

# FOSTERING HEALTH COMMUNICATION WITH SINOPHONE PATIENTS IN ITALY: TOWARDS AN ETHICAL AND CULTURE-CENTERED FRAMEWORK FOR LANGUAGE AND CULTURAL MEDIATION TRAINING

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Citation: Vallati, Alessandro (2026) “Fostering Healthcare Communication with Sinophone Patients in Italy: Towards an Ethical and Culture-centered Framework for Language and Cultural Mediation Training”, in Ardizzoni, Sabrina, Marta Aurora, Claudia Buffagni, Anna Di Toro, Imsuk Jung and Andrea Scibetta (eds) *Advanced Technologies, Methods and Materials for Human Health and Well-Being: A Transcultural and Interdisciplinary Perspective*, *mediAzioni* 50: A159–A178, 10.60923/issn.1974-4382/24468, ISSN 1974-4382.

**Abstract:** In recent years, growing attention to intercultural communication in healthcare has highlighted the crucial role of linguistic and cultural mediation (LCM) in facilitating interaction between medical professionals and Chinese-speaking patients. Yet, the linguistic complexity of medical Chinese – shaped by culturally embedded terminology, historical stratification, and epistemological differences – poses significant challenges for both written and oral mediation practices. Beyond linguistic competence, mediators are required to navigate culturally rooted conceptual systems and uphold key ethical principles such as confidentiality, impartiality, informed consent, and cultural sensitivity. Despite its essential contribution to healthcare communication, LCM in Italy still lacks formal recognition and standardized professional frameworks. Ethical and methodological dimensions of LCM training and practice therefore remain largely underexplored and insufficiently systematized. This article addresses this gap by offering a critical examination of current approaches to mediation in medical contexts involving Chinese-speaking patients. Drawing on a critical literature review, it proposes a theoretical and conceptually integrated framework developed through a top-down, culture-centred, and interdisciplinary lens. The framework aims to clarify the ethical underpinnings and methodological challenges of mediation practice, serving as a basis for future validation and further theoretical and empirical research within the field of intercultural communication.

**Keywords:** language mediation; medical Chinese; healthcare communication; ethics; professional training.

## 1. Introduction: LCM as an emerging field of inquiry in Italy

In recent decades, Italy has undergone significant demographic transformations, marked by the steady growth of migrant communities that now play a central role in shaping the country's social and cultural fabric. Among these, the Chinese community stands out for its size, geographic distribution, and internal cohesion. According to the latest annual report issued by the Italian Ministry of Labour and Social Policies (MLPS 2023: 6–16), as of January 1st, 2023, there were 284,495 Chinese nationals legally residing in Italy, accounting for 7.6% of the total population from non-EU countries and ranking fourth among the largest extra-EU communities. The majority of Chinese residents are concentrated in Northern (57.1%) and Central Italy (31.6%), with notable presences in Lombardy (24.3%), Tuscany (19.7%), and Veneto (12.3%). The demographic profile of this community is further characterized by the prevalence of large family units and a high percentage of long-term residence permits (65.2%), indicating a relatively stable and structured presence within Italian society.

This consolidated demographic presence has intensified the need for effective intercultural communication, particularly in healthcare, where interactions between providers and patients from different linguistic and cultural backgrounds have become increasingly frequent (Partida 2007: 566–569). Within this setting, language barriers have emerged as a major obstacle to effective medical communication, creating significant challenges in ensuring mutual understanding and appropriate care, and leading to a growing societal demand for medical interpreting services (Cai and Yang 2018: 25–26). Consequently, LCM<sup>1</sup> has progressively gained relevance as both a professional practice and a field of academic inquiry, reflecting a growing awareness of the need to bridge linguistic and cultural gaps in healthcare communication (Zuccheri 2016: 292; Antonini 2014: 13–19).

This growing interest aligns with European institutional frameworks that emphasize plurilingual and intercultural education as essential competences in multilingual societies. Since 2001, the Common European Framework of Reference for Languages (CEFR) has recognized mediation as a core language activity alongside reception, production, and interaction, shifting the focus from mere information transfer to dynamic negotiation and cultural bridging. This emphasis was further developed in 2016 by North and Piccardo, leading to the 2018 CEFR Companion Volume, which introduced detailed descriptors for mediation skills and advanced its pedagogical importance. More recently, the

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<sup>1</sup> As evidenced by Ornaghi (2024: 273–274), in China, the concept of LCM is still relatively unfamiliar compared to interpreters or translators. The academic discourse on mediation is limited and recent, with no fixed terminology to identify LCM practice and practitioners. The terms commonly used emphasize the cultural dimension, highlighting mediation primarily as a process of intercultural communication. Similarly, in Anglophone regions, the terms *service translator* and *service interpreter* are commonly used to refer to professionals facilitating communication in institutional or community settings, particularly within healthcare and social services. In the Italian context, the boundaries between interpreters and intercultural mediators remain fluid, as no national accreditation system or uniform professional standards exist (see Section 1.2). This article employs the term *mediator* to denote the broader practice of LCM, while *translator* and *interpreter* are used more selectively to indicate written and oral modalities.

2022 Council of Europe publication, *Enriching 21st Century Language Education – The CEFR Companion Volume in Practice*, presented diverse case studies, demonstrating how mediation approaches have been effectively implemented across various educational contexts. This volume highlights mediation as a vital tool for fostering plurilingual and intercultural competences, consistent with the CEFR's socio-constructivist and action-oriented approach (Ornaghi 2024: 272–273).

In this context, the pedagogical reconfiguration of language education promoted by the CEFR – especially through its emphasis on mediation as a complex, purposeful, and socially embedded activity – offers a particularly fertile framework for rethinking the training of mediators in contexts marked by linguistic and cultural plurality. The long-established and demographically consolidated presence of the Chinese community in Italy makes the healthcare sector a particularly salient arena in which to observe the challenges and potentials of LCM. While growing institutional and academic attention has led to the proliferation of degree programs in LCM, the integration of mediation-oriented teaching practices – particularly in specialized domains such as medical communication – remains limited and methodologically fragmented.

In this light, this article seeks to contribute to the growing field of research on LCM in healthcare by critically examining the ethical and pedagogical challenges that shape the training and professional development of mediators engaged in medical settings involving Sinophone patients. Drawing on a critical review of existing literature, it seeks to identify the ethical principles and disciplinary intersections that underpin current mediation practices, highlighting the need for interdisciplinary training pathways that integrate applied linguistics, medical humanities, and intercultural ethics. Within this framework, the article advances a theoretical and conceptually grounded model developed through a top-down, culture-centred, and interdisciplinary approach. The proposed framework is intended to systematize ongoing reflections on the ethical foundations of mediation and to support the gradual definition of context-sensitive professional guidelines. Such a perspective aims to ensure that mediators not only acquire the linguistic and pragmatic competences required by their role but also adhere to ethical standards, mitigate communicative asymmetries, and foster equitable access to healthcare in increasingly diverse clinical environments.

### **1.1. LCM curricula in Italy**

In Italy, the training and professionalization of mediators have developed within a complex and often fragmented legal and institutional framework, deeply intertwined with national immigration policies (Castiglioni 1997: 106–108). The mediator's role, variously labelled as linguistic-cultural mediator, intercultural mediator, cultural mediator, or transcultural mediator, has been formally recognized in multiple legislative and programmatic texts since the early 1990s (Machetti and Siebetchu 2017: 66–71).<sup>2</sup> The coexistence of these overlapping

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<sup>2</sup>Although mediation is referenced in several national and regional regulatory frameworks (see d.lgs. 286/1998; DPR 394/1999), its governance remains defined by a complex division of

designations mirrors the absence of a unified national framework and underscores the regional variability in how the mediator's functions are defined, implemented, and institutionally recognized. However, despite the lack of unified national standards, mediators are generally conceived as

a social actor who monitors the process of interaction and acts when some type of intervention is required in order to help the communicative process and sometimes to influence the outcome; a facilitator in social events during which two or more parties interacting are experiencing a communication breakdown or when there is a communication gap between them; a meaning negotiator operating as a meaning-making agent especially when s/he intervenes in situations which require reconciliation, settlement or compromise of meanings. To play his/her role effectively, the mediator is required to interpret and create meanings through speech or writing for listeners or readers of a different linguistic or cultural background. Here, the mediator takes on an active role as an arbiter or arbitrator of meaning. That means that s/he must decide on the meaning of something said or written meaning that interlocutors cannot understand or meaning they misunderstand and help event participants out (Dendrinis 2006: 11).

Although the role of mediators is gradually achieving institutional recognition, it remains precarious due to the absence of standardized qualification frameworks and the persistent marginalization of the profession (Antonini 2014: 19–20). As Ornaghi (2022; 2024) notes, such recognition has developed incrementally, influenced by growing migratory flows since the 1990s and by major educational reforms. A decisive step was the Ministerial Decree No. 509/1999, which introduced the “3+2” degree system and formally established Language Mediation Sciences as an academic field, later consolidated by Decree No. 270/2004 under Class L-12, Linguistic Mediation.<sup>3</sup>

Despite these advances, many academic programmes still appear to lack coherent pedagogical frameworks capable of responding to the complex professional demands of the field. Recent developments within the Italian model

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competences between the State and the Regions (art. 117 Const.; Corte Cost. 2005–2008). This has led to fragmented and locally managed services, often entrusted to cooperatives, associations, or informal interpreters, with resulting ethical concerns (Ardizzoni 2024: 239–241) and marked territorial disparities. To date, Lombardy, which hosts the largest concentration of Chinese residents, lacks professional registers or specific regulations, unlike other regions such as Basilicata, Friuli Venezia Giulia, Liguria, Puglia, Rome, Sicily, Valle d'Aosta, and Veneto. Regional provisions (e.g., D.G.R. VII/9568/2002; L.R. 25/2017; D.G.R. XI/6693/2022; Decree No. 1456/2022) primarily address mediation in social, educational, or penitentiary contexts, without explicit recognition of linguistic and cultural mediation in healthcare. The most recent D.G.R. XI/6693 (18 July 2022) and related decree outline accreditation procedures for training providers but fail to establish a professional framework for mediators in the socio-health sector. Despite this institutional gap, training in LCM remains active, with several programs offered by higher education institutions (see Section 1.1).

<sup>3</sup> This bachelor's degree generally offers interdisciplinary training in two or more foreign languages, combined with courses in linguistics, translation and interpreting theory, intercultural communication, and area studies. Depending on the university and department, the curriculum may also include modules in law, economics, sociology, or international relations, as well as language-specific courses addressing the cultural, historical, and institutional contexts of the relevant countries. Although programmes vary across institutions, they share the overarching aim of preparing graduates for professional roles that require advanced linguistic proficiency and intercultural mediation skills.

increasingly point to the need for a national certification system integrating linguistic and sociocultural competence while promoting equity, neutrality, and empathy as guiding principles of professional practice (Chessa 2012: 30–32). This need becomes particularly evident in relation to the Chinese context, where linguistic and cultural specificities – especially the complexity of medical terminology – continue to challenge the alignment between institutional recognition and comprehensive, domain-oriented training that encompasses linguistic, pragmatic, cultural, and ethical dimensions. Addressing these challenges seems to require an interdisciplinary perspective, combining insights from linguistics, intercultural communication, and applied ethics to design pedagogical models capable of preparing mediators to sustain effective communication across the increasingly multilingual and multicultural settings of Italian healthcare.

## 1.2. LCM in the Italian healthcare domain

In light of the issues previously outlined, it becomes increasingly urgent to reimagine models of care through a genuinely intercultural lens. If communication lies at the heart of the therapeutic relationship, it must no longer be conceived as a mere exchange of technical information between doctor and patient. Rather, it should be understood as a complex dialogic process, one that incorporates the linguistic, symbolic, value-based, and identity-related dimensions of each individual.

In particular, currently, the provision of LCM services is regulated under European guidelines and the UNI 11591:2015 standard, which defines the competencies of unregulated professional figures in translation and interpreting (Ardizzoni 2024: 239–241). Despite this framework, the integration of mediators into the healthcare system remains fragmented and inconsistent. Services are often outsourced to NGOs or associations, and employment conditions vary significantly. While some regions – particularly in Northern and Central Italy – have established stable services, others operate on an ad-hoc basis. Moreover, the reliance on informal interpreters, including relatives and even children – commonly referred to as “(child) language brokers”<sup>4</sup> – poses ethical and practical concerns, especially in high-stakes medical settings. These dynamics highlight the urgent need for standardized, professionalized, and culturally informed medical interpreting services for the Chinese population in Italy.

Within the Italian healthcare system, LCM should be understood as an integral component of patient-centred care rather than as an emergency response. By promoting active listening, mutual respect, and shared meaning-

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<sup>4</sup> The term language brokers generally refers to bilingual individuals who facilitate communication between parties lacking a common language, often outside formal or professional interpreting frameworks (Rudvin 2006: 57). In Italian healthcare settings, this category may include untrained bilinguals such as family members, other staff, or acquaintances temporarily assisting in the absence of professional mediators. A particularly recurrent phenomenon is that of child language brokers, minors who mediate for their relatives in institutional encounters, including healthcare contexts – a practice widely documented in migration contexts and indicative of structural gaps in the provision of professional interpreting services (see Baraldi and Gavioli 2016; Nikitina and Montenovio 2023).

making around illness and treatment, mediation transforms communication into a genuinely intercultural and dialogic process. In this sense, diagnosis cannot be separated from the patient's cultural background, emotions, and worldview; consequently, the quality of care depends not only on clinical competence but also on its degree of cultural responsiveness (Machetti and Siebetchu 2017: 108–110).

Empirical research has identified several models of mediation in healthcare, such as physicians fluent in the patient's language, professional interpreters, and trained cultural mediators. In Italy, these figures operate through both in-person and remote services, contributing to more equitable and humanised forms of care. However, as observed in medical anthropology, communication failures often originate less from linguistic misunderstanding than from an inability to interpret culturally embedded meanings. Mediators therefore operate at the interface of linguistic, cognitive, and symbolic systems, making interpretive choices that directly influence understanding and clinical outcomes (Chessa 2012: 52–53).

Against this backdrop, rethinking healthcare communication requires a shift from reactive translation practices to ethically grounded and culturally informed dialogue. Mediators, in this regard, should be viewed not as passive transmitters of discourse but as active co-constructors of trust and mutual understanding within therapeutic encounters. Their effectiveness, however, ultimately depends on the availability of adequate linguistic and terminological resources – particularly when dealing with languages whose medical lexicon reflects distinct epistemological and cultural traditions, such as Chinese. This consideration leads to a deeper examination of the nature and structure of medical Chinese.

## ***2. Medical Chinese language in contemporary healthcare settings***

Following the definition of medical language proposed by Magris (1992: 3), medical Chinese can be described as a heterogeneous subcode of the standard language used in healthcare communication between professionals and patients. It constitutes a language for specific purposes (LSP), encompassing both linguistic and non-verbal practices with communicative functions ranging from anamnesis and diagnosis to therapeutic intervention (Jiang 1998: 4; Jiang and Zeng 2000: 5). As with other specialized languages, it fulfils a distinct functional role by responding to the specific communicative needs of healthcare actors. In Chinese, the notion of *special language* is generally expressed by the terms 专业语 (*zhuanyeyu*) or 专用语言 (*zhuanyong yuyan*), both calques of the English LSP. It refers to a linguistic system employed for defined communicative purposes within limited professional domains, such as medical or scientific discourse (Richards *et al.* 2002: 254). Its study involves both terminology (*shuyu* 术语) and register (*yucheng* 语域), with terminology playing a central and often primary role (*ibid.*: 428). In this sense, 术语 has become the standard term denoting LSPs in Chinese, combining the sinograms 术 (*shu*, 'skill, technique, art') and 语 (*yu*, 'language, term, or code') (Casacchia and Bai 2013: 1400; 1776). Regarding

*specialized terminology*, a definition developed by sociolinguist Xia Zhonghua (1986: 94) states:

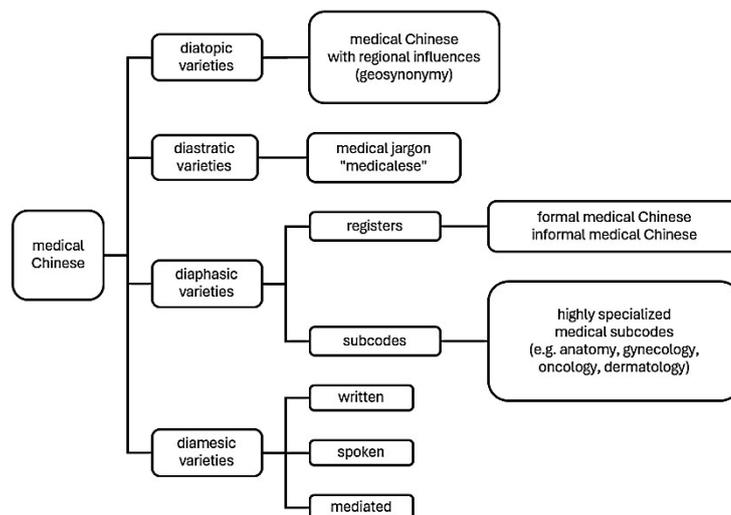
术语可以是词，也可以是词组；它们是用来正确标记生产技术、科学、艺术、社会生活等各个专门领域中事物、现象、特性、关系和过程的。

Specialized terminology encompasses words or phrases employed to accurately denote objects, phenomena, properties, relationships, and processes specific to various specialized domains, including production technology, science, art, and social life.<sup>5</sup>

Analysing shared characteristics across specialized subcodes, medical language is foremost marked by semantic unambiguity or monoreferentiality (*danyixing* 单义性), whereby any ambiguity that could compromise the subcode functionality is strictly excluded. A one-to-one correspondence between signifier and referent is essential to ensure clarity and prevent disruptions in specialist communication or scientific advancement. A second defining feature is semantic precision (*zhunquexing* 准确性), requiring each lexical item to denote a specific concept unambiguously and objectively. Emotional connotations are avoided, and contextual inference is considered inadequate for interpreting specialized terms. Synonymy is also excluded, as it introduces potential ambiguity. Thirdly, medical terminology is marked by a high degree of specialization (*zhuan yexing* 专业性), being confined to narrowly defined professional domains. These terms convey dense technical content and are primarily used within expert communities, though rhetorical extensions via neologisms or semantic shifts do occur. Finally, systematization (*xitongxing* 系统性) is essential: specialized terms are embedded within a structured, interdependent network of vocabulary. Each discipline forms a coherent terminological system in which the meaning of a term is derived from its relationship to the system as a whole and its constituent parts (Xia 1986: 94–95). Concerning its particular features, Chinese medical–scientific language represents a notably intricate subcode due to its richness in exclusive lexical and structural elements, which are distributed across a wide array of textual genres. These genres often remain inaccessible to lay audiences and span both horizontal and vertical continua, as well as major axes of linguistic variation generating a complex configuration (Figure 1).<sup>6</sup>

<sup>5</sup> Unless otherwise indicated, all translations from Chinese are by the author.

<sup>6</sup> Beyond these vertical and horizontal dimensions, medical subcodes can also be differentiated along the principal axes of linguistic variation: diatopy (geographical or institutional origin and workplace of healthcare professionals), diastraty (usage of sector-specific jargon), diaphasy (level of discourse formality), and diamesy (medium of communication, whether written, oral, or mediated through electronic channels such as email, forums, or telemedicine).



**Figure 1.** Architecture of medical Chinese (adapted from Piro 2022: 18).

Vertically, medical Chinese exhibits internal stratification determined by diaphasic variation, that is, social parameters linked to the speaker's role and communicative setting. Specialists' discourse spans a continuum of formality and complexity depending on context and interlocutors (Gualdo 2021: 17–22). This adaptability allows language to adjust to textual function and genre (Scarpa 2008: 6–7), distinguishing between specialist-oriented texts used in academic research, technical texts in clinical communication, and popularization texts for lay audiences (Cortelazzo 1994: 29–30).

Horizontally, variation among medical subcodes mirrors the growing fragmentation and specialization of disciplines throughout the twentieth century. Each subfield – such as gynaecology, cardiology, or oncology – develops partially distinct terminological and stylistic conventions. This diversity reflects the interplay between diachronic evolution and horizontal differentiation: as knowledge expands, a complete taxonomy of medical sublanguages remains unattainable (Kontutytė 2017: 15). For the present study, medical–scientific language is thus examined holistically, emphasizing convergent features to provide a unified analytical perspective.

## 2.1. Methodological challenges in the mediation of medical Chinese terminology

The Chinese medical terminology associated with conventional (i.e., biomedically oriented) practice, as opposed to that pertaining to Traditional Chinese Medicine (TCM), shares a considerable number of features with English, from which it is primarily derived. Etymologically rooted in Greek and Latin (Zhao 2016: 4748), modern medical terminology was integrated into the Chinese writing system through culturally and scientifically prestigious languages such as French and, later, English. Following the introduction of Western medical knowledge into China, a vast array of new concepts entered the language via translations of Western scientific literature across multiple disciplines (Bulfony 2004: 337), resulting in an extensive incorporation of foreign specialized xenisms

(*wailaici* 外来词) into Chinese. Given the structural and typological differences between the two linguistic systems, this transmission of knowledge proved particularly complex and necessitated the coinage of neologisms through various word-formation strategies.

As a result of this historical process, while many peripheral technical terms – sector-specific lexemes often used to raise the register and typically derived from Classical Chinese – have long been part of the language, core technical terms – lexical items that convey domain-specific concepts, notions, instruments, and processes (Serianni 2012: 92) – display marked heterogeneity. In the process of translating Chinese medical terminology, recurrent lexical processes include (i) borrowing from English, which operates as the global lingua franca of medical and scientific discourse (Mičić 2013: 219–227); (ii) phonetic calques such as 基因 (*jiyin*, gene), 荷尔蒙 (*he'ermeng*, hormone), and 盘尼西林 (*pannixilin*, penicillin); (iii) semantic calques like 脱发 (*tuofa*, alopecia, lit. *to lose + hair*) and 缺氧 (*queyang*, hypoxia, lit. *lack + oxygen*); and (iv) semantic redefinition, such as 因子 (*yzinzi*, factor), in 类风湿因子 (*leifengshi yinzi*, rheumatoid factor), or 波 (*bo*, wave) in 蠕动波 (*rudongbo*, peristaltic wave). Other formation strategies include (v) compounding, as in 皮炎 (*pjiyan*, dermatomyositis) and 肌凝蛋白 (*jining danbai*, myosin), both containing the morpheme 肌 (*ji*, muscle, myo-); (vi) derivation, as in 低血糖 (*dixuetang*, hypoglycaemia) with the prefix 低 (*di*, hypo-) or 肝炎 (*ganyan*, hepatitis) with the suffix 炎 (*yan*, -itis); (vii) acronyms, both pure (e.g., DIC, Disseminated Intravascular Coagulation) and hybrid, as in B型超声 (*B-xing chaosheng*, B-mode ultrasound); (viii) eponyms, such as 卢·贾里格症 (*Lu Jialige zheng*, Lou Gehrig's disease) and 鸠宁病毒 (*Jiuning bingdu*, Junin virus); (ix) non-alphanumeric symbols like  $\geq$  and  $\downarrow$  (Lippi and D'Elios 2012: 7); and (x) non-Latin alphabets, mostly Greek, as in  $\alpha$  (alpha) and  $\delta$  (delta) (Ardizzoni 2024: 229–230; Vallati 2024: 229–242).

The high specialization and internal variability of Chinese medical terminology often hinder comprehension, particularly for mediators without domain-specific expertise. Beyond terminological opacity, challenges arise from the coexistence of neologisms, hybrid forms, and culturally embedded expressions that resist direct equivalence. This is evident in cases where TCM employ distinct nomenclatures for the same condition, as for 'impotence' which is rendered in TCM as 阳痿 (*yangwei*), whereas conventional urology adopts 阳萎 (*yangwei*) (Gan 2013: 50–53). Such divergences highlight the need for contextual and disciplinary awareness. Effective mediation therefore depends not only on terminological precision but also on the ability to reproduce the stylistic and formal conventions of medical discourse in the target language (Viezzi 1992: 58), supported by advanced linguistic competence and collaboration with medical experts.

Recent developments have introduced digital and AI-based tools to assist in medical translation and terminology management (EPRS 2022; Chen *et al.* 2022; Mehandru *et al.* 2022; Bakdash *et al.* 2023), a trend increasingly visible in the Sinophone world (Huang 2022; Chen and Li 2023). While neural machine translation has improved access to specialized corpora, significant challenges persist concerning the accuracy, contextual adequacy, and ethical implications of AI-assisted outputs (Chambers 2022; Landi 2023). Post-editing and expert

validation remain indispensable (Chen and Li 2023: 5898), particularly when mediating sensitive information in doctor–patient communication (Mehandru *et al.* 2022: 2023).

Such complexity foregrounds the inherently dialogic nature of medical communication, where linguistic mediation entails the negotiation of knowledge, authority, and trust within clinical encounters, dimensions that ultimately intersect with the ethical responsibilities and interpersonal dynamics central to mediation practice.

### **3. Ethical dimensions in written and oral LCM practices**

Across various medical disciplines, a gradual yet decisive increase in scholarly interest in doctor–patient communication can be observed. This growing attention is primarily motivated by the goal of improving dialogic exchanges, fostering trust, and facilitating the clear transmission of medical information. In this context, elements such as empathy, attentiveness to the patient’s individual characteristics (Moja and Poletti 2016: 18–36), and their cultural background, particularly in light of the migratory dynamics shaping contemporary societies, play a pivotal role in dialogic exchanges and the broader care process (Benucci and Grosso 2021: 106–107).

This shift reflects a broader transformation in the role of medical professionals towards the contemporary figure of the “human” doctor, who engages with patients as active participants in the healing process (Fiorini and Granata 2019: 74–75). Concurrently, both the patient’s role and the conception of illness have changed. A new paradigm has emerged transcending the traditional biomedical model and emphasizing the citizen’s proactive involvement in care (Censini and Tagliaferri 2011: 6–7). Illness is now increasingly seen not solely as a biological dysfunction, but as a complex bio-psycho-social condition shaped by molecular, psychological, cultural, and societal factors (Wang *et al.* 2008: 192–193). This expanded perspective highlights the need for multidimensional approaches to healthcare and communication.

Patient satisfaction, in this framework, consists of two interrelated components: a cognitive dimension, influenced by the physician’s verbal behaviour – how medical information is requested and conveyed, shaping the patient’s perception of clinical competence – and an emotional dimension, shaped by paraverbal and non-verbal cues such as tone of voice, facial expressions, eye contact, and gestures. These aspects work together through synchronisation processes that foster emotional resonance and relational trust (Pensieri 2009: 57–60).

Building on this interactional perspective, Guo (2004: 23–24) argues that strengthening the doctor–patient relationship directly contributes to improved therapeutic outcomes. This process relies on the physician’s capacity to convey respect, empathy, and accessibility, values rooted in both professional ethics and

the broader moral imperatives of clinical care.<sup>7</sup> Linguistic behaviour plays a crucial role in this regard: the use of clear, considerate, and emotionally attuned language enhances patients' sense of safety and fosters active participation.

In this context, Xu *et al.* (2005: 67–68), building on Resnik's ethical framework, identify eight fundamental principles for effective doctor–patient communication. Interaction, they argue, should be guided by the principles of non-harm (*bu shanghai* 不伤害) and active beneficence (*shanxing* 善行), ensuring that communication contributes positively to the patient's well-being rather than causing distress or confusion, promoting patient autonomy (*zijue* 自决) and privacy (*shoumi* 守密), while upholding fairness (*gongzheng* 公正), honesty (*chengshi* 诚实), fidelity (*zhongshi* 忠实), and utility (*xiaoyi* 效益). Achieving this requires avoiding ambiguities caused by imprecise use of specialized terminology. The language employed must strike a balance between technical specificity and accessibility, respecting the patient and avoiding overly complex or foreign terms that may hinder understanding.

Ultimately, the precise and considerate use of medical terminology – along with paraverbal elements such as tone, gesture, and facial expression – has the potential to reshape the doctor–patient relationship, influencing the patient's receptiveness to care and strengthening trust and compliance.

### 3.1. Ethical insights in written LCM practice: addressing terminological accuracy

As a field of inquiry, the ethics of LCM in healthcare constitutes an interdisciplinary domain at the intersection of medicine, linguistics, and professional ethics, addressing the moral implications embedded in intercultural communication during clinical encounters. The ethical dimension of LCM in medical settings is not a marginal concern, but a foundational element that shapes not only the outcome of the clinical exchange, but also the patient's psychological security, trust in the institution, and overall satisfaction (Lin 2018: 36–37).

Specifically, according to Cai (2014: 45), scientific translation – including medical translation – must necessarily adhere to two cardinal principles: fidelity to content (*zhongshi* 忠实), understood as accuracy in conveying the meaning and style of the source text's author, and formal coherence (*tongshun* 通顺), that is, the appropriate adaptation of the source text to the linguistic and rhetorical norms of the target language to ensure it is logical and fluid (Li 2012: 1–8). However, in light of the growing interdisciplinarity between medicine and translation studies, specialized translation has come to encompass cultural, etymological, and ethical dimensions as well, which must be taken into account in the process of rendering a medical text into the target language.

To further clarify what is meant by the ethics of translation, Cai provides an illustrative example concerning the Chinese translation of the acronym AIDS

<sup>7</sup> According to Dai (2007), medical ethics is founded upon four basic principles: non-maleficence (*qiewu shanghai* 切勿伤害); beneficence (*liyi binghuan* 利益病患); respect for patient autonomy (*bingren zizhu* 病人自主); and justice (*gongping zhengyi* 公平正义).

(Acquired Immunodeficiency Syndrome). In Sinophone regions, various designations have been used for the infectious disease, such as 爱之病 (*aizhibing*, lit. *love disease*), mainly used in Singapore, 爱滋病 (*aizibing*, lit. *disease spread by love*), and 爱死病 (*aisibing*, lit. *deadly disease caused by love*). Since the 1980s, Chinese translation studies have seen heated debates concerning the standardization of medical terminology for AIDS, with researchers supporting different naming conventions. The primary argument in favour of these renderings was that they were excellent results of the phonetic loan method, while also effectively condensing – through the character 爱 (*ai*, *love*) – the perceived link between the transmission of AIDS and sexual promiscuity, regarded as the main cause of HIV's spread.

However, medical science clearly indicates that sexual transmission is only one of several modes of HIV infection, which also include contact with the blood of an HIV-positive person or transmission through breast milk. This understanding led to the adoption of a new official designation in mainland China: 艾滋病 (*aizibing*), a hybrid term formed by the phonetic transliteration 艾滋 (*aizi*) of the English acronym AIDS, combined with the semantic component 病 (*bing*, *disease*). According to Cai (2014: 47), the use of the character 爱 in the original renderings – intended to explicitly highlight the role of sexual behaviour in HIV transmission and to maintain phonetic-semantic balance – violates both translation and medical ethics. Such renderings offer a partial and potentially harmful interpretation of the original term AIDS, as they establish an inseparable link between love and disease in the public imagination, resulting in misleading and culturally damaging consequences.

Scarpa (2008: 321–322) revisits the theme of ethics in specialized translation by drawing on the work of Anthony Pym. According to Pym, ethical considerations in translation studies reemerged in the early 2000s, particularly around two main perspectives. The first is an economic model, in which the translator's responsibility is linked to the quality of the produced translation. The second focuses on the interpersonal relationship between the translator and other participants in the translation process or the end users of the translated text. From this second perspective, the translator must demonstrate loyalty and responsibility toward the source text (textual responsibility) and all communicative stakeholders (interpersonal responsibility). This dual responsibility necessitates the development of a code of ethics, or deontology, by professional translators' associations.

Nonetheless, to avoid methodological and epistemological shortcomings, translators should also engage in collaboration with domain experts and draw on specialized resources, particularly the extensive online repositories of professional discourse now available. The goal is not to attain full medical expertise, but to acquire a functional understanding of the linguistic and conceptual structures that shape medical communication, thereby enabling accurate and contextually appropriate interpretation (Soubrier 2014: 147–150). Translating medical language, therefore, cannot be reduced to the mechanical selection of equivalent terms but requires the ability to reproduce the discursive strategies and phraseological patterns that a domain expert would naturally employ in professional practice. As Rouleau (1995: 29–32) advocates, “[i]l faut

*savoir les enchaîner dans un discours qui reflète les usages du domaine*” [one must be able to link them together in a discourse that reflects domain usage].

### 3.2. Ethical considerations in oral LCM practice

LCM in healthcare shares core principles with other interpreting domains – accuracy, completeness, fluency, and cultural sensitivity – but its distinctive humanistic orientation introduces additional ethical and existential dimensions. Because medical encounters concern life and health, mediators are expected to combine domain-specific linguistic competence with a strong ethical commitment to preserving human dignity (Cai and Yang 2018: 24–25). Their dual role entails giving voice to patients’ needs and emotions while assisting healthcare professionals in ensuring clarity, reassurance, and support. As such, mediators act not only as linguistic intermediaries but as agents of empathy and care. Within the broader healthcare process, LCM constitutes a crucial interface through which communication, trust, and patient well-being are co-constructed. The ethical dimension of LCM is thus intrinsic: the mediator’s linguistic performance and cultural awareness directly influence both clinical outcomes and the legitimacy of the medical encounter as a space of transparency and relational trust.

This ethical and relational dimension also entails navigating the intrinsic asymmetries of the clinical encounter. As Lin (2018: 37) observes, healthcare is marked by unequal power relations, cultural divergences, and decisions that may directly affect a patient’s dignity, autonomy, or survival. Mediators are therefore required to balance institutional protocols and clinical precision with the interpersonal and cultural needs of both parties, ensuring that communication remains accurate, empathetic, and ethically grounded. Specifically, their role is structured by a three-tiered ethical framework: as conduits of the physician’s voice (a), they are tasked with fidelity and neutrality to ensure patient comprehension, consent, and participation; as interlocutors of the patient (b), they must promote empathy, clarity, and respect for autonomy; and as hospital employees (c), they must adhere to institutional standards and maintain linguistic and biomedical competence.

This model reflects the ethical foundations of the physician–patient relationship, articulated through four core principles: autonomy (*zunzhong yuanze* 尊重原则), beneficence (*youli yuanze* 有利原则), non-maleficence (*bu shanghai yuanze* 不伤害原则), and justice (*gongzheng yuanze* 公正原则). These principles entail the patient’s right to informed, confidential, and equitable care; the duty to act in their best interest; and the obligation to prevent harm and ensure fairness. They underpin the broader ethos of medical professionalism – integrity, discretion, and impartiality – which also governs interpreters, who, as institutional actors, are regarded as part of the clinical team and subject to the same ethical responsibilities.<sup>8</sup>

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<sup>8</sup> These foundations are further articulated in the so-called ABCD model, which emphasizes Attitude (*taidu* 态度), Behaviour (*xingwei* 行为), Compassion (*tongqing* 同情), and Dialogue (*duihua* 对话) as essential components of clinical interaction (Lang 2010: 408-409).

In particular, as conduits of the physician's voice (a), mediators are expected to support the physician's authority by faithfully transmitting medical content. Within this configuration, interpreters serve as conduits of medical information, operating under the ethical imperative of representational fidelity. Regardless of linguistic strategy or communicative technique, the interpreter must reproduce the physician's message with semantic equivalence, without omissions, additions, or alterations. Crucially, interpreters shouldn't assess, filter, or reinterpret clinical content based on their biomedical knowledge or assumptions (Lin 2018: 38).

The ethical relationship between medical interpreters and patients (b) is rooted in the principle of trust (*xinren* 信任), a foundational element of norm-based ethics that requires interpreters to meet the informational needs of target language users (Mei 2011: 98). From the outset of interpreted care, a presumption of trust is established, obliging mediators to render the physician's specialized discourse in an accessible and culturally appropriate manner, without compromising accuracy (Li 2011: 256). This reflects their ethical responsibility to ensure clarity and transparency in intercultural communication. Owing to their vulnerability, patients often attribute to mediators a role comparable to that of clinical staff. Interpreters are therefore expected to combine bilingual proficiency, intercultural competence, medical knowledge, and a strong ethical commitment to patient welfare (Lin 2018: 39).

The ethical relationship between medical interpreters and hospitals (c) is based on a service-oriented model in which interpreters support the provision of linguistically accessible care. Their work should comply with hospital regulations while upholding the ethical principles of fidelity, responsibility, and professional integrity (Mei 2011: 99–100). Furthermore, they are required to act with accuracy, honesty, and efficiency, ensuring message equivalence and optimizing communication. While the ethic of commitment discourages accepting tasks beyond one's competence, interpreters often face urgent, unpredictable assignments where refusal could compromise patient welfare. In such cases, alternative solutions must be sought to preserve ethical standards. At the same time, hospitals bear ethical responsibility to recognize interpreters' roles, guarantee equal respect, and support their professional development through clear career paths and training opportunities.

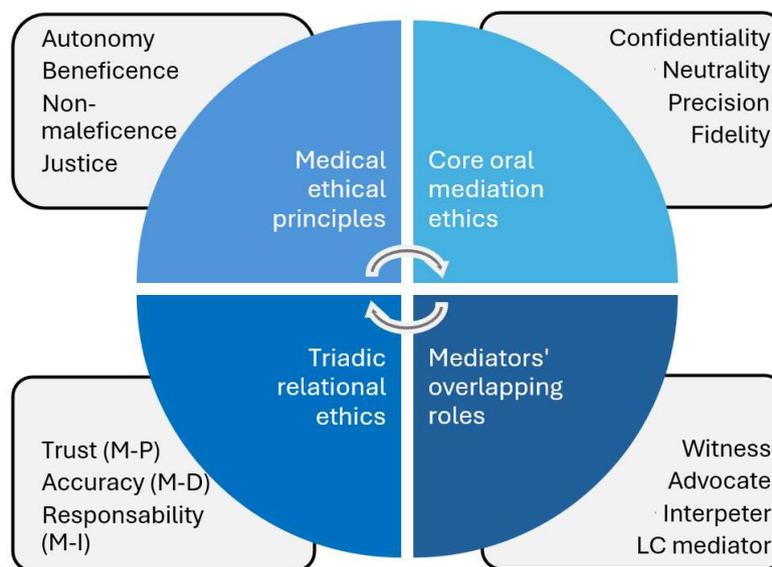
Building upon this ethical triad of relationships, Zhu *et al.* (2015: 112–113) outline three core principles guiding medical interpreting: flexible loyalty (*dongtai zhongcheng* 动态忠诚), impartial neutrality (*keguan zhongli* 客观中立), and strict confidentiality (*gaodu baomi* 高度保密). Flexible loyalty emphasizes fidelity to meaning rather than literal wording, grounded in professional ethics; impartial neutrality requires interpreters to maintain an unbiased stance and to mediate both voices faithfully, acknowledging cultural differences; strict confidentiality concerns the protection of all information exchanged in clinical contexts, aligning with the broader ethical norms of medical practice.

Similarly, the National Council on Interpreting in Health Care (NCIHC 2004) codifies comparable standards – accuracy, completeness, impartiality, and confidentiality – while explicitly recognizing the interpreter's potential advocacy role (*liyi daiyan* 利益代言) when patient welfare or dignity is at stake. These

convergent frameworks confirm that medical interpreting is not a merely linguistic service but an ethically bound professional practice situated at the intersection of medicine and communication.

As further noted by Cai (2014: 45–47), medical interpreting occupies an intermediate space between medicine and translation, governed by a dual ethical framework that integrates the principles of translation ethics – fidelity, confidentiality, and neutrality – with those of medical ethics, centred on the preservation of life and human dignity. Within this intersection, interpreters function not merely as conduits but as communicative and ethical agents who actively shape the doctor–patient dialogue, acting as both bridges (*jiaoji qiaoliang* 交际桥梁) and witnesses (*jianzhengzhe* 见证者) of the clinical encounter. When these ethical domains come into tension, Cai argues, medical ethics must prevail, as the interpreter’s ultimate duty lies in safeguarding the patient’s welfare and autonomy.

Further elaborating on this perspective, Cai and Yang (2014: 33–34) conceptualize the interpreter’s professional identity as multi-layered. At the technical level, interpreters ensure accuracy and neutrality; at the communicative level, they act as cultural mediators fostering mutual understanding; and at the humanistic level, they embody the ethical core of medicine as upholders of trust and compassion. These interdependent dimensions underscore the interpreter’s complex role as both linguistic specialist and ethical participant within the therapeutic process. Building on this framework, Figure 2 provides a concise synthesis of the four principal ethical dimensions that define oral LCM practice in healthcare.



**Figure 2.** Conceptual model of the primary ethical dimensions in oral LCM.<sup>9</sup>

<sup>9</sup> In the proposed conceptual overview, the triadic relational framework refers specifically to the dynamic interactions among mediators (M), patients (P), healthcare professionals (D), and institutional actors (I).

Despite the multitude of roles interpreters may assume, situations may arise in which these roles conflict or become incompatible. In such cases, the interpreter's primary ethical obligation should be to uphold the principles of medical ethics – respect for life and the promotion of health – above all else.

#### ***4. Conclusions: for an ethical and culturally-informed LCM practice in healthcare***

The growing demand for qualified mediators within the Italian healthcare system underscores the urgency of developing a coherent, context-sensitive framework capable of addressing the multifaceted challenges of medical communication with Chinese-speaking patients. As this paper has argued, these challenges extend well beyond the linguistic domain as they encompass intricate terminological, cultural, and ethical dimensions that should be considered in any serious attempt to advance the professionalization of healthcare mediation.

Among these, the methodological dimension remains particularly critical. The hybrid nature of Chinese medical terminology – shaped by the coexistence of Western biomedical discourse and culturally embedded concepts from Traditional Chinese Medicine – appears to require pedagogical approaches that are both linguistically precise and culturally responsive. Training programmes might therefore aim to foster not only terminological competence but also the ability to interpret and convey pragmatic and symbolic meanings in ways that enhance communicative clarity and safeguard patient well-being. These methodological aspects are closely intertwined with the ethical dimension of mediation, understood as a practice of relational and professional responsibility. Mediators function as co-constructors of understanding and trust between patients and healthcare professionals; hence, pedagogical models would ideally incorporate a solid ethical component grounded in internationally recognized principles such as impartiality, confidentiality, accuracy, and respect for cultural diversity. The development of context-specific ethical guidelines informed by empirical realities may represent a necessary step toward the professional and institutional consolidation of the field.

More broadly, this study has advanced a theoretical framework intended to systematize the ethical and methodological foundations of healthcare mediation through a top-down, culture-centred, and interdisciplinary approach. While conceptual in scope, this framework could serve as the basis for future empirical validation through qualitative and mixed-method research, including ethnographic observation, structured interviews, and case studies in clinical settings. Such studies would provide much-needed empirical grounding for the theoretical assumptions outlined here and strengthen the bridge between conceptual reflection and pedagogical application.

In conclusion, this paper has sought to articulate the necessity of an integrated, ethically grounded approach to the training and professionalization of mediators in healthcare contexts involving Sinophone patients. Future research and institutional initiatives should continue to refine and validate the proposed framework, ultimately contributing to the promotion of equitable,

culturally competent, and ethically sound communication in healthcare, an essential precondition for fostering dignity, trust, and inclusion in increasingly multilingual clinical environments.

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