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A pilot study of language and culture mediation in medical interpreting at border crossing points in Moscow, Russia

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Abstract

The paper analyzes provision of medical interpreting services at border crossing points in the Russian Federation. It is argued in the article that medical interpreting at border crossing points should be viewed as linguacultural mediation in the context close to emergency situations, which requires specific interpreter's competences. The article **aims** at indenting relevant competences of medical interpreters at border crossing points through conducting an experiment on quality of medical services provision to migrants and refugees in terms of effective interpreter assisted doctor–patient communication. The research **methodology** rests on cluster, factor and discriminant analysis and integrated two stages: desk and field stages. To conduct the survey part an open-ended questionnaire has been developed which included 7 items. The survey was anonymous and involved native speakers of Arabic, Pashto, Dari, Uzbek, Tajik languages. The conducted research made it possible to identify factors that negatively influenced ultimate assessment of medical services provision at border crossing points. These factors are two-fold: the fists category relates to organizational issues such as lack of specific medicines and doctors with narrow specialization, stressful atmosphere and lengthy border crossing procedure;

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second category includes linguistic factor such as interpreter's knowledge of communicants' cultural background, ability to act as mediator, goal oriented communicative skills. The research **results** reveal that medical interpreting at border crossing points should be regarded as intercultural mediation as takes place in unstandardized setting and involves a range of culturally and socially significant issues. As the research **outcomes** the preliminary list of medical interpreter's competences has been drawn.

Keywords: Linguistics, Anthropology, Education

1. Introduction

The rapidly developing processes of globalization have had a strong impact on the migration of the population, its patterns and structure. Migration and social mobility are an integral part of life and development of modern society. In this regard, public services in developed countries have faced the need to adapt their activities to new conditions and develop new strategies for approaching the work with different ethnic groups of the population. Increased migration, including cross-border migration, accelerates ethnopolitical processes, complicates the situation in terms of the global humanitarian and legal context. The current situation calls for the development of collective approaches based on the principles of humanism and a reasonable balance between the protection of linguistic human rights and the national interests of countries with a certain official language.

Therefore language and culture mediation is urgent need to implement interaction between coming and receiving communities in key social spheres, including administrative, legal, healthcare, educational settings.

1.1. Background

In today's societies, language and culture mediation is implemented by translators and interpreters. Those working in healthcare settings, carry out their activities in the multifaceted context that uses language to discuss healthcare issues. Translators and interpreters in this setting bear responsibility for human lives.

Regarding the migration situation in Russia general growth of migration has stabilized at the level of 250−300 thousand people per year. Immigration in Russia is encouraged in terms of compensating for the natural loss of the population able to work. The main region-source of migration to Russia is CIS (Commonwealth of Independent States) countries, Syria, Afghanistan, some other Asian countries. The exact figures on each of the countries would vary as migration flows also depend on season.

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Discussing the provision of healthcare services to migrants it must be stressed that it is determined by Federal Law on "Compulsory medical insurance in the Russian Federation", which means that migrants have right to free of charge medical aid if they are lawfully residing in the territory of the Russian federation. Tackling the issue of the Russian language proficiency for migrant the government of Russia adopted the law (its latest amendment came into force on 1 January 2015) that makes it obligatory to pass the test on elementary knowledge of Russian and basics of Russian legislation for migrants who wish to obtain permits for work or have the right to apply for Russian citizenship. Such measure is focused on better integration of migrants into the host society through eliminating the language barrier on the one hand, and ensuring social security on the other.

1.2. Hypothesis

From the above perspective, we believe that discussing the issue of ensuring access for forced and regular migrants to healthcare services through eliminating language barrier is topical and timely. Health is one of the basic people's needs; inability to have these needs accommodated might lead to eventual marginalization of ethnic or migrant communities (Booth and Lynch, 2003), which in its tern may provide fruitful grounds for spreading extremists' ideas (Hales and Williams, 2018; Kruglanski et al., 2018).

The research goal is to explore the healthcare services provision at Russian border crossing points for migrants who are not part of regular migration, have fled their home countries due to emergency situations.

This aim can be achieved through solving the following tasks:

a) to explore the relevant literature and previous findings in the field to gain sufficient underpinning for empirical studies;

b) to collect empirical data by means of questionnaires on provision of healthcare services at Russian border crossing points, for people with no or limited communicative ability in languages other than their mother tongue;

c) to draft recommendations for enhancing access to healthcare services in Russia for people with limited foreign language capacity.

2. Materials & methods

The research integrated desk and field stages:

1. Literature analysis of international experience in the field under study was conducted.

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2. Empirical studies were conducted. The research rested on mixed methods, using quantitative and qualitative approaches to empirical data. The authors took into account the opinion of those scholars who consider survey questionnaires as a method for further qualitative interpretation (Jansen, 2010).
3. The questionnaires were offered to persons who have got temporary asylum status and stayed in Moscow at the moment of being experiment participants.
4. The respondents were invited to fill in the questionnaire after they visited one of Moscow outpatient clinics, that are located near the University and often ask university administration about language support for foreign patients. It should be noted the procedure turned out to be really sensitive.
5. The detection period — procedure of gathering the pool of respondents — took a year.
6. Another 10 months were spent for their interviews' data processing. Therefore, the total period on data collection and processing took nearly two years. The respondents were intercepted in the course of arranging their support for healthcare service provision by university language specialists who have degree in translation/interpreting.

Only 15 % of those invited agreed to participate and only on conditions of anonymity. Totally 134 persons agreed to participate. According to mixed methods pilot study (Creswell and Plano Clark, 2017), it can satisfy pilot study goals.

All the respondents asked for confidentiality and non-disclosure of their personal data. They were from Syria, Afghanistan, Uzbekistan, Tajikistan. Respectively, they spoke Arabic, Pashto, Dari, Uzbek, Tajik.

The following variables were sat: age, gender, country of origin, religion, travelling alone/with other family members (minors/elderly/disabled), existence/absence of diagnosed chronical diseases before move to another country, types of border crossing points (airport/road/rail crossings points), foreign language skills.

The research aimed to balance respondents in terms of set variables that also were the reason for extended selection procedure.

The participants (patients) were invited to participate in the open-ended self-administrated questionnaire and answer the following questions:

1. Did you need healthcare services at the border crossing points? (yes/no, why/what kind of, if yes)
2. Did you received healthcare services (that you urgently needed) at the border crossing points? (yes/no, why)
3. Were you satisfied with the healthcare services (that you urgently needed) at the border crossing points? (yes/no, why)

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4. What is your native language?
5. Can you speak any other languages? (yes/no, which ones?)
6. What language did you use to communicate regarding medical assistance at the border crossing points?
7. Did anybody else helped you with translation through healthcare service provision at the border crossing points? (If yes, please, specify who this person was)

Respondents were offered to provide comments in free form regarding *why/what kind* of questions.

Further the replies of those who focused on language issues in their free comments to the questionnaire items were subject to specific analysis.

The research included cluster, factor and discriminant analysis. Statistical Package for the Social Sciences was used to process the data.

The obtained figures laid grounds for further qualitative interpretations.

The study complies with all regulations and ethical guidelines in force for research within RUDN framework activities under the guidance of the Russian Ministry of education. The informed consent was obtained prior to conducting the research. The research was approved by the Law Institute human resources and ethics committee.

3. Study area

The countries that are receiving immigrants have developed or developing their own strategies in dealing with matters of ensuring access to healthcare services for people with limited official language proficiency. Countries implement various practices that are determined by the current demographic and social situation as well as the nature and structure of migration. The aim of this section is to identify relevant interpreter's competencies in healthcare settings, analyze and compare existing practices in ensuring access to healthcare services for persons with limited official language proficiency in various countries.

Healthcare interpreting as a specific field of professional practice within Public Service Interpreting domain is a multifaceted phenomenon which has been an object of many aspect-specific researches.

The main reason, that makes access to healthcare services difficult, most authors identify as the lack or insufficiency of official language competencies of immigrants (Moreno Preciado, 2004). Many authors point out that the cross-language barrier can significantly affect the quality of the healthcare service provided (Flores, 2006). However a number of primarily focus their attention on translating medical

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terminology and the problems of language pairs. The scholars also consider the typology and nature of scientific texts, various branches of medicine, the problems of translating pharmaceuticals and the variability of their names in different countries (Marsh, 2004).

Doctor—patient communication is one of the central issues within healthcare domain analyzed from various perspectives. Specificity of doctor-patient communication mediated by an interpreter is developed by B. Rosenberg (2001). The scholars also consider the issue of the attitude of the medical workers themselves to the possible importance of the role of an interpreter-cultural intermediary. Medical community since ancient times has been considered as prestigious and closed community in terms of their knowledge, skills, and activities focus on human life and healthcare (Burgard et al., 2003; Foucalt, 1980), which to this day determines some asymmetry of doctor-patient relationship (Hoftvedt, 1991). In this regard, there is often an ambiguous perception of the figure of an interpreter by medical personnel, namely, understating the significance of his/her status, the translator, in the opinion of the majority of healthcare professionals, is only an assistant, not an equal participant (Abril Marti and Martin, 2011). As healthcare interpreting takes place in institutional setting it automatically entails issue of power balance in doctor – patient communication. There are researches (Davidson, 2000) the results of which indicate that due to the influence of institutional contexts interpreters tend more to take sides with medical professionals, rather than advocate for patients' rights. In this connection, mention should be made of the works that underline the need to recognize the official status of an intercultural mediator and to consolidate its role at the legislative level (Sales, 2005; Abril Marti and Martin, 2011; Atabekova et al., 2018). Castiglioni pointed out that linguacultural mediation is aimed at preventing possible conflicts and this important work must have clear legal frameworks (Castiglioni, 1997). There is a point of view that linguacultural mediator is not to make any decisions, all the decisions are made by the direct parties co communication: medical professionals and service users (Bermúdez, 2002), which means that lingua cultural mediator is not regarded as an equal participant in the doctor - patient communication. However, there are scholars who stich to an opposing point of view and regard linguacultural mediator as a key figure who ensures effective communication in medical setting.

Research literature also covers such specific aspects as risks associated with interpreter's mediation (Meyer and Bührig, 2014; Johnstone and Kanitsaki, 2006; Flores, 2005). Medical professionals' perception of interpreter assisted communication with patient is also much discussed issue (Rosenberg, Leanza and Seller, 2007; Aranguri et al., 2006). The use of so-called ad hock interpreters or family members in medical settings potentially involves risk of ineffective or even miscommunication (Meyer et al., 2010; Cambridge, 1999; Lee et al., 2006). It is also noted that the emotional state of proximity to the patient (proxy interpreters) can affect the accuracy of the translation. Researchers emphasize that the polyclinical consequences

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of an error committed by an unqualified translator are much more dangerous than the possible slips of a professional interpreter (Navaza, 2010: 142; Ramirez et al., 2008). There is also an opinion expressed by some authors that the role of intercultural mediator and translator should be assumed by the medical personnel themselves, and it is them who must take appropriate linguistic training (Antonín and Tomás, 2004; Limia et al., 2005).

Medical interpreter working in healthcare setting takes more than one role in communication unlike court interpreter who is expected to adhere strictly to "conduit" model (Meyer, 2000). In the course of communication the interpreter can also adopt various communicative goals such as obtaining correct medical history of the patient, being doctor's aid, or patient's advocate (Hsieh, 2003). It is highlighted that the ability of the interpreter to adopt a specific communicative goal to ensure effectiveness of medical-related communication and consequently to enhance the quality of healthcare services' provision (Harrington, 2014).

Since communication in healthcare setting sometimes involves sensitive issues, these issues tend to become even more sensitive in interpreter mediated communication. A number of researches have been undertaken into cultural barriers that impact doctor − patient communication (Schyye, 2007).

Public Service Interpreting as an independent field of training and professional practice (and healthcare interpreting as part of it) has originated relatively recently. As its basic objective is to ensure equal access to healthcare services to people with limited official language proficiency, practical implementation of this instrument in host countries required specific legal regulation. A comprehensive analysis of existing legislation and recent legal developments in addressing the issue of language barrier in the USA, a country which traditionally experiences an influx of migrants, was undertaken by Chen et al. (2007), recommendations developed by the authors in the research are of significant practical as well as theoretical value.

However, in Russia the issues of language and culture mediation in healthcare (via translating and interpreting) are still to be explored. Although it should be mentioned that some research was conducted in 2014 regarding administrative and legal aspect of medical service provisions to foreigners in Russia with reference to migrants as target audiences (Cook, 2014). Moreover particular target migrant audience (Kyrgyz labor migrants) social and administrative needs and challenges regarding healthcare services provision in Moscow were subject to special analysis, as well (Kashnitsky and Demintseva, 2018).

All the above confirms that provision of effective interpreter mediated communication in healthcare setting requires specific training of professionals. As far as the European Union member States are concerned there are networks of professional

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associations and universities that provide degree training for translating and interpreting at public institutions.

Regarding Russia, one can find only two Russian universities that run educational programs focused on training translators and interpreters in medical setting, but they are few in numbers. There are two major universities -participants of "5 top 100" Russian Academic Excellence Project implementing such programs. The RUDN University (Peoples' Friendship University of Russia) launched in 2013 and currently running the MA Program "Interpreter and Translator for Public Services and Institutions" The program provides specialized training in medical translation and interpreting and envisaged compulsory interpreting internship in the city polyclinic No 25 affiliated to the University.

Sechenov First Moscow State Medical University was the first among specialized medical universities to launch the linguistic MA program "Foreign Languages and Intercultural Communication". The program focuses more on translation in medical setting as well as intercultural communication in various health related domains. As far as majority of Russian degree course on translation are concerned their curricula (officially made public on the respective university sites) do not focus on interpreting in healthcare settings.

4. Results

The desk studies laid grounds for empirical analysis that included pilot survey of the migrant patients in Russia.

First, the analysis of respondents' opinions regarding healthcare service provision at border crossing points was conducted. The investigation resulted in a number of clusters that show different views and opinions. See Table 1.

The figures concerning ***the first and second clusters*** reveal that over 30% of those who cross Russian borders with the view to get temporary asylum need some kind of medical check and assistance. This ration confirms the importance of the

Table 1. Respondents' opinions on healthcare service provision at border crossing points.

Clusters	% of those who mentioned the point
1. No need for healthcare services at the border crossing points	53%
2. Need for healthcare services at the border crossing points	47
3. Received and was satisfied with services	22%
4. Received and was not satisfied with services	17%
5. Did not receive	8%

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border services administrative and professional readiness to deal with healthcare issues.

Regarding ***the second cluster***, formed by replies of 42% of the respondents, the following factors were mentioned.

- 1st factor was related to temporary tiredness and time-consuming procedure (0.914), the factor was mentioned by 91% of all those who responded positively.
- 2nd factor was related to minors'/elderly needs (0.84), 8% of those questioned mentioned that their little children felt slight cold/elderly companions.
- 3rd factor concerned intensified chronic illnesses (0.315), 32 % of the respondents mentioned the item.

The discriminant analysis revealed as statistically significant the travelling alone/or with other family members ($\lambda = 0.221$, $\chi 2 = 2.87$, $p < 0.01$), age under/over 60 ($\lambda = 0.217$, $\chi 2 = 2.41$, $p < 0.001$), existence/absence of diagnosed chronical diseases before move to another country ($\lambda = 0.374$, $\chi 2 = 3.02$, $p < 0.01$).

76% of the respondents whose replies compiled the cluster were over 60 years old or travelled with other family members (minors/elderly). Other 24% pointed out they had diagnosed chronical diseases before their move to another country.

As for ***the third cluster***, the respondents when clarifying the reasons for their satisfaction, mentioned the following:

- 1st factor concerned availability of the doctor and required medicine (0.742), 75% of those questioned mentioned the point.
- 2nd factor was related to doctor's ability to communicate with the patient in a foreign language that the patient understands (0.21), 21% of the respondents cited the item with no reference to interpreters.
- 3rd factor was related to the interpreter's availability (0.381), 39 % of the respondents mentioned this position.
- 4th factor concerned the fist-aid help of the border officers (0.231) who called the doctor immediately, 23% of the survey participants referred to the point.

The discriminant analysis confirmed a number of specifics related to the chosen variables.

- First, the discriminant analysis revealed as statistically significant the patient's mastery of foreign language ($\lambda = 0.436$, $\chi 2 = 3.91$, $p < 0.02$).
- Second, existence/absence of diagnosed chronical diseases before move to another country turned out to be statistically relevant ($\lambda = 0.264$, $\chi 2 = 3.45$, $p < 0.001$), and such factor as types of border crossing points ($\lambda = 0.115$,

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$\chi 2 = 1.02$, $p < 0.001$) and professional interpreter available (($\lambda = 0.574$, $\chi 2 = 4.768$, $p < 0.01$).

21% of the respondents confirmed the availability of interpreter on site, 42% of those satisfied informed they (or their relative(s) travelling with them spoke at least basic English, French, or German. 34% of the respondents to this cluster crossed borders at the airports, 66% - by train. They informed they got first-aid services at the airports or at the railway stations.

The fourth cluster revealed a number of reasons for people's dissatisfaction with the medical assistance at the border crossing points.

- 1st factor concerned the situations when the local doctor was not able to help due to lack of required medicines (1.0), 100% of the respondents mentioned the factor.
- 2nd factor referred to the language gap in communication with the doctor with no interpreters on site (1.0), 100% of the respondents mentioned the factor.
- 3rd factor related to the doctor's gender (0.813), 81% of those questioned mentioned the factor.
- The discriminant analysis revealed as statistically significant the age under/over 60 ($\lambda = 0.436$, $\chi 2 = 3.91$, $p < 0.02$), gender ($\lambda = 0.347$, $\chi 2 = 3.41$, $p < 0.001$), existence/absence of diagnosed chronical diseases before move to another country, ($\lambda = 0{,}374$, $\chi 2 = 3{,}02$, $p < 0.01$), types of border crossing points ($\lambda = 0.115$, $\chi 2 = 1.02$, $p < 0.001$), patient's and doctor's lack of foreign language skills ($\lambda = 0.325$, $\chi 2 = 4.02$, $p < 0.01$), no professional interpretation provided (($\lambda = 0.574$, $\chi 2 = 4.768$, $p < 0.01$).

All the respondents who got part of this cluster acknowledge they could speak only their mother tongue, and 78% of the people with only mother tongue communication ability were over 60 years old. All these peoples mentioned they did not get professional interpretation. Besides, 61% of the replies came from persons who confirmed they had got diagnosed chronical diseases before move to another country. Those dissatisfied were mostly female respondents (77% of female against 23% male patients) who confessed they felt ashamed to speak to the doctor of the opposite gender about the details of their poor health conditions. Those dissatisfied did not fly, they travelled by train (19% of the cluster replies) and by cars and buses (81% of the respondents whose replies compiled the cluster).

The fifth cluster included replies of 5% of the respondents who did not get medical assistance though it was necessary.

The survey participants mentioned the following reasons for the case under study.

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- 1st factor was related to the niche specialization of the doctor in need and specific medication (0.781), 78% of the respondents mentioned the problem
- 2nd factor related to the patient's refusal to deal with the specialist of opposite gender (0.689), 70% mentioned the matter
- 3rd factor concerned the language gap between the doctor and the patients with no professional interpretation provided (0.631), 63% of the participants mentioned the fact.

The discriminant analysis revealed as statistically significant gender ($\lambda = 0.347$, $\chi 2 = 3.41$, $p < 0.001$), language issues ($\lambda = 0.374$, $\chi 2 = 3.02$, $p < 0.01$), types of border crossing points ($\lambda = 0.115$, $\chi 2 = 1.02$, $p < 0.001$), existence/absence of diagnosed chronical diseases before move to another country ($\lambda = 0.786$, $\chi 2 = 4.02$, $p < 0.02$), The above figures show the importance of healthcare professionals' availability at the border crossing zones. Moreover, the figures confirm that foreign language skills mastery matters. Open-ended questionnaire revealed that 87 % of the respondents were not satisfied with the interpretation. Gender turned out to be a sensitive issue, as well. Although border-crossing points settings make it hardly possible to meet the patients' preferences regarding the doctor's gender. Furthermore, it is possible to conclude that the most critical situations occur on the land border check points, primary in case of migrants moving by buses and cars.

The pilot survey results show that 25% of those who applied for medal assistance at the border crossing points mentioned language problems in communication with the doctor.

The next stage included the ***free-style comments*** of those respondents who specified their critical attitude to the level of language support regarding the following points:

- lack of interpreters who work with patient's mother tongue (19%)
- interpreters' poor mastery of medical terminology regarding patient's concrete conditions (25%).
- psychological difficulties in communication with doctor via interpreter who used very "direct" style of communication (19%),
- interpreter's use of words and structures that lacked respect to patient's religious beliefs and cultural values (16%)
- no interpreter's wish to help both the patient and the doctor understand each other (18%)
- interpreter's failure to help solve administrative (orientation on the site) and paper issues (medical records) quickly (13%)
- necessity to search for necessary words in patient's mother tongue in the on-line sources to lack of understanding between the actors to the communicative situation (11%).

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All the above goes in line with previous studies that point out that the cross-language barrier can significantly affect the quality of the healthcare service provided (Abril Martí and Martin, 2011). The present findings confirm the statement regarding new communicative context (cross language communication for medical assistance at the host country border crossing points.

5. Discussion

The data from the questionnaires confirmed the importance of interpreter' attention to the communicative need of the patients (Elderkin-Thompson et al., 2001). Patients' comments showed that even in the speedy and emergency situations of doctor-patient interaction the border −crossing points (and not in a standard settings of a hospital) the interpreter should demonstrate to the patient his/her human readiness to help communicate with the doctor.

Respondents' replies revealed that cultural barriers that impact doctor − patient communication emerge not only stable contacts during some lasting period of time (Hsieh, 2016) but also during such a short period communication that takes place at the border crossing points. The context of communication does not imply long - standing interaction between patient or doctor. Both of them try to quickly solve the problem. Although the questionnaire confirms that even spontaneous patient- doctor communication require interpreter's care.

Moreover, the data shed new light on ways to advance patients' health outcomes through interpreting services. This topic has emerged in the academic research this year (Gonzales and Bloom-Pojar, 2018). The present research has showed that regarding the healthcare support for migrants at the border crossing points there should be interpreters' human readiness and wiliness to support doctor-patient communication and tailor it to particular individual contexts.

The patients' comments help to specify the general understanding of interpreter's multiple tasks regarding healthcare domain (Hseih and Kramer, 2012). As far as the border crossing point are concerned the interpreter is supposed not only to meet the aspirations of the patient and to help the doctor, but also to bridge administrative, communication, psychological issues. The interpreter's activities of this kind can help avoid unscheduled migrants marginalization that scholars mention with regard to migrant community in general (O'Donnell et al., 2016).

Therefor the present research elaborates on earlier statement regarding specific needs for interpreter's competences in the settings that go outside the standardized patterns of communication a due to social situation emergency (Atabekova et al., 2017) and shed new light on the issues under study. Thus, Di Izabel E. T. de V. Souza (2016) provided opinions of 458 interpreter practitioners from 25 different countries to

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conclude that intercultural mediation goes beyond interpreters, and requires the attention of other related stakeholders (educators, researchers, administrators, and policy makers). The present research confirms the statement with regard to the situation in the Russian Federation. Moreover, both previous data and present research raise the question of bespoke training for diverse stakeholders engaged in the work with target audience under study.

Furthermore, the present research elaborates on certain needs of unscheduled migrants within the healthcare settings. Latest developments in the academic research (Wenzel and Drožđek, 2018) have specified the fields of current health challenges in the new refugee crises. These include long-term displacement, questions related to legal, medical, social and health economic issues, ethics, period of stay in host countries, etc. The present research provides a new angle of prospective in terms of interpreter's role and skills in quality assurance with respect to unscheduled migrants in case they need healthcare services at the border crossing points.

The data lays grounds for further discussion on the possibility to introduce training modules regarding the work with interpreters in preventive healthcare programmes for unscheduled migration. The scholars confirm that generally preventive healthcare programmes provide a good opportunity to implement intercultural mediation (Čebron et al., 2017). The angle of preventive activities with regard to healthcare services for unscheduled/urgent/forced migration can contribute to systematizing and coordinating diverse stakeholders' activities.

The proposed thesis of the above bespoke training goes in line with the latest research statements on the impact of interpreting services for patients' health outcomes (Hlavac et al., 2018). The present research confirmed the above vision with respect to particular settings (border crossing areas).

6. Conclusion

The conducted research has revealed a number of factors that directly affect the level of migrants' satisfaction with interpreting services provided on cross border points. The pilot survey proved that about the half of those crossing the border of the Russian Federation needed medical aid either in the form of preliminary care or emergency treatment. the survey revealed that almost a half of the respondents received such aid, however about 17% of the respondents expressed their dissatisfaction with the services provided.

Among the critical variables identified in the course of the research are the following: organizational issues related to lack of required medicines, doctors with narrow specialization, lack of attention to migrants' medical needs on border officials' part; language and culture related issues such as poor knowledge of medical

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terminology by interpreters' lack of communicative skills in socially significant contexts, including medical setting, migrants' command of only their mother tongue, culture barriers in doctor-patient communication.

It has to be acknowledged that various types of border crossing points do not provide both medical and interpreting services of the same quality. Land border crossing points where migrants arrive on motor vehicles or even on foot in case of forced refugees, are frequently understaffed with professionally qualified interpreters, more frequently interpreting is provided by ad- hock interpreters, medical professionals or border officers, while border crossing points in airports and railway stations are usually staffed with professional interpreters working with major European languages, who can provide adequate medical interpreting.

The research data analysis reveals that medical interpreting at border crossing points should go beyond conduit model and is rather viewed as intercultural mediation beyond the standardized settings. People who turn out to be in need of medical assistance at the border did not plan to visit the doctor in the mentioned context (as part of traditional border crossing procedure). Doctors who work with patients at the border crossing point have neither the patient's previous medical record nor the opportunity to correct the treatment at further stages. Such rapid but durable solutions are required.

The pilot survey convincingly demonstrates that interpreter assisted doctor-patient communication at border crossing points involves many culturally sensitive issues such as gender, age, family status of the communicants, etc and no long time available to consult relevant sources. In this regard attention should be drawn to interpreters' training as cultural mediators in emergency settings. It should also be underlined that medical interpreting at border crossing points significantly differs from interpreting provided at medical institutions during arranged appointments with doctors. Border crossing interpreting involves greater component of stress as communication participants (migrants, doctors, border authorities) are not always open to communication and sometimes even demonstrate no wish to communicate. All the above requires tailored training of interpreters-to-be to acquire specific competences for interpreting in healthcare settings at border crossing points.

Having processed the survey results the authors drafted an approximate and, of course, an open list of competences that the interpreter-mediator is expected to have, it should be noted that linguistic skills are only part of this list.

Apart from medical terminology mastery, awareness of cultural background of the participants to communication, interpreting, communication and negotiation skills the interpreter who works at the border crossing points should act as part of the interdisciplinary team of border officials, needs such socio-psychological traits as

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flexibility, openness and initiative, - empathy, interest in the patient's problems, stress resilience, and impartiality, as well.

The identified competences necessary for ensuring effective doctor-patient communication at border crossing points should be considered in developing study courses for public service interpreting training programs on both bachelor and master level as traditional approaches to interpreter's training are not enough to form competences for interpreter assisted communication in socially significant contexts.

Declarations

Author contribution statement

Ekaterina Zvereva, Larisa Lutskovskaia: Performed the experiments; Analyzed and interpreted the data; Wrote the paper.

Anastasia Atabekova: Conceived and designed the experiments; Wrote the paper.

Olga Gorbatenko, Elena Kalashnikova: Performed the experiments; Analyzed and interpreted the data.

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Competing interest statement

The authors declare no conflict of interest.

Additional information

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