




Medical interpreting in assisted reproduction clinics in Spain: Female interpreters' experiences and roles

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Abstract: This article examines the role of interpreters in private assisted reproduction clinics in Spain, a sector that attracts international patients due to the high quality of the healthcare system and favourable legislation. Based on questionnaires and interviews with more than twenty professionals in the field, the study explores both working conditions and the specific tasks carried out by interpreters in a highly specialised and emotionally sensitive environment. The findings reveal a predominantly female professional profile, with interpreters undertaking responsibilities that go beyond translation and interpreting. Furthermore, despite strong appreciation from patients and medical staff, interpreters report a lack of institutional recognition. The study highlights the need for greater professionalisation, regulation, and institutional acknowledgement of the interpreter's role in this context, emphasising their crucial contribution to healthcare quality and intercultural communication.

Keywords: interpreter role; intercultural communication; linguistic mediation; medical interpreting; job satisfaction.

1. Introduction

Medical interpreting plays an increasingly important role in the global healthcare context, due, among other factors, to the steady rise in international mobility. Processes such as migration, tourism, retirement, asylum and refuge seeking, as well as the pursuit of specific medical treatments, have led to a substantial increase in the demand for interpreting services in clinical settings. Within this context, assisted reproduction constitutes a domain of particular interest, given that Spain has become a leading destination for international patients seeking access to treatment (Ferrer, 2023). The scarcity of studies addressing this issue has prompted the present study to investigate interpreting within this highly specific medical field, namely assisted reproduction.



The reasons underlying this phenomenon are manifold. On the one hand, sociocultural and economic changes have contributed to the postponement of motherhood, thereby increasing the demand for assisted reproductive technologies (Peire & Di Stefano, 2022). On the other hand, legislative restrictions in countries such as France, Italy, Germany, and the United Kingdom have led many patients to choose Spain as a destination to access these treatments (Aparicio Morcillo, 2021). This trend reinforces the notion of Spain as a hub for cross-border reproductive tourism. With particularly permissive legislation and a gamete donation system that has enabled it to position itself as the leading oocyte-donor country in Europe and the second worldwide (Molas Closas, 2021), Spain has become the main destination for cross-border reproductive mobility, especially among French women and couples (Molas Closas, 2021; Perler & Schurr, 2022). Consequently, doctor–patient communication in this specific context has become a critical issue that goes beyond mere linguistic transfer, emerging as an essential factor in ensuring both a clear understanding of the clinical process and the emotional well-being of patients.

In this regard, the role of the medical interpreter not only facilitates the transfer of information between healthcare professionals and international patients but also serves a key function in reducing cultural barriers, fostering a climate of trust, and improving the overall patient experience. Interpreting in assisted reproduction, in turn, provides a particularly illustrative example of the specificities of medical interpreting, as it is characterised by the need for terminological precision, the management of highly specialised discourse, and mediation in contexts marked by a high emotional burden.

The present study aims to analyse the specific features of medical interpreting within the field of assisted reproduction in Spain. Drawing on questionnaires and interviews with professionals in the sector, we will examine not only the linguistic and communicative aspects inherent to this practice, but also the working conditions and professional perceptions of the interpreters who carry out this work. In doing so, we seek to provide a comprehensive perspective that contributes to an understanding of the impact and development of this discipline within a healthcare sector undergoing constant transformation.

2. Healthcare interpreting within the framework of doctor–patient communication

The doctor–patient relationship occupies a central position in medical practice, both due to its complexity and to the extent to which communication and patient health literacy may influence treatment adherence and outcomes. Bak and Saborido (2024) note that, from the very first consultation, a “medical alliance” is established between the healthcare professional and the patient, grounded in mutual trust. In other words, both parties choose to engage in a relationship which, through their collaboration, facilitates the provision of medical care for the patient.

For this reason, it can be argued that the doctor–patient relationship, as Mendoza (2017) explains, is above all an interpersonal encounter in which both parties deliberate jointly in order to make the most appropriate decisions, always within the framework of bioethical principles and fundamental human rights. It is also a communication system in which each party constitutes both a receiver and a sender of information (Erazo-Coronado et al., 2024).

In recent years, the patient has ceased to be viewed as a passive subject in clinical communication and has instead become an active agent involved in decision-making regarding their



health (Krystallidou et al., 2018). This paradigm shift has led to a more dialogic and participatory model of communication that departs from the traditional paternalistic approach, in which the physician's or healthcare professional's voice was the only one considered relevant (Díaz et al., 2022; Montalt-Resurrecció & Shuttleworth, 2012). Alongside this shift, the role of the physician has also evolved over time, adapting to this new communicative dynamic (Rield & Schußler, 2017) and demonstrating that active patient involvement not only strengthens the doctor–patient relationship, but also optimises the management of diagnoses and treatments (Erazo-Coronado et al., 2024; Lerman & McCabe, 2017). Clinical communication, as an essential component of the doctor–patient relationship, makes it possible to obtain more accurate information, achieve precise diagnoses, provide appropriate guidance, and reinforce the therapeutic alliance, which collectively contributes to patient satisfaction (Domínguez-Samamés et al., 2022). Nevertheless, the effectiveness of communication between the two parties will largely depend on whether they share a common language (Paternotte et al., 2017).

The Spanish healthcare system is increasingly confronted with language barriers as a result of the country's demographic transformation. Since the 1990s, Spain has shifted from being a country of emigration to becoming a destination for immigration, which has significantly altered the profile of patients. As of April 2024, the number of foreign residents registered in Spain amounted to eight million people (INE, 2024), a substantial proportion of whom do not have Spanish as their first language. In the scientific literature, numerous studies have examined the negative impact of communication barriers on the healthcare provided to allophone migrant populations (Abril Martí & Martín, 2011; Brisset et al., 2013; Granhagen et al., 2019; Pérez-Estevan, 2023), showing that the presence of professional interpreters improves the quality of care, facilitates mutual understanding between interlocutors, enhances treatment adherence, and contributes to informed decision-making (Best et al., 2015; Flores et al., 2012; Nevado Llopis, 2015).

However, in a multilingual and multicultural context, what should the interpreter's role be in healthcare communication? This question has been the subject of extensive reflection in the specialised literature (Álvaro Aranda, 2021; Sleptsova et al., 2014), as interpreting in medical settings entails specific challenges due to the sensitive nature of the issues addressed. The absence of clear and standardised guidelines regarding the interpreter's work in this context has prompted a range of studies seeking to address this gap.

Healthcare interpreters may be required to clarify cultural issues (Rosenbaum et al., 2020) as well as institutional norms and/or procedures that hinder communication and access to care (Álvaro Aranda, 2020). In some cases, research has examined how interpreters filter messages—for instance, by mitigating them when confronted with utterances that convey negative judgements from one of the participants (Seale et al., 2013). When acting as patient companions, interpreters have been observed making comments aimed at improving understanding of medical procedures (Hsieh, 2013; Gavlovyh, 2021) and articulating patients' needs and preferences (Krystallidou et al., 2017), monitoring their level of health literacy (Espinoza Suárez et al., 2021) and providing emotional support (Lara-Otero et al., 2019). In addition, scholars have reflected on how interpreters function as representatives of the healthcare service (Parrilla Gómez, 2019) and may collaborate with clinical staff by assisting in the elicitation of the patient's medical history (Davitti, 2019), attempting to (re)direct the patient's responses (Mirza et al., 2017), or exploring ambiguous answers (Baraldi & Gavioli, 2018).



However, defining the interpreter's role in healthcare settings remains a complex issue. It is clear that medical interpreting differs substantially from other interpreting modalities, as multiple external factors shape and influence communication. In this respect, in line with Almommani (2024) and Moreno (2024), we argue that the role of the healthcare interpreter lies on a continuum between that of a cultural mediator and that of a strictly linguistic interpreter, depending on the communicative needs of each situation.

Indeed, one of the most widely debated issues in medical interpreting concerns interpreter invisibility, a topic extensively addressed in the literature (Álvaro Aranda, 2021). Existing studies have examined, among other aspects, the interpreter's role as a facilitator of communication (Crezee, 2013; Leanza, 2008), the use of ad hoc interpreters (Aguilar Solano, 2015; Del Pozo Triviño, 2020), and communicative asymmetries between interlocutors in healthcare settings (Álvaro Aranda & Lázaro Gutiérrez, 2021).

From an institutional perspective, the United States National Council on Interpreting in HealthCare (NCIHC, 2004) states that interpreters must remain impartial, avoiding the provision of advice, counselling, or the projection of personal beliefs. Accordingly, the NCIHC emphasises that interpreters should refrain from becoming personally involved in the interaction and that, in general terms, they may not act as patient advocates. Nevertheless, the NCIHC outlines two exceptions in which interpreters may assume a more active role: when it is necessary to speak up to protect an individual from serious harm, and when intervention is required to address potential mistreatment or abuse (Jessler, 2024).

The impact of communication in medical settings has been extensively examined in recent years (Al Samsi et al., 2019; Meuter et al., 2015), within a context in which the concept of *intercultural mediation* has gained increasing relevance by drawing attention to the range of barriers—beyond purely linguistic ones—that characterise doctor–patient interaction. Factors such as cultural differences in the perception of health and illness, socio-economic conditions associated with membership in minority groups, and the potential psychological implications of migration may hinder the communicative process (Rodríguez Cala & Llevot Calvet, 2011; Sepúlveda & Cabieses, 2020). In healthcare, intercultural mediation is considered a key resource for achieving an accurate diagnosis and implementing appropriate treatment (Verrept, 2019). However, the technical and specialised language of medicine constitutes an additional challenge, as it may hinder patients' understanding and, in many cases, discourage them from requesting clarification, which can negatively affect the quality of care (Watermeyer et al., 2021).

All of the above lays the groundwork for interpreting in assisted reproduction. Thus, within a field that remains relatively underexplored, the interpreter's role appears to become blurred, and a range of additional elements come into play that may be unfamiliar in other types of interpreting, even within healthcare settings. The interpreter becomes not only the person responsible for ensuring effective communication, but also a key point of reference for patients attending clinics (López, 2025) and is therefore required to deal with tasks that extend beyond their strictly interpreting-related duties. Similarly, the emotional dimension and the management of emotions emerge as another fundamental aspect of interpreters' work in this domain.

After examining the role of clinical communication and interpreting in healthcare settings, it is essential to consider how these practices also affect the well-being and job satisfaction of medical interpreters. Given that interpreting in health-related contexts requires specific skills and a deep



understanding of intercultural and linguistic dynamics, the working environment can significantly shape interpreters' professional experience. Therefore, job satisfaction is not only associated with the quality of the service they provide, but also with factors such as institutional support, ongoing training, and stress management, which will be explored in the following section.

3. Job satisfaction in medical interpreting

Since job satisfaction began to be studied in the 1930s, the concept has progressively incorporated nuances that closely link it to individuals' lived experiences in the workplace. From a theoretical perspective, it has been conceptualised as a psychological process involving recognition, awareness, perception, and reasoning (Zhu, 2020). In academic terms, it is regarded as a multidimensional phenomenon influenced by factors such as motivation, affect, stress, emotional intelligence, and self-efficacy (Atkinson, 2012; Courtney & Phelan, 2019; de Jong, 1999; Hubscher-Davidson, 2017).

Research on job satisfaction has been extensively developed within psychology (Spector, 2022), but it has also incorporated sociological and ergonomic dimensions, such as relationships with colleagues and clients, work organisation (e.g., job security and autonomy), and the professional environment (Ehrensberger-Dow et al., 2016; Leblanc, 2017; Lee, 2017; Piecychna, 2019; Virtanen, 2019). Within translation and interpreting studies, concepts such as stress and motivation have been examined since the 1980s (Cooper et al., 1982; de Jong, 1999). However, more recent research on job satisfaction in this field largely dates from the past decade (Bednárová-Gibova & Madoš, 2019; Lee, 2017; Liu, 2013; Rodríguez-Castro, 2015). Interestingly, in recent studies on the psychology of translation, job satisfaction is scarcely addressed (Jääskeläinen, 2016; Kessler et al., 2020), which motivates us to place greater emphasis on this aspect within the domain of healthcare interpreting.

In this context, healthcare interpreters' job satisfaction is shaped by a range of issues, from the lack of regulation to the working conditions under which their activity is carried out. Unlike other fields, healthcare interpreting in Spain is not governed by specific regulations, nor is it supported by dedicated professional associations tasked with safeguarding interpreters' rights. This lack of institutional backing generates uncertainty, which may reduce motivation and these professionals' perception of job stability (España Ladrón, 2014).

Another factor affecting interpreters' job satisfaction is the coexistence of qualified professionals alongside ad hoc interpreters. In many cases—either due to limited availability or the absence of a clear policy regarding interpreter recruitment—family members or individuals without specialised training in interpreting are asked to perform this role (Dam & Zethsen, 2016). Although this practice may expedite the delivery of care, it raises serious concerns in terms of communicative quality and ethical standards. The involvement of such improvised interpreters not only hinders effective doctor–patient communication, but also generates dissatisfaction among professional interpreters, who may perceive their work as undervalued and their role as increasingly blurred. This frustration is further intensified by the fact that untrained individuals may assume interpreting responsibilities without the expertise required to ensure accurate and ethically sound communication.

Moreover, relationships with both medical staff and patients play a fundamental role in healthcare interpreters' job satisfaction. A lack of recognition from physicians or institutions may



affect interpreters' perceived status and professional well-being (Dam & Zethsen, 2016; Katan, 2011; Ruokonen et al., 2024). Although intrinsic motivation is a key component of job satisfaction, external validation remains a determining factor. Positive feedback from the medical team or from patients themselves contributes substantially to interpreters' professional development, while also strengthening their confidence in the quality of their work.

Alongside these aspects, the emotional burden of professional practice constitutes another crucial factor influencing interpreters' well-being. By its very nature, healthcare interpreting exposes practitioners to situations with a considerable psychological impact. The management of vicarious trauma has been examined in the specialised literature, as interpreters may be affected by patients' stress and distress, which in some cases may lead them to develop aversion towards their work (Ballesteros, 2018). From this perspective, scholars have highlighted the need to provide healthcare interpreters with tools to cope with the emotional and psychological strain associated with their role (Monzó-Nebot, 2023).

The lack of a clearly defined role for healthcare interpreters also has implications for their job satisfaction. On many occasions, their work extends beyond mere linguistic mediation and encompasses functions related to accompanying patients throughout the care process (Angelelli, 2019). In practice, interpreters may be expected to perform additional tasks that are not clearly delineated, such as guiding patients in their interactions with different hospital departments (Bischoff et al., 2012). While this expansion of responsibilities may be perceived as a sign of trust in their work, it also reinforces the notion that their function is not well established within the healthcare system. The literature indicates that, in many cases, healthcare interpreters are viewed as administrative staff within the institution, which contributes to a perceived lack of professional recognition (Major & Napier, 2019).

Finally, the lack of opportunities for career advancement is another factor that may generate dissatisfaction among healthcare interpreters. While the initial acquisition of terminology and interpreting techniques may constitute a challenge, over time the repetitiveness of tasks can lead to a sense of professional stagnation (Abdallah, 2010). Nevertheless, the healthcare domain requires continuous knowledge updating, particularly depending on the medical specialties in which interpreters work. This suggests that professional development in this field largely depends on the opportunities for continuing education made available to interpreters.

In sum, although healthcare interpreting involves multiple challenges that may affect practitioners' job satisfaction, studies suggest that most healthcare interpreters experience a high degree of satisfaction with their work (Ehrensberger-Dow et al., 2016). Despite the difficulties associated with the lack of regulation, the coexistence with unqualified interpreters, the emotional burden, and limited opportunities for professional advancement, the direct impact of their work on patients' lives appears to largely offset the profession's challenges. Nevertheless, in order to ensure greater stability and job satisfaction in this field, it is essential to continue researching healthcare interpreters' working conditions, with the aim of developing strategies that strengthen their well-being and professionalisation.

To date, no research has examined the role, professional situation, or factors that directly affect the job performance of interpreters in the field of assisted reproduction. Accordingly, the main objective of this article is to shed light on their professional practice and on how it directly shapes their job satisfaction. Nevertheless, some information has been outlined regarding the job



satisfaction of other professionals working in assisted reproduction, such as those in nursing or gynaecology (Cova & Bonilla, 2022; Vélez-Muentes & Torres-Jerves, 2025). We therefore proceed to describe the methodology adopted to further investigate interpreting and its role within the domain of assisted reproduction.

4. Methodology

The present study aims to analyse the current situation of interpreters working in fertility clinics in Spain in the context of care provision for international patients. Specifically, it seeks to examine their role, the functions they perform, and the factors that influence their job satisfaction. To this end, we designed a study combining quantitative and qualitative approaches, structured in several phases. This mixed-methods design was adopted to contrast the responses obtained through questionnaires with interpreters' testimonial accounts, thereby expanding and enriching the information collected.

First, we conducted a mapping of private assisted reproduction clinics in Spain that receive international patients, that is, individuals who are not part of the Spanish healthcare system. This identification was carried out using the official registry provided by the Spanish National Commission on Assisted Human Reproduction¹, which allowed us to access the full list of clinics and hospitals specialised in assisted reproduction across the country. Based on this initial list of 303 registered centres, a first screening was undertaken to identify those clinics offering treatment to international patients, by reviewing the services provided by each clinic, resulting in a total of 41 clinics.

After identifying the centres included in the study, we designed and administered a questionnaire addressed to interpreters, containing questions relevant to our research objectives. The questionnaire elicited information on participants' academic and professional background, the experience gained within the clinic, the language combinations in which they work, and their professional practice within the institution. On the basis of these data, we sought to gain insight into the tasks they perform, the role they assume, and the extent to which these variables affect their job satisfaction. Clinics were contacted via email in order to present the study and invite them to participate. Those that responded positively were sent a link so that they could forward the questionnaire to their interpreters. A total of 22 interpreters completed the questionnaire distributed through clinics working with international patients, with the aim of obtaining as many responses as possible to enable subsequent data analysis. However, we found that responses were consistent across participants, and we therefore decided not to expand the distribution of the questionnaire on a larger scale.

In a second phase of the study, the information obtained through the questionnaires was complemented by means of semi-structured interviews. This qualitative approach made it possible to explore participants' personal experiences in greater depth and to expand the analysis of the results from the previous phase. We conducted five interviews, as we observed that the accounts provided similar—yet highly relevant—information for the purposes of our study, and we therefore did not carry out additional interviews. Although all interviews addressed a set of predefined topics, their semi-structured nature allowed for the incorporation of emerging issues arising from

¹ Available at: <https://cnrha.sanidad.gob.es/registros/busqueda.htm>.



participants' testimonies. The thematic axes guiding the interviews were as follows: training, professional practice and functions within the clinic, the interpreter's role, professional recognition and job satisfaction, and doctor–patient communication. Once the interviews had been transcribed, they were analysed thematically following the model proposed by Braun and Clarke (2006), whereby concepts were categorised into overarching thematic macro-categories in order to identify, analyse, and describe patterns of meaning in line with the proposed framework.

For participant selection, we developed a typological framework that enabled us to identify profiles suitable for the study. Non-probabilistic methods were applied to select appropriate candidates based on the information provided by the clinics. To determine the number of interviews, we considered the point of data saturation in participants' accounts (Glaser & Strauss, 1967). Thus, after interviewing five interpreters and observing no emergence of new perspectives, themes, or approaches, the process was deemed complete. The average duration of the interviews was 45 minutes, and all interviews were conducted in Spanish.

The data interpretation process began with a systematic review of the interview transcripts, from which thematic categories were established. Within each category, the data were compared with particular attention to convergences, divergences, and the internal relationships among the different analytical categories.

The combination of these techniques has enabled us to obtain a comprehensive overview of interpreters' work in private fertility clinics in Spain, examining both the conditions under which they carry out their activity and their perceptions of the profession, as well as the factors influencing their job satisfaction. Having thus established the foundations of healthcare interpreting, we now turn to the field of assisted reproduction to gain closer insight into interpreters' perspectives. The analysis of all the data collected has allowed us to outline the main characteristics of interpreting within this highly specific domain.

5. Data analysis

As noted above, the present study examines the role of interpreters in the assisted reproduction sector in Spain. The findings allow us to delineate the professional profile of these practitioners and to identify the main challenges and issues they face in their professional practice, although it should be noted that these results cannot be assumed to represent the entirety of Spanish clinics. Data analysis will be conducted jointly on the basis of both research instruments (the questionnaire and the interviews), with the information collected organised into thematic categories. When direct quotations from the interviews are included, we will use the letter *I* (for Interview) followed by the corresponding interview number (I1–I5).

5.1. Profile of interpreters in assisted reproduction

In this first section, we present the profile of the interpreters who responded to the questionnaire (Table 1), as well as the profile of those who participated in the interviews (Table 2).

The first relevant aspect that can be observed is the strong feminisation of the sector, as all respondents ($n = 22$; 100%) identified as women (Table 1). According to the interviewees, this phenomenon is not limited to the group of interpreters, but also tends to extend to the clinical staff,



which is almost entirely composed of women. Indeed, I3 notes that “*some patients express a preference for being treated by female medical staff*”, a choice that may be influenced by cultural factors and that further reinforces the association between this field and women. Similarly, I1 reports having worked in two clinics and having always had female interpreter colleagues, “*since you have to be in direct contact with patients*”. I2 highlights that, prior to starting treatment, “*some patients specifically ask whether the gynaecologist and the anaesthetist will be women*”.

Regarding the professionals’ average age, the data show a relatively homogeneous range, with a mean between 30 and 35 years, as indicated in Tables 1 and 2.

Table 1: Demographic profile of the interpreters (questionnaires)

Age	M = 31
<30	16.6% (n = 4)
30-35	46.4% (n = 12)
>35	22.7% (n = 5)
Gender	
Man	0%
Woman	100% (n = 22)

Source: Author (2026)

Table 2: Demographic profile of the interpreters (interviews)

Participant	Age	Gender	Experience
Interviewee 1 (I1)	37	Woman	8 years
Interviewee 2 (I2)	30	Woman	4 years
Interviewee 3 (I3)	26	Woman	8 years
Interviewee 4 (I4)	25	Woman	6 months
Interviewee 5 (I5)	32	Woman	8 months

Source: Author (2026).

Eighty per cent of the interpreters who completed the questionnaire are Spanish nationals. The second most represented nationality is Italian (16%, n = 2). To a lesser extent, we find professionals of German (8.3%, n = 1), Moroccan (8.3%, n = 1), and Polish (8.3%, n = 1) origin. Regarding the interview participants, four are Spanish and one is Italian.

With respect to interpreters’ language combinations, the responses reveal a diverse range, with the following languages reported as the main working languages: English (81.1%, n = 18), French (45.5%, n = 10), Italian (36.3%, n = 8), and German (18.2%, n = 4). To a lesser extent, Russian (4.5%, n = 1) and Arabic (4.5%, n = 1) were also reported. As for the interviewees, their working languages were English and Italian (I1 and I3), German and English (I2), and French and English (I4 and I5).

5.2. Academic background and perceptions of professional competence

The data reveal a diversity of educational trajectories among questionnaire respondents (Table 5). While slightly more than half (59%, n = 13) hold a bachelor’s degree in Translation and Interpreting (T&I), the remaining participants come from other disciplines (philology or other non-related fields, n = 2; 9.1%) or acquired specialisation in T&I through postgraduate studies (n = 3; 13.6%). As for the interviewees, all five hold degrees in T&I, and I5 additionally holds a degree in Psychology.



Table 3: Educational Background of Clinic Interpreters (Questionnaires), item 5

Academic background	n	%
BA in Translation and Interpreting	13	59.1%
BA in Philology and Other Linguistic Specialties	2	9.1%
Other Bachelor's	8	36.4%
MA in Translation and Interpreting	3	13.6%
MA in other Linguistic Specialties	2	9.1%
Other MA	5	22.7%

Source: Author (2026)

When exploring interpreters' specialisation in clinical settings, most interviewees stated that such specialisation does not necessarily stem from holding a degree in T&I, but rather tends to develop through a process of gradual familiarisation. This is because it is a field that is initially unfamiliar to many of them and extends beyond the competences acquired during undergraduate training. As I3 puts it:

When I was hired, I was a bit scared because I was not specialised in this field at all, and I was really afraid of making mistakes with medical terminology. But little by little you learn everything. During the degree you learn other things, or, if you're lucky, you have some medical content. The rest you learn day by day.

With regard to their specific training, the interviewees clarify that clinics provide some initial training when interpreters join the team. However, this is not “comprehensive training; rather, they explain the basics so that you can start working as quickly as possible. It is in day-to-day practice that you begin to understand the concepts they introduce at the beginning. The gynaecologists are very helpful in this process” (I2).

The interviewees also note that clinics usually have certain templates and translation models available, although these “are not always available in all languages” (I5), and there is no systematic approach that would allow previous work to be effectively reused. According to I3, these templates help them become familiar more quickly with the terminology they are required to handle and, consequently, to automate certain knowledge. This observation is also reflected in item 9 of the questionnaire (Table 6), where there is a degree of consensus ($\bar{x} = 3.8$; $SD = 1.38$) that interpreters have access to glossaries, models, or templates that support the internalisation of knowledge.

5.3. Types of tasks performed

Beyond interpreting, professionals also carry out other activities more or less directly related to translation and interpreting, such as translating reports, interpreting and assisting in the operating theatre, among others (item 7, Table 6). The most common task is the translation of medical reports (81.8%, $n = 18$), followed by the translation of the clinic's administrative documentation (36.4%, $n = 8$). The interviews reveal a similar pattern. By way of example, I2 mentions the translation of hysteroscopy reports as a particularly recurrent part of her work. Regarding the context in which they most frequently interpret in their day-to-day practice, the questionnaire (item 7, Table 6) reports the following: interpreting during medical consultations ($n = 17$; 77%) and in the operating theatre ($n = 10$; 45%).



Table 4: Interpretation Contexts in the Clinic (Questionnaire, item 7)

Context	n	%
Consultation	17	77.3%
Theatre Room	10	45.5%
Care services	9	40.9%

Source: Author (2026)

Table 5: Questionnaire item 6 on the Types of Texts Most Frequently Translated in the Clinic

Type of translation	n	%
Medical reports	18	81.8%
Administrative documentation	8	36.4%
Other (IC, internal clinic documentation)	9	40.9%

Source: Author (2026)

The interviews indicate that interpreting in consultations with specialists (e.g., urology or immunology) poses an additional challenge, as interpreters are often not initially familiar with the relevant terminology. The questionnaire data reflect the same pattern, with 70% of respondents (Table 6, item 6, n = 17) confirming that medical consultations are the setting in which they interpret most frequently.

The interviews unanimously indicate that, in addition to tasks strictly related to T&I, participants also perform a range of more administrative duties, as well as patient-accompanying tasks. Indeed, I2 links this directly to job satisfaction, noting that many responsibilities extend beyond T&I:

This job goes far beyond being a pure translator and interpreter. We do many administrative tasks that are not visible and that require a lot of work. In the end, we are the patient's main point of contact, and they turn to us for everything.

The questionnaire responses point in the same direction. In item 13 (Table 6, n = 9), interpreters report performing tasks that go beyond T&I. Some interviewees (I1, I2, and I5), who have more years of experience, state that this aspect makes their daily work more monotonous. By contrast, I3 and I4, who have only recently entered this field, appreciate administrative tasks as an opportunity to take a break from the pressure of interpreting in consultations, as they do not yet feel fully comfortable with the medical context.

In any case, assigning interpreters administrative tasks unrelated to their training and competencies can be understood as not only diverting them from their core role, but also contributing, to some extent, to the devaluation of their profession. By delegating administrative functions to them, their specialised expertise becomes diluted, and the mistaken notion is reinforced that their work is secondary or merely ancillary, rather than being recognised as a key component of communication between patients and healthcare professionals. This additional workload not only renders their actual contribution less visible but may also affect service quality by dispersing their attention across tasks that do not constitute the main focus of their work. Such “invisibilisation” has a direct impact on their professional satisfaction and, consequently, may lead to a decrease in the quality of their interpreting, as will be discussed further in the section on job satisfaction.

Regarding access to patients' medical histories, the questionnaire data (Table 6, item 11) indicate that most interpreters ($\bar{x} = 4.7$; $SD = 1.04$) have access to patients' records and background



information prior to interpreting, in order to prepare for the encounter. While access to such information constitutes a clear advantage, I2 warns that, unlike situations in which they are asked to translate clinical documentation, “*the element of surprise in each consultation can mean that entirely unexpected issues are discussed*”. The questionnaire results further suggest that there is generally no manual or set of best-practice guidelines for translation or interpreting (item I0; \bar{x} = 1.2; SD = 0.98).

Table 6: Items from the questionnaire (Likert Scale)²

Item	n	Min	Max	Mean	SD	1	2	3	4	5
Item 8	22	1	5	1.5	1.12	31.8%	18.2%	13.6%	27.3%	9.1%
Item 9	22	1	5	3.8	1.38	22.0%	13.6%	27.3%	18.2%	18.2%
Item 10	22	1	5	1.2	0.98	36.4%	27.3%	27.3%	4.5%	4.5%
Item 11	22	1	5	4.7	1.04	-	9.1%	18.2%	22.7%	50%
Item 12	22	1	5	2.3	1.05	4.5%	36.4%	27.3%	22.7%	9.1%
Item 13	22	1	5	4.7	1.31	4.5%	18.2%	18.2%	18.2%	40.9%
Item 14	22	1	5	3	1.43	18.2%	27.3%	9.1%	27.3%	18.2%
Item 15	22	1	5	4.7	1.02	-	4.5%	18.2%	27.3%	50%
Item 16	22	1	5	4.7	0.61	-	-	4.5%	40.9%	54.5%
Item 17	22	1	5	4.8	0.58	-	-	9.1%	45.5%	45.5%
Item 18	22	1	5	4.8	1.08	4.5%	9.1%	22.7%	31.8%	31.8%

Source: Author (2026)

With regard to documentation practices, the interviewees once again confirm that the quickest and most direct source of information is the gynaecologists or the medical staff. I3 explains that “*sometimes it takes less time to sit in on the gynaecologist’s consultation and have her explain what the report for a given test consists of than to search for it online*”.

In addition, I5 emphasises that “*most of the time, what becomes complicated is reverse translation and interpreting*”. It should be noted that translation and interpreting tasks in fertility clinics are always bidirectional, meaning that interpreters routinely work with reverse translation and bilateral interpreting. In this respect, I4 adds the following:

During the degree we are used to translating and interpreting always into Spanish, and here it is precisely the opposite: most of what we do is reverse, so you need to have a very good level of the language you work with. I thought I would never work into the foreign language, and here it is part of our everyday routine, which is challenging and at the same time creates some tension because I’m not used to it.

5.4. Perceptions of professional recognition and job satisfaction

The questionnaire responses reveal a marked discrepancy between the recognition interpreters receive from patients (Table 6, item I5: \bar{x} = 4.7; SD = 1.02) and the recognition they perceive from the clinic management (Table 6, item I2: \bar{x} = 2.3; SD = 1.05). While patients identify interpreters as key figures in their care process (I3), most interviewees report that clinic management does not adequately value their work or the complexity of the situations they face daily, instead “*increasingly burdening them with more work, especially administrative tasks*” (I1). This issue is directly related to the invisibility discussed earlier, as it has a direct impact on their day-to-day job

² The list of questions for each item is included in the Appendix. For each one, respondents were asked to indicate on a scale from 1 to 5 how much they agree with the statement (where 1 means strongly disagree and 5 means strongly agree).

satisfaction and, consequently, on their performance as interpreters. Assigning them tasks that go beyond their interpreting role blurs the function they fulfil as interpreters and directly affects their personal perception of their professional work.

This appears to be the main negative aspect related to the interviewees' job satisfaction: not feeling valued or recognised by the clinic management (in contrast to the medical and healthcare staff, with whom they work closely on a daily basis). I1 adds that the level of responsibility they are expected to assume is not acknowledged by the organisation, which causes them discomfort. Along the same lines, I3 states:

I think the company as such does not value us enough. Fortunately, it doesn't feel the same with the rest of the clinic staff. I think everyone is willing to help and they always value our work, whether it's the medical staff, reception...

Similarly, the questionnaire indicates that patients not only express trust in interpreters, but also evaluate their work very positively (Table 6, item 15: $\bar{x} = 4.7$; $SD = 1.02$). Most interviewees agree that, in their view, patients perceive them as someone they can rely on and that they value their work as interpreters. As I5 notes, "many times, even after they have given birth and had their baby, they write to us and send us photos to thank us for our work".

With regard to medical staff, item 14 ($\bar{x} = 3.0$; $SD = 1.43$) indicates that interpreters do not perceive the clinical team as adopting a paternalistic attitude towards them. Indeed, according to some interviewees (I1, I2, and I5), this contributes to their feeling that they are positively valued by the clinic's medical staff. Such expressions of gratitude may be linked, as I1 and I2 suggest, to another factor that negatively affects interpreters and their job satisfaction: the expectation that they remain available to patients "24/7", since they are often the main point of contact with the clinic:

There is an unwritten belief that we have to be available at all times. Many times, patients—and the company—are not aware that we are also employees and have working hours. This is something that can lead to burnout (I1).

When asked about their overall day-to-day level of job satisfaction, the interviewees generally rate it as fairly high. They explain that, despite the negative aspects of the job, they find the work highly interesting and feel that they are making a meaningful contribution by supporting patients (I1). In addition, they report feeling strongly supported by colleagues within their department, which has a direct positive impact on their daily professional practice (I3).

I4 adds that she still feels somewhat insecure when interpreting, as this is her first experience with medical interpreting, which increases her work-related anxiety. In this regard, I2 notes that "over time, you learn and the technique of bilateral interpreting becomes increasingly easier". She also explains that each gynaecologist has their own way of expressing themselves, and that interpreters gradually learn how to interpret for each one, which increases their confidence during interpreting encounters and reinforces the sense of being useful and doing the job well.

Regarding the presence of colleagues without formal training in T&I, the interviewees express a certain degree of discomfort. In their view, specialised training directly impacts on service quality ("even if sometimes it is not recognised", as I1 notes), since interpreters without a T&I background tend to avoid interpreting tasks because they do not feel sufficiently prepared to handle them:



Many times, those who are not translators or interpreters do not want to interpret for specialist consultations, which are generally the longest and most specialised. They say they don't feel capable of doing them, but of course this means that the rest of us also have to take on those interpreting assignments in addition to the ones that are already ours (11).

As a result, the workload is unevenly distributed among interpreters with formal training, which, according to 11's testimony, generates tensions and dissatisfaction within the team. This imbalance is also reflected in relation to interpreters' language combinations. While healthcare staff often have some command of English, the situation differs substantially with other languages. Interpreters working in these combinations are required to accompany patients throughout all stages of treatment—from consultations to the operating theatre and email management—which contributes to an unequal distribution of workload:

It's true that there are colleagues who only work with English, and in the end they have the lightest interpreting workload because most medical staff speak English and can manage. However, the French and German combinations require the most work from colleagues. We have more work per patient because, without us, communication with the medical team is simply not possible (15).

5.5. Emotional dimension and the interpreter's expanded role

In connection with workplace satisfaction, the interviewees' accounts highlight the emotional dimension inherent to their work. These narratives are consistent with the survey results, where a substantial proportion of participants (Table 6, item 13: $\bar{x} = 4.7$; $SD = 1.31$) consider that their work goes beyond simple translation or interpreting. In a setting in which patients often feel vulnerable, interpreters report becoming figures of trust, establishing a close bond that at times exceeds their strictly professional role.

Emotional management represents a challenging aspect for many of them (11 and 14). While some view empathy as an essential quality for their work (13), others note that the emotional burden of the setting may affect their well-being (14). This is further supported by the questionnaire responses (Table 7, item 19; $n = 17$; 77%), which indicate that their role includes additional functions for which they may or may not be prepared—such as psychological support—thereby expanding their responsibilities and potentially affecting their job satisfaction. In other words, the tasks they assume beyond interpreting or translation may, in many cases, have a direct impact on their daily experience and, consequently, on their job satisfaction as healthcare interpreters.

Table 7: Item 19 of the Questionnaire on Interpreter Competencies in Clinics

Interpreter skills	n	%
Translation and Interpreting	3	13.6%
Mediation	4	18.2%
Both	17	77.3%
Other (Psychological support etc.)	16	72.7%

Source: Author (2026)

Among the interviewees, a range of perspectives emerges. For instance, 11 expresses a strong emotional involvement with patients and explains that, at times, she finds it difficult to manage her

emotions. By contrast, I2 states that she does not find it difficult at all, because “it is a field that, personally, feels very unfamiliar to me, and I think that is why it is not hard for me to detach emotionally”. However, the same interviewee also argues that empathy is one of the fundamental qualities required to work in this type of interpreting (“I firmly believe that you have to have—or develop—empathy in this job no matter what, as well as a great deal of patience”).

Regarding clinics’ expectations, both the questionnaire and the interviews reflect an implicit requirement for interpreters to go beyond a strictly traditional interpreting role. The role assumed by interpreters thus extends beyond that of the conventional interpreter. The questionnaire data (Table 6, item 17: \bar{x} = 4.8; SD = 0.58), for instance, indicate that interpreters almost always need to provide their own clarifications—rather than merely relaying explanations from clinical staff—during interpreting encounters to ensure that the message is conveyed clearly to patients.

The interviews align with this pattern. I1 and I5 state that they do not hesitate to add extra information during interpreted medical consultations. They prefer to provide the additional information themselves, as they often anticipate what the doctor will say in certain situations and thus streamline communication. In relation to the previous point, I5 adds: “In fact, on many occasions the gynaecologist tells us: ‘Well, you already know what I’m going to explain—could you tell her, please? That way I can keep writing her medical record’”. I1 adds that gynaecologists often take for granted many concepts that patients may not be familiar with. Consequently, she prefers to explain such concepts *motu proprio* while interpreting, to streamline communication.

The role of interpreters in this type of context raises ethical concerns. While the intention to facilitate communication is rooted in a relationship of trust with medical staff, delegating the explanation of medical information to interpreters entails significant risks. If the interpreter provides inaccurate or incomplete information, this may affect the patient’s decision-making and compromise the quality of care. Moreover, ambiguity regarding how much information should be conveyed—and in what terms—places interpreters in a delicate position, in which they assume responsibilities that extend beyond their original role.

The only divergent account is found in I2, who does not feel comfortable explaining concepts that have not been explicitly clarified by the physician, despite being familiar with them (“I am nobody to explain a medical concept. If they have doubts, they should ask, and I will relay it to the gynaecologist so that she can explain it herself”). Nevertheless, the interviewee acknowledges that drawing the line between the interpreter’s role and that of a facilitator, so to speak, is not straightforward, and that clinics do not provide a clear code of conduct to rely on:

[...] We are another person participating in the communication at that moment, if you know what I mean. Patients make comments, they speak directly to us, but not for us to tell the gynaecologist—simply because they already trust us, so they make comments, jokes... Basically, in the end there are three of us in the consultation. It is very difficult not to get involved.

6. Conclusions

The analysis of the responses obtained through the questionnaires and interviews has enabled us to draw a number of key conclusions regarding different aspects of translation and interpreting in the field of assisted reproduction in Spanish clinics.



First, we have been able to confirm that this is a highly feminised domain, both among interpreters and within the medical staff. This highlights the predominantly female profile of healthcare interpreters, particularly in assisted reproduction clinics. Future research could further explore the gendered profile observed in these settings (Susam-Saraeva et al., 2023). Likewise, training in T&I emerges, in the interviewees' view, as a determining factor in professional performance. Differences in academic preparation lead to significant variation in perceived professional competence and job satisfaction, which in turn influences team dynamics and the distribution of responsibilities.

Second, linguistic demand in assisted reproduction clinics follows a specific pattern. Although English is the predominant language, its use as a lingua franca among medical staff reduces the need for interpreting services in this language. By contrast, languages such as French, Italian, and German show higher demand, which results in a heavier workload for professionals working with these language combinations compared to those who work exclusively with English and Spanish.

It is also important to highlight the directionality of this type of interpreting. As our findings confirm, both interpreting and translation in this field are predominantly reverse and bidirectional. Interpreters therefore need to acquire bilateral interpreting techniques and routinely perform reverse translation, which represents a challenge in relation to their prior training and professional trajectory.

Third, the interpreter's role in assisted reproduction appears to be partially blurred due to the multiplicity of functions they are required to perform beyond T&I. Unlike other contexts, interpreters in this setting tend to adopt a predominantly active role, facilitating interaction between patients and medical staff by providing additional explanations that ensure mutual understanding. This, in turn, raises ethical dilemmas concerning the interpreter's role, their degree of involvement, and the responsibility they assume within the doctor–patient relationship. Interpreters often become a key point of reference for patients, which, while reinforcing their importance in the communicative process, also generates tensions stemming from a lack of professional recognition and the assumption of responsibilities that exceed their primary function. This aspect has a direct impact on their perceived job satisfaction.

Despite the sense of being undervalued by clinic management (as reflected in the interviewees' accounts), interpreters report receiving support from medical staff, which helps to reinforce their role within the clinic. Likewise, interpreters perceive that patients value their work highly, recognising them as the primary point of contact and, in many cases, placing greater trust in them than in the medical team itself. The analysis highlights the complexity of translators' and interpreters' work in the field of assisted reproduction. Not only do they play a crucial role in facilitating communication between patients and healthcare professionals, but they also assume a form of emotional accompaniment which, although appreciated by patients and clinical staff, is not always acknowledged by their employers.

In sum, medical interpreting in the field of assisted reproduction presents specific features that distinguish it from other contexts. As evidenced by the interpreters' testimonies, the workload extending beyond their core interpreting duties, together with the emotional burden associated with the expanded role they are expected to assume, makes this a technically specialised area that requires targeted preparation. Their relevance to the experience of international patients is undeniable, as they help ensure effective communication throughout a highly specialised and



emotionally complex process. Nevertheless, the diversity of tasks undertaken by interpreters in this setting has a direct impact on their job satisfaction and on how they perceive their professional identity within the institution.

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Appendix

Below, we include the list of statements used for Table 6, which were presented to interpreters using a Likert scale:

1. The clinic I work for provides training to help me improve in my job position.
2. The clinic I work for has guidelines, glossaries, or text templates that facilitate my work as a translator.
3. The clinic I work for has a set of best-practice guidelines for interpreting with patients.
4. Before interpreting, I have access to all the necessary information about the patient and the treatment to prepare adequately.
5. I feel that the clinic I work for values the work I do as a translator or interpreter appropriately.
6. I am sometimes asked to carry out tasks that fall outside my role as a translator or interpreter.
7. Medical staff can sometimes be somewhat paternalistic towards the translator or interpreter, even when we have years of clinical experience.
8. Patients evaluate my work very positively.
9. Patients see me as someone they can trust.



10. I sometimes go beyond interpreting to help patients (e.g., by providing additional information, clarifying doubts, etc.).

11. It is difficult to maintain a neutral or emotionally detached stance when interpreting for a patient.

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Conflicts of interest

Not applicable.

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