that took place from December 2018 to November 2019, as well as the interviews that were conducted between March and September 2019.

Interview participants were asked about their professional experiences and the tasks they had performed as IMs, the organisational aspects of their work, and their views on the professionalisation of intercultural mediation. At times, our roles in the interviews were reversed, as the IMs sometimes asked for advice and wanted to discuss a problem with us, the researchers, who were at the same time the coordinators of the group meetings and training courses. On the other hand, the focus groups were part of monthly meetings with IMs and were mostly semi-structured due to the need to create a space for sharing experiences and questions which arise in the everyday work of IMs. After each focus group meeting, a thick description of the meeting was written. During the focus group meetings and interviews, we noted at least three important issues. First, most IMs participating in the group were eager to collaborate in the research, since they saw the use of IMs in community health centres as an opportunity for their own professional development. They expected that this development would improve their standing in the community as well as in relation to healthcare workers. Second, due to the ambiguity and incremental development of intercultural mediation as a profession, during the interviews IMs spoke of numerous problems and dilemmas regarding terminology, approaches and expectations regarding the role of IMs. Third, the precarious nature of IMs' employment status in Slovenia had a significant impact on the interviews and focus groups; with some IMs it was almost impossible to set the date of the interview, since the interviews were occasionally interrupted by urgent calls or IMs could not attend a meeting due to their obligations as mothers and spouses in their own families. Therefore, two interviews had to be conducted over the phone.

We interviewed 15 women (all the IMs who participated in the project were women), and their average age was 39. The IMs were born in Kosovo (5), Slovenia (3), Iran (2), Macedonia (2), Iraq (1), Bosnia and Herzegovina (1) and Albania (1). Among those not born in Slovenia, their average length of residence in Slovenia was 14 years. During intercultural mediation most of them had used Slovene and Albanian languages (10), while others spoke Slovene and Arabic (3) and a few English and Arabic or Farsi (2). On average, they had worked as IMs for 3.6 years, and very often as volunteers before they obtained their first professional contract. Most of the IMs (10) held a bachelor's degree, while the others had completed higher (1), secondary (2), and primary (2) education. Three had education connected to health-related disciplines.

Shifting Allegiances in Intercultural Mediation

To assure equity in healthcare, intercultural mediation must cover a wide range of roles or tasks. One of the best-known models, which aims to conceptualise this complexity, is the "ladder model" developed by anthropologist Hans Verrept and public health expert Isabelle Coune (2016) who coordinate intercultural mediation in Belgium. The first step on the ladder is called "linguistic interpreting" and contains accurate and full transmission of oral messages between healthcare workers and patients. The second step on the ladder is named "facilitation" and stands for resolving misunderstandings, cultural brokerage, and helping the healthcare provider and the patient to take up their respective roles. The last step is called advocacy. A similar model ranging from interpreting to advocacy can be found among other scholars. Gavioli and Zorzi (2008), for instance, identify the following roles for IMs: linguistic translator, cultural broker, patient advocate, and clarifier. Kaufert and Koolage (1984) detected four different roles of medical interpreters among Native Canadians, as they operated as direct linguistic translators, culture broker-informants, culture broker-biomedical interpreters and patient advocates. It is important to note that all these seemingly very different roles are intertwined in daily practice and can be simultaneously activated in one single episode of mediation (Gavioli & Zorzi 2008: 156).

Each of the tasks or roles of IMs has its own unique impact on the triadic interaction between healthcare provider and patient. To portray this, the ladder model is organised around the criteria of *visibility* and *facilitation* provided by IMs. It means that an IM is less visible and facilitates the interaction to a lesser extent in the role of linguistic interpreter and is more visible in the role of an advocate. Instead of visibility, Kaufert and Koolage (1984) state that the principle of control shows best how different roles impact the triadic interaction. They claim that on one hand "linguistic translation" is

the role in which an IM has little control over the interaction, and, on the other hand, an IM has the most control over the interaction while conducting an advocacy.

Standards in intercultural mediation have developed from those of medical interpreters. IMs claim that interpreters are bound to impartiality and neutrality which is, according to some scholars, a rather uncritical and unrealistic stance (Kaufert & Putsch 1997). Standards of intercultural mediation claim neutrality to be best (if ever completely) attainable in the task of language interpreting, which is the basic task of intercultural mediation (Verrept & Coune 2016). However, neutrality is seriously put into question in tasks of facilitation and advocacy – in situations when taking up these tasks is necessary, remaining neutral would not help to achieve the goal of intercultural mediation, which is equity in access to healthcare (ibid.).

We show that both parties (patients and healthcare professionals) may demand certain kinds of allegiances from IMs. Also, IMs may engage in conscious or unconscious actions that position themselves more to one side or the other. The source of the allegiance issues lies in the intrinsic duality of IMs, since they belong to both the "host" and the immigrant community. We claim that these shifting allegiances influence power relations. How IMs handle them is one of the central[6] aspects of every intercultural mediation.

Allegiance to the Patient

There are several aspects to be considered when examining IMs' allegiances to patients. First, based on our fieldwork material we provide an analysis of the context of IMs' work and show how this context might encourage IMs' allegiances towards patients. We identify three contextual aspects: IMs mostly share the migration background of patients; IMs are perceived to be part of the same immigrant community as patients; and intercultural mediation is not seen to be a response to the needs of healthcare institutions but rather a response to the needs of the individual patient. Second, we provide an analysis of the advocacy role of IMs – *how* they show their allegiances to patients in practice.

Contextual Aspects of IMs' Allegiances to Patients

The first aspect that reinforces IMs' allegiance to patients is the fact that IMs in Slovenia usually have their own experience of migration which can make it easier to empathise

[6] However, also other issues may seem central to understanding intercultural mediation, namely culture and interculturality. These are sometimes employed by IMs or other stakeholders to describe the role of IMs or to advocate for the necessity of introducing intercultural mediation to healthcare.

or identify themselves with patients. From 15 IMs who collaborated in our study, the majority (12) migrated to Slovenia (from Kosovo, Iran, Macedonia, Iraq, Bosnia and Herzegovina, Albania). Only three IMs were born in Slovenia – however, because their parents immigrated, they identify themselves as a part of an immigrant community. This resembles the picture from countries (such as Belgium and Italy) where intercultural mediation is considered a distinct profession and where it is common that IMs are mostly of migrant background (Theodosiou & Aspioti 2015: 65–66).

From the perspective of many IMs from our research, sharing similar immigration experiences facilitates their work. An IM in her 40s who has lived in Slovenia for 12 years, for instance, stated that she is better able to execute the tasks of intercultural mediation since she has been through the immigration process herself. She emphasised that many patients she has accompanied have reminded her of her own immigration experiences:

> I accompanied a woman who had moved from Macedonia a month earlier. She was completely disoriented in Slovenia. She reminded me of when I came here. My husband gave me some money and told me to go buy some bread. I wanted to buy some but since Slovenia used a different currency to the one we used back in Macedonia, I had no idea of how to pay. The shopkeeper realised I did not have enough money to buy a loaf of bread, so I had to return home. I will never forget it.

The second aspect is connected to the fact that IMs are often perceived by patients as belonging to the same immigrant community as themselves and therefore as having social ties outside of the mediation meetings (Urpis 2018). As one IM in her 30s explained: "I meet patients in town, in shops, and they think they have to stop and have a chat with me. The other day I was buying a shirt and a woman asked me when I could accompany her to her doctor." Even if an IM would like to be known strictly as a professional at the community health centre, the patients for whom she mediates may see her primarily as a member of their community. Another interlocutor in her 20s, who had been working as an IM for only one year, reported that a patient had called her father to reach her and ask her to come and mediate at a check-up at the community health centre: "I do not ask [the patients I work with] where they are from or what they do. But it seems they know a lot about me. Once I received a marriage proposal (…) I also find it disturbing that they want me to be available 24/7 to mediate for them at healthcare institutions." It is common for IMs to face challenges while trying to set clear boundaries between their profession and the people they help in that profession. Since it is quite challenging for IMs not to become involved in conflicts in their patients' communities, this may be a significant reason why IMs struggle not to show allegiance towards patients.

The third aspect which in some cases encourages IMs' allegiance to patients is the fact that the presence of foreign language-speaking patients is commonly perceived as an exception at healthcare organisations in Slovenia and is therefore not addressed systematically. This attitude could be considered a form of institutional discrimination or even institutional racism (Dominelli 2017), since the prevailing impression at healthcare institutions across Slovenia is that they are designed for and function only for the Slovene-speaking population. This is obvious from numerous features of these institutions: from the monolingual directional signage to information on patient's rights usually only being provided in Slovene (Lipovec Čebron 2021).

In these circumstances intercultural mediation is seen as a response, which – from the healthcare workers' perspective – inevitably places IMs on the side of the patients. Healthcare workers' perceptions of IMs' allegiances with patients are further deepened by IMs working in a context that is embedded in the neoliberal paradigm of self-care, where people are expected to take care of their bodies and lead healthy lifestyles, and in this way become good citizens (Alftberg & Hansson 2012). Within this paradigm, where individuals are increasingly responsible for their own health (Leskošek 2013), the problems of overcoming language and socio-cultural barriers as well as demanding rights to equal treatment are not an institutional obligation anymore, but become the patient's duty. Therefore, healthcare workers expect that foreign language-speaking patients themselves provide a suitable solution for ensuring adequate communication (Lipovec Čebron 2021).[7] When patients with migrant backgrounds appear at healthcare institutions unaccompanied by someone who speaks Slovene, they are often seen as irresponsible for not having arranged an "ad hoc interpreter" and are denied medical treatment. An IM in her 40s recalls: "I work with a woman, and she tried to speak Slovene with her doctor, but she was refused a check-up since she did not come with somebody who could speak Slovene. But before that, I had spent so much time teaching her Slovene and encouraging her to speak with doctors by herself."

Advocacy: IMs' Allegiance towards Patients in Practice

An IM in her 40s with more than five years of professional experience reported having helped a patient choose another doctor due to racist remarks made by the first doctor: "I stopped the check-up and said that the patient and I are not obliged to endure such treatment. We left the doctor's office and found the patient another doctor. Simple." Another experienced IM in her 40s reported having argued with a gynaecologist: "She

[7] Consequently, patients often rely on the most convenient and accessible solution, and therefore use their children or other family members and close friends as "ad hoc interpreters", although experts in the field of interpreting and intercultural mediation advise against such practices (Hadziabdic & Hjelm 2014: 6; Kocijančič Pokorn 2019: 41).

[the gynaecologist] asked me if the patient was clean. I responded that she [the patient] does not come from a different planet. But she went on and told me to tell the patient to cut her nails. And I said: 'What do nails have to do with a gynaecological check-up?'" After having been exposed to discriminatory conduct on numerous occasions, this IM decided to write down everything that was said, in front of the healthcare professionals. The IM concluded that "[note-taking] has changed the attitudes of many healthcare professionals".

On the one hand, the IMs from the quotations above have defended patients against unequal medical treatment. These types of attitudes and actions, known as advocacy, can be found in various descriptions of roles in the field of intercultural mediation in healthcare (Kaufert & Koolage 1984; Gavioli & Zorzi 2008; Verrept & Coune 2016; Verrept 2019: 9–10). On the other hand, advocacy is less common among professional standards for interpreters in healthcare (Archibald & Garzone 2014: 12) – a profession that, like intercultural mediation, is meant to facilitate the overcoming of language, socio-cultural, and other barriers.[8]

Recently there has been a lively debate in Europe about the distinction between the roles of IMs and interpreters in healthcare (Verrept 2019: 11–12); the question of impartiality was one of the main themes of this debate. When working as patient advocates, IMs are alleged by some to "violate" several standards of professional conduct as defined by many professional codes for IMs, namely standards of neutrality and/or impartiality. According to Kaufert and Putsch (1997: 76–77), the presence of the principle of impartiality is the result of the professional standards for medical interpreting that have developed according to the standards for sign language and court interpretation. The principle of impartiality may come into conflict with other principles held important by the IM, such as accuracy and completeness (e.g. if a healthcare provider does not pay attention when a patient refers to commonly held beliefs or practices and the IM intervenes to help the patient be heard); or the patient's self-determination (e.g. when the IM is asked for opinions or advice by the patient and gives the patient information that has not been explicitly said by the healthcare professional) (Kaufert & Putsch 1997: 76–77). This was confirmed also in our research. We observed that in some cases IMs have chosen to overlook principles such as accuracy, impartiality, and completeness to assure equal and quality medical treatment for the patient. The IM from the previous case who mediated between a patient and a gynaecologist, for instance, did not aim to interpret in detail the gynaecologist's discriminatory conduct,

[8] Some scholars understand interpreting as an umbrella term that includes intercultural mediation (Souza 2016), while others see linguistic interpreting as one of the tasks provided by IMs (Verrept & Coune 2016).

therefore she failed at assuring accuracy, however, by stepping into the role of an advocate, she assured that the check-up actually took place. By doing so, the IM did not blindly adhere to the different and often conflicting interpreting principles set out for IMs, but rather had in mind the bigger picture – the objective of assuring equity and quality in healthcare.

Allegiances towards Biomedicine, Healthcare Workers, and Healthcare Institutions

Besides allegiance to patients, our fieldwork material contains many examples of IMs taking the side of biomedicine and healthcare professionals, whether such allegiance is demanded or not. IMs' apparent sharing of the knowledge paradigms held by healthcare workers is less mentioned in the scientific literature than is their advocacy and patient empowerment. Yet recognition of IM's attitudes towards biomedicine and healthcare workers is crucial to understanding the work of IMs and the power relations that arise in typical triadic situations. When researchers understand health education or health promotion to be a task of IMs (Verrept 2019: 10–11), there seems to be almost no consideration of the fact that IMs could uncritically promote biomedical perspectives on health, disease, and medical treatment. One of the rare counterexamples to this is Kaufert's and Koolage's (1984) definition of IMs' twofold "culture broker" role: IMs can act both as an informant of a patient's lifeworld and as an interpreter of biomedical culture.

Moreover, as intercultural mediation is still not a fully institutionalised service in healthcare institutions, IMs are forced to assume a number of different roles, among them also the role of institutional insiders in which they act as loyal representatives of healthcare institutions. This attitude by IMs towards healthcare workers relates to IMs' precarious positions in healthcare setting as their financial dependence makes them more apt to agree with healthcare professionals in order to receive mediating jobs and good references from healthcare institutions in the future.

IMs' internalisation of the norms, language, explanatory models of biomedicine also tended to not be subject to critical reflection by IMs themselves in our fieldwork material. One IM in her 40s has been engaged in health promotion activities at a community health centre, where she was trying to encourage women from the Albanian community to participate in workshops focused on healthy weight loss and a healthy diet. Although she observed that "many dietary guidelines were unknown to the Albanian women and they were not familiar with some products", she judged the fact that "many Albanian women did not know that they were fat before coming to the workshop, but they learnt this after going home" as a success. When faced with our

observation that she was in this way uncritically promoting nutritional and slimness standards that were not largely accepted in the Albanian community, she admitted that she had "never thought of it".

The reproduction of the biomedical interpretative framework in the IMs' practice can also be found in their attitudes towards traditional treatments that are still present mainly among Albanians from Kosovo. When talking about this subject in the focus group on traditional medicines, we discovered that IMs not only do not promote medical pluralism or medical syncretism (Baer 2011), but tend to denigrate the use of medical practices that are different from those of the dominant biomedical paradigm. When IMs described traditional procedures (the use of unwashed sheep wool to treat asthma and other pulmonary diseases, lard for boils and abscesses, using vacuum cups for spinal problems and general exhaustion, treatment against magic spells etc.) they laughed self-consciously, some adding that these are "old superstitions" or "nonsense". Only two out of six opposed these statements, saying that these methods should not be ridiculed. However, they admitted that they do not reveal their users' traditional medical practices to the doctors, as they would laugh at them and their patients. When IMs notice that their users favour these procedures over biomedical practices, they try to convince them to "abandon these old customs and go to the doctor", since "it does not have that much effect". Only two of them argued that traditional medicines should coexist with biomedicine and that these medical procedures should be respected (Notes from focus group, 5 November 2019).

As we have shown above, the declared role of IMs is that of bridging communication gaps in clinical communication due to language and socio-cultural barriers between healthcare professionals and patients with migrant backgrounds. In reality, IMs are pressured into several other roles. As our fieldwork material indicates, IMs usually carry the weight of responding to needs that remain systematically unaddressed: they therefore assume health coordination tasks and help patients with issues before and after the clinical encounter.

This results in a significant disparity between their declared roles and their roles in practice. One of the strongest examples we came across was reported by an IM in her 40s, who was considered an institutional insider and therefore forced into assuming the responsibility for clinical communication – which clearly is not a part of any professional standards of IMs:

> The child died at 3.30 a.m. in the morning and exactly at 3.30 a.m. I received a phone call from the hospital. Because the child was alone in the hospital, they [healthcare workers] wanted me to communicate with the parents about the death of their child.

> So, I waited until 7 a.m., I called them firstly to tell them that the situation was pretty bad and after half an hour I told them that the child had died. It was the best thing I could do at that moment.

One of the most cited studies in this field (Davidson 2000) found the reason for such a conduct, which can be seen from the previous quote to lie in the institutional embeddedness of IMs. Based on a study of hospital interpreters in the United States, Davidson explains that IMs are institutionally embedded because they are "members of the hospital community where they work and interact daily; they are institutional insiders and ally themselves as such" (Davidson 2000: 400–401).[9] Similarly, some IMs in Slovenia also perceived themselves as part of the healthcare team.

However, in most cases IMs do not function as institutional insiders. Unlike healthcare workers, who usually have permanent employment contracts, most IMs have project-based contracts with healthcare institutions, as can be seen in the experience of an interlocutor in her 40s who had worked as an IM for more than five years:

> What hurts me the most is that when you have a project, you can work well. Then the project is over, and you stay in the middle of the process. And then a new project is on, whoopee, you find the same people again and continue the work. But again, this project will end and so on. It is horrible, foreign language-speaking patients are not projects.

IMs' employment depends largely on short-term projects and on decisions by health institutions on whether to continue collaborating with them. Their financial dependence (and fear of losing the contract) lead many IMs to show that they agree with the perspectives of healthcare professionals. Consequently, they are seldom prepared to question biomedical concepts, much less to openly confront or oppose the views of healthcare workers.

Conclusion

At the beginning of this article, we asked: what power relations arise in the triadic situation between doctor, patient and IM? What challenges do IMs face in their role as the nexus of this triad? To answer the first question, we showed that power relations

[9] A study of community interpreters in Switzerland presented the hypothesis that due to healthcare professionals' power there is more space for showing allegiance to patients outside rather than within clinical encounters (Leanza 2005: 186).

can be best seen in the way that IMs' allegiances are pulled in both directions: that is, both the healthcare workers and the patients expect the IMs to side with them and assist them. In some cases, this is difficult because of conflicting views and interests between patients and healthcare workers, and IMs are caught in the middle. On one hand, we found that there are several contextual aspects which might encourage IMs' allegiance towards patients. IMs themselves mostly share experiences of migration; IMs are perceived to be part of the same immigrant community as patients; and the absence of systemic responses in order to bridge language and cultural gaps inevitably creates a tendency for IMs to side with patients. Moreover, what often makes IMs opt for a more advocative role are cases where IMs defend patients against unequal medical treatment and inappropriate attitudes by healthcare workers. On the other hand, several factors push IMs to side with healthcare professionals, including the precarity of their employment positions in healthcare institutions. Moreover, their internalisation of the biomedical views of healthcare providers is noticeable in their uncritical promotion of biomedical norms, procedures, and practices at the cost of traditional explanatory models and practices held by patients.

To answer the second question, the challenges faced by IMs in their role as the nexus of the triad include a lack of boundaries between their role in the community and their work in health institutions; between private time and professional time; and navigating between conflicting principles such as impartiality, accuracy, completeness on one hand and assurance of equity and quality care on the other. Although some of these challenges arise from the fact that intercultural mediation has only been recently established as a distinct profession in Slovenia, the majority of them are a result of the fact that IMs are caught in the middle between the conflicting expectations of the two parties they work with. In this situation, IMs continuously strive to find a balance by working towards an equilibrium between their own community and the larger society, through their private engagement with migrant patients and with professional services within the healthcare organisation.

Some of these challenges are shared by those in many other precarious and marginalised professions (Lipovec Čebron & Pistotnik 2015). Even though IMs are described as central to equal healthcare provision, they simultaneously occupy the margins (Gustafsson, Norström & Fioretos 2013: 196–197) in the sense that they often do not possess enough power to actively transform healthcare services in order to make these services more accessible to patients with migrant backgrounds (Agustí-Panareda 2006: 424). This dilemma seems to be one of the main characteristics of the role of IMs throughout Europe. Intercultural mediation has been implemented in some parts of Europe as a response to healthcare barriers posed by language and socio-cultural

factors (Cattacin, Chiarenza & Domenig 2013; Seeleman et al. 2015). Yet it would be naive to assume that the introduction of intercultural mediation alone would assure the overcoming of the numerous barriers to healthcare faced by patients with migrant backgrounds. In increasingly neoliberally-oriented healthcare institutions across Europe where discriminatory healthcare attitudes are tacitly accepted, the principle of inclusion is frequently neglected. Discriminatory practices towards newcomers are camouflaged by complex bureaucratic rules (Fassin 2004; Leskošek 2013, 2016) and intercultural mediation seems to function as an outdated ethical "corrective" or "accessory". In other words, intercultural mediation should not be seen as a purely technical solution or as a measure meant to seemingly "fix" problems (Venneri 2008: 143) that are highly complex and therefore completely outside the scope of IMs' competencies. Although the introduction of IMs can help patients overcome various barriers to quality healthcare, their role will achieve the most beneficial results for patients and healthcare professionals only when systemic changes are introduced to ensure equity in healthcare.

Competing Interests

The authors have no competing interests to declare.

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