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When Interpreters Really Are Machines: The Use of Artificial Intelligence in Intercultural Health Care Communication

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Abstract

Machine translation (MT) and artificial intelligence (AI) are used in an ad hoc manner to negotiate intercultural communication in health care settings. As AI is currently subject to public debate, it is important to consider perceptions of and discourses around it. Through a literature review of translation and interpreting studies and health sciences, this article first explores some challenges that MT and AI pose, along with the persistence of reductive thinking around language and the role of the interpreter. It then develops a qualitative content analysis of 41 semi-structured interviews with health care and intercultural communication actors in Catalonia. Informants view MT and AI as useful for simple, low-stakes communication while preferring humans. Despite this, there is an 'acquiescent anxiety' around the unstoppable progress of science. In addition, there is a tendency to distinguish between 'mere' translation and other 'added value' activities, like intercultural mediation. We argue that, when interpreters are not merely thought of as machines, but really are machines, the relentless reduction of interpreting to 'mechanical parroting' paves the way for its automatisation. On the flipside, informants reclaim an expanded interpreter role that involves knowledge of language, culture,

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medicine, the sociology of health and illness, social science methodologies and ethical intercultural communication.

Keywords
health care interpreting, language-discordant consultations, machine translation, artificial intelligence, discourse, intercultural mediation

1. Introduction

This article investigates perceptions of and discourses around the use of artificial intelligence (AI) translation in health care, together with social understandings of 'artificial intelligence' more generally. AI translation is not new in the translation and interpreting industry, which has been undergoing changes for some time, especially since the introduction of neural machine translation (MT) in 2016. However, both in the language industry and society at large, AI has become a powerful catch-all for various existing and evolving technologies and an existential point of inflection on the nature of knowledge, skills and the future of human and machine labour. As AI begins to form part of society, public debate and intercultural health care, this empirical study assesses how relevant actors explain and problematise it (see Roberge et al., 2020) to reflect on possible futures for health care interpreting.

A large body of research has demonstrated the frictions and risks that linguistic and cultural diversity – often compounded by low levels of literacy and education (Floyd & Sakellariou, 2017; Haw, 2024; Ugas et al., 2023) – pose for access to and delivery of health care, whether in terms of written information or patient–provider communication (see, e.g., Hsieh, 2016 or Susam-Saraeva & Spišiaková, 2021). In societies where immigration is a fact of life, the provision of health care is undermined when health systems have no or limited intercultural communication services for patients who are unable to receive care in the state's dominant language(s). In this context, patients and health care providers turn to MT and generative AI technologies to carry out, often concurrently, translation (written) and interpreting (speech) tasks. Studies on the use of various translation apps find that they are mobilised alongside other verbal and non-verbal resources to meet a range of written and oral health care communication needs (Cox & Maryns, 2021; Piccoli, 2022; Valdez & Guerberof-Arenas, 2025; Yang & Valdez, 2025). In addition, AI translation is being used in an ad hoc manner to facilitate communication in language-discordant consultations (Valdez & Guerberof-Arenas, 2025; Vieira et al., 2021). Some health care providers even report that such tools are among their main improvised strategies (Rubio-Carbonero & Gil-Bardají, 2025).

This article begins by examining tendencies in recent research in translation and interpreting studies (TIS) and the health sciences (HS) with regard to the way in which AI translation is conceptually framed. Drawing on our backgrounds in interpreting studies, the sociology of translation and the humanities, we use critical theory to unpack debates on the relationship between the human and the machine in TIS, while also using TIS research to overcome some unhelpful assumptions regarding language and the role of the interpreter in HS.

This preliminary interdisciplinary discussion will provide the thematic and conceptual foundations for a qualitative content analysis (QCA) of 41 semi-structured interviews with a variety of actors on the frontline of IC in the Catalan public health care system. Informants include health managers, intercultural communication (IC) managers, politicians, policymakers, health care providers, interpreters, intercultural mediators, patients, ad hoc language brokers and (former) child language brokers. The QCA will explore (a) how the various actors perceive and understand AI translation and AI more generally; (b) how they construe the relationship between the human and the machine; and (c) how they describe and differentiate various health care interpreter and mediator roles. In this way, this study is innovative in that it responds to the need to consider AI translation and its impact from the perspectives of various actors in the health care space (van Lent et al., 2025), as well as the need for more cross-disciplinary collaboration among communication and health disciplines (de Boe, 2025; Pöchhacker, 2024; Vieira et al., 2021) and among translation studies *and* interpreting studies (Vieira et al., 2023). Although it focuses on the case of Catalonia, its analysis is relevant for broader debates on the use of AI translation in intercultural health care communication and the future of the health care interpreter in the current context of technological development.

Regarding terminology, while MT is a widely established term, Pöchhacker (2024) notes that across various technological and humanistic disciplines, there is considerable variation regarding how to name AI-assisted interpreting. Interpreting that is aided by machines is more commonly referred to as 'speech (to speech) translation' or 'spoken language translation', as opposed to 'machine interpreting', even though this overlooks the written/spoken distinction between translation and interpreting. For the sake of coherence, we will use the umbrella term AI translation (following Vieira, 2026) to refer to both MT and generative AI translation insofar as they are employed to assist translation and interpreting processes in health care. While these processes are increasingly hybrid and permeable (Cai & Li, 2025; Vieira, 2026), the ultimate focus is health care interpreting.

2. TIS: Language Workers, Humans and Machines

AI translation is transforming the modern translation and interpreting workplace within a globalised, digitalised and platformised industry (Baumgarten & Bourgadel, 2024; Fırat et al., 2024; Giustini, 2024). The development and deployment of this technology have been guided by the neoliberal values of speed, efficiency, precision, progress and techno-triumphalism, leading to the accumulation of translation data and its dispossession from translators, interpreters and laypeople alike (Baumgarten, 2024; Baumgarten & Bourgadel, 2024). Rather than reaping the rewards of digitalisation, translators and interpreters face insufficient income, lack of social security and collective bargaining power, poor work–life balance, and psychosocial and physical health issues at an ever-increasing scale (see Fırat et al., 2024). Overall, AI is having the effect of increasing exploitation and multiplying labour control, as well as undermining the value of translation and interpreting professionals on the labour market (Giustini & Dastyar, 2024).

At this critical juncture, recent research on translators' and interpreters' responses to AI translation has identified resistance to employing automated technologies, anxiety around exploitative business practices and concerns regarding an increased cognitive

load (Asscher & Glikson, 2023; Cadwell et al., 2018; Vieira, 2020; Yin, 2025). However, some have noted contradictions in terms of perceptions of AI translation tools and their actual impact on the translation process and its products (see Cadwell et al., 2018). For example, Asscher and Glikson (2023) find a negative bias towards the quality of AI translation output among translators and non-translators. This research on responses and data dispossession and waning labour rights – in an industry that has always been lacking in terms of worker protection – suggests that it is especially important to keep paying attention to how translators and interpreters perceive AI translation, including the causes and context of potential resistance, anxiety and negativity.

Within TIS, there is also a tension regarding the proper attitude to adopt in relation to AI translation, with emerging discourses that appear incompatible: on one hand, the need to be wary of techno-triumphalism (see Baumgarten, 2024 or Peeters et al., 2026) and, on the other hand, the need to overcome technophobia (see O'Brien, 2024). At the heart of this controversy is the question of how to navigate the relationship between what is purportedly human and what is purportedly machine, along with their mutual interaction and the effects of this on human labour and life. O'Brien (2024) borrows from Haraway's (1985/1991) ideas in *A Manifesto for Cyborgs* regarding hybrids, the blurring of boundaries and the kinship between humans and machines to detract from what she sees as the technophobic human/machine dichotomy. She employs the cyborg metaphor in conjunction with the human-centred artificial intelligence (HCAI) paradigm, in which AI empowers humans and amplifies – rather than emulates – their capacities. However, if we only focus on Haraway's celebration of the pleasure and possibilities that can emerge in technologically mediated societies in which humans, machines *and animals* (let us not forget) fuse, we risk missing the irony and tension that weave this famous manifesto together. In the text, new technologies also mean modern war, deadly machines, human pain, appropriation of women's bodies, the feminisation of work, privatisation, surveillance, etc. The ironic cyborg metaphor articulates the need to adopt a double vision that is attuned to incompatibilities and 'many-headed monsters'. Haraway's call to action is to seize the imaginative possibilities of a feminist science and, indeed, new relationships with machines, but, importantly, it is also about the need for fresh forms of unity, resistance and labour organisation in the face of new sources of power.

Similar to O'Brien, Giustini suggests that we should displace "the centrality of the interpreter's anthropomorphic brain as the producer of knowledge" as part of developing critical AI literacy based on synergistic human–AI capabilities (Giustini & Dastyar, 2024, pp. 198–199). Within the field of interpreting, she refers to two sides in the current debate: one side that sees 'machine interpreting' as the future and another that sees the human interpreter as irreplaceable due to its uniquely humanising features, such as emotions, culture and creativity (Giustini & Dastyar, 2024, pp. 197–199). Drawing on Braidotti (2013), she argues that we must rethink the interpreter as an assemblage and a complex multiplicity of the human and the machine. Further examination of Braidotti's work shows that she critiques Eurocentric humanism and defends the need to understand the self in an expanded and relational way that reconnects humans with other species. Yet she also argues that biogenetic advanced capitalism successfully does this: blurring the distinctions between humans and other species in its ongoing effort to turn life into profit. Braidotti points out that the latter is post-anthropomorphic, but it is not post-humanistic or human(e). This is a reminder that there may be good political and ethical reasons to be

phobic of the AI industry, and that thinking post-anthropomorphically AND post-humanistically must also involve contemplating the ways in which the synergies between the human and the non-human are used for commodification, exploitation and control. As Haraway warned, the monster has many heads.

As the notion of the human/machine assemblage begins to take hold as a paradigm, it is important to recognise that this occurs in the context of an increasingly powerful, super-rich, politicised, monopolised and unregulated technological industry. Hence, this so-called assemblage often has unfair and unjust consequences for language professionals, among many others. For instance, the crucial role of translators and interpreters in the production of AI translation is downplayed and concealed, while the supposed agency of technology is magnified and (ironically) construed as having human-like qualities (Moorkens, 2025). The machine is highly visible, while the human labour behind it is invisibilised and deceptively fluent translations are produced – this time instantly (see Venuti, 2008). In our view, before celebrating a human/machine assemblage in translation and interpreting tasks, the social use and function of the constructed opposition between human and machine requires more empirical exploration (as also argued by Rozmysłowicz, 2024) – which is exactly what we seek to explore in the analysis of the interviews.

3. HS: AI Translation as a 'Fix' and Moving Beyond Accuracy (Again)

In the HS, researchers tend to focus on how useful, reliable and safe AI translation is for health care communication. Most studies, predominantly conducted in the United States and Europe, highlight a series of issues in relation to health care interpreting before going on to suggest that AI translation could offer a solution. Health care interpreting is described as costly, difficult to schedule and lengthening consultation times (Bakdash et al., 2024). Further problems mentioned are a lack of availability for certain language pairs; delays in accessing telephone interpreting and interpreters' difficulty assessing situations remotely; no systematic screening to determine which patients need an interpreter; limited awareness of the option to access interpreter services; and a lack of intercultural training among health care providers (Brandenberger et al., 2025; Mehandru et al., 2022; Turner et al., 2019). There are also clinical settings where the immediate availability of an interpreter is viewed as infeasible, such as in emergency departments (Lee et al., 2023). In the United States, there is a lack of funding to comply with language access laws and policies, which has been exacerbated by recent cuts to Diversity, Equity and Inclusion (DEI) programmes (Kaur & Mekled, 2025). It is against the backdrop of this litany of issues that HS researchers perceive AI as a potential 'fix', suggesting that it may be able to offer a service that is rapid, readily available and cost-effective (Bakdash et al., 2024; Birkenbeuel et al., 2021; Genovese et al., 2024; Tougas et al., 2022). However, as many of these enduring problems are of different natures, turning to AI as a silver bullet indicates a discourse of techno-solutionism. The potential remedies to all these problems are not always augmented human cognition, but rather augmented human will, especially with respect to the allocation of resources, provision of training and raising of intercultural awareness.

Several exploratory, simulated and scenario-based studies have been conducted on various translation apps like Google Translate (GT; Birkenbeuel et al., 2021; Brandenberger et al., 2025; Lee et al., 2023; Tougas et al., 2022), the fixed-sentence tool QuickSpeak (Turner et al., 2019) and ChatGPT 3.0 and 4.0 (Hampers et al., 2025). These studies tend to focus on few language combinations and high-resource languages, such as English-Spanish and English-Chinese, as opposed to digitally disadvantaged ones (see Zaugg, 2019). The general criterion for assessment is accuracy, fluency, acceptability, usability and levels of user satisfaction, although accuracy is by far the main concern. Accuracy is described as 'correctly interpreted paragraphs' (Brandenberger et al., 2025, p. 3), and it is often evaluated by bilinguals. In these studies, the extent to which accuracy is achieved depends on whether meaning is lost or changed, and whether this represents a clinical risk. One of the main potential gains from AI is said to be instant accuracy: 'The future of AI translation in health care lies in its ability to deliver real-time accurate communication across diverse clinical scenarios' (Genovese et al., 2024, p. 13).

Overall, AI translation is found to perform worse than human interpreters – based on the criterion of accuracy – with some exceptions: GT and ChatGPT perform on par in the case of simple messages (van Lent et al., 2025) or potentially better in the case of typed text (Hampers et al., 2025). The low ecological validity, however, of most studies should be noted, as they have not been carried out in real-life situations and may not reflect how these tools are actually used. For instance, in research based on actual and reported experiences in TIS (Cox & Maryns, 2021; Piccoli, 2022; Valdez & Guerberof-Arenas, 2025; Yang & Valdez, 2025), translation apps are not used as stand-alone tools; rather, they are mobilised ad hoc alongside other verbal and non-verbal resources in creative attempts to negotiate communicative friction.

Despite the presentation of AI as a possible 'fix' and indications of techno-triumphalism in terms of how AI translation is understood, including its supposed potential of "making communication more seamless" (Kapoor et al., 2022); the expectation that it will eventually be as "accurate" as humans (Tougas et al., 2022); and the perception that it is an "inevitable force" and an "enormous untapped opportunity for technology to fill gaps in medical interpreter use" (Bakdash et al., 2024, pp. 492–493), the HS studies conclude that, at present, human interpreters should not be replaced by machines. Some studies recommend a pragmatic case-by-case approach, assessing the advantages and disadvantages among the options available (Brandenberger et al., 2025). More health care interpreters, bilingual health workers and the use of AI translation are presented as complementary solutions (Kaur & Mekled, 2025). Meanwhile, a critical approach to AI translation is emphasised, including the need for policy, guidelines and training on patient confidentiality, informed consent and data protection (Brandenberger et al., 2025; Genovese et al., 2024).

However, the centrality of accuracy in these empirical studies is still very concerning. One explanation is that in the United States, an inaccurate translation in health care settings can be a cause for legal and financial liability (Quan, 2010). While accuracy is obviously important, the emphasis on it reflects a reductionist understanding according to which language is merely a device for producing meaning or, in other words, the job of language is to give independently existing meaning a recognisable form. In turn, the interpreter, apparently, impartially identifies meaning in language and unproblematically reproduces it in another language. Within TIS, this is described as a conception of the

role of the interpreter as a "passive conduit" who neutrally reveals "the sameness of the world beyond language" (Inghilleri, 2012, p. 13). It dates back to the "conduit model of communication" that was standard in the 1970s (Angelelli, 2019, p. 150) and conceptualises interpreters as robots or as neutral, passive and invisible translation machines (Cho, 2023; Downie, 2020; Hsieh, 2008; Leanza, 2005).

Given the current climate of overexcitement in which AI supposedly "can or will soon be able to do just about anything" (Peeters et al., 2026, p. 4), it is worth revisiting key theorisations of the role of language when it comes to interpreting. According to Inghilleri (2012), language should not be thought of as a barrier but as a tool that conversation partners use, along with others, in their always-ongoing efforts to reach intersubjective understanding and communicative goals. Meaning is not to be found exclusively in language; it is produced through its use. In other words, it is the outcome of the relationship between utterances in specific contexts. Language has indispensable non-instrumental functions as well. Bielsa draws attention to the central role that language plays in the socialisation process and as "a basic means of social interaction" and relating with others (Bielsa, 2022, p. 10). Words are not containers for established meaning either; they live elapsing sociohistorical lives (Bielsa, 2023). These reflections assert the importance of language itself (as something we use and something we shape as it shapes us), as opposed to suggesting that interpreting is about breaking through the language to figure out the meaning.

Furthermore, empirical research in TIS has time and again identified that the role of the interpreter exists on an active-to-neutral continuum, depending on the interpreter's subjective evaluation of the context (see Angelelli, 2019). The interpreter is a co-participant in the interaction (Wadensjö, 1998) and a collaborator of health care providers (Aranda et al., 2021), who assesses the relevant speaker positions and communicative goals before making critical decisions regarding the appropriate discursive strategy (Hsieh, 2020). Such research allowed for a shift in approach from considering potential errors and meaning loss/change to a more interpersonal and dynamic view of the cultural, medical and ethical complexity of interpreter-mediated encounters (Hsieh, 2016). In addition, professional ethics guide interpreter decision-making in the face of dilemmas (Howes, 2023) and promote the end goals of social justice, autonomy, fairness, the right to be heard and included, etc. (Boéri, 2023). These aspects of the role of the interpreter are wholly absent in the HS studies reviewed above. Ultimately, 'testing' AI translation based on whether it accurately reproduces supposedly fixed meaning in language reduces language to meaning and interpreters to conduits, while totally overlooking the fact that language and interpreting are multifaceted material, social and ethical practices. In a world with sophisticated and readily available AI translation, these very questions regarding the nature of language and the role of the interpreter acquire newfound relevance, which we will further discuss through the empirical data.

4. Methodology

The following analysis draws on 41 semi-structured interviews with various actors involved in IC in the Catalan public health care system: health managers (9), IC managers (4), politicians (2), policymakers (3), health care providers (6), interpreters (5), intercultural mediators (3), patients (3), ad hoc language brokers (3) and (former) child

language brokers (3). The health managers are involved in public health, migrant women's health and social work, although most are also health care providers and many have recent experience in situated communication with migrated patients. The IC managers coordinate interpreting and intercultural mediation programmes in government and non-profit organisations. The politicians form part of the health commission at the Parliament of Catalonia. The policymakers all work at the Department of Health.[1] The health care providers include primary care doctors, a nurse, a psychiatrist and an internist. Among the interpreters, intercultural mediators, ad hoc language brokers and child language brokers, a large variety of languages are spoken: Arabic, Spanish, Catalan, Armenian, Ukrainian, Polish, French, Italian, German, Urdu, Hindi, Punjabi, Bengali, Chinese, Russian, Romanian and Bulgarian. The patients are of Ukrainian and Moroccan origin.

The sampling strategy was to include actors involved in management and political roles (18 in total) to consider perceptions of and discourses around AI translation among those in positions to shape policies and practices, together with actors currently involved in IC on the ground (23 in total). It is important to point out that interpreters and intercultural mediators are two distinct profiles in Catalonia, although, in practice, there are fuzzy boundaries between the two (Arumí Ribas, 2017; see also Pokorn & Mikolič Južnič, 2020, for a discussion of this problematic distinction). In other contexts, both profiles would fall under community interpreting. We use the term 'ad hoc language broker' and 'child language broker' to refer to multilingual actors (whether family members, friends or health workers) who mediate communication on an improvised basis but have no relevant formal training. Furthermore, in the analysis, readers will find references to a third profile: the 'community health worker', who participates in public health programmes promoting health literacy and disease surveillance among certain migrated communities.

The semi-structured interview guides were created by the research team within the framework of the "CIMAS: Mediated Intercultural Communication in Healthcare" project, financed by the Spanish Ministry of Science.[2] The relevant interview questions for this article covered a range of topics in relation to interpreting or intercultural mediation needs and strategies; suggestions for improvement; and the use of AI translation and new technologies. The duration of each interview was 1 hr on average. They were conducted mostly in Catalan and Spanish, with one in Russian and two in Arabic. The latter interviews were translated into Spanish by members of the research team.

The analysis is based on QCA, which is a "systematic and methodologically controlled scientific analysis of texts, pictures, films and other contents of communication. Not only manifest but also latent contents are analysed" (Kuckartz & Rädiker, 2023, p. 21). In this approach, analysis goes beyond the pragmatic examination of respondents' statements (manifest contents) to uncover discourses following the principles of hermeneutics (Kuckartz & Rädiker, 2023, p. 12). This method is thus especially useful for analysing perceptions and discourses (Kuckartz & Rädiker, 2023, p. 27) – in the sense of discursive patterns and ways of framing an issue – since "projects that work with QCA are mostly concerned with understanding the meaning of social action and understanding the meaning of statements and arguments" (Kuckartz & Rädiker, 2023, p. 30).

The latent contents we sought to understand and compare are the tropes, metaphors and analogies that informants use when discussing or making claims about AI

translation. To this end, two researchers independently coded the interviews in NVivo, holding regular meetings to discuss divergences, reach intercoder agreement, refine the codebook and recode where necessary. To develop the analytical categories in the codebook, we followed a deductive-inductive process, drawing on the themes and concepts we have presented in our critical overview of literature in TIS and HS, together with a preliminary analysis of the transcripts based on thorough reading and memo-writing to identify recurring themes. In this way, we were open to 'serendipity' (incidental findings) and 'in-vivo coding' (highlighting terms and expressions that have metaphorical meaning). After coding, two of Mayring's (2014) "fundamental forms of interpreting" served as tools to explore the already coded fragments: summary (reduction to essential contents and paraphrasing) and explication (comment and illustration through additional materials), while still paying attention to the relationship between the whole and the part, including potential divergences among the informants (Kuckartz & Rädiker, 2023, p. 62). By placing all this in relation, we sought to listen to our informants and arrive at valid theoretical arguments.

Finally, translation into English was also employed as a reflexive research tool (de Casanova & Mose, 2017; Palmary, 2011). For presenting verbatim quotes, we followed specific guidelines: "(i)f the insight lies in the way a research subject speaks" (Bielsa et al., 2024, p. 293), we provide the original and the translation into English to shed light on our mediation of language as researcher-translators.

5. Analysis

5.1 Perceptions of AI Translation

There was a clear pattern among the various profiles in that many informants consider AI translation[3] to be useful or effective for facilitating health care communication when or precisely *because* they do not have access to another suitable solution. When asked to rank various multilingual options, Child Language Broker 1 explained that he would put GT in last place, but that it is "very effective when you don't have other options". In a more positive vein, Health Care Provider 2 is a fan of GT, as its quality has significantly improved; she uses it to prepare for sexual and reproductive appointments. This concurs with Patient 2, who suggests that health care providers view GT favourably:

> Es decir, no dicen: «no, vamos a buscar a un intérprete». Bueno, vale, Google Translate es Google Translate, los médicos sacan el teléfono y comienzan a traducir con el traductor.
>
> [They don't say "no, we're going to look for an interpreter". Well, OK, Google Translate is Google Translate, the doctors take out their phones and start using the translator.]

Health Care Provider 6 suggests that it is often patients who come to primary care appointments ready to communicate via the translation apps on their phones. Interpreter 2 notes good results with certain languages (Spanish, English and Catalan) and sees AI as having brought improvements to MT. Interpreter 1 and Interpreter 4 also see AI translation as useful for simple messages and low-stakes communication, such as scheduling appointments or assisting patients to navigate a health care centre. Similarly, IC Manager

2 indicates that it can be used for "clear and concise messages" that leave no margin of error. Health Care Provider 5 is sure that AI will assist doctors to improve their interactions with patients, and Health Manager 5 thinks that we should take advantage of it without replacing humans. These comments, like the HS literature discussed in Section 3, indicate that AI translation is perceived as useful in medical contexts for brief interactions and as a last resort but not as a replacement solution. Also reflecting previous research in TS, AI translation is valued as a tool within a larger toolset. Appraisals were similar among the various profiles, including the interpreters. In fact, even among the latter there was surprisingly little demonstration of resistance and negativity towards AI translation, apart from some anxiety around the future, which we will discuss below.

These perceptions of usefulness were often qualified with an awareness of shortcomings. Even though Health Care Provider 2 is enthusiastic about GT, she goes on to mention that using the text-to-text mode is not possible with patients who are unable to read and write. In addition, despite the improvements to MT to which Interpreter 2 referred, this interpreter of Armenian, Russian and Ukrainian still does not think it is an adequate device for conversations with medical specialists, as it is not without errors and 'barbaritats' [nonsense]. In a similar way, in spite of mentioning the usefulness of AI translation for low-stakes communication, Interpreter 1 still thinks that health care providers prefer a human (in-person) solution. While Health Care Provider 5 believes that AI will bring improvements, as an older doctor, he finds it difficult to enter the world of technology and does not think that it is adequate for building doctor–patient relationships. And while Child Language Broker 2 has a positive attitude towards technology, she points out that varying levels of digital literacy could make using AI translation impractical and slow. Some health care providers may be happy to use GT, but it is clear that others are not. Intercultural Mediator 2, who works with Chinese-speaking patients, explains that when she is unavailable to mediate, younger health care providers sometimes use GT; however, they often find that "hay muchas cosas que se quedan un poco ahí en el aire" [there are many things that are left a bit up in the air]. As a result, appointments are rescheduled subject to her availability.

The issue of trust sometimes arose as a matter of relevance with respect to perceptions of AI translation and the human–machine relationship. Interpreter 1, an Arabic interpreter, claims that speakers of Arabic dialects do not trust AI translation, as it only offers standard Arabic, which they may not speak, in which case they do not even consider it as an option. In contrast, Interpreter 3, who mostly works with Polish speakers, states that AI translation is becoming more trustworthy and reliable. However, she caps this by exclaiming that "Però és només sempre una màquina" [But it is always only just a machine]. Meanwhile, interpreters are not machines ["no som màquines, saps?"], as it is impossible for them to know everything. According to her, vastly knowledgeable machines are limited by making mistakes, translating based on the "number of entries" and not making case-by-case decisions. Likewise, IC Manager 2 holds the view that AI translation only works with concrete commands:

> Però quan entres en matisos, els matisos no te'ls dona una màquina [. . .] i el llenguatge està ple i ric i gràcies a Déu, hi ha tots els matisos, tots els grisos.
> [But when it comes to nuances, a machine can't give you nuances [. . .] and language is full and rich and thank god for that; there are all the nuances, all the grey areas.]

For this informant, who is the head of the telephone interpreting service offered by the Department of Health, AI translation cannot provide the conditions necessary to conduct a clinical interview. Taken together, IC Manager 2 and Interpreter 3 give the impression that humans, unlike machines, have limits to their knowledge yet are flexible and alert to ambiguity and uncertainty, making them more trustworthy.

While across the interviews, there is a general rejection of the idea that humans could be fully replaced by machines, some informants also express that it is only a matter of time – that is, they situate replacement in the future. Policymaker 1, the Head of Language Planning at the Department of Health, suggests that a time will come when AI translation may not even require a proofreader. Interpreter 3 describes the inexorable promise and progress of science leading to the extinction of the translation trade:

> Jo sempre dic que aquesta generació, jo crec que la meva, ja serà, si no l'última, doncs la penúltima de traducció. Perquè cada vegada la, diguéssim, la ciència anirà sempre un pas més i un pas més i un pas més endavant. [. . .] Doncs jo crec sí que arribarà un moment que potser sí que, diguéssim, l'ofici de traductor es veurà en extinció. Però de moment crec que encara tenim alguns anys. Ojalá.
>
> [I always say that this generation, I think my generation, will be, if not the last, then the second last generation of translators. Because, science will always take another step and another step and another step forward. [. . .] So I think that the time will come when perhaps, yes, well, the trade of the translator will become extinct. But for now I think we still have a few more years. I hope so.]

Facing the "extinction" of her profession, she wishes for it to occur slowly, though, in a manner of speaking, it is in god's hands (*ojalá*). This relates to a trope that appears in some of the interviews, according to which AI is the future that is here now (Health Manager 5), and AI translation, which will "keep developing", is the future whether we like it or not (Interpreter 1). Similarly, Health Manager 1 suggests that "very soon, if not now", AI will be capable of what he sees as the "simple" task of translation. Yet, for him, this is a disaster as it will lead to the "failure of natural intelligence" or "our intelligence". Again, facing what he refers to as the failure of human intelligence, he remarks, "Però bueno, és lo que hi ha avui en dia" [But anyway, that's the way it is today].

These comments are striking, as anxiety around the future is expressed in acquiescent terms; it is as if AI is the future that is already the present since the future has been decided without us, regardless of its unwanted consequences for human jobs or intelligence. This type of talk recalls what Zuboff (2019) refers to as inevitability doctrines and the "dictatorship of no alternatives". Emanating from Silicon Valley, such doctrines seek to eliminate resistance and creativity from the possibilities at our disposal. In the age of surveillance capitalism, Zuboff argues that it is the very "right to future tense" that is at stake or the right to a future in which we can live a fully human life without our behaviour being subject to constant and unchecked anticipation, shaping and modification.

On balance, the views that AI translation is useful and effective (although it has significant shortcomings) and that it cannot replace the health care interpreter (although it could in the future) point to attitudes that are not techno-triumphalism or technophobia, but somewhere between uptake and caution, anxiety and acquiescence. Interestingly, we

did not uncover the two camps to which Giustini (see Section 2) refers in the field of interpreting: the human interpreter is irreplaceable versus AI translation is the future. Rather, within a single interview and across the interviews, we found both these "opposing" ideas to hang together in all their contradiction.

5.2 Replacement Discourses With Respect to Differing Roles

While we have not identified a replacement discourse in general, nuances emerge when the informants discuss different types of intercultural health care communication tasks in terms of which could correspond to machines and which are necessarily human. Informants from among most of the profiles (health managers, IC managers, health care providers, interpreters, intercultural mediators and ad hoc language brokers) tend to describe the role of the interpreter (though they use the term translator)[4] in comparison with the roles of the intercultural mediator and, to a lesser extent, the community health worker.[5] This comparative discourse is most pronounced among the two management profiles. The translator (read: interpreter) is said to be merely linguistic, "un traductor i ja està" [a translator and that's it] (Health Manager 3). The Catalan telephone interpreting service is portrayed as very basic: "Entonces es una traducción pura y dura" [So it's pure and simple translation] (Health Manager 5). In contradistinction, intercultural mediation is said not to be "un servei de traducció pura i dura" [a pure and simple translation service] (Health Care Provider 2). This means, to them, that it does not involve "just" translating but rather culturally adapting health messages (Health Manager 2 and IC Manager 3). Essentially, translation (read: interpreting) is perceived as a means to achieve other ends in that it ensures that basic health care is provided (IC Manager 1). In fact, the role of the interpreter is hardly a role at all; it is viewed as a tool that is adopted within the context of more complex roles (Health Manager 1). The role of the intercultural mediator, however, is viewed as consisting of accompaniment, knowledge of lifestyles and the creation of an intercultural space (IC Manager 1). The latter is also supposed to have the ability to understand clinical procedures and treatments, empathetically break bad news and assist with decision-making (Health Manager 5), as well as to tailor messages to everyday language, the patient's educational background (Ad Hoc Language Broker 3) and cultural models of health and illness (Policymaker 3).

In an illustrative intervention, Ad Hoc Language Broker 3, a bilingual health care social worker who provides language assistance for Arabic-speaking patients, likens translators to robots or parrots who merely repeat or echo, while the intercultural mediator creates a communicative climate of trust:

> No solo traduces como un robot [. . .]. Entonces, para mí de las estrategias es hacerle ver al usuario que no soy un loro y te voy a traducir literal lo que te está diciendo [. . .] o sea, crear un clima de confianza y de comunicación y que la otra persona no te vea como un mero traductor.

> [You don't just translate like a robot [. . .]. So, one of my strategies is to make the user see that I'm not a parrot that is going to literally translate what they're saying to you [. . .] I mean, to create a climate of trust and communication and for the other person not to see you as a mere translator.]

In this comparison of the two roles, the informant strips "mere" translation of any capacity to perform anything other than mechanical parroting, while he assumes that translation can be carried out without any form of context-specific, cultural or ethical knowledge or training.

In another illustrative intervention, Health Manager 1, who spearheads the community health worker programme, describes the translator as an unskilled and subordinate ball kid compared with the goal-scoring community health worker:

> Llavors, a veure, tenir una agent comunitària de salut nostra a la consulta traduint és com tenir el Messi recollint pilotes a la banda. El Messi pot estar fent gols, per què el tens recollint pilotes a la banda?
>
> [So, getting a community health worker to translate during a consultation is like getting Messi to collect balls on the sidelines. If Messi can be scoring goals, why do you have him collecting balls on the sidelines?]

In his view, translation is passive and imitative, while community health work is active and autonomous: rather than following the lead of the health care provider, he explains, the community health worker can organise health literacy workshops and monitor public health interventions. As such, the latter is said to draw on their intercultural "competencies" – notably, not their communication skills – to adapt crucial health messages to the cultural, social and logistical contexts of migrated communities.

Through such comparisons, the informants draw a distinction between, on one hand, language and a translator and, on the other hand, culture and an intercultural mediator or community health worker. This discourse, however, assumes that language and culture are separate entities, and that languages do not constitute culturally informed practices. While the routine distinction between language and culture, and between translation and mediation, is most patent among the management profiles, it is often upheld among some of the interpreters and intercultural mediators too, leading to the impression that it has become a kind of gospel. Intercultural Mediator 3 differentiates "linguistic interpreting" from explaining cultural codes. Interpreter 3 refers to translation as helping two parties understand each other, while mediation has an added value. What is more, Interpreter 3 sees additional tasks beyond translation as the vital force for keeping the profession alive.

Once again, these views recall the conduit model of communication that conceptualises interpreters as translation machines (see Section 3). While this model may be outdated from the point of view of TIS research, it still holds true on the ground in the context of our interviews. Moreover, the concern is that when interpreters are not merely thought of as machines, but they really are machines, the tenacious insistence on the "linguistic" and "mechanical" nature of interpreting becomes a necessary step in the claim that AI can perform the role of the interpreter. Thus, it is the labour of the human interpreter *specifically* that is devalued. Consider the following:

> Health Manager 3: Amb les noves tecnologies i tal, pots arribar a entendre't amb els usuaris, però ja el que és una mediació ja és una cosa més especifica, més d'entendre aquella cultura.

[With new technologies, you can manage to understand the users, but a mediation is more specific, more about understanding the culture.]

Health Manager 1: Llavors, si ens centrem molt en la traducció, molt bé, perfecte, la tecnologia ho pot resoldre.

[So, if we focus a lot on translation, great, perfect, technology can solve it.]

The implication is that machines can supposedly crack the code of language (i.e., translate), while humans are needed to intervene in culture (i.e., intercultural mediation or community health). In his book on the long social history of AI, Pasquinelli (2023) explores how the social relations of technological development during the Industrial Revolution involved dividing workers and labour into hierarchies and drawing *constructed* distinctions between skilled and unskilled labour – the latter was performed by the working class and therefore automatable. According to Pasquinelli (2023), this social structuring persists today, as AI does not only replace labour but it also attaches value to certain types of knowledge and skills, while imposing comparisons between human and machine intelligence, which are based on passing judgement on which human behaviours and social groups are superior to others. In this light, many interviewees deskill translation precisely by setting intercultural mediation and community health work apart from it, which, in the quotes above, serves as the foundation for asserting the feasibility of mechanising translation. Just as Downie (2020) has argued, the understanding of an interpreter as an invisible and impartial non-actor who "leaves no trace" and "changes nothing" promoted by the conduit model leads us directly to the dispensability of humans for this task (pp. 57–58).

Despite taking issue with some of the informants' reductionist or simplistic views of language and translation, we must not overlook that many of the health managers, IC managers and health care providers are also reclaiming an expanded role that involves a variety of responsibilities. They express a need for actors who adapt, tailor and accompany, with the agency to intervene and make decisions in various scenarios (consultations, workshops, public health interventions, system navigation, etc.). While the extent to which or when adapting, tailoring or accompanying are appropriate is debatable, this recalls Inghilleri's (2012) "expanded interpreter role". She argues that a skill-based understanding of interpreting, such as one grounded on accuracy, reduces it to sociolinguistic and cognitive competencies. In an expanded interpreter role, the interpreter is a highly visible actor who constantly makes informed decisions in relation to the cultural and institutional contexts in which they work, the ethical implications of their words and actions, and the routines and relationships established with others.[6] As workers are being displaced and structured into a new social order, we would do well to listen to this reclamation for highly trained humans who are able to draw on versatile knowledge of language, culture, medicine, the sociology of health and illness, social science methodologies and ethical intercultural communication – call them what you will.

6. Conclusion

In this article, we have drawn on previous literature in TIS and HS to conduct a QCA in which we analyse perceptions of and discourses around AI and the use of AI translation

in health care settings. The critical overview of TIS and HS literature has provided the thematic and conceptual foundations for this analysis, namely the need to empirically address questions of resistance, anxiety and negativity; techno-triumphalism and technophobia; the human/machine relationship; and the nature of language and the role of the interpreter. Debates on the latter have acquired newfound relevance in a context in which 'interpreters are machines' converges as both a trope and a reality.

Generally speaking, the informants perceive AI translation as useful in simple, low-stakes communication and often because patients and health care providers find themselves with no other multilingual resources. However, they suggest that language combinations, literacy levels (including digital literacy) and age influence the effectiveness of these tools and people's willingness to use them. Furthermore, some informants view flexibility, relationship-building and alertness to ambiguity and uncertainty as the province of humans. While we have identified a general rejection of the idea that machines could or should replace humans, in some cases, there is a surprising acquiescent anxiety in terms of the perception that AI is part and parcel of the unstoppable progress of science, regardless of the consequences for human jobs or intelligence. Overall, the interviews painted a complex picture, neither entirely technophobic nor techno-triumphalist, in which humans have a necessary place in intercultural health care communication *and* the future is already taking its machine course.

In our contribution to the role debate in the context of AI translation, we have argued that the relentless reduction of interpreting to mechanical parroting, along with the distinction between interpreters versus the supposedly added-value roles of intercultural mediators and community health workers, undermines the role of the health care interpreter and paves the way for its automatisation. Beyond this, we have observed that many of our informants (particularly the health managers, IC managers and health care providers) express a need for humans in what we have referred to as an expanded interpreter role: highly trained professionals who ethically negotiate intercultural communication and collaborate with others in various health care settings and initiatives, while drawing on their broad-ranging knowledge of language, culture, medicine and the sociology of health and illness. One of the benefits of this expanded role is that it could be perceived as more automation resistant than a so-called 'mere' interpreter. In an area as delicate as health care, if a human interpreter can and is expected to intervene in positional misunderstandings at the intersection of health and culture; establish working relationships with health care providers and patients; make ethical decisions that take the institutional and interpersonal contexts into account; compassionately and knowledgeably communicate bad news or complex treatment plans; design and monitor health literacy workshops and programmes; and assist patients in navigating complex health care systems, it is less likely that AI translation will be seen as usefully, reliably and safely taking their place.

A limitation of this study is that the results are shaped by the existence of three different profiles (interpreter, intercultural mediator and community health worker) in Catalonia. Hence, just as the response to and uptake of AI translation varies across health care settings in different countries (de Boe, 2025), perceptions of the role of the interpreter also relate to how intercultural communication strategies are organised in specific contexts. Regardless, the notion that there is such a thing as 'simple' translation or 'just' translation, as opposed to a host of other cultural mediation and health care outreach activities, is clearly not a uniquely Catalan phenomenon. Another shortcoming is the low

number of patients interviewed, as they are the ones who are most affected when care, conversation and relationship-building within the health care system are inadequate. Future research and recommendations on the use of AI translation should closely consider the needs and desires of migrated individuals and groups.

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Ethical Considerations

This research was approved by the Research Ethics Committee at the Universitat Autònoma de Barcelona (CEEAH 6602) on October 20, 2023, and the Jordi Gol Primary Care Research Institute (IDIAPJGol: 24/044P) in Catalonia on July 10, 2024.

Consent to Participate

All participants signed written informed consent statements before participating in the interviews.

Consent for Publication

Some of the participants signed written informed consent for publishing individual details, including their names and identifiable professional profiles. Finally, only their professional profiles have been included.

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Data Availability Statement

The research data are available in a relevant public data repository.

Notes

1. All participants signed written informed consent statements before participating in the interviews. The health managers, IC managers, policymakers, and politicians participated non-anonymously. They signed written informed consent for publishing individual details, including their names and identifiable professional profiles. Finally, only their professional profiles have been included.
2. The IPs on this project are Anna Gil-Bardají and Gema Rubio-Carbonero. The project was approved by the Research Ethics Committee at the Universitat Autònoma de Barcelona (CEEAH 6602) on October 20, 2023, and the Jordi Gol Primary Care Research Institute (IDIAPJGol: 24/044P) in Catalonia.
3. For the sake of coherence, in the analysis, we continue employing 'AI' for AI in general and the umbrella term 'AI translation'. However, the latter term was not used by the informants. Rather, they used a variety of words such as 'el traductor' [translator], 'traducció automàtica' [machine translation], 'eines' [tools], 'màquina' [machine], Google Translate, ChatGPT, etc. We retain these terms where relevant for the analysis.
4. Most informants refer to translators; however, they mean interpreters. It is mainly only the interpreters who are familiar with the translator/interpreter distinction.
5. The child language brokers and patients do not make this distinction, and they may not be aware of it.
6. This is not quite the same as role heterogeneity, according to which, strictly speaking, an interpreter transposes messages and is unable to intervene in their own voice, except when they explicitly adopt other roles (becoming advocate, system navigator, co-diagnostician, etc.).

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