

Handling dissatisfaction in onsite and telephone healthcare interpreting: Reflections and insights from empirical data

Cristina Álvaro Aranda

University of Alcalá, FITISPos-UAH Research Group  

Raquel Lázaro Gutiérrez

University of Alcalá, FITISPos-UAH Research Group  

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ENG Abstract: providing professional onsite or telephone interpreting services is an effective strategy to address the linguistic and cultural needs of increasingly diverse patients. In this respect, healthcare interpreters contribute to the development of more equitable and inclusive societies by enabling effective communication that allows healthcare providers to fulfil their professional duties and patients to exercise their rights. These rights include the ability to express dissatisfaction with the services received, whether this concerns healthcare professionals, interpreters or both. Drawing on an exploratory approach grounded in observation and discourse analysis, this study examines four interpreter-mediated (both in-person and telephone) interactions to explore how user dissatisfaction is managed. The findings suggest that healthcare interpreters adopt very different strategies and roles depending on the context and underlying needs, including mediation and active involvement in the search for solutions.

Keywords: quality; interpreting services; healthcare settings; complaint.

ES La gestión de la insatisfacción en la interpretación sanitaria presencial y telefónica: Reflexiones y perspectivas basadas en datos empíricos

Resumen: facilitar servicios profesionales de interpretación presencial o telefónica es una estrategia eficaz para dar respuesta a las necesidades lingüísticas y culturales de pacientes cada vez más diversos. En este sentido, los intérpretes sanitarios participan en la consecución de sociedades cada vez más igualitarias e inclusivas, facilitando una comunicación efectiva que permite a los proveedores cumplir con sus deberes profesionales y a los usuarios ejercer sus derechos. Dichos derechos incluyen poder expresar insatisfacción con los servicios prestados, ya sea por parte de los trabajadores sanitarios, los intérpretes o ambos. Con un enfoque exploratorio que se nutre de la observación y el análisis del discurso, este trabajo analiza cuatro interacciones mediadas por intérpretes sanitarios presenciales y telefónicos para determinar cómo gestionan la insatisfacción de los usuarios. Los resultados sugieren que los intérpretes sanitarios adoptan estrategias y papeles muy diferentes en función del contexto y sus necesidades subyacentes, entre las que destacan la mediación o la participación activa en la búsqueda de soluciones.

Palabras clave: calidad; servicios de interpretación; ámbito sanitario; queja.

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1. Introduction

Increasing population movements over the last decade have given way to multicultural and multilingual societies. According to the World Health Organisation (2022), societies are greatly influenced by migration, which

has an important impact on the health and development of migrant and host communities. Large migration waves have resulted in calls for multi-faceted solutions, measures and policies to face migratory challenges (European Parliament, 2019). Access to healthcare services is acknowledged as a key move to promote integration and inclusion (European Commission, 2020), but using healthcare services for migrant populations usually implies confronting cultural and linguistic barriers. In fact, according to Aelbrecht et al. (2019), the language barrier between patients and healthcare providers is one of the main factors contributing to persisting health access inequalities. On the other hand, Lázaro Gutiérrez and Tejero González (2022) underline cultural differences not only as barriers to access healthcare for migrants, but also as a factor that results in misunderstandings and lack of trust, which influences the provision of adequate and equal healthcare.

To bridge language and culture barriers in the healthcare setting, intercultural mediators and interpreters have been considered the best solutions, as they play a key role in improving health and patient safety (Kletečka-Pulker et al., 2021). Interpretation services can be offered onsite or remotely, and it is not unusual that both modalities coexist in the same premises. Onsite healthcare interpreting or intercultural mediation is usually offered within a particular schedule and for certain languages. However, in healthcare settings, the number of language combinations in demand is high and, even though many medical consultations are scheduled beforehand, registers do not include information about the patient's language or communication needs. Furthermore, there are many unscheduled healthcare interactions, particularly at the emergency room or for administrative procedures. Because of these factors, it is difficult to predict which language will be needed and when. Together with an increasing telephonic and telematic provision of healthcare services, this situation makes using remote interpreting services a convenient approach.

Either onsite or remotely, interpreting in healthcare settings implies the deployment of mediation skills. This is due to the characteristics of the encounters, which include the alignment of interests of all the participants in the interaction towards the well-being of the patient, the discussion of culturally bound topics (e.g., differing conceptions about health and illness), institutional differences in the provision of healthcare services, or the occurrence of emotionally demanding situations. Requests for service provision in an emotionally charged interaction may give way to exacerbated expression of feelings, particularly those related to frustration or dissatisfaction (Macary, 2020). Dealing with this kind of discourse and interaction has been proved challenging for interpreters (Lázaro Gutiérrez, 2024), who deploy a set of strategies to convey meaning while keeping the conversation going, among which mediation techniques are included (Lázaro Gutiérrez and Cabrera Méndez, 2023).

This contribution examines a reduced sample of interpreter-mediated healthcare interactions to uncover the strategies interpreters employ when addressing patient dissatisfaction. The conversations analysed are drawn from two broader datasets: one based on direct observation of onsite encounters and another consisting of recorded telephone-mediated interactions. To establish the theoretical framework, Section 2 provides a comparative overview of onsite and telephone interpreting modalities, while Section 3 reviews the notions of quality and (dis)satisfaction in healthcare (interpreting) contexts. Drawing on Donabedian's model (2005) as our primary analytical tool for identifying instances of patient dissatisfaction in the dataset, our exploratory methodology facilitates a more nuanced analysis of interpreter behaviour in Section 5. This qualitative approach, in turn, supports a tentative comparison based on the mode of interpreting provision (onsite vs telephone), which may inform the development of hypotheses for future large-scale studies, as outlined in Section 6.

2. Healthcare interpreting: a comparative overview of onsite and telephone modalities

Healthcare interpreting is provided in healthcare centres, clinics and public and private hospitals, either in person onsite or through remote means. Remote modalities of interpreting, particularly telephone interpreting, are becoming increasingly common in homecare settings and during emergency calls. Although a growing number of university programmes now offer training in healthcare interpreting, such as the Master's Degree in Intercultural Communication, Interpreting and Translation in Public Services at the University of Alcalá, the complexity of healthcare interpreting (in terms of linguistic diversity, the irregular frequency of requests, and variability in working conditions and the establishment of minimum professional standards, among others) means that university training alone is not sufficient. Brief onboardings provided by employers as part of continuing professional development are popular options, particularly for interpreters of languages of lesser diffusion (LLD) or working in remote settings.

The tasks performed by healthcare interpreters are many and varied, further reinforcing the need for continuous, lifelong learning. This is because healthcare interpreting can vary significantly depending on the specific context in which it occurs (e.g., whether it takes place in an emergency department or a mental health consultation), the participants involved (e.g., children in a paediatric consultation or women who are victims of gender-based violence) and the (onsite or remote) mode of delivery (Cox and Lázaro Gutiérrez, 2016; Echaury Galván, 2014). Furthermore, it is common for healthcare interpreters to perform additional tasks, including mediation, sight translation, written translation of various types of documents, accompanying patients, compiling and drafting informative materials and even delivering health promotion talks. This blurred definition of professional tasks goes hand in hand with a complex understanding of interpreter's roles. Apart from and as well as being interpreters, in healthcare settings in Spain they are often regarded as members of the healthcare team assisting the patient. As such, they must adhere to the ethical principles of beneficence and non-maleficence, which at certain times may imply providing clarifications, additional information or other forms of assistance, always contributing to the well-being of patients (Lázaro Gutiérrez, 2017). As the only

participants with whom direct communication is possible, healthcare interpreters are also those who often face patients' (and providers') frustration and dissatisfaction when their needs and expectations are not met (Álvaro Aranda, 2025).

As previously mentioned, remote modalities in healthcare settings are gaining increasing popularity, particularly telephone interpreting. This modality is employed both when the service provider and the patient are physically together and connect with the interpreter via telephone, and in interpreter-mediated or three-way phone calls (Lázaro Gutiérrez, 2021). Previous studies proved that interpreted conversations contain a high number of face-threatening acts (Lázaro Gutiérrez and Cabrera Méndez, 2017). Face-threatening acts are the cornerstone of the politeness theory developed by Brown and Levinson (1987), who, in turn, were inspired by Goffman's concept of face-work: a set of strategies that safeguard, protect, and repair the speakers' face during social and communicative interaction (1967: 15-23). Face-work is constructed jointly by the different participants in a conversation (Goffman, 1967; O'Driscoll, 2007) and is shown by the presence, absence or combination of markers on discourse, including linguistic, paralinguistic, and nonverbal elements. It can have a positive, negative (threatening), or neutral effect on the face of the sender, the recipient, or even other people, such as the interpreter (Hernández Flores, 2013). Politeness, therefore, can have functions of repair, enhancement, attenuation, strengthening, or protection (Hernández Flores, 2013), and can also vary in intensity depending on the effect it achieves (O'Driscoll, 2007). Brown and Levinson (1987) describe two types of face: negative and positive. Positive face refers to self-esteem and is related to the desire to relate positively to others. On the other hand, the negative face relates to autonomy and represents freedom from imposition and implies the right to individual action. The positive and negative aspects of face play an essential role in social interaction, and cooperation between all participants is necessary to save everyone's face.

The high number of face-threatening acts in healthcare interpreted interactions is because this kind of communication is indirect, as main speakers do not receive messages directly from their interlocutors but instead get a rephrased or reworked version by the interpreter. Whether consciously or unconsciously, interpreters reformulate information to safeguard both the face of the primary speakers and their own (Jacobsen, 2008). By exercising their relational agency, interpreters actively co-create a supportive dynamic within the triad, typically through mitigation of face-threatening and face-flattering acts (Delizée and Michaux, 2022). At the same time, primary speakers are aware that reformulation is an inherent part of the interpreted exchange and that responsibility for their utterances is, at least in part, shared with the interpreter (Lázaro Gutiérrez, 2021). Our findings further indicate that telephone-interpreted interactions, due to their non-face-to-face nature, tend to contain a higher frequency of face-threatening acts (Lázaro Gutiérrez 2017, 2021). This resonates with Bechet et al. (2012), who describe the annotation of the corpus DECODA, comprising telephone conversations to a call-centre, with the aim of analysing operator behaviour and client satisfaction. Similarly, Macary et al. (2020) annotated the AlloSat corpus, which consists of real-life call centre conversations in French that include indicators of frustration and satisfaction after an intra and inter-annotator agreement methodology. Annotations for frustration and (dis)satisfaction frequently include face-threatening acts.

3. Quality and (dis)satisfaction in healthcare (interpreting) settings

The concept of quality is firmly embedded in individuals' everyday experiences. It underpins the functioning of numerous public and private sectors with which users engage, who increasingly expect to receive the highest possible standard of products and services. Clients typically assess service quality by comparing expectations with actual experiences and, when the service is perceived as high in quality, it tends to enhance satisfaction and long-term loyalty (Kurniawan et al., 2025). Over recent decades, research has identified multiple dimensions of quality, alongside a growing consensus that health services must be timely, equitable, integrated, and efficient, as well as effective, safe and people-centred (World Health Organisation et al., 2018). The latter is particularly significant, as patients' views on the quality of care constitute essential components of quality assurance and quality improvement programmes in healthcare settings (Sixma et al., 2002). In a similar vein, Donabedian (1990) indicated that healthcare professionals should consider patient and societal preferences when assuring and assessing quality. This allows conceptualising healthcare quality across three interrelated dimensions: structure (material, human and organisational resources), process (actions involved in providing and receiving care) and outcome (the resulting health status of the patient) (Donabedian, 2005).

When these reflections are applied to multilingual and multicultural care, translation and interpreting activities are part of service provision, quality assessment and patient satisfaction (Krystallidou et al., 2024). After reviewing the literature on interpreter intervention, Heath et al. (2023) found that professional interpreter involvement leads to higher patient satisfaction and improved communication outcomes. This resonates with earlier studies, such as Baker et al. (1996), which show that patients with access to qualified interpreters (whether onsite or remote) report better understanding of medical instructions and, consequently, improved health outcomes. In contrast, language barriers are linked to poor adherence to treatment, higher rates of hospitalisation and increased risk of medical errors (Karlner et al., 2007). In some areas, particularly rural or underserved regions, there is a shortage of qualified interpreters (Jacobs et al., 2001). This is also the case for languages of lesser diffusion, as interpreter training opportunities and available resources in these languages are scarce (Vitalaru, 2024). Counting on trained interpreters is key in the provision of quality interpretation services. However, training is not only provided prior to be hired, whether by a training body or as an onboarding process within the employing organisation. Quality-aware employers implement quality control and quality assurance mechanisms, which typically include ongoing training for their staff (Zhang et al., 2024).

This kind of training is usually informed by current practice and actual challenges in the field of healthcare (Lázaro Gutiérrez and Cabrera Méndez, 2024).

(Dis)satisfaction is at the core of perceived quality. In interpreter-mediated situations, end-users might express dissatisfaction towards the services provided by interpreters or by service providers. Most of the times, the expression of dissatisfaction takes the shape of face-threatening acts. As previously mentioned, these are the cornerstone of (im)politeness theories, which are very popular in Pragmatics. Previous findings have revealed that there is a high prevalence of face-threatening acts in interpreter-mediated conversations, both onsite and over-the-phone, and that interpreters, indeed, perceive them as a great difficulty. Recent studies (see, for instance, Lázaro Gutiérrez, 2024) identify end-users' dissatisfaction with both the primary service and the interpreting service, as well as service providers' dissatisfaction with interpreting, as the main causes of the production of face-threatening acts. Instances of end-users' dissatisfaction are more frequent in our corpora and interpreters usually react to them deploying an array of mediation abilities that contribute to repairing the face of both main speakers and to the attainment of their goals. A deep analysis of this phenomenon is needed to understand its dimensions.

4. Objectives and methodology

This study explores the behaviour of onsite and telephone interpreters when allophone migrant patients express dissatisfaction with the healthcare services provided. To this end, we analyse a sample of four interpreter-mediated interactions recorded in distinct clinical settings. The conversations selected for analysis are part of two larger datasets. The first comprises direct observations of authentic interpreter-mediated healthcare encounters conducted at a public hospital in Madrid, Spain (see Álvaro Aranda, 2025), whereas the second consists of recordings of telephone-interpreted interactions between Spanish-speaking providers and allophone clients in different settings, including healthcare (see Lázaro Gutiérrez, 2024).

Regarding the first dataset, observations were collected by means of an observation protocol over a period of five months in 2017, including nurse interactions and medical consultations in several specialties, such as Nephrology, Sexual Health, Urology and Tropical Medicine. Prior to data collection, approval was obtained from both the home university and the host institution. Research subjects granted informed consent, which was conveniently registered, and were given the opportunity to ask questions concerning their rights and refusal to participate. The second dataset is the multilingual and multimodal corpus PRAGMACOR, compiled in the framework of the project "Corpus Pragmatics and Telephone Interpreting: Analysis of Face-Threatening Acts (PID2021-127196NA-I00). Compilation and annotation went on from 2022 to 2025. Data extraction was possible thanks to agreements with the most important Spanish telephone interpreting companies. Audio recordings of conversations (roughly 40,000 minutes) in Spanish and English, French, German and Chinese were selected. The corpus includes a wide variety of topics within service provision, such as road-side assistance, insurance services, social welfare, child protection, and medical consultations, which are the target of this contribution. The project has been approved by the ethics committee of the University of Alcalá with the code CEIP/2023/4/108. Further details regarding data compilation, ethical clearance procedures, and methodological aspects can be found at Lázaro Gutiérrez (2024).

To identify instances of dissatisfaction, we draw on Donabedian's model (2005), which conceptualises healthcare quality across three interrelated dimensions: structure (material and human resources, and organisational frameworks), process (the actions involved in providing and receiving care) and outcome (the resulting health status of the patient). Given that this is an underexplored area of inquiry, we adopt a qualitative research framework (Denzin & Lincoln, 2005), which enables a nuanced understanding of individuals' behaviours, attitudes, experiences and meaning-making processes in relation to specific social phenomena (Wahyuni, 2024). Our exploratory approach is not aimed at hypothesis testing but rather seeks to enhance conceptual understanding of the topic and to identify paths for more fine-grained research in the future (Neuman, 2014).

5. Results and discussion

This section examines the conversations chosen for analysis. Based on their illustrative potential, two conversations have been selected to represent each of the healthcare interpreting modalities previously described. To facilitate comprehension, utterances originally produced in languages other than English (i.e., French and Spanish) have been translated by the authors and appear in brackets, together with non-verbal or contextual information whenever deemed necessary. To preserve confidentiality, personal information has been removed and general identifiers are used in its place (i.e., interpreter, patient, provider).

5.1. Onsite interpreting 1: "Everytime I come here they make me wait"

In this case, the interpreter is a Spanish female undertaking her internship as part of the master's programme in Intercultural Communication, Public Service Translation and Interpreting at the University of Alcalá. A native of Spain, she works with Spanish and French, the latter often serving as a *lingua franca* for patients from Sub-Saharan Africa seeking medical care at the hospital. On this occasion, she has been assigned to interpret for a male Ivorian patient who requires a blood sample and a tuberculin skin test (TST) for screening purposes. In addition to facilitating communication, the interpreter's responsibilities include accompanying the patient to the nursing area and handing over his referral slip.

Upon entering the room, the nurse addresses the interpreter directly, informing her that the necessary materials for performing a QuantiFERON®-TB Gold In-Tube test are currently unavailable. She instructs the

interpreter to wait outside while the materials are located. If the required collection tubes cannot be found, the patient will need to schedule a new appointment. The interpreter nods and relays this information to the patient in the target language. Both leave the room to wait in the hallway, in accordance with the nurse's instructions. It is during this unsupervised moment when the following interaction occurs:

(Agitatedly) Patient: À chaque fois que je viens ici, ils me font attendre. C'est toujours le même. Ils me disent que je dois prendre je ne sais pas quel médicament et après je dois attendre ! [Everytime I come here they make me wait. It's always the same. They tell me I need to take whatever medication and then I need to wait]

Interpreter: Non, ça arrive à tout le monde. Tranquillisez-vous, ne vous inquiétez pas, c'est pour votre santé [No, that happens to everyone. Stay calm, don't worry, this is for your health]

Rather than voicing his concerns directly to the nurse through the interpreter, the patient waits until he is alone with the latter to express his dissatisfaction with the long waiting times he has repeatedly experienced. This aligns with Donabedian's (2005) process measures, as it highlights the patient's perceived deficiency in the delivery of care. The complexity of this case is further heightened by the symbolic significance of blood in the patient's culture. Mistrust related to blood procedures is a recurring source of intercultural tension across the first dataset (see Álvaro Aranda, 2025) and it underscores the patient's discomfort.

The interpreter's behaviour can be seen as an attempt to avoid a potentially conflictive situation that could affect the therapeutic relationship between the patient and the nurse, and also impact on the quality of the care received. Thus, she positions herself as an active agent in preventing conflict and mitigating tensions. By explaining that delays are common and affect all patients, irrespective of their cultural or linguistic background, she seeks to appease the patient and reposition the delay as a generalised problem. Furthermore, she reminds the patient that waiting is necessary to access the required medical tests and, although inconvenient, it is essential for his well-being.

In this interaction, the interpreter assumes the role of a "recipient of complaint", rather than being the direct target of the patient's dissatisfaction. This is evident in the patient's accusatory use of the pronoun *they*, which refers to the healthcare institution and clearly excludes the interpreter. As previously observed in onsite healthcare interpreting, patients often seize moments when providers are absent to pursue alternative relational or transactional goals (Álvaro Aranda, 2024). These moments, in turn, create opportunities for interpreters to act beyond their traditional conduit role (ibid.). In this instance, therefore, the interpreter not only facilitates communication but also offers emotional support by soothing the patient, a role similarly documented by Lara-Otero et al. (2019).

Furthermore, the analysis of this interaction must be situated within the broader context of institutional power dynamics (Nimmon & Stenfors-Hayes, 2016) and culturally situated understandings of the provider-patient relationship (Alkamees & Alasqah, 2023). In many cultural frameworks, deference to medical authorities may inhibit patients from directly confronting or disagreeing with healthcare providers. In this light, the interpreter offers the patient an outlet for expression that may not otherwise be available.

5.2. Onsite interpreting 2: "I'm not a doctor. It's up to the doctor to make the referral"

This interaction takes place during a Tropical Medicine consultation involving a male Ivorian refugee diagnosed with trachoma. A native speaker of Dioula, the patient communicates in French with a Spanish-speaking medical resident and consultant. The interpreter assigned to this encounter is a female staff interpreter with four years of professional experience who has previously worked with both the patient and these members of the medical team. An intern interpreter is also present for training purposes, although he does not participate in the interaction. The encounter is initially characterised by a sense of detachment on the part of the patient and an underlying tension, as evidenced in the excerpt below:

(The patient sits down facing the providers. He is wearing sunglasses. The interpreter takes a seat between them)

Medical resident: ¿Puedes quitarte las gafas de sol para que pueda verte los ojos? [Could you take your sunglasses off so I can see your eyes?]

(Consecutive interpreting into French)

(The patient huffs and takes his sunglasses off)

Medical resident: ¿Te has hecho la prueba del Mantoux? [Have you had the Mantoux test done?]

(Consecutive interpreting into French)

Patient: No.

(Consecutive interpreting into Spanish)

Medical resident: ¿Por qué no te la has hecho? [Why haven't you had it done?]

(Consecutive interpreting into French)

Patient: Je ne suis pas médecin, c'est le médecin qui doit m'adresser [I'm not a doctor. It's up to the doctor to make the referral]

(Consecutive interpreting into Spanish)

Medical resident: Tenemos que pedirlo de nuevo [We'll need to request it again]

(Consecutive interpreting into French)

Patient: Encore ? Encore du sang ? Non, ça ne est pas possible [Again? More blood? Impossible]

(Consecutive interpreting into Spanish)

Medical resident: No, (name of the patient), listen—

(Interruption)

(Simultaneous interpreting into Spanish)

(Angrily) Patient: C'est un énorme effort pour mon corps de produire du sang et quand on m'en prélève... eh, bien... Et ça fait mal [It takes a huge effort for my body to gather blood and when they take it from me... well... And it hurts]

Medical resident: Como a todo el mundo. Pero quieres curarte, ¿no? [It's like that for everyone. But you do want to get better, don't you?]

(Consecutive interpreting into French)

(Harsh tone) Patient: Je veux que vous me soigniez, mais je ne veux plus qu'on me prenne de sang [I want you to make me better but I don't want to have more blood tests done]

(Consecutive interpreting into Spanish)

Consultant: ¿Tú aquí has venido voluntario o te han obligado? [Did you come here voluntarily or were you made to come?]

(Consecutive interpreting into French)

Patient: Personne ne m'a forcé [Nobody forced me]

(Consecutive interpreting into Spanish)

Consultant: Por eso. Y tenemos que hacer esto para curarte— [That's right. And this is something we need to do in order to treat you]

(Interruption)

(Consecutive interpreting into Spanish)

(Hurriedly) Patient: Écoutez, je comprends. Mais parfois j'ai des vertiges et c'est parce que je n'ai pas assez de sang. Si quelqu'un a des vertiges et que ce n'est pas à cause d'un manque d'eau, alors c'est un manque de sang. Je ne suis pas médecin, mais c'est ce qu'on m'a dit [Look, I understand. But sometimes I get vertigo and that's because I don't have enough blood. If someone has vertigo and it's not due to lack of water then it's lack of blood. I'm not a doctor, but that's what they've told me]

(Consecutive interpreting into Spanish)

Consultant: Es lo que normalmente tiene un tracoma [That's what usually happens with trachoma]

(...)

In contrast to the previous scenario, the patient explicitly voices his dissatisfaction with the care received while the doctors are present, which the interpreter conveys over several turns. His twofold complaint concerns what Donabedian (2005) categorises as processes, as it reflects both his disagreement with the proposed diagnostic plan and his refusal to accept responsibility for not having undergone the test, citing the absence of a referral from a doctor. The interpreter conveys the patient's messages without introducing any self-initiated contributions, adhering strictly to a conduit role at this stage of the consultation. This approach enables the patient to express his discontent, while allowing the healthcare providers to attempt to persuade him to follow the recommended steps towards diagnosis and recovery.

Case 2 offers insight into notable behaviour on the part of the interpreter. As seen in the previous excerpt, she switches from consecutive to simultaneous interpreting whenever the patient becomes agitated. This shift helps prevent information loss and potential turn-taking conflicts that might arise from the patient's agitated emotional state. In the context of telephone interpreting, however, such a shift would be problematic and potentially confusing, owing to technical limitations such as overlapping speech and the absence of visual cues, which may hinder intelligibility. Moreover, in addition to his harsh tone, both providers and interpreter can further understand the patient's attitude through his non-verbal behaviour. For instance, when he huffs and avoids removing his sunglasses until directly instructed to do so by the provider. In the case of telephone interpreted interactions, due to the lack of non-verbal cues, most of the times the identification of dissatisfaction by the service provider is not that easy, as it depends on the information conveyed verbally and paraverbally. Interpreters are the ones understanding the message and it is their responsibility to transmit it. Due to social and communicative needs, interpreters also take more responsibility in handling the frustration and dissatisfaction of end-users.

5.3. Telephone interpreting 1: "Bureaucracy in Spain is ridiculous"

In this situation, a 74-year-old English-speaking woman calls the emergency line. Upon realising that the caller does not speak the local language, the Spanish-speaking female provider contacts a telephone interpreting service and an English<>Spanish male interpreter is assigned to the call. The patient explains that she missed an appointment with the Plastic and Reconstructive Surgery Unit because she was never notified. Since she has only just received the appointment letter, she wishes to reschedule.

The interpreter has previously worked with this patient and is familiar with her case. At the beginning of the call, he addresses the patient directly, poses his own questions to gather further information and even instructs her to check her text messages in case the notification had been sent that way. He then brings the provider into the loop, who explains that such procedures may vary depending on the institution and that the patient needs to contact the hospital switchboard. Drawing on his prior knowledge of the patient's circumstances, the interpreter warns the provider that the patient has never received a response when calling, a point the patient herself later confirms during the call. When, frustrated, the patient asks whether a new appointment is available for her, a side conversation unfolds between the provider and the interpreter. The interpreter actively pursues the patient's best interests by suggesting alternative solutions to cater for her

needs. Although this behaviour on the part of interpreters has been described in the literature (e.g., Angelelli, 2004), for reasons of space, the following extract is presented simply to provide contextual background to how the interpreter subsequently manages the patient's dissatisfaction.

Interpreter: ¿Pero tú puedes mandarle al hospital una nota a ver...? (...) ¿Y si le damos una cita telefónica que le pida al médico? (...) Es que ella es una señora mayor, ¿sí? Que no puede desplazarse de un pueblo a otro, de un pueblo a la ciudad con facilidad, ¿qué alternativa le podemos dar? [Could you send the hospital a note to see...? (...) And what if we arranged a telephone appointment so she could speak to the doctor? (...) I mean, she's an elderly woman, right? She can't easily travel from one village to the city. What alternative can we offer her?]

The provider indicates that there are only two ways to reschedule the appointment: either by contacting the hospital switchboard or by attending in person. The patient insists that she is unable to travel due to her age and illness, and repeatedly points out that the hospital does not answer her calls. When it does, the call is ended as soon as it becomes clear she does not speak Spanish. The provider responds that she should use telephone interpreting services and offers to share the number of the hospital switchboard registered in the system, in case it differs from the one the patient is currently using. The patient refuses and, notably upset, says: "I've had enough." She then asks whether the provider can check the computer system to see if a new appointment has already been scheduled, but the provider replies that no new appointment will be arranged until the patient requests it herself. The patient insists that she cannot travel and has already attempted to contact the hospital on several occasions without success. The call continues:

Interpreter: OK, so we can't do anything anymore for you, we could give you the telephone number and that's it. ¿Le puedes dar el de cirugía plástica...? [Could you give her (the number) for Plastic Surgery...?] (*Angrily interrupts*) Patient: How come, how come, how come is this the only hospital I have trouble with? All the others they'll look up for my appointment for the future and tell me what they are for the future, I've got one on the 23rd of October. How come this is only this one I have trouble with??

Interpreter: Que cómo es que este es el único hospital con el que tiene problemas [She's wonders why this is the only hospital she's having trouble with]

(*Brief pause*)

Provider: Ah, no le puedo decir [Ah, I can't tell you that]

Interpreter: (...) Ya, claro, yo quiero que cuelgue, pero no, no nos va a dejar. Es que no podemos ayudarle más. [Yeah, of course, I want her to hang up too, but she won't let us. We really can't help her any further]

Provider: Sí, no, no [Yeah, no, no]

Interpreter: Right, so that's all we can do for you.

Patient: I've got one coming up... and I always...

Interpreter: Que tiene una cita... [She's saying she has an appointment] Ma'am, you are calling an emergency line, we can't help you, we already gave you all the information (...) So, she (the provider) has no more information for you.

Patient: Argh, waste of time. Bureaucracy in Spain is ridiculous. Thank you.

Interpreter: Thank you, have a good day. Bye-bye, bye.

Interpreter: Vale... Que vaya bien, compañera. [OK... I hope it does well, colleague]

(*Overlapping speech*) Patient: Have a good day? Good day? You're joking!!!!!!!

(*End of the call*)

Following Donabedian's (2005) model, the patient's dissatisfaction is primarily rooted in the process dimension. She expresses frustration at the lack of clear communication on the part of the hospital, contrasting this with her more positive experiences at other centres. Perhaps more closely related to the dimension of structure (Donabedian, 2005), she also criticises the rigidity of the Spanish healthcare system more broadly, describing it as overly complex, confusing and inaccessible. Her discomfort is uttered explicitly and further reinforced by exasperated sighs, interruptions and a distressed tone of voice.

The interpreter's behaviour throughout the session underscores the complexity of the interaction. Rather than limiting his role to rendering messages, he continuously seeks to resolve the situation by proposing alternative courses of action that may benefit the patient. He adopts a proactive attitude in managing her dissatisfaction, at times responding directly to her and subsequently relaying information to the provider, acting as another member of the care team. Although his actions are clearly aimed at safeguarding the patient's interests, he also demonstrates alignment with the institution by working to advance the provider's agenda (see Davidson, 2000). This dual positioning becomes evident when he tells the provider that he wants the patient to end the call, stating that they can no longer assist her. The strategic use of *us* and *we* may be seen as identitarian markers within an interprofessional dynamic, reflecting a shared position between healthcare interpreter and provider: both seek to support the patient, yet are constrained by intrinsic limitations. Furthermore, contextual factors must be acknowledged. Emergency calls are marked by time constraints, which may explain why the interpreter draws on prior knowledge of the case (e.g., informing the provider that the patient is an elderly woman) and suggests terminating the call once it becomes apparent that no immediate solution is available. In this instance, he transcends the role of a conduit for complaints and emerges as a key actor in proposing alternative solutions and managing patient dissatisfaction.

5.4. Telephone interpreting 2: “We were there for sixteen days, sixteen, *dieciséis* for a *biopsia*. No treatment, nothing”

A British citizen contacts a healthcare centre because his wife requires oxygen. He has been attempting to reach the liaison nurse for over two hours, but has received no response, as she is currently on holiday. Unaware of this, he phones the healthcare centre and a male liaison nurse tries to communicate with him, albeit unsuccessfully. The nurse contacts a telephone interpreting company and a female telephone interpreter is assigned to the call to facilitate communication. The nurse informs the caller that, if his wife is experiencing difficulty breathing, he should contact emergency services immediately. The caller, however, is hesitant. His reluctance is rooted in a previous hospital admission, during which he was dissatisfied with the care his wife received: they waited over two weeks for a chest biopsy and the results have yet to be delivered. He fears that calling emergency services might result in another hospital admission. The following excerpt illustrates part of the interaction:

Caller: Because the *médicos* do not know what this *bulto* is, I do not want her back in hospital. We were there for sixteen days, sixteen, *dieciséis*, for a [sic] *biopsia*, OK? No treatment, nothing, yeah, Tramadol, but for different reasons. Do you understand what I say?

Interpreter: Vale, pero es que yo... [OK, but the thing is I...]

[*Overlapping speech*] Patient: Do we have...?

Interpreter: One moment. A ver, es que yo... yo es que ya fuimos al hospital, los médicos no saben lo que tiene, no saben qué es ese bulto que tiene en el pecho y estuvimos... entonces yo no quiero que la vuelvan a ingresar al hospital, estuvimos dieciséis días para que le hicieran una biopsia y no sabemos los resultados ni sabemos nada, y ni siquiera le dieron tratamiento en ese tiempo ni nada. ¿Entienden lo que quiero decir? [The thing is... we've already been to the hospital. The doctors don't know what's wrong with her, they don't know what that lump in her chest is. And we were there... so I don't want her to be admitted again. We were in hospital for sixteen days just to get a biopsy and we haven't had any results, we don't know anything, and she wasn't even given any treatment during that time. Do you understand what I mean?]

Nurse: Sí, que él lo que está diciendo, vale, es básicamente es que... pero claro, es que si se está ahogando hay que llamar al médico para que le pongan, ellos ya le pueden decir cuando llegue el médico que no quieren un ingreso, pero sí que le pueden poner oxígeno, vale, o poner un tratamiento los médicos de urgencia [Yes, what he's saying, OK, basically, is that... but the thing is, if she's struggling to breathe, they need to call the doctor so they can give her... Once the doctor arrives, they can say they don't want her to be admitted, but the doctor can still give her oxygen or the A&E doctors can give her some kind of treatment]

Interpreter: Yes, but you have to talk to the medical service and once the doctor in the medical team is at your house you can explain them the situation. You can tell them that you don't want her to go to the hospital but that you want an oxygen, or they will see her and see if she needs any kind of treatment.

Caller: Yes, because she has no medication from the hospital, nothing, understand?

Interpreter: Vale, pero es que a ella no le han dado ninguna medicación del hospital, nada de nada, ¿entienden? [OK, but she hasn't received any medication from the hospital, absolutely nothing. Do you understand?]

Nurse: Un momento, estoy entrando en la historia suya para ver [One moment, I'm just opening her medical record to check]

(*The patient sighs in frustration*)

Interpreter: One moment, I'm looking at the medical records. One moment, please.

Caller: OK.

(...)

In this case, the caller's complaint stems from a previous negative hospital experience related to the process dimension (Donabedian, 2005). He expresses frustration at the absence of a clear diagnosis and subsequent treatment, as well as delays in both the performance of the procedure and the delivery of results. Signs of nervousness are evident throughout the interaction, manifested in frustrated sighs, interruptions of both the nurse and the interpreter and the insertion of certain Spanish terms (e.g., *bulto*, *dieciséis*). This may signal either an emphatic intent or, conversely, a lack of trust in the interpreter's competence.

In contrast to the earlier telephone-interpreted conversation, the interpreter in this instance adheres closely to the conduit role, repeatedly requesting the caller to wait until she has finished rendering the messages. Although the caller complies by interrupting himself when prompted, such behaviour underscores the challenges of turn-taking coordination in telephone-based healthcare interpreting. Whereas onsite interpreters can rely on eye contact, gestures or body language to manage conversational flow, telephone interpreters must employ alternative strategies conveyed with politeness (Fernández Pérez, 2017). These difficulties must be addressed with sensitivity when dealing with patient dissatisfaction, as (perceived) mismanagement may exacerbate the situation and contribute to a perception that the interpreter is an additional source of frustration regarding the care received.

6. Conclusions

This contribution analyses examples of dissatisfaction management by healthcare interpreters. Interpreters adopt various roles and employ a range of strategies when patients express dissatisfaction, typically arising

from a mismatch between their expectations and their current or past experiences (Kurniawan et al., 2025). Interpreters can take the responsibility of receiving the complaint voiced against healthcare providers, as in the first of our examples, with the aim of solving and mitigating the patient's dissatisfaction before it escalates into a conflict that could affect the consultation outcomes. In this role, interpreters intervene to offer (cultural) explanations about the functioning of the healthcare system and the role of the staff involved in care. Thus, interpreters employing this strategy adopt a mediator role, seeking to preserve the face of both the providers and themselves.

Interpreters may also intervene out of empathy to offer accompaniment and emotional support for dissatisfied patients. Personal engagement and attachment are used to contribute to the successful outcomes of the healthcare encounter. Patients, on their side, might align better with interpreters than with healthcare staff, as they might find more common background points with the former or might feel a weaker power imbalance that with doctors, considered a medical authority. This self-identification might lead patients to find way to interact with interpreters directly and in the absence of medical staff members, as seen in the first example.

When patients directly express dissatisfaction to healthcare staff, interpreters also contribute to handle the situation. Even if they stick to a conduit role, they are responsible of grasping the patients' emotions, which is not always obvious, particularly in telephone interpreting, because of the lack of visual cues. They must also accommodate to irregular paces of discourse, which are frequent when emotion expression occurs. In telephone interpreting situations, where the coordination tasks of interpreters exacerbate and, particularly, when time constraints apply (as in emergency hotline calls), interpreters have a key role in solving conflicts caused by dissatisfaction. Our examples show how challenging it is to keep turn-taking (see fourth example) or how they decide to deconstruct the classic structure of turns in interpreted conversations to take the floor and intervene using previous background knowledge and mediating amongst both parties.

The dissatisfaction of patients in our examples is usually directed towards Donabedian's process dimension (2005). When complaining against processes and not against people, interpreters might find it easier to receive or reconduct dissatisfaction. Contrary to the interpreters' behaviour in the management of blunt face-threatening acts observed in other pieces of analysis of our corpora, interpreters in our present study choose to intervene with mediation strategies to solve dissatisfaction and contribute to healthcare outcomes.

This study is based on a limited sample of conversations and the results should therefore be interpreted with caution. Further analysis of both onsite and remote interpreter-mediated interactions is necessary to support the preliminary findings presented in these pages. Additional research should encompass a larger number of conversations and a wider range of language combinations, given that culturally informed notions of politeness may influence how patients express dissatisfaction. Beyond advancing scientific knowledge, our forthcoming research aims to develop training materials and practice protocols that will contribute to enhancing the quality of interpreting services.

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CRedit author statement

Both authors have contributed to the development of this paper, as detailed below:

Cristina Álvaro Aranda: conceptualisation, methodology, investigation, formal analysis, writing, review & edition, funding acquisition (PRE FPI-UAH-15).

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