INTERPRETER WANTED. THE IMPACT OF SPECIALISED LANGUAGE ON MIGRANT WOMEN'S PERCEPTION OF HEALTHCARE INTERACTION

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Abstract. This paper focuses on healthcare communication and the impact of specialised language within doctor-patient relations in an intercultural context and from a gender-oriented perspective. A sample of twenty migrant Romanian female patients was surveyed to explore the way they perceived interactions with physicians back in Romania and the way they do so in Spain today. Providers of health services for linguistic minorities are expected to cope with needs and cultural beliefs, expectations and behaviours in an effective and culturally sensitive way. My hypotheses are: doctors and patients' perceptions of medical terms with various degrees of scientificity differ; the usage of medical terms with face-threatening effects influences the doctor-patient relationship; the interpreter, as a third party who mediates doctor-patient interactions can overcome misunderstandings. The two first hypotheses will be contrasted with the results of my survey analysis, whereas the third is dealt with in previous research in the matter.

Keywords: specialised medical language; migrating women; healthcare communication; interpreters.

CONTEXTUALIZATION: ROMANIAN MIGRATION IN THE 21ST CENTURY

Although the term "global" in our current economic and political acceptation is new, global structures have always existed: "corporations of craftsmen" in classical Greece, or guilds in the Middle Ages. These communities of practice (see Iliescu and Lambert 2014: 13) were not mere groups of people working on their own, but large organizations, based on knowledge sharing, learning and change. They developed their own communicative codes, which went beyond the use of technical terms and identified them epistemologically both on a professional level (in everyday work, conferences, journals, manuals) and on an academic level (in knowledge acquisition). One of the main consequences of globalization is a large-scale global movement of people and groups, making the boundaries of the global village fluid and its inhabitants highly mobile.

The drastic reforms that Romania was required to implement in order to join the EU (January 2007) provoked frustration and disappointment among many citizens who expected capitalism to bring higher living standards. Instead, it brought privatization[2], firm restructuring, legal and tax reform, which made some people yearn for the past, when the

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[2] Some 2.5 million jobs were lost in ten years due to the closing down of large factories (steel production) and downgrading of agriculture.

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state was the only provider of housing, culture, education, health, and employment. In fact, when Doboș (2006) assessed health service access, she reported that Romania had difficulties in providing healthcare cover for the whole territory and that the rural population was particularly vulnerable. The analysis by Suciu et al. (2012) of the post-crisis effects on the health system in Romania revealed physicians' frustration (for example with discriminatory remuneration and extra-shift-loads) and their subsequent massive migration.

At present, there are 675,983 Romanians (half of them women) registered in Spain[3], the second most numerous segment of migrants (after the Moroccans). Their main labour/professional sectors are: agriculture (seasonal jobs), building (the construction boom prior to the crisis) and housework (caring for children and the aged included). The reasons why many Romanians choose Spain (Viruela 2010: 159) are: difficulties in settling in other countries of their preference, a strong chain of migration networks based on family and social bonds (ethnicity, religion), a favourable attitude on behalf of the receiving society and the linguistic and cultural similarity. The two main features of Romanian migration in the twenty-first century are regionalization (neighbourhood affinities) and feminization. According to the UCL-Lancet Commission on Migration and Health (Abubakar, 2018), increases in the migration of women are due to shifts in gender, social and migration norms. In the case of young women, financial incentives and hopes for greater freedom and empowerment play a decisive role. This global phenomenon is "changing health services delivery in countries around the world" (Squires 2017: 2). In the following pages, I will present the results of a case study I carried out with Romanian women residing in the Province of Alicante, who explained perceptions they recalled from medical encounters at different stages in their lives.

AIM, METHODOLOGY AND DATA

The purpose of this case-study was to focus on communication between self and society in healthcare settings, from a gender perspective, and with a special focus on medical specialized language and its impact on the care provider-patient therapeutic process.

Medical science represents a form of control on the human body through technology and the authority of knowledge – conveyed by discourse – which in turn, reveals power patterns in relation to gender, ethnicity (otherness) or educational level. Through field data, I will try to verify that the presence or absence of specialised language in such encounters is a parameter that influences communication and, consequently, behaviour during the process of curation/prevention.

My corpus consists of a semi-open questionnaire comprising 45 questions divided into 3 blocks referring to care-provider-patient interactions (a) in Romania during the dictatorship, (b) after the fall of Communism (1989) and (c) in Spain, associated with migration[4]. The questionnaire was filled in by 20 Romanian women aged between 35 and

[3] INE (National Statistics Institute), 01/01/2018.

[4] These are the issues covered by the questions: dressing for consultation; preference between male and female physician; addressing formulae; tenor of exchange; use of technical terms; reluctance to talk about body and symptoms; patient's position in medical encounter; positive and negative aspects in consultation and hospitalization; doctor`s status on social scale; patient's personal feelings during consultation or hospitalization.

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80 (half in their thirties – which is the average age of Romanian women settled in Spain) who had lived in Alicante for 6 months to 15 years and with a wide range of professions (teaching, nursing, media, research, arts, domestic work). They came from different regions of Romania, mainly from urban environments (towns of 70,000 inhabitants) and their educational background was of middle or high school, occasionally university graduates. As for religion, most were orthodox, three were neo-protestant. In terms of social class, they were low or middle in Romania and broadly speaking middle-class in Spain.

CONCEPTUAL BACKGROUND

The central concept in this analysis is "specialised or professional languages", more precisely, medical professional language. As Alcaraz (2007) shows, specialised languages are not confined to the use of a certain jargon or lexical repertoire of terms which are opaque for the non-initiated in the field, but rather complex communicative codes characterised by their: lexicon (labelling elements and realities that belong exclusively to a field of knowledge and are recognisable as such); morpho-syntax (multiple noun units, hypotactic structure); speech strategies; communicative contexts; specialized texts (laws, contracts, posology); differentiating cultural frameworks referring to anysomorphism in hierarchies of the same "guild" round the world. Already mentioned by Saussure as "special languages" entailed by societies' progress, they grow in response to interdisciplinarity by borrowing neologisms to cater for new socio-communicative necessities. For instance, different areas within medical language were born as new pathologies emerged and as new therapeutic instruments were required. This becomes more complex when communication is not between peers, but between members of a guild and laypersons.

In Van Hoof's opinion (1999: 147), there are three categories of terminological problems in the translation of technical texts: different usages within the linguistic community itself; the use of terms from common language with a medical acceptation and cultural terminological divergences. Cicourel (1981) defines medical communication as a type of discourse guided by institutional purposes and professional knowledge structures (comprising a certain vocabulary, formulaic syntax, organization of discourse) that affects mutual understanding.

Meyer (2001: 91) shows that medical terminology of Greek/Latin origin is opaque for German speakers; that is why, for better comprehension by laypersons, physicians prefer hybrid, semi-professional or even common terms. He further classifies medical language in doctor-patient encounters into: professional, semi-professional and common language and elsewhere (Bührig and Meyer 2004: 51), he defines semi-professional terms as designating specific medical entities and being "at least partially comprehensible even for persons who do not know anything about medicine", thus permitting adjustment between experts and laypersons. Semi-professional terms also contribute to the purpose of discourse because they name the concern or procedure as a whole (defining or describing it), making it identifiable to the patient thus helping him/her to understand. These terms anchor the explanation that will follow, in which the physician expands and elaborates on the term, creating trust, which in turn is needed for the subsequent phase (patient's cooperation in the planned action for recovery). In fact, as Cambridge (1999: 205) shows, patients often feel intimidated by specialised language which they consider impenetrable

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jargon: "Where no communal common ground exists, patients can be alienated and even disempowered by the inappropriate use of a lexicon which belongs to a particular speech community". In turn, Squires' (2017: 3) observes that changing countries is stressful and "impacts individual and family health" and Hsieh (2017: 48), when describing the "Trust-Control-Power" model of bilingual health communication, shows that the provider has "legitimate power"[5] (i.e. institutional hierarchy) and "expert power" (i.e. medical expertise) and one manner of exerting it is through specialised language, but in order to elicit the patient's collaboration, interpersonal trust and therapeutic alliances must be shaped. An overuse of specialised language is likely to hinder this part of the process.

RESULTS, DISCUSSIONS AND LIMITATIONS OF THIS STUDY

I approached specialised language from two perspectives: (1) the macro-discursive concerned with *tenor*[6]; and (2) the micro-discursive referring to content (lexical-semantical options) and the use of specialized terminology.

The macro-level of analysis

I first asked Romanian female migrants whether they had used a colloquial *tenor* when they addressed physicians in Romania before 1989 or whether they made the effort to employ a more sophisticated language, perhaps containing medical terms and structures in consultation. The latter was clearly the case for 85% of participants and only 15% preferred to adopt a colloquial tenor. One of my suppositions was that a change occurred with the fall of the totalitarian regime from a more rigid, distant authoritative framework, to a more relaxed, closer, equal one. My supposition was not confirmed by data. A more relaxed doctor-patient interaction is perceived by my respondents after migration. They do not recall significant changes in the 90s as compared to the 80s in Romania, probably because while still living there, native language allowed for register selections depending on each patient's educational level. After migration, 60% of participants still opt for sounding "more learned" and 30% prefer to talk "like at home". They appear to do so in both languages. When speaking in Spanish with health providers, some explained that even if they did not know a term, they tried to adapt a Romanian one. For instance, from the Romanian "obstretică" they produced the inexistent "obstrética" which in Spanish is "obstreticia". Occasionally, some of these women performed the role of *ad hoc* interpreters accompanying relatives in consultation (see Iliescu, 2012). When *ad hoc* interpreters were asked whether their relatives adopted a more "learned" language to address a Spanish physician, one recalled her father using "selected words" in Romanian, whereas others noticed that female patients talked "like at home", maybe (they suggest) because they knew

[5] According to Schouten (2017: 83) it is based on having expertise or knowledge that is needed by another, while *legitimate power* is based on feeling entitled to exert power over another because of existing cultural norms and values.

[6] According to Halliday (1978) *field* comprises the speaker's purpose and the event in which the text functions as well as its subject-matter. *Mode* refers to the genre of discourse and its channel of transmission. *Tenor* defines the variety of language, its degree of formality, the set of social relations existing among participants as well as their identity.

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that their discourse would be interpreted (i.e. their register adjusted). From responses to the questionnaire it would appear that male patients, more than female, try to save face in this doubly vulnerable position (patient in a country whose language they do not speak and problematic visitor to a daughter's house) by using high register words and structures. This tentative hypothesis would deserve further inquire.

With regard to our Romanian participants' recall of their own feelings, I undertook to check whether, apart from the threat represented by their own condition of patients (health concerns), other variables intervened, such as the inhibiting perception (complex) of own lack of scientific knowledge when faced with an authority in the field. My supposition is that the use of (opaque) medical terms functions as a face threatening device, mostly because doctor and migrant patients do not have the same perception of opacity. My assumption is based on previous research by Clark (1996:12) who shows that impenetrable jargon disempowers the listener and becomes intimidating, and Mason (2004:93), who considers that a search for common ground in communication is seen as a device of positive politeness, an attempt on the part of the person in power to reduce "social distance". When asked if they had ever experienced the "sensation of not having enough knowledge" of anatomy or physiology, or if they felt "embarrassed to talk about certain symptoms", 15% chose the first option and 30% chose the second, out of a range comprising five options. After the fall of the communist regime, 25% of the women acknowledged that the feeling of embarrassment when talking about certain symptoms had disappeared and 10% of them had lost their inferiority complex caused by their lack of knowledge on a number of medical aspects. In my view, this change is not a direct consequence of linguistic aspects of interaction, but rather the effect of a change in the healthcare paradigm from care focused on the provider to cure pivoted on the patient and the process of healing in which the latter is as essential as the physician. This empowerment is based on language (including non-verbal and paralinguistic elements), empathy, politeness, or what Geist calls "the sensitive communication perspective". However, 15% still remember having felt "embarrassed to ask for further explanation" in their host country (Spain), whereas 25% did so in Romania before and after 1989.

The level of respect for the prestige of the profession is reflected in language, more exactly in courtesy formulae and in the degree of scientificity of the chosen terms. These issues have been thoroughly investigated by specialists in politeness theory who have addressed the healthcare encounters from the perspective of power relationships and FTA[7]. In the second part of this paper I will examine the presence of specialised language and I will argue that this choice does affect women's bodily self-perception in healthcare interaction. This implies that it consequently intervenes in their communicative processes and reflects their beliefs and construction of the self. Ultimately, the results might be influential in the prevention/healing process, but this hypothesis remains beyond the scope of this research.

[7] Brown and Levinson in 1987, defined "face" as the image of the self that an interlocutor wants to project and preserve in social interactions. "Positive face" is associated with self-esteem and social regard, whereas "negative face" refers to the right to freedom from imposition. In order to preserve equity in talk, face threatening acts (FTA) should be mitigated by minimizing imposition through indirectness, questions and hedges, impersonal style and passives, that is, by "negative politeness strategies".

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The micro-level of analysis

The second perspective (micro-discursive level) from which I approached healthcare interactions was the actual use of specialised language. In my participants' views, Romanian physicians were reported to have used, a semi-scientific terminology[8] (55% of participants), while 40% of participants thought their language was quotidian. Similarly, Spanish doctors were said to have used semi-scientific terminology (45% of participants) and quotidian terms (35% of participants), while only 15% of participants believed the scientific language to be preferred in Spain. Although there are no great differences of perception between the two countries, we find Spanish staff to be less accessible in terms of lexical choice (or more prone to using technical terms) than Romanian Public Health staff in the years before my respondents left the country, which is rather surprising given respondents' answers to other questions where they revealed they felt more relaxed in healthcare contexts in Spain than in their homeland. This contradiction might have at least three reasons: a) other variables intervene in their "more relaxed" feeling, some related to non-verbal and paralinguistic elements (proxemics, eye-contact, pitch, shaking hands); b) this is due to the way our participants classify "scientific", "semi-scientific" and "quotidian" terms, i.e. quite heterogeneously in the 20 polls; c) as suggested above, the use of a foreign language might provide a certain distance that reduces pressure. There are up to six different combinations of terms selected by our participants for some of the categories (e.g. semi-scientific), showing that our participants have a divergent appraisal of the terms, which we could classify according to several degrees of "ease of understanding" in at least three categories: easily understandable, deducible and opaque terms. Some of the factors that might have influenced responses are: 1) health tradition; 2) different levels of proficiency in L1 and L2; 3) partial equivalence between similar terms in L1 and L2 (seno-sân).

1. The divergent appraisal of terms might be related in the first place to health traditions in Romania and Romanian medical language. According to Van Hoof (1999: 151), Anglo-German languages are more "defining" and less "esoteric" than Romance languages which adopted Greek/Latin terminology. Therefore, for a Romanian speaker "hemoragie" is as normal as "sângerare" for "bleeding". This could be one of the reasons why they find it difficult to distinguish between common, scientific and semi-scientific registers. Their classifications of Romanian terms do not bare symmetry with those they offer for the Spanish language. In other words, the equivalents of those terms which they consider to be "scientific", "semi-scientific" or "quotidian" in their mother tongue, are classified differently in their L2.

2. These results may be due to various reasons: 1) they obviously have a more precise sense of language in their mother tongue, although they are not necessarily accurate in detecting the degree of technicality of a term; 2) their awareness of field and tenor and their handling of specialized terminology in Spanish is limited, depending on education levels, environment and period of time spent in Spain; or 3) they may have developed

[8] This term is used as part of the threefold lexicological view characterizing both specialised translation and LSP fields. According to this approach, technical terms belong to highly specialised terminology; semi-technical terms are the result of a transfer of meaning through metaphors or lexical composing mechanisms (see Fuertes, 2007: 206); and non-technical terms are those frequently used in a certain field which have been borrowed from the general language. I preferred the pair "scientific/semi-scientific" for a rapid comprehension on behalf of my participants.

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registers of Spanish either very familiar or very professional; thus, a scientific term might seem to some of them quotidian on grounds of daily use (by the mass-media for instance). As a consequence, their perception of either Romanian or Spanish physicians' inaccessibility marked by the use of technical terms might be somehow biased due to their misclassification of some of these terms. Nonetheless, opacity of professional language is compensated by its persuasiveness (based on a tradition of unintelligible scientific jargon) so, even if accessibility is lower, therapeutic alliance is still possible.

Table 1.

Spanish

Scientific	▸	mama	hematoma	deposición
Semi-Scientific	▸	pecho	cardenal	heces
Common	▸	seno	moratón	excremento

Table 2

Romanian

Scientific	▸	mamelă	hematom	fecale
Semi-Scientific	▸	sân	vânătaie	excrement
Common	▸	piept	învinețire	scaun

3. The terms chosen as an exemplification of the three different categories (see Tables 1 and 2) were *mama*, *hematoma* and *heces*. *Mama* (scientific, health sciences, associated with a formal register, from mammary gland, a cultism in Spanish since the thirteenth century); *pecho* [breast] (semi-scientific, not registered in the medical dictionaries *Diccionario médico-biológico, histórico y etimológico*, 2012; and *Diccionario Mosby de Medicina y Ciencias de la Salud*, 1995): *seno* [bosom] (common) and in Romanian: *mamele/glande mamare*; *piept*; *sâni*. Here, Romanian participants consider the Spanish term "mamas" to be as popular as "senos" because of a probable influence from the syntagm "cancer la sân" in Romanian with the Spanish equivalent "cáncer de mama" [breast cancer] frequently used in the media and in prevention campaigns. The second series consisted of: *hematoma* [haematoma] a scientific term in pathology, traumatology, and rheumatology, borrowed from English in the nineteenth century, referring to blood exuded from vessels to tissues, associated with a formal tenor; *cardenal* [bruise] (semi-scientific, not registered in medical terms dictionaries); *moratón* [bruise] (common language, associated to a colloquial tenor); and in Romanian: *hematom*; *vânătaie; învinețire*. Although "hematom" is a medical term in Romanian, it is classified by 30% of participants as everyday language; none of these respondents consider it to be scientific, perhaps because it was regularly used by Romanian doctors. Regarding Spanish terminology as seen by Romanian migrants, again they produced a wide range of classifications for what they considered to be scientific, semi-scientific and common language/popular terms. Thus, we find the series: "pechos/hematoma/heces" or "mamas/hematoma/deposición" classified as quotidian, or a popular term such as

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"moratón" corresponding to a colloquial tenor, placed in the scientific/formal category, which might be due to their irregular lexical-semantic knowledge of Spanish, a language most of them acquired spontaneously, as migrants. Medical jargon was one of the seven causes of miscommunication identified by Geist (1999:350) in health contexts, even in those mediated by expert translators. This opacity is not confirmed by my interviewees in the case of Spanish medical terms because they do not gauge scientific terms as clearly as in their mother tongue. For instance, the term "heces" (faeces) was classified as semi-scientific by 50%, as scientific only by 30% and as quotidian by 20% of my participants.

To summarize, in terms of *specialised language*, this analysis has brought some unexpected results. In 55% of my interviewees' opinions, Romanian providers used semi-scientific terms and in 40% of their opinions, they used quotidian terms. No one seems to have detected scientific terms in their interactions. After migration, 45% found Spanish doctors employed semi-scientific terms most of the time and 35% thought they chose quotidian terms. Only 15% thought Spanish physicians used scientific terminology on a regular basis. This is somehow unexpected if we consider the relaxed, unembarrassed perception they expressed on previous issues. But when we observe their examples of scientific, semi-scientific and quotidian terms, we understand these results: 30% of participants perceive Romanian "hematom" or Spanish "heces" to be quotidian. One possible explanation is that they might consider "hematom" common language because this is what Romanian doctors have traditionally called a bruise. Nevertheless, even if their classification is not reliable, we still can draw a conclusion from this: in their perceptions, Spanish doctors use more scientific terms than Romanian doctors and yet, in answer to the subsequent question (did they feel inferiority or fear in consultation in Romania), most of them pointed at fear caused by the illness itself, followed by inferiority in dialogue with physicians.

THE INTERPRETER'S ROLE

One of the results of this analysis is that Romanian women's handling of Spanish language is in general imbalanced; compared to their mastery of their mother tongue, their knowledge of L2 scientific terms is erratic and their discernment of registers (scientific; semi-scientific; colloquial) often presents deficiencies. Also, cross-linguistically they sometimes mix registers if they know a given term in one but not in the other. As Iliescu (2007: 182) shows, due to the differences between technical terms or health rules from one country to another, the probability of misunderstanding is higher in medical settings than in everyday interaction. In addition, we should consider the comprehension problems of the patient, who, occupying the weaker position in the relationship of power, will probably feel embarrassed to admit that she does not speak Spanish as well as expected. Although Romanian residents are known to acquire a high level of fluency in Spanish, their accuracy may diminish under stress and when they make an extra effort to decode scientific terms (Iliescu 2012: 339). This issue has been studied not only in the case of foreign residents but also regarding home populations in bilingual regions. For instance, Roberts (2017: 117), when describing medical settings with Welsh patients, showed that even if they may appear bilingual in both official languages, "they will often lose command of their English language in a healthcare context and revert to their primary language to fulfil different cognitive, emotional and social functions". If bilinguals in their home country may become vulnerable in certain situations (mental health problems, learning disabilities, age factor –

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elderly people or preschool children raised in the minority language), migrant populations are likely to be even more exposed. Grosjean, cited in Roberts (2017: 117) shows that not only does language play a crucial role in transmitting information safely and effectively, but it also "helps people assert their identity and express their thoughts, feelings and anxieties, especially at times of stress". Therefore, in medical settings where healing or wellbeing is at stake, being able to use one's primary language is essential, hence the necessity of interpreters.

This case study also suggests that an interpreter would not only solve the linguistic vacuum between L1 and L2 but balance socio-psychological factors intervening in this kind of interaction. Medical terms are used not to impress but because they are the most exact and shortest ways to define a medical reality. The choice to use them is influenced by the speech situation (context, participants). West (cited in Cambridge 1999: 205) wrote: "patients do not like medical jargon and physicians do not know what constitutes it". According to Hsieh (2017:48) or Schouten (2017: 83) this choice has to do with "expert power", but if patients do not understand, healthcare providers cannot influence them sufficiently to deliver adequate care. This loss of expert power may help to achieve the healing goals. When opting for the common language "excrementos" or even baby talk "caca", instead of "heces" or "deposiciones" (probably opaque for recent immigrants), a doctor displays accessibility and solidarity (by almost totally reducing social distance). The paradox Spanish physicians face in the case of Romanian patients is that if they do not use scientific terms (as expected in the original culture in accordance with imagological appreciations) they lose face and consequently cannot build enough trust to involve patients in the healing process; but if they do use those terms, they risk a communication gap. An interpreter can bridge this gap. Dialogue or social interpreting (also known as community or public service interpreting) was born as a result of linguistic, cultural and ethnic diversity and the need for interaction. Interpreters are the safekeepers of communication and the linguistic minorities' right to access services such as the public healthcare system. Intralingual healthcare interactions held in one's native language (already unequal in terms of access to medical knowledge) become doubly unequal in the case of patients whose competence in the providers' language is heterogeneous and whose beliefs and healing traditions might diverge from those of the host culture. The healing process needs some degree of negotiation. I argue that this negotiation is more efficient through a professional interpreter who can address specialised language avoiding FTAs and who can also coordinate speech turns in order to introduce glosses, settle bilateral micro-dialogues to clarify issues, split long sentences, add socio-cultural tips, and thus enable comprehension and preserve the face of both parties. Therefore, this paper advocates for the use of interpreters in medical settings on a regular basis even if patients have a certain command of L2.

CONCLUSIONS

In this paper, I have examined the presence and impact of professional language on migrant women's perception of healthcare interaction. I started this study from the hypothesis that doctors and patients have different perceptions on specialised terminology that lead to misunderstandings in intralingual and especially interlingual communication. Through a survey of 20 Romanian women living in Spain, I observed how the use of professional language by physicians influences women patients' perceptions of the

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therapeutic interaction and their self-construction in general, and that it does so even more in a migration context.

On the one hand, I looked at specialised language as *tenor* and I found that 85% of my interviewees attempted to sound impressive by using a learned language in consultation in Romania, but only 60% felt the necessity to do so in Spain. If 40% were embarrassed by their lack of medical knowledge and did not dare to ask for further clarification in their country, only 15% did so in Spain. In terms of tenor, the conclusion is that Romanian migrants seem to go through a relaxation process in their host country when it comes to learned language expectations and I believe this aspect deserves further study to delve into the other variables that intervene (interviewees' age; non-migrating patients; women versus men).

On the other hand, I delved into *specialised language* as a face threatening element. It has become evident from this analysis that the use of medical terms affects not only comprehension (informational structure) but also politeness, more exactly, face. Physicians are trained to communicate efficiently (exactness, economy) but also empathically. Opaque terms threaten patients' face. The use of common terms helps patients save face. On the other hand, physicians lose face, because in a number of cultures, the physician must not only know but must also be seen to know and there is an expectation that knowledge be manifested through scientific terms. This dilemma can be sorted out by a third party, a professional interpreter who is not bound to the same constraints, and who is able to oscillate on ranges of tenor and jargon.

However, in the case of the 20 Romanian migrant women surveyed, in spite of their perception that Spanish doctors used more scientific terms during consultation (or what they perceive as scientific terms in a highly heterogenous way, as we have seen), they do seem to agree that doctor-patient encounters in Spain are "more relaxed" than those in their home country. At least two developments are left open for further research: a comparative study of doctor-patient interaction within Romania to contrast present and past perceptions of migrant populations and a study of other variables intervening in interactions that might lead to the impression of a "more relaxed" doctor-patient communication in host countries than in home countries.

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