The use of interpreter in healthcare

Perspectives of individuals, healthcare staff and families
THE USE OF INTERPRETER IN HEALTHCARE

PERSPECTIVES OF INDIVIDUALS, HEALTHCARE STAFF AND FAMILIES

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Abstract


This thesis focuses on the use of interpreters in Swedish healthcare. The overall aim was to explore how individuals, healthcare professionals and family members experience and perceive the use of interpreters in healthcare.

The study design was explorative and descriptive. The thesis included Serbo-Croatian (Bosnian/Croatian/Serbian) speaking individuals (n=17), healthcare professionals (n=24), official documents (n=60) and family members (n=10) of individuals using interpreters in healthcare. Individual interviews, written descriptions, review of official documents in the form of incident reports from a single case study and focus group interviews were used to collect data. Data were analyzed using phenomenography, qualitative content analysis and qualitative data analysis of focus group interviews.

The overall finding from all perspectives was the wish to have a qualified interpreter whose role was as a communication aid but also as a practical and informative guide in healthcare. The qualified interpreter was someone highly skilled in medical terminology, Swedish and individuals’ native language with ability to adapt to different dialects, wearing non-provocative and neutral clothes, of the same gender, with a professional attitude and preferably in personal contact through face-to-face interaction. Besides being a communication aid, the interpreter was perceived as having an important role in helping individuals to find the right way to and within the healthcare system because foreign-born individuals were unable to understand information in healthcare. Another aspect was to have a well-developed organization with good cooperation between the parties involved in the interpretation situation, such as patients, interpreter, interpreter agency, family members and healthcare professionals to offer a good interpretation situation.

In conclusion, the use of an interpreter was determined by individual and healthcare situational factors. Individualized holistic healthcare can be achieved by offering and using high-quality interpreters and cooperation within a well-developed interpreter organization.

Keywords: communication, healthcare service, patient-safe quality care, qualitative data collection, qualitative data analysis, users’ perceptions/experiences, utilization of interpreters.
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The thesis is based on the following papers, which are referred to by Roman numerals in the text:


The papers have been reprinted with permission of the respective journals.
INTRODUCTION

In the context of globalization, societies are becoming more multicultural and multi-ethnic in nature, and these trends are expected to continue. There are now about 192 million people living outside their country of birth, which means that roughly one of every thirty persons in the world is a migrant (Irving & Mosca 2010). The growing multicultural population poses a major challenge to healthcare professionals to provide individualized and holistic care based on each individual's needs (Leininger & McFarland 2006, Giger & Davidhizar 2008). Individualized and holistic care addresses the need for respect for individuals' autonomy. To have basic rights and freedom, healthcare interventions should be guided by the value of benefiting others and individuals should be treated fairly, equally and impartially (Swedish Health and Medical Services Act (SFS) 1982:763, World Health Organization (WHO) 2008). Individualized and holistic care focuses on the interaction between healthcare staff and individuals and also includes care for families, groups, communities, cultures and institutions (SFS 1982:763, Leininger & McFarland 2006, Giger & Davidhizar 2008). The main aim in the Swedish healthcare is delivery of high-quality care and good accessibility to care to all individuals and their families (SFS 1982:763).

One important prerequisite for holistic healthcare is the capacity for clear communication between the individuals who are involved in healthcare, for example individuals, healthcare professionals and family members. Effective communication is important in all kinds of healthcare regardless of the context where it is delivered. Communication can be reduced in quality and problems can arise when communicating with individuals from different cultures. Healthcare professionals face a greater challenge when patients do not speak the same language as them and communication is conducted through an interpreter (Leininger & McFarland 2006, Giger & Davidhizar 2008). A sense of powerlessness might arise when individuals, healthcare professionals and family members give too little attention to the use of interpreters and its influence on communication and healthcare (Srivastava 2007).
Previous studies concerning the use of interpreters have been limited to studies focusing on communicating through interpreters in healthcare from migrants’ perspective, particularly those of Asian origin (Rhodes & Nocon 2003, Edwards et al. 2005, Fatahi et al. 2010b) but also Serbo-Croat and Russian refugees (MacFarlane et al. 2009) experiences of arranging and negotiating the use of informal interpreters. Studies concerning healthcare staff’s perspective are scarce and limited to investigating physicians (Rosenberg et al. 2007, Fatahi et al. 2008) and nurse radiographers (Fatahi et al. 2010a). There is also a study of bilingual medical students’ experiences of being used as interpreters (Yang & Gray 2008). The families’ perspective has only focused on their experiences of being used as interpreters since they were bilingual (Free et al. 2003, Green et al. 2005, Rosenberg et al. 2008). Thus, there is a lack of a holistic approach to individuals, different healthcare professions and family members’ experiences/perceptions of the use of interpreters in healthcare. This study focuses on the experiences and perceptions of the use of interpreters from different perspectives: the individual, different healthcare professions and family members. Each of these three perspectives are important because healthcare professionals provide healthcare to the individual, the family and the community and they face the need to use an interpreter in their contacts when they meet language barriers. This is in an attempt to better understand the whole of how situation to adapt holistic care and to build a successful interpretation service. The study also attempts to promote communication in order to prevent the negative effects of language barriers on foreign-born persons’ health. The use of interpreters needs to be seen against the wider background of decision making and to be framed within the options and limitations of individual, healthcare staff and family members. Furthermore, experiences/perceptions of the use of interpreters are important to study in order to improve the quality of communication and thus provide high-quality holistic healthcare.
Background

Migration and Health

There are several factors influencing the increase of migration, including so-called forced and voluntary movement. In the first part of the 20th century economically motivated (voluntary) migration predominated. The number of people forced to move for reasons of conflict and political repression grew during the last century and has continued to increase (Carballo & Mboup 2005).

Since the Second World War many people in Europe have left their homelands. In countries like the USA, Canada and Australia there was a need for labour, which therefore exerted a powerful attraction on individuals in Europe. Economic recovery in Western Europe after the Second World War started in the 1950s, and increased the need for labor (Carballo & Mboup 2005). Large number of workers emigrated from the Mediterranean countries to northern parts of Europe, especially to Sweden. In the 1980s and 1990s refugees seeking asylum became the main group of migrants to Northern and Western Europe, mainly from Iran, Iraq and the former Yugoslavia. In recent years, the composition of immigration changed with an increasing number of individuals and family migrants and with a large proportion of people from outside Europe (Ekberg 2009:3). The migrant population in Sweden today consists of about one third labor immigrants, one third refugee immigrants and one third immigrants coming for family reasons. Migrants in Sweden are a very heterogeneous group, with about 220 different nationalities represented. However, the largest groups of immigrants in Sweden are Finns and persons from the former Yugoslavia (SCB 2009).

Migrational background and the change in lifestyle can affect the health of foreign-born people (Hjelm 1998). The interaction between health and migration is a complex and dynamic one that is influenced by the socio-economic and cultural background of migrants, genetics, their previous health history and the nature and quality of the healthcare situation in their home country (Albin 2006). Knowledge of an individual’s cultural conditions is important for promoting health (Willman 1996). Health is also dependent on the individual perception of health and disease, which is in turn culturally influenced (Kleinman 1980, Helman 2007). Migrating means leaving
something behind and encountering something new (Berry 1990) and can lead to both positive and negative effects on a person’s health. Positive factors can be higher standard of living with better nutrition and dietary habits, or the avoidance of certain types of diseases that exist in the homeland (Hull 1979). Negative factors can be stress due to the migration which can affect health. Migration leads to changes in lifestyle which can also have a negative effect on health, as can the degree of cultural distance, the ability to adapt and the length of time spent in the host country, as well as new health challenges (Hjelm 1998).

In the encounter between the original culture and the culture in the host country the migrant will be forced to adapt and a new culture will be defined (Berry 1990). Acculturation means accepting changes in society, reassessing one’s previous values and acquiring new ones. The person is exposed to changes in a number of different areas – physical, biological, political, economic, cultural and social – and these can lead to changed behaviour. The process of change means that acculturation stress can arise, to which a person must adapt. The adaptability depends on a number of factors such as personality, gender, prior knowledge and experience, migration experience/background, the reason for migrating and cultural distance. Adjustment, reaction and withdrawal are used as adaptation strategies and give the least possible internal conflict (Berry 1997). There are four stages of acculturation: assimilation, integration, separation or marginalization. Assimilation means renouncing one’s cultural identity and moving into the larger society. Integration means maintaining cultural identity and progressing to bond with the dominant society. Separation or segregation means that the group forms its own life, and marginalized groups lose cultural and psychological contact both with their traditional culture and with the larger society by exclusion or leaving. Therefore, assimilation and integration imply accepting the new culture while separation and marginalization involve denying membership in the new society. Acculturation leads to stress and the effects depend on the individual's ability to adapt and to communicate (Berry 1990). Acculturation impacts on the individual level but also on society level e.g. power relations in the recipient community (Eastmond 2011). The results of acculturation stress for the individual's state of health depend on the individual ability to adapt, and problems are often manifested among those with low mental health status and sensitive psychosomatic and psychological symptoms. Acculturation stress can be the basis for identity confusion and problems in daily life with family, work and school (Berry 1990).

The process of migration is neither simply nor uncomplicated (Hull 1979) and the migrant population may have a history of forced migration and traumatic experiences (Södergard & Ekblad 1998). After migration, problems may arise if a foreign-born person carries attitudes and behaviours differing from those of persons the host country (Helman 2007). Individual beliefs about health and disease are culturally determined (Helman 2007) and are
essential for self-care practice and care-seeking behaviour (Hjelm et al. 1999, Hjelm et al. 2003, Hjelm et al. 2005). Foreign-born persons living in Sweden reported poorer health than native-born people. The poorest health was reported among individuals born outside Europe (Socialstyrelsen, National Board of Health and Welfare 2009). Lack of access to healthcare is one of the main barriers that foreign-born persons face (Gerrish 2001). Bedsides lack of access to healthcare, foreign-born persons also had less access to employment (Ahmed et al. 2009). Higher rates of unemployment entail limited economy, smaller social networks and a sense of exclusion from society (Eastmond 2007), which can influence health and lead to poorer health and well-being (Blight Johansson 2009).

**Communication and health**

Misunderstandings due to different cultural behaviour or barriers to communication have been described as difficulties in the exchange of information between healthcare staff and patients (Hultsjö & Hjelm 2005) and increase the risk of misdiagnosis (Hampers et al. 1999), which can lead to inappropriate treatment (Rhodes & Nocon 2003). Barriers in communication lead to healthcare consequences, as it has been shown that foreign-born persons received poorer healthcare because they were part of a migrant community and had language hindrances (Bischoff 2003). Furthermore, the consequence of language barriers can be fewer medical contacts (Bernstein et al. 2002), patient dissatisfaction (Baker et al. 1996), more tests being conducted and people being more often admitted to hospital and receiving more treatments (Hampers & McNulty 2002). Besides, crucial stages in the nursing process could not be performed properly, subsequent treatment was hampered, symptoms suggesting post-traumatic stress may have been under-reported and much fewer referrals to psychological care were given when language comprehension was inadequate (Bischoff et al. 2003). Communication barriers could also result in higher mortality due to lower utilization of hospital care and difficulties in establishing a clear diagnosis (Albin 2006). Effective communication is central to an individual’s ability to function as a member of society (Berry 2006) and fundamental to the delivery of high-quality healthcare. The best way to overcome language barriers is to use an interpreter (Förvaltningslagen 1986:223, Bischoff 2003, Leininger & McFarland 2006, Giger & Davidhizar 2008).
Interpreting in the healthcare setting

What legal right a person has to language access in contacts with healthcare is not always clear internationally and differs in different countries (Adams 2007). Internationally, providing legal rights to patients’ communication support in the United Kingdom (UK) is influenced by the Disability Discrimination Act 2005, the Race Relations (Amendment) Act 2000 and the Human Rights Act 1998, and supporting guidance. This requires organizations in the UK to provide language and communication support to ensure that patients are able to communicate effectively and appropriately with healthcare staff. To address inequities in the United States (US) healthcare includes access to language help for individuals who do not speak English (Office of Minority Health Resource Center 2001). Canada lacks a law to ensure language rights, with the exception of interpretation services for deaf patients (Health Canada 2006).

In Sweden anyone who experiences a communication difficulty in contact with healthcare is entitled to access interpreting and translation services. This includes people from all cultural and ethnic backgrounds who may need to communicate in another language (Förvaltningslagen 1986:223). The law does not state who can be used as an interpreter. However, it is recommended to use authorized interpreters (Kammarkollegiet 2010). An authorized interpreter is a person who has completed the knowledge test that covers the medical terminology prescribed by Kammarkollegiet.

Interpreters have been trained and educated since the late 1960s in Sweden. The government authority Kammarkollegiet (National Judicial Board for Public Lands and Funds) is responsible for the authorization of interpreters since 1976 (Wadensjö 1998).

All interpreters are members of the interpreter service, even non-authorized ones, covered by the professional ethics of the official document “God tolksed” (Good interpreting practice) published by Kammarkollegiet. According to Kammarkollegiet’s guidelines for interpreters, an interpreter should translate all information into the other language, be neutral, ensure confidentiality, interpret in the form of the first person (I-form), only interpret and not carry out other assignments for either party or to express personal views and values. An interpreter shall act as discreetly as possible, be effective and a neutral aid for others’ communication by staying in the background (Kammarkollegiet 2010).

If a patient requires interpreting services it is the responsibility of the local healthcare organization to ensure that it employs an interpreter who has the necessary knowledge and understanding. Responsibility for calling upon an interpreter lies with the institutions, and the interpreter service offices are often run by the municipality or as private enterprises outside healthcare. The interpreter service employs interpreters who are authorized and also those who are not authorized (Kammarkollegiet 2010). The interpreter service office is
asked in advance by healthcare professionals to send an interpreter to the healthcare service at the same time as the patient. The interpreter is usually unknown to both the healthcare professionals and the patients (Kammarkollegiet 2010).

There are also differences between countries in interpretation technique. The method often used internationally involves summarized interpretation including the content and not only transmitting words but also general information about the patients cultural background (Muñoz & Luckman 2005). In Sweden, an interpretation technique of sequential nature, “word by word” and “sentence by sentence”, is used (Kammarkollegiet 2010).

**Previous studies of using interpreters in healthcare**

The benefit of using professional interpreters is that they have a good knowledge of medical terms and systems, which facilitates effective and productive communication (Wiener & Rivera 2004). Using professional interpreters was recommended in a systematic literature review (Flores 2005, Karliner et al. 2007). An underuse of professional interpreters has been found in the US (Baker et al. 1996), Australia (Kazzi & Cooper 2003) and Switzerland (Bischoff et al. 2003) and the use of bilingual healthcare professionals and family members or friends as interpreters is common in healthcare in the UK (Gerrish 2004), the USA (Kuo et al. 2007) and Norway (Kale & Syed 2010). This has been shown to be related to the limited availability of professional interpreters and financial considerations (Gerrish 2004, Kuo et al. 2007). An investigation in the UK found that patients were unaware that healthcare professionals could access interpreting services for their healthcare consultations (Barron et al. 2010).

Asian patients in the UK expected that a good interpreter should speak the same language as the patient, have good language ability, empathize with them and be understanding of and relate to their situations (Edwards et al. 2005). Furthermore, patients preferred to use family members as interpreters (Rhodes & Nocon 2003, Edwards et al. 2005). In contrast, European migrants in Ireland (MacFarlane et al. 2009) thought that the use of family members can be inadequate and problematic. Migrants described the situations as inadequate and problematic because they were often left worried, frustrated with experiences of error and misdiagnosis and unsure about following doctors’ advice for treatment at the end of their consultation (MacFarlane et al. 2009). Interpreters’ competence and patients’ confidence in interpreters were essential for cross-cultural communication for Kurdish patients in Sweden (Fatahi et al. 2010b).

Canadian physicians perceived that professional interpreters were expected to serve as culture brokers and family interpreters to function as caregivers (Rosenberg et al. 2007). Consultation through interpreters raises obstacles to establishing optimal communication, and it required an active role by all participants to achieve an optimal clinical encounter (Fatahi et al. 2008).
Investigating experiences of Swedish nurse radiographers’ communication with people who do not speak the same language showed that the need for an interpreter was strongly associated with the type of examination (Fatahi et al. 2010a). Examinations, including e.g. injections of contrast medium, required a qualified interpreter because inadequate communication increased the risk of misunderstanding. Examinations such as those of wrist or ankle joints needed no specific verbal communication and could be carried out without an interpreter (Fatahi et al. 2010a). A study in the UK (Greenhalgh et al. 2007) focused on identifying and exploring ways to improve communication across a language barrier in primary healthcare, and developing an organizational routine for interpreter services, found that there was a problem related to the fact that the interpreters provided by the interpreter service did not match the requirements of those in need of interpreters.

Bilingual young people in the UK (Free et al. 2003, Green et al. 2005) and medical students in New Zealand (Yang & Gray 2008) who acted as interpreters experienced situations where they were used as interpreters because of limited access to interpreter services. An investigation in Canada of family members’ roles and tasks as interpreters found that family members perceived that acting as an interpreter and interpreting was a part of their responsibilities as family members (Rosenberg et al. 2008). Furthermore, they said that their focus was on the well-being of the person for whom they were interpreting.

In summary, the literature review showed that studies of experiences of communicating through interpreters have been limited to those focusing particularly on people of Asian origin (Rhodes & Nocon 2003, Edwards et al. 2005, Fatahi et al. 2010b) but also Serbo-Croat and Russian migrants (MacFarlane et al. 2009) experiences of arranging and negotiating the use of informal interpreters. Studies concerning healthcare staff's perspectives are scarce and limited to investigating certain groups of healthcare professionals such as physicians (Rosenberg et al. 2007, Fatahi et al. 2008) and nurse radiographers (Fatahi et al. 2010a). There is also a study focusing only on bilingual medical students’ (Yang & Gray 2008) and family members’ (Free et al. 2003, Green et al. 2005, Rosenberg et al. 2008) experiences of being used as interpreters. Thus, no studies have been found focusing on how individuals, healthcare professionals and family members themselves perceive and experiences the use of interpreters in contact with healthcare services. The rationale for studying the use of interpreters from the individual’s perspective is that migrants account for a large part of the Swedish population (approximately 15%) (SCB 2009). Furthermore, migrants originating from former Yugoslavia and speaking Serbo-Croat constitute the second largest group of foreign-born persons living in Sweden (SCB 2009). The angle from several professions in hospital and primary healthcare is essential because different professions face the need to use an interpreter in their contacts with patients. The perspective of family members is important because their
involvement is perceived as a source of mutual support, security and fulfilment for the patient (Leininger & McFarland 2006, Giger & Davidhizar 2008). Furthermore, this investigation is necessary to present a holistic picture of individuals, healthcare staff and family members in order to achieve the main aim of Swedish healthcare law (SFS 1982:763), requirements of WHO (2008) and codes of ethics for healthcare professionals (World Medical Association 2009). The healthcare goal is to provide individualized and holistic care based on each individual’s needs (SFS 1982:763, WHO 2008) including cultural rights, the right to choice, to dignity and to be treated with respect regardless of the patient’s age, colour, creed, culture, disability or illness, gender, nationality, politics, race or social status (World Medical Association 2009). This is to ensure high-quality communication in order to provide safe and high-quality healthcare.

**Theoretical framework**

The encounter in healthcare consists of an interaction between the individual, healthcare staff, and family that integrates the individual experiences, cultural beliefs and cultural norms. A basic requirement is placing the individual and the care of the individual at the centre, but the families must be included too. Communication is the essential core of caring. The result of healthcare is influenced by the possibility to communicate, and thus language is a prerequisite. For patients who do not speak the same language as healthcare staff, a qualified interpreter is an aid in transmitting messages clearly but also risk of change of the intended message (figure 1) (Leininger & McFarland 2006, Giger & Davidhizar 2008).
Transcultural caring means providing care measures that are in harmony with an individual’s or group’s cultural beliefs, practices and values. The primary goal of transcultural caring is culturally congruent care that is possible in the relationship between individual and healthcare staff. In cooperation they design a new or different care for the health or well-being of the individual. The culture can and does influence how individuals are viewed and the care is provided. The care is individual-centred as every individual is culturally unique and should therefore be assessed according to communication that helps healthcare providers in delivering individually appropriate care (figure 2) (Leininger & McFarland 2006, Giger & Davidhizar 2008). The individually culturally congruent care is based on emic (insider knowledge) and etic (outsider knowledge) perspectives (Leininger & McFarland 2006). Good quality of healthcare requires that good communication with cultural competency be extended towards all individuals by all healthcare professionals based on social relationships and life ways. Families are one of the basic social units in healthcare and often responsible for providing the care (Leininger & McFarland 2006, Giger & Davidhizar 2008).
The communication helps the healthcare staff to know aspects of the patient’s way of living, how illness and care are viewed and received. It also supports trust between healthcare staff and the individual. Learning from the individual’s verbal and nonverbal language, with security in order to understand language, healthcare staff can make decisions about what care is needed or would be of the greatest benefit to the individual. Communication is also needed to convey the individual must know (Leininger & McFarland 2006, Giger & Davidhizar 2008).

Communication is an ongoing and dynamic social process which includes spoken language as well as non-verbal aspects, and it occurs on the relationship level and on the content level. The relationship level means how two participants are bound to each other and the content level means words, language and information (Watzlawick et al. 1967, Giger & Davidhizar 2008).

Communication is often described as consisting of a sender, a message, a receiver and a channel of communication (Berry 2006). Thus, communication is complex: it is not only the transmission of information via messages, but a process through which meaning develops (Craig 1999), and it must address individual concerns (Leininger & McFarland 2006, Giger & Davidhizar 2008, Wright et al. 2008). However, verbal communication can take place as intrapersonal communication (individual as sender and receiver), or as
interpersonal communication (between two or more than two persons). Interpersonal communication can be one-to-one communication, group communication and/or mass communication. It can be a one-way process, where a sender is perceived to have all the power, and/or a two way process, where the power relationship is more balanced (Berry 2006).

The healthcare professional's assignment is to provide healthcare to the individual, the family and the community and organize their facilities to also include those in related groups. In a healthcare encounter the interaction between healthcare staff, the individual and the family is the core and often involves persons with different cultural and linguistic backgrounds (Srivastava 2007, Leininger & McFarland 2006, Giger & Davidhizar 2008). This requires the use of both generic (known as emic care, humanistic and based on the individual) and professional knowledge (known as etic care and based on scientific knowledge focused on curing, diagnosis and treatment) and ways to fit such diverse plans into caring actions and goals (Leininger & McFarland 2006).

Linguistic diversity is an important aspect to consider in healthcare, especially when interpreters are used to bridge and close the communication gap between individuals and healthcare staff when language is not shared. In encounters in healthcare when language is not shared, the use of interpreters promotes the relationship between healthcare staff and individuals (Leininger & McFarland 2006, Giger and Davidhizar 2008). There is an interaction between the three parties in the room and the interpreter tends to have a coordinating role with his or her specific role in the middle (Wadensjö 1998) as an aid in transmitting messages between sender and receiver (Leininger & McFarland 2006, Dysart-Gale 2007, Giger and Davidhizar 2008). Communication through a third party compounds the problem of sending messages clearly (Leininger & McFarland 2006, Giger and Davidhizar 2008).

To develop individually congruent healthcare, interpreters are used as language mediators in healthcare encounters. Therefore it is best to examine the variations and similarities of perceptions and experiences that exist between individuals, healthcare professionals and family members of the use of interpreters. Examining the individual's perspective (I) gives the opportunity for emic knowledge. Examining the perspective of healthcare professionals (II, III) and family members (IV) gives the opportunity for etic knowledge. The overall picture in this thesis from both emic and etic perspectives can contribute to increased knowledge and understanding of not being able to communicate in the same language as healthcare professionals, leading to the need to use interpreters and the implications this has for healthcare such as improved healthcare outcomes and lower costs for healthcare through the mechanism of improved communication (Leininger & McFarland 2006, Giger and Davidhizar 2008).
AIM

The overall aim of this thesis was to explore how individuals, healthcare professionals and family members perceive and experience the use of interpreters in healthcare. The specific aims were:

- To describe how individuals from former Yugoslavia perceived the use of interpreters in Swedish healthcare service (I).

- To describe how healthcare professionals experience and perceive the use of interpreters in their contacts with patients with whom they do not share a common language (II).

- To explore what problems are reported by healthcare professionals in primary healthcare concerning the use of interpreters and what the problems lead to (III).

- To explore family members’ experiences of their near ones’ use of interpreters in healthcare (IV).
MATERIAL AND METHOD

Design

In order to explore and describe perceptions and experiences of the use of interpreters from the perspectives of individuals, healthcare staff and families, an explorative and descriptive design was used in four different studies to examine the studied problem area from three different perspectives. The goal was to study individuals, healthcare staff and family members from their own perceptions and in their natural state, and to use techniques that allowed the target studied area to present itself as it would if it were not under study (Sandelowski 2000, Patton 2002, Leininger & McFarland 2006). Different qualitative methods for data collection and analysis were used in order to provide answers to the specific aims of the research (see table 1) and give a complete picture of the studied area.
### Table 1. Background data and research features of Studies I–IV

<table>
<thead>
<tr>
<th>Study</th>
<th>Study design</th>
<th>Study area</th>
<th>Study population</th>
<th>Methods for data collection</th>
<th>Methods of data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Descriptive</td>
<td>Primary healthcare centres and hospital</td>
<td>17 Serbo-Croat (Bosnian/Croatian/Serbian) speaking individuals: aged 29–74 years (Md 55 years) – 10 females – 7 men</td>
<td>Individual semi-structured interviews</td>
<td>Phenomenography</td>
</tr>
<tr>
<td>II</td>
<td>Explorative and descriptive</td>
<td>Primary healthcare centres and hospital</td>
<td>24 healthcare professionals: – 11 physicians, – 9 nurses, – 2 physiotherapists, – 2 assistant nurses, experience of work in healthcare 1–36 years (Md 27 years)</td>
<td>Written descriptions</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td>III</td>
<td>Explorative and descriptive</td>
<td>A unique primary healthcare centre in a migrant-dense area</td>
<td>A single case study of 60 incident reports written by: – physicians, – nurses, – assistant nurses</td>
<td>Review of official documents in terms of incident reports</td>
<td>Qualitative content analysis</td>
</tr>
<tr>
<td>IV</td>
<td>Explorative and descriptive</td>
<td>Primary healthcare centres and hospital</td>
<td>Three focus groups including 10 Serbo-Croat (Bosnian/Croatian/Serbian) speaking family members, aged 29–61 years (Md 46 years)</td>
<td>Focus group interviews</td>
<td>Focus groups analysis</td>
</tr>
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</table>
Individual interviews (I) analysed with a phenomenographic approach (Sjöström & Dahlgren 2002) were used to capture individuals’ perceptions of the use of interpreters. Written descriptions (II) were used to elicit healthcare professionals’ experiences of the use of interpreters and were analysed using qualitative content analysis (Krippendorff 2004). A unique single case study of official documents (III) was used to ascertain what problems are reported by healthcare professionals in primary healthcare concerning the use of interpreters and what the problems lead to. Data were analysed using qualitative content analysis (Patton 2002). Focus group interviews (IV) were applied to capture family members’ experiences of their near ones use of interpreters in healthcare. Data were analysed with a method developed to analyse focus group interviews according to Krueger & Casey (2009).

**Participants**

A purposeful sampling procedure was used to obtain maximum variation in sampling to explore the common and unique expressions of a studied area across a broad range of demographically varying cases and different perspectives of individuals, healthcare staff and families (Marton & Booth 1997, Sandelowski 2000, Patton 2002, Krueger & Casey 2009). The inclusion criteria for individuals (I) were individuals who had Serbo-Croat (Bosnian/Croatian/Serbian) as their native language and had used an interpreter on several occasions during the last six months in healthcare in Sweden. In the case of healthcare staff (II) the requirement was that they had experience of using interpreters several times and represented different healthcare professions. In order to further analyse in more detail what problems were experienced when using an interpreter, a healthcare centre situated in an immigrant-dense area with frequent daily use of interpreters in a real-life case was studied (III). The family members who had Serbo-Croat (Bosnian/Croatian/Serbian) as their native language, and had experienced using an interpreter in healthcare for their near ones several times, were asked if they were willing to be included in the investigation (IV).

Thus, to enable exploration from different perspectives on the use of interpreters, the participants in the study were individuals (I), healthcare professionals (II, III) and family members (IV). The participants had various educational levels, length of residence in Sweden (range 4–17 years, Md 11), age (range 29–75 years, Md 48 years), gender (37 female and 14 males) and experience of work in healthcare (range 1–36 years, Md 27 years). All participants (I, IV) were refugees, born in former Yugoslavia and have valid residence permits.
Procedure

The individuals and family members were contacted by representatives of adult education facilities for migrants (I) and migrants’ associations for former Yugoslavians (I, IV) by the principal investigator. The information (both verbal and written) in Swedish and Serbo-Croat (Bosnian/Croatian/Serbian) about the study and assurance of voluntary participation was given to all participants at the meetings. The principal investigator’s contact details were also included in the written information in case the participants had any questions. Those interested in participating in the study had sent their contact address in a prepaid envelope to the principal investigator, who contacted them to set a time and place for the interview.

To come into contact with healthcare staff (II) the principal investigator contacted by telephone the managers in different institutions in primary healthcare and hospitals in areas where interpreters are often used to obtain approval for the study. Information about the study was given to the managers and they were requested to invite different kinds of healthcare professions to participate. A time was set at ordinary healthcare staff meetings when information (verbal and written) about the study and the respondents’ rights was given. Written information and a guide with instructions were delivered to voluntary participants in a prepaid envelope. The written descriptions were to be returned by mail to the principal investigator. The principal investigator’s contact details were included in case the participants had any questions. The participants were asked to give some background information and it was voluntary to state their name on the sheets.

Using a single case study (III) was a strategy to explore and develop a deeper understanding of the current nature of the phenomenon studied in its “real-life” situation (Yin 2009). The single case (based on a real-life situation) consisted of a healthcare centre in primary healthcare in a particular area (1.16 square kilometres) serving approximately 9000 persons located in an immigrant-dense region where 63% of the population had a foreign background and where the healthcare staff had frequent daily use of interpreters. The principal investigator was invited by the manager of the healthcare centre who expressed frustration about the increasing number of incidents reported concerning the use of interpreters and wanted it to be investigated. Existing incident reports were offered for scrutiny.
Data collection

Different methods for data collection was used to capture the whole picture of the studied area, to discover the who, what and where of studied area, and the techniques consist of minimally to moderately structured open-ended questions (Sandelowski 2000, Patton 2002).

Individual and focus group interviews (I, IV)

Data were collected by semi-structured individual interviews (I) which are the preferred method of data collection in phenomenography (Marton & Booth 1997). An interview is a dialogue between the interviewer and the interviewee centred on the topics of interest for the research, where the interviewer's background and personality affect the results of the interview. Semi-structured interviews have an ability to generate data of depth and complexity. They have predetermined topics and open-ended questions laid down in an interview guide. The interview guide ensures that the same questions or topics are pursued with each person interviewed (Patton 2002, Kvale & Brinkemann 2009).

The semi-structured focus group interviews (IV) were used to explore a range of different views about the research topics from the perspective of the participants themselves on a predefined set of issues (Krueger & Casey 2009). Group interactions are an important attribute and an integral part of the data collection process. The purpose of focus groups is not to reach agreement on the topic discussed, but to encourage a variety of answers which provide a greater understanding of the participants' perceptions of the research issues. Through group discussions a person can be carried away and thoughts and experiences, even unconscious, come up. It is the interaction in the groups that is essential for the results, not the group size. The size of a focus group varies depending on the nature of the subject area (the more sensitive the topic, the smaller the group), the level of group structure (the more structure, the larger the group), the resources available (funding) and moderator expertise (the less experienced the moderator, the smaller the group) (Krueger & Casey 2009). In this study (IV) a small group design (three to four persons) was chosen.

To encourage discussion an interview guide was used (I, IV) (Marton & Booth 1997, Patton 2002, Krueger & Casey 2009) developed from a literature review, peer-reviewed by a researcher experienced in transcultural communication with foreign-born persons (I) and experience of previous studies (I, II, III). Two main questions in the individual interview were: How do you perceive the use of interpreters? Please describe a positive and a negative situation where you have used an interpreter. The two main questions in the focus groups were: How did you perceive the use of interpreters for your family members or friends? Please describe a positive and a negative situation where your family members or friends have used an interpreter. Follow-up questions in both individual and focus group interviews were: What
functioned well? What did not function well, and why? What did you think? What did you feel? What did you do?

The interview guide (I, IV) was translated into Serbo-Croat (Bosnian/Croatian/Serbian) to improve the quality of the information received and to increase reporting within the individual and group (Hennink 2007). As preferred by informants, the interviews were conducted in Serbo-Croat (Bosnian/Croatian/Serbian) by the principal investigator. The principal investigator is a registered nurse educated in Sweden, a native speaking Serbo-Croatian (Bosnian/Croatian/Serbian) and is familiar with both Swedish and Serbo-Croatian (Bosnian/Croatian/Serbian) expressions in daily life, familiar with the research topic and the participants’ culture (I, IV) (Hennink 2007, Squires 2008).

Two pilot individual interviews and a pilot focus group were performed to test the interview guides (I, IV) and the role of the moderator (IV) (Hennink 2007). The individual pilot interviews led to minor corrections of language and ordering of questions and were included in the study. The focus group turned out well, and the data from pilot interviews were found to be of good quality and were therefore included in the analysis.

The individual interviews and focus groups took place in a neutral setting chosen by the participants, where they felt comfortable. The sixteen individual interviews took the place in the participants’ homes and a secluded room at the principal investigator’s workplace. One focus group was held in a secluded room at an immigrants’ association for former Yugoslavians, another group was conducted in a secluded room at the principal investigator’s workplace and the third group met in a secluded room at one of the participants’ workplace. Each interview, whether individual or focus group, lasted about one hour. Flexibility was employed to ensure that participants talked about matters that interested them and concerned them in the use of interpreters (Marton & Booth 1997, Krueger & Casey 2009). Communication in individual interviews was unproblematic and free-flowing. The interaction in the focus group interviews was intensive, particularly while discussing literal interpretation and interpreters’ national background. The individual and focus group interviews were audiotaped, transcribed verbatim and then translated into Swedish by the principal investigator. Transcribed individual interviews generated about 340 double-spaced pages (A4) of text and transcribed focus group interviews generated about 150 double-spaced pages (A4) of text.
Written descriptions (II)

Written descriptions were used as a data collection method (II) to enable healthcare staff to define the use of interpreters in their own terms (van Manen 1990). It gave the opportunity for healthcare staff to write down their perceptions and experiences, which are optimally undisturbed by the authors. Writing forces informants into a reflective attitude, and together with the linguistic demands of the writing process places certain constraints on the free obtaining of descriptions (van Manen 1990). An instruction guide was used, based on a literature review and a previous study (Ozolins & Hjelm 2003) using the same method. Two pilot written descriptions were carried out in order to evaluate the instruction guide, resulting in slight changes with regard to follow-up instructions, but were included in the study. The overall instruction was: Please describe as thoroughly as possible a positive and a negative situation where you used (professional or informal) interpreters in the care of foreign-born patients. The participants were asked to describe the situations in terms of: What happened? What did you/others do? What did you think? What did you feel? How did you react?

The written description had been written by different healthcare professionals including physicians, nurses and assistant nurses, and included in total about 48 double spaced pages (A4) of text.

Single case study (III)

A single case study approach was used to explore problematic situations by reviewing incident reports about the use of interpreters (III). Official documents in the form of incident reports function as a patient safety reporting system. The incident reports are intended to produce a visible, useful response to justify the resources expended and to stimulate reporting adverse events and are clearly of value for learning from others’ experience (WHO 2005, SOSFS 2005:12). A single case approach provided a holistic, humanistic, intense and systematic investigation of a complex phenomenon. The single case was bounded by time and activity, and researchers collected detailed information over a sustained period of time (2 years). It was treating and exploring the studied area in the context in which it takes place (Yin 2009). In this type of research, incident reports were used to elicit thoughts and behaviours as regards the significant features of issues of particular dealings and to gain knowledge of the experiences of healthcare staff in a particular context and at a particular time (Stake 1995, Yin 2009). The incident reports had been written by different healthcare professionals, including physicians, nurses, midwives and assistant nurses, over the years 2006 and 2007, and included 60 incidents describing problematic situations when using interpreters.
Data analysis

Phenomenographic analyses (I)

Data from the individual semi-structured interviews (I) were analysed by the principle of phenomenographic analysis described by Sjöström and Dahlgren (2002). The procedure comprised seven steps. The first step was familiarization with the text by reading through the transcripts to become familiar with the data and correcting any errors in transcription. The second step included compilation to identify the most significant statements in the answers given by all informants, and asking questions of the text based on the study aim. Statements were marked with a highlighter. The next step was to condense longer statements to find the core of each answer or dialogue. The fourth step was to group/classify similar answers together. The fifth step was to compare the selected statements to find dividing lines between variations, established categories which were distinct from each other, and to revise preliminary analysis. The sixth step was to name categories to capture the essence of the understanding. The seventh step was contrasting the categories to find the unique character of each category, resulting in the ways of understanding, and then different perceptions and categories were related to each other – what is called the outcome space.

Categories of description in the outcome space illustrate the different ways in which a certain phenomenon is experienced and the logical relationship between phenomena (Marton & Booth 1997). The descriptive categories together gave an understanding of the perceptions of interpreter use in Swedish healthcare by individuals from former Yugoslavia living in Sweden. The descriptive categories were all related to each other in a horizontal line and no hierarchical relation was found as none of the perceptions could be seen as having more dimensions than the others (Marton & Booth 2000).

Qualitative content analysis (II, III)

Qualitative content analysis derives from data by attempts to identify core consistencies and meanings and to provide knowledge and understanding of the phenomenon under study (Krippendorff 2004, Patton 2002). Categorizations are used as a basis to create meaning in participants’ lives and influence how individuals perceive/experience and relate to other people. Based on the aims of studies II and III, the data were presented in the participants’ own terms and were described and named as closely as possible to the original text (Sandelowski 1993, Patton 2002, Krippendorff 2004). An inductive approach was chosen to analyse data because no previous knowledge about the studied area was found. Inductive analyses start with specific observation of the content and construct toward general patterns. Categories of analysis emerge from data as the inquirer comes to understand patterns that exist in the phenomenon being investigated (Patton 2002, Krippendorff
In this thesis the terms main category and category are used synonymously.

The texts from written descriptions (II) were read thoroughly several times to achieve a sense of the whole. The texts were broken into smaller textual units. The core content of each account was identified and units of similar meaning were grouped together. In the next step they were coded into preliminary subcategories. Comparisons were made during the whole analysis between the subcategories and the text as a whole, and the subcategories with similar meaning were brought together into categories. The aim was to be open to as much variation in the material as possible and to discover regularities, contradictions and patterns that then built subcategories and categories. Collection of data and analysis of data proceeded until no new information was obtained (Krippendorff 2004).

The texts from incident reports (III) were read several times to obtain a sense of the whole (Patton 2002). Then, the descriptions were sorted into two broad content areas addressing a specific topic: (1) problematic interpretation situations; and (2) consequences of the problematic interpretation situations. Thirdly, the text in each content area was divided into meaning units, and thereafter, each meaning unit was coded and grouped together with those similar in content. Finally, the codes were compared concerning differences and similarities and sorted into subcategories and categories. The content area of problematic interpretation situations resulted in two categories: problems related to language and problems related to organization, each with subcategories. The content area of consequences of the problematic interpretation situations resulted in two main categories: consequences: incorrect time and resource use and consequences: limited possibilities to communicate, each with subcategories.

**Focus group analysis (IV)**

Focus group interviews (IV) were analysed in accordance with the method described by Krueger & Casey (2009) and used to identify patterns in the data and to discover relationships between experiences. Analysis of data proceeded simultaneously with data collection and the principle of saturation guided the study. Saturation is a term used to indicate that the analyses proceeded until no new information emerged or provided any additional understanding of the research issues (Krueger & Casey 2009).

The focus groups analysis (IV) started with notes directly after the group interviews of the content of what participants said and the interaction in the group (Krueger & Casey 2009, Morgan 2010). Then, the interview text was read several times in order to give a comprehensive picture of the data. The text was coded and statements with similar meanings were brought together in subcategories according to their differences and similarities. Comparisons were made during the whole analysis between subcategories and the text as a whole. The subcategories with similar meanings were brought together into
categories. The categories were shaped on the basis of differences in the subcategories in such a way that they are distinct from each other (Krueger & Casey 2009).

**Rigor**

Establishing trustworthiness in all qualitative studies is a topic of truth value, applicability, consistency and neutrality in the findings. This includes being able to describe the research process together with the study design, sample of informants, data collection and analysis in a systematic and honest way. The terms used in qualitative research are credibility, transferability, dependability and confirmability (Patton 2002).

Credibility consists of the relationship of empirical data and the categories for describing ways of experiencing a certain phenomenon (Sjöström & Dahlgren 2002). The thesis ensured the credibility by means of quotations, which support the relevance of the categories. The subcategories and main categories constituted the visible and obvious components, and were described and named as closely as possible to the text (Sandelowski 1993, Patton 2002, Krippendorff 2004). Triangulation of the data collection methods, investigator and analytical methods was also used to enhance credibility (Patton 2002). Establishing credibility involved using individual interviews (I), written descriptions (II), incident reports (III) and focus group interviews (IV) to collect data (Patton 2002). The principal investigator’s methods for collecting, transcribing and analysing data and the content of the categories were double-checked to confirm their relevance by three supervisors with different research experience but also all with research experience in the area of migrants’ health. With the intention to describe different perspectives of interpreter use, perceptions were explored from the perspectives of individuals who use interpreters (I), family members of persons who use interpreters (IV) and healthcare staff both in individual written descriptions (II) and from incident reports of situations experienced as problematic interpreters (III). This could also be seen as a form of triangulation of data sources, describing the studied area from different qualitative perspectives. Using multiple qualitative methods for analysing data, such as phenomenography, qualitative content analysis and a method developed to analyse focus group interviews according to Krueger & Casey (2009) to address studied area is a kind of analysis triangulation. The studies (I, II, III, IV) followed the principle of saturation in analysis. Thus, analysis proceeded to the point at which no new information was obtained (Leininger & McFarland 2006, Krueger & Casey 2009), in the focus group interviews this is usually reached after three interviews (Krueger & Casey 2009). This also increased the credibility of the research.

It is important to interview the participants in their first language to maximize the trustworthiness of the qualitative data (Twinn 1997). This was
done in the present study with the principal investigator involved, since the principal investigator is a bilingual registered nurse who has Serbo-Croatian (Bosnian/Croatian/Serbian) language as her mother tongue and is familiar with both Swedish and Serbo-Croatian expressions in everyday life, and also familiar with the participants’ (I, IV) culture and the research topic (Hennink 2007, Squires 2008). Particular attention has been paid to describing the principal investigator’s competence and style of interpreting, and also the setting arranged for the interviews is important for the reader’s ability to determine the trustworthiness of a cross-cultural interview study (Wallin & Ahlström 2006). Furthermore, an important factor considered was the self-awareness of any personal influences and their effect on the interviews. The principal investigator’s background of originating from the same cultural and language heritage and nursing experience helped in the establishment of the interviewer-interviewee relationship. The individual and focus group interviews were audiotaped, and the recorded data were transcribed and translated into Swedish by the principal investigator. To achieve trustworthiness in the translation of data (Wallin & Ahlström 2006), the translation was checked by an independent professional translator for accuracy in the transcriptions (Hennink 2007, Squires 2008) and showed high agreement in translations of data.

Transferability means the level to which results from the data can be transferred to other settings or groups similar in characteristics (Patton 2002). As the participants varied in age, gender, time of residence in Sweden, educational level, professions and workplaces, and yet expressed similar perceptions, the findings can be transferred to other comparable contexts. The broad range of experiences and the within-group variations need to be covered to find out whether the findings are applicable to other settings (Marton & Booth 2000, Patton 2002). However, the most important benefit is deeper understanding of the studied area.

Dependability includes the possibility to use quality technical instruments and also refers to data stability over time and over conditions (Patton 2002). The interviews (I, IV) were conducted by the same interviewer (principal investigator) and they were recorded to facilitate documenting what was said during the interviews. The ambition was to describe the research processes as clearly as possible to minimize errors and biases, and also so that other researcher can clearly follow the decision trail used through the study (Patton 2002, Krippendorff 2004, Yin 2009). Further, different techniques were used to study the problem area from three different angles (individual, healthcare staff and family member) and different time perspectives, which ensured dependability (Patton 2002).

Confirmability means that data are connected to their sources for the reader to judge that conclusions and interpretations arise directly from them (Sandelowski 1993, Patton 2002). According to Krippendorff (2004), a text never implies merely one meaning, just the probable meaning from a certain
The differences and similarities between groups were supported by the empirical data: categories followed in the form of literal citations and naming of categories as closely as possible to the text (Patton 2002).

**Ethical issues**

The thesis followed the Swedish law concerning the regulation of ethics in research involving humans (SFS 2003:460) and has been conducted in accordance with the principles for human clinical research in the guidelines stated in the World Medical Association Declaration of Helsinki (2008). The terms used in guidelines are: written informed consent, right to self-determination, confidentiality and beneficence (World Medical Association Declaration of Helsinki 2008).

Written informed consent was applied and involves informing participants about the overall purpose of the research and the main aspects of the design, as well of any risks and benefits from participation in the study. It also includes obtaining the voluntary participation of the participants and informing them of their right to withdraw from the study at any time without explanation (World Medical Association Declaration of Helsinki 2008). Verbal and written information in Serbo-Croat (Bosnian/Croatian/Serbian) (I, IV) and Swedish (I, II, IV) about the study purpose, approach and their rights were given to all probable participants. The principal investigator’s contact details were included in case the participants had any questions (I, II, IV). Written informed consent also entails that participants in investigation have the right to self-determined participation in the study (World Medical Association Declaration of Helsinki 2008). During the interviews (I and IV) the participants were informed once again verbally and in writing about the study’s purpose, approach and their rights. They also had the opportunity to ask questions before the interview began. Written informed consent was given by all participants (I, IV) and was regarded to be assured when the participants sent in their written descriptions (II). Entering one’s name was voluntarily. All incident reports (III) were already accessible to the public in anonymous form (SOSFS 2005:12). However, the head medical manager, after approval from the lawyer in the county council, gave approval for the study.

Confidentiality in research means ensuring that private data identifying the informants will not be disclosed (World Medical Association Declaration of Helsinki 2008). To preserve the confidentiality of the participants’ data, the audiotapes and transcripts were anonymized and coded by number. Copies of the anonymized incident reports (III) were handed over to the principal investigator. The analysis and presentation of the data were done in a way that concealed the participants’ identity. All data were stored in a locked space to which only the principal investigator had access. Focus group research requires the maintenance of confidentiality, the management of discovery and
maintaining the respect and feelings of self-worth of each participant (Hennink 2007, Krueger & Casey 2009). To preserve the confidentiality of the participants in the focus groups, informants agreed that the discussion held within the group is confidential and should not be shared outside the group. Thus, the principal investigator pointed out that she could not guarantee that others in the focus group would maintain confidentiality.

Beneficence means that the risk of harm to a participant should be as little as possible and the benefits outweigh the risks or harm. This means that the researcher is responsible for being aware of the possible consequences not only for the persons taking part in the study, but also for the larger group they represent (World Medical Association Declaration Declaration of Helsinki 2008). A literature review was conducted before the thesis started to identify and define a problem area that lacked knowledge in order to develop the knowledge that can contribute to developing and strengthening healthcare for individuals who use interpreters. The personal consequences of taking part in the study can bring painful memories and changes in self-understanding. This was not noticed during the study; it has not happened that the participants became sad or upset.

The role of the principal investigator as an individual, the investigator’s integrity, is essential to the quality of the scientific knowledge and the dependability of ethical decisions in qualitative studies. The knowledge and experience of the researcher can influence individual and focus group interviews (Hewitt 2007, Kvale & Brinkemann 2009, Krueger & Casey 2009). In this thesis, the interviews were conducted by a female bilingual registered nurse who informed participants about the studies and collected the data. The researcher had the same linguistic and cultural background as the participants (I, IV). This increased trust in the interviewer and made it easier to develop an environment for discussion through a shared and appropriate language (Douglas 1998, Papadopoulos & Lees 2002, Elam & Fenton 2003, Hennink 2007). An ethnically matched interviewer might raise concerns about confidentiality if the participants are suspicious about whether the interviewer knows people familiar with them (Elam & Fenton 2003). However, the interviewer had no relation to the participants, either professional or private. In relation to healthcare staff (II) the principal investigator had a different cultural background but shared the same professional background as them. The different cultural background provided some legality in asking for explanation, which may enable a greater depth of information to be drawn from the participants (Hewitt 2007, Hennink 2007). The same professional background could increase a tension between professional distance and personal friendship (Hewitt 2007). Thus, it was ensured by using the written descriptions (II) and incident reports (III) to avoid face-to-face meeting between the principal investigator and participants during data collection. However, there was no dependency relationship between the participants and the researcher (I, II, IV).
FINISHINGS

This thesis is based on four studies which explore how individuals, healthcare professionals and family members perceive the use of interpreters within the context of primary healthcare centres and hospitals. The main findings affecting interpreter use were highlighted as the qualities of an interpreter and the working alliance between interpreter, interpreter agency and healthcare.

Qualities of an interpreter

Type of interpreter

Most of the individuals (I) and the healthcare staff (II) preferred to use a professional interpreter. Using a professional interpreter enhanced the possibility that the interpreter would interpret literally and objectively with high-quality language skills. However, some of the family members (IV) stated that the type of interpreter should be adapted to the care situations and the patient’s age and gender.

Family members should be avoided as interpreters because of the risk of incomplete translation, their inability to fully grasp the language (I, II) and negative influence on the family member’s practical and emotional state (I, IV). Concerning the use of bilingual health professionals (I, IV) negative experiences were reported because they were perceived as not interpreting objectively and because interpreting was not part of their work assignment and they did not have a duty of confidentiality.

There were individuals (I), healthcare staff (II) and family members (IV) who preferred personal contact with face-to-face interaction with the interpreter, while others preferred interpretation by telephone. The face-to-face interpreter made it possible to observe body language, which led to improved communication. Conversely, telephone interpretation was perceived to improve the direct communication between staff and individuals with regard to sensitive matters and/or physical examination, as the interpreter
became only a communication aid and participants could then be more anonymous.

Both individuals (I) and family members (IV) found that on unplanned visits access to a face-to-face interpreter was unusual. In those cases the healthcare staff expected accompanying family members to interpret or they wished to use telephone interpreters.

**Language skills**
The interpreter's language skill, knowledge of medical terminology and translation ability were perceived as important by the individuals (I), healthcare staff (II) and families (IV). Further, in order to facilitate the translation it was deemed important that an interpreter talked the same dialect as the individual (I, IV).

The individuals (I) perceived that they often had a professional interpreter who spoke the wrong language/dialect, which resulted in inadequate communication. There were participants (I, IV) who perceived that having the same origin and the same native dialect shared by the patient and interpreter was important. It was not the person’s way of using the language that was relevant for the trust but what the language conveyed about the national background. They questioned the interpreter's objectivity if he/she had a strong national agenda.

Problems were reported related to the interpreter's lack of competence in the Swedish language and the individual's language (III). As a result, communication between healthcare staff and individuals did not work as the interpreter and the patient did not understand each other.

**Personal characteristics**
The same gender and ethnic origin shared by the individual and the interpreter was an important prerequisite for good interpretation (II, IV). Other essential factors were the interpreters' education, language skill, behaviour and attitude. Non-provocative and/or neutral clothes worn by the interpreter inspired respect for the interpreter (I, II, IV). The interpreter's higher age (IV) and language skills (I, II, IV) increased the trust in interpreters. Furthermore, the professional attitude of an interpreter could improve the quality of an interpretation situation. A professional attitude included the interpreter showing respect for the parties involved in the encounter, being polite, introducing themselves, keeping the code of confidentiality and showing empathy (I, II, IV).

The interpreter's attitude was sometimes perceived as unprofessional (I, II) if the interpreter did not talk to the individual but instead turned to the family or staff, or when interpretation by telephone was used and background noise could be heard (II). This disturbed the encounter. Sometimes the individuals (I) perceived that the interpreter displayed a superior attitude and the participants did not trust the interpreter to maintain confidentiality. It could
also happen that the interpreters put in their own opinions and gave their own suggestions for medication and even talked to the patient without translating for healthcare staff (II).

The working alliance between interpreter, interpreter agency and healthcare

The interpreter’s role

The interpreter had an important role as a communication aid (I, II, IV) but also as a practical (I, IV) and informative guide (I). There were participants (I, II, IV) who perceived that it was important that interpreters translate literally and objectively. Other family members (IV) considered that an interpreter should not interpret literally and objectively but adjust the interpretation by conveying bad news in relation to the patient’s age, hearing and educational level.

The practical helper role involved meeting the patients at the entrance to the healthcare institution (I, IV), help with transport to the place where interpretation was to be done and home again, reading letters from the hospital and understand their content and contacting healthcare staff (I). The informative guide (I) meant helping within the healthcare system, as foreign-born individuals were unable to understand information received from healthcare.

Using the interpreter was perceived as a disability and a form of physical handicap, which in turn could decrease the intimacy in the relation between individuals and healthcare staff (I).

Organizational frame

Problems were documented related to the interpretation environment in terms of a lot of background noise when using interpretation by telephone (III). A secluded room with a peaceful atmosphere during consultation was important to ensure a good environment for interpretation (I, II). Technical problems were experienced when using interpretation by telephone, such as background noise (II, III) and impaired hearing because of the poor sound quality of the telephone or a speaker-phone being out of order, which limited the communication (I). Well-functioning technical equipment was crucial for communication in telephonic interpretation (II).

Documentation in the medical record of the patients’ communication status, including the appropriate language and dialect, was important in order to book a relevant interpreter and to be able to plan for the consultation (II, III). Investigating incident reports (III) showed that lack of documentation of patients’ language ability in the medical record was a common problem.
Participants experienced the interpreter’s absence in the appointed consultation. The interpreter did not turn up at the appointed time and/or broke off the consultation prematurely (I, II, III, IV). Other problems were limited accessibility to the interpreter agency and the availability of interpreters of appropriate gender and language (III). Good accessibility to the interpreter agency and continuity in the use of interpreters resulted in perceived feelings of security for all kinds of participants (I, II, III, IV). However, it was also found that healthcare staff did not book interpreters (I, IV), or ask about patients’ wishes for the use of an interpreter, and expected the accompanying family member and/or bilingual healthcare staff to act as an interpreter (IV). The family members felt that their role was to give both practical and emotional support when they acted as interpreters, and this led to tension between positive and negative emotions.

Consequences related to problems in the use of interpreters
The perceived consequences of problems related to the use of interpreters were incorrect use of time and resources by healthcare staff, which also led to delayed treatment of the patients and to limited communication between healthcare staff and individuals (III). The healthcare staff were bound to the telephone when they were trying to contact the interpreter agency in order to book the interpreter, which resulted in an increased workload for healthcare staff, so that the consultation time for the actual patient was delayed or a new time for an appointment had to be set. The time delay disrupted the planned schedule for appointments at the healthcare centre and meant that other patients had to wait (III).

When an interpreter did not turn up, the consultation was conducted without an interpreter in a curt conversation or using family members as interpreters (III). It was difficult to ensure the code of confidentiality and the communication was perceived as limited in the consultation when family members were used as interpreters (II, III).

Establishing the interpreter situation
Healthcare staff must ensure that both the interpreter and individual have correctly understood the information (IV) and to be more flexible when planning and choosing interpreters (I, IV) to facilitate the interpreter situation. Other suggestions included written information in both languages in the letter that patients received at home, better cooperation with other care institutions (IV), better accessibility to interpreters and continuity in the use of an interpreter (I, IV). Further, they suggested developing an agency for non-Swedish-speaking patients where they could turn for help with booking interpreters (I, IV). Training of interpreters, both in language skills in general and in medical terminology (I, IV), and evaluation of the quality of the interpreter agency regarding the service they provide (II) were also perceived as important to improve interpretation.
DISCUSSION

This thesis is unique since the use of interpreters is studied from the point of view of individuals, healthcare professionals as well as family members, to give a complete and all-round picture of the use of interpreters in healthcare. The main finding was the desire to have a qualified interpreter whose role was as a communication aid but also as a practical and informative guide to finding the right way in healthcare. It is important that an organization with good cooperation between the parties involved, such as patients, interpreter, interpreter agency, family members and healthcare professionals, is developed to work to achieve a good interpretation situation.

Methodological discussion

The strength of this thesis was the wide range of perspectives (individual, healthcare staff and family members) on interpreter use, studied by several different qualitative methods of data collection, such as individual and focus group interviews, written descriptions and reviews of official documents in the form of incident reports which were analysed with different qualitative methods: phenomenography, qualitative content analysis and analysis of focus group interviews. Qualitative inquiry allows studying real-world situations as they unfold naturally, as there is no previous knowledge about the studied area, and enables openness to adapt the inquiry as understanding deepens and/or situations change (Patton 2002). Using a single case study contributed to information and knowledge development from clinical experience. It is one of the preferred strategies when the focus is on complex characteristics of real-life events (Yin 2009). An alternative to the selected qualitative data collection methods could have been to choose an observation as a method of data collection. Implementing an observation study was excluded because it can only observe behaviours happening at the time of the study and opinions and perceptions may not always correspond exactly (Patton 2002, Yin 2009). However, the intention of this thesis was to explore both emic and etic perspectives through patients’, healthcare staff’s and families’ eyes, ears and
perceptions/experiences of interpreter use, not to study the behaviours and activities of a particular group based only on an etic perspective. Another option could have been to use a quantitative research approach to measure phenomena empirically, but the overall aim of the thesis was to identify individual perceptions/experiences which are best captured using interviews and written descriptions (Marton & Booth 1997, Sandelowski 2000, Patton 2002, Krueger & Casey 2009).

The principal investigator’s own insider (shared similar background) and outsider (not shared similar perceptions/experiences) perspective of being an immigrant and speaking the same language as the respondents while being a stranger to participants during the individual and focus group interviews helped her to behave spontaneously, just like other members of the group (Ogilvie et al. 2008). The ability to communicate across ethnic boundaries was supported by the openness of individuals and family members while discussing sensitive topics such as the interpreter’s nationality. This was also shown in the mixed focus group interviews of participants with different national backgrounds from former Yugoslavia, where family members felt comfortable in the group discussion about sharing their feelings and attitudes without fear of judgment by the moderator or other participants. Being an immigrant or refugee may be more important to insider status than is identification with a specific ethno-cultural group (Ogilvie et al. 2008). It is important to remember that the study also has involved meetings and discussions across ethnic boundaries in a situation still marked by war and mutual suspicion. The relationship between the interviewer and the participants may influence the outcome in the individual and focus group interviews (Patton 2002, Kvale & Brinkemann 2009). Different hierarchical, cultural and sociodemographic backgrounds between the interviewer (principal investigator) and the participants, and also between participants, may have the result that some family members in focus group discussions feel less confident and more prone to self-censorship and are afraid to express their views. However, there were no indications during the focus group interviews that any participants were reluctant to express their views. The ability to handle focus group interviews where there may be differences in hierarchical and cultural backgrounds between participants depends on the principal investigator’s own personality, particularly when other identities such as gender, social status or internal conflicts are concerns (Ogilvie et al. 2008).

The individuals (I) and family members (II) identified the language in which they felt most comfortable to converse in interviews (Hennink 2007, Krueger & Casey 2009) but all wished to use Serbo-Croatian. This could have influenced the findings in both a positive way and a negative way as the language differed from the supervisors’ language which was Swedish. The positive factor that the bilingual interviewer (I, IV) was familiar with the studied area and originated from the same ethnic group as the participants was exploited in order to use a more appropriate language to explore the concepts,
expressions, ideas and issues discussed. A negative factor was that the interview guide was translated into the participants’ language (Serbo-Croatian) and the recording of the interviews needed to be translated and transcribed into the language of the supervisors (Swedish) for data analysis. In selecting a translator it was previously recommended (Hennink 2007, Squires 2008) to identify a person who is a native speaker of the selected language and who is broadly familiar with the research topic and the local culture. The translation involves more than simply translating the words, but also conveying the meaning of what is being said, and a professional translator may not achieve this objective. The use of translated data (I, IV) must be noted as a limitation due to its potential for distorted meaning (Squires 2008). However, the translation of data was checked by an independent professional translator for accuracy in the transcriptions (Hennink 2007, Squires 2008) and showed high agreement.

The individuals (I) and family members (IV) represented one group of foreign-born people living in Sweden, Ex-Yugoslavians. However, this is the second largest group of migrants in Sweden (SCB 2009). The language in the studied group is very different from Swedish and thus interpreters are often used, e.g. in healthcare. The studies (I, IV) included adults’ (over 18 year) and persons younger than 18 year were not included in the study as they are not recommended to be used as interpreters for family members (Förvaltningslagen 1986:223, Leininger & McFarland 2006, Giger & Davidhizar 2008). The individuals (I) and family members (IV) included persons of different age, gender, educational level and time of residence in Sweden. Thus, the data collected gave a consistent picture and the findings may be transferred to other settings or migrants with similar characteristics (Sjöström & Dahlgren 2002, Patton 2002) but further studies of other migrants group are needed.

Another strength was that healthcare staff (II, III) represented several different professions such as physicians, nurses, midwives, physiotherapists and assistant nurses. As different healthcare professionals use interpreters, choosing one specific group of healthcare staff would have switched the focus to one specific care provider group instead of gathering the common experiences/perceptions of those working in healthcare who use interpreters in their daily work.

The participants were recruited through adult education facilities for immigrants (I) and immigrants’ associations for former Yugoslavians (I, IV). Therefore, it is possible that individuals who did not attend these facilities were not asked to participate. To try to reach these persons at the information meetings, participants were also initially asked if they knew others who met the study criteria who could be recruited to the study. Written information in Swedish and Serbo-Croat (Bosnian/Croatian/Serbian) together with a prepaid envelope in which to send in the agreement to participate was given to participants who identified any individual who met the study criteria. Seven
informants were recruited in this way to achieve the richness in data and thus contributed to strengthening the trustworthiness of the findings.

The recruitment procedure (II) of contacting managers in healthcare to get into contact with informants could be seen as a threat to the independence of the informants (Patton 2002). However, contacting a range of different managers, thereby tapping into different social networks through information meetings about the study held at ordinary staff meetings, including all kinds of healthcare staff minimized the risk of bias.

The healthcare staff’s perspective (II) begins by identifying individual perceptions. Then the principal investigator and supervisors were invited (III) by a manager in a primary healthcare centre to investigate incident reports about adverse events in order to improve their organization. This gave the investigators a unique opportunity to study in more detail what problems there were in using interpreters, based on the experience of staff in a healthcare centre situated in an immigrant-dense area with frequent use of interpreters in the daily work. This contributed to a consistent picture of problematic situations when using interpreters and increased the trustworthiness of the findings.

The intention with using semi-structured interviews and the interview guides (I, IV) was to ensure that all interviews were held in a standardized framework and that the interviews concerned issues that would answer the purpose of the study (Patton 2002, Kvale & Brinkmann 2009). The disadvantage of using the interview guide could be that the interviewer may focus on the interview guide instead of concentrating on the existing conversation and then adherence to the interview will be lost and information will be missed (Patton 2002, Kvale & Brinkmann 2009). To avoid this, the interviewer maintained flexibility in following issues raised by participants that had not been expected. The questions in the interview guide were also adapted in terms of sequence and tempo, depending on what was considered appropriate based on each interview situation. Furthermore, open-ended questions allowed participants to talk freely and to respond to questions in their own words (Patton 2002, Kvale & Brinkmann 2009).

Focus group facilitation is difficult. Therefore, it is recommended that one person should acts as the moderator of the group while a second researcher acts as an observer (Hennink 2007, Krueger & Casey 2009). A final limitation of the study could be that there was no assistant moderator during the focus group interviews for practical and financial reasons. Therefore, a small group design (three to four persons) was chosen to make it possible for the moderator to facilitate the group process and also to take notes on the interactions during the interviews (Krueger & Casey 2009). Small groups also eliminated the risk of frustration resulting from participants not having enough time or opportunity to express themselves in larger groups. Thus, the influence of the absence of an assistant moderator was minimized.
As an alternative to using written descriptions as a data collection method (II), the critical incident technique could have been used. The aim of the critical incident technique is to study behavior or activity in a particular situation and its ultimate goal is to provide solutions to practical problems (Flanagan 1954). However, the aim of the study (II) was to explore and describe perceptions and experiences of the use of interpreters, not to study behavior to provide solutions to practical problems.

The advantage of using written descriptions was that they can give data on an individual level and can be written whenever and wherever they are made (van Manen 1990). However, the limitations of using written descriptions (II) could be concerns about the objectivity of participants’ answers, e.g. if they described how they would react and not their actual behaviour. The data gave no opportunity to ask supplementary questions as is possible during an interview (van Manen 1990). The benefits of using written descriptions were that healthcare staff had the opportunity to choose the appropriate time and place to formulate their stories. Healthcare staffs live in a stressful environment and this data collection method made it possible to obtain access to the participants’ experiences. The foremost strength of this data is that it gave retrospective information about events that had happened in the past, the information represented various healthcare professions although a large number were physicians. The information obtained was informative and rich in content. Reading written descriptions gave an opportunity for a deeper understanding of the different assumptions and views of various staff members.

The study based on the healthcare staff’s archival documentation of incident reports (III) was not originally meant for research, and some important data may have been omitted. However, incident reports were written about adverse events related to interpreter use in healthcare in order to use the results to formulate and disseminate recommendations for system changes (WHO 2005, SOSFS 2005:12). These types of documents were useful in this study, verifying what healthcare staff reported as problematic when using an interpreter with the opportunity to go behind the scenes that might not be mentioned in an interview. Review of official documents gave the author an opportunity to study the details of an event in greater depth, to cover a long span of time (2 years), and many situations with several healthcare professions (Yin 2009).

Pilot studies were conducted (I, II, IV). The advantage of starting with pilot study was to ensure that the proposed methods are workable, acceptable to participants and manageable. Qualitative data collection and analysis is progressive, in that interview procedures can be improved as the interviewer may have gained insights from previous interviews (Patton 2002). Therefore, pilot data was used as a part of the study.
Focus group analysis, as described by Krueger and Casey (2009), was used to analyse focus group interviews as this method considers the role of interaction in the group when analyzing data (Morgan 2010).

The main intention of the study was to explore the rich content concerning the use of interpreters from different perspectives of individuals, healthcare staff active in the clinical area of healthcare and family members. The findings from these four studies can contribute to improved knowledge of the context in which the clinical practice occurs (Stake 1995, Patton 2002, Krippendorff 2004, Yin 2009). The findings are contextual, and the results from data collected by different methods may be transferred to other contexts with similar characteristics, as several individuals, professional groups and family members gave similar perceptions and described a homogeneous picture of their experiences (Marton & Booth 2000, Patton 2002). Further, the aim of the study was to give a deeper understanding of the studied phenomenon instead of explanation (Stake 1995, Patton 2002).

Discussion of findings

The main finding of this thesis was the desire to have a qualified interpreter whose role was as a communication aid but also as a practical and informative guide in healthcare.

In talking about who is the best qualified interpreter, individuals (I) and healthcare professions (II) preferred a face-to-face professional interpreter who interprets literally and objectively. In contrast, from family members’ point of view there was no homogenous picture; they stated that it depends on the situation and the person. Other studies (Rhodes and Nocon 2003, Edwards et al. 2005, MacFarlane et al. 2009) have found that there were differences between different patient groups in different countries, preferring different kinds of interpreter. European migrants in Ireland (MacFarlane et al. 2009) preferred professional interpreters while mainly Asian-born respondents in the UK preferred family members as interpreters (Rhodes and Nocon 2003, Edwards et al. 2005). The difference between studies can be explained in the dissimilarity of legal right to language access in different countries, interpretation technique, culturally related health behaviour, educational statuses and/or migration statuses.

In Sweden there is a legal right (Förvaltningslagen 1986:223) to access interpreting and translation services in all contacts with authorities, as e.g. in healthcare, but the legal right to have access to interpreters differs internationally. Many patients in the US (Grubbs et al. 2006) and UK (Barron et al. 2010) lacked knowledge of their right to have access to professional interpreters at no cost. Patients who speak little or none of the language spoken by healthcare staff probably do not know their legal rights and are thus unlikely to file complaints, as without communication skills they are unable to
obtain the knowledge they need to access services (Ward et al. 2008). Therefore, individuals should be offered an authorized interpreter and be informed that interpreters are free and trained to ensure confidentiality.

According to the interpreters’ guidelines in Sweden (Kammmarkollegiet 2010), interpretation should be done word by word and interpreters should not express their own views and values. In contrast, interpreters in other countries use thematic interpretation, not only interpreting words but also general information about the individuals’ cultural backgrounds (Muñoz & Luckman 2005). Thus, there were family members (IV) whose desires were contrary to the wishes of individuals (I), healthcare staff (II) and guidelines for authorized interpreters in Sweden (Kammmarkollegiet 2010), as they did not want interpretation to be done literally in all healthcare encounters. The difference between some of the family members, individuals and healthcare staff may be due to the different roles they have in the healthcare encounter, where healthcare for elderly persons is mostly delivered by families (Socialstyrelsen 2006). However, the difference needs to be further studied in other migrant groups.

The thesis shows that there was disagreement between individuals’ (I), healthcare staff’s (II) and family members’ (IV) perspectives in the choice of qualified interpreters. The findings of this thesis indicate that the choice of interpreter should be made in agreement between individual, healthcare staff and family members based on situations and health conditions and thus individualized (SFS 1982:763). It is the healthcare staff’s challenge to be able to identify when different types of interpreter are adequate so that the individuals who use interpreters are able to communicate adequately. However, the instruments by which healthcare staff can investigate individuals’ wishes may be through the use of an independent interpreter. This is an opportunity to prevent the effects of poor communication due to language barriers, with the result that individuals find the care satisfactory and meaningful in order to achieve health (Leininger & McFarland 2006, Giger & Davidhizar 2008).

This study showed that a face-to-face interpreter enabled the user to observe non-verbal language, behaviour and personal characteristics, which led to better perceived communication. The interpreter cannot be a passive element in a conversation; his/her very presence affects the circumstances of the conversation (Wadensjö 1998). This means more than oral and written communication; nonverbal signals play a very important role in conveying messages (Watzlawick et al. 1967, Leininger & McFarland 2006, Giger and Davidhizar 2008). This highlights the need to improve the interpreter situation considering not only the interpreters’ language skills and cultural background but also their personal characteristics. According to Leininger and McFarland (2006) and Giger and Davidhizar (2008), little attention has been paid to other factors such as age, sex and educational level. The findings of this thesis showed that healthcare providers must take account of interpreters’
individual background differences as part of individual care planning. The interpreter should preferably be a person with the same gender (at least in sensitive encounters). Beside all parts preferred an interpreter with non-provocative and neutral clothes, have a professional attitude and a good knowledge of medical terminology, Swedish and the individuals’ native language. Shared cultural background and mother language between individuals and healthcare staff creates a common ground for communication and an understanding which enables a relationship between healthcare staff and the individual, leading to increased well-being (Leininger & McFarland 2006, Heikkilä et al. 2007). Language can both reflect and form how the world is interpreted by the individuals of particular linguistic societies, which may not be shared across cultures. Even among those speaking the same language but coming from different countries or groups there might be differences related to cultural aspects (e.g. UK, USA) (Mudakiri 2003). This study group of ex-Yugoslavian (I, IV) consisted of participants with different cultural backgrounds. The language was one of the criteria of cultural identity in the former Yugoslavia (Nyström 1993, Resic 2006). Besides the alphabet, Serbo-Croat languages differ in vocabulary, grammar and intonation. The Serbo-Croatian language was a common means of communication among cultural groups but was also a known problem with a strong tension between groups, where language struggle led to a barrier between them (Nyström 1993, Resic 2006). For some of the participants (I, IV) the interpreter’s native dialect was related to the person’s national background, and they were doubtful whether they could trust the interpreter’s objectivity if a person had a strong national agenda. Therefore, it is important that the person acting as an interpreter is highly skilled in language with an ability to adapt to different dialects and has an objective and professional attitude to provide a basis for good communication and understanding, which in turn, promotes the individual’s health and well-being. The healthcare staff should explore individual wishes in planning the use of interpreters.

Statements by individuals (I) and some family members (IV) concerning the interpreters’ role showed a wish for a role of the interpreter as a practical and informative guide in the healthcare system; this new finding not previously described and not found in studies of healthcare staffs (II) experiences. The individuals’ (I) and some of the family members’ (IV) wish for the interpreter’s role was as an active participant in healthcare. The function of being a practical and informative guide in the healthcare system is not addressed by the interpreters’ code of ethics (Kaufert & Putsch 1997) nor by the guidelines for interpreters in Sweden (Kammarkollegiet 2010). According to the rules the appropriate interpreter role is conceptualized as a non-thinking, non-feeling and highly skilled translation machine providing accurate and neutral communication to others (Kaufert & Putsch 1997, Kammarkollegiet 2010), and the complexity of the information is conveyed through an interpreter who acts as a channel transmitting the information.
from source language to target language, with the interpreter conceived as a neutral communication aid between sender and receiver. This kind of role can be considered unrealistic, oversimplifying the interpreter’s role (Dysart-Gale 2007). The interpreters were found to adopt purposeful strategies to manage context, problems and conflicts that emerge during the staff–patient interaction (Hsieh 2006, Rosenberg et al. 2008). This result has shown that individuals (I), healthcare staff (II) and some family members (IV) have different perceptions of the interpreter’s role and healthcare staff expected interpreters to be only neutral communication aids by transferring information from one language to another (Fatahi et al. 2008). Thus, the disparity between individuals’ and family members’ perspective on the one hand and the experiences of the healthcare staff on the other may be due to the different roles they have during the encounter; this needs to be further studied. In the revision of the interpreter’s guidelines, the individuals’ perspective should be taken into account when changes are made, considering the interpreter not only as a communication aid but also as a practical and informative guide. This finding is important in order to achieve the main goal of the Swedish Health and Medical Services Act (SFS 1982:763), which is a holistic approach and not only a focus on sporadic sequences. Holistic individualized healthcare ensures that patients feel that they get help and support to handle the whole situation, not only the interaction between individual and healthcare staff during the encounter.

The individuals (I) described an interpreter as a sort of disablement and felt that the atmosphere in the encounter was negatively influenced by the healthcare staff’s attitude expressing discomfort about the situation. This finding has not been described in the study of healthcare staff (II, III) and family members (IV). A previous study (Baker et al. 1998) has shown that patients who spoke through an interpreter rated their healthcare staff as less friendly, less respectful, less concerned for them as a person and less likely to make patients comfortable. This highlights that the use of interpreters not only exacerbates the problem of sending messages clearly (Giger and Davidhizar 2008) but may also influence interaction between individuals and healthcare staff. Still, it is better to have an interpreter than to have no interpreter at all in the healthcare encounter.

It has been found that healthcare staff (II, III) described how documentation of the patients’ language ability and interpretation preferences in medical records was limited. According to the Swedish patient data law (Patientdatalag 2008:355) it is the duty of authorized healthcare staff to document patient data, which reflect needs, diagnoses, planned and executed interventions as well as outcomes. However, in a previous investigation (Gebru et al. 2007) it has been found that only half of records had some documentation about communication and language, and some of these medical records identified individuals’ difficulties in speaking and understanding. It would be beneficial for the encounter if the patient records
contained more data about language ability and interpretation preferences in order to fulfil the existing law: ensuring equal access to health information, which is crucial for treatment, patient safety and high-quality care.

A large majority of incident reports (III) registered dissatisfaction with the accessibility of the interpreter agency and the availability of interpreters of appropriate gender and language. Healthcare staff reported to the management when access to interpreters compromised patient care and safety. The language barriers increased the risks to patient safety (Divi et al. 2007). The primary purpose of patient safety reporting systems, e.g. incident reports, is to learn from error experiences and to reduce caring errors (WHO 2005, SOSFS 2005:12). According to the Swedish Health and Medical Services Act (SFS 1982:763), healthcare has a responsibility to provide good-quality care with a commitment to support and encourage general patients’ rights such as autonomy and privacy. Reviewing the incident reports has indicated that it was difficult to fulfill the aim of delivering quality care (SFS 1982:763) since this was dependent on the ability of the interpreter agency to provide the appropriate interpreter. Without the appropriate interpreter the communication was limited and individuals’ right such as autonomy, privacy and right to confidentiality could not be met when the conversation was carried out with family members as interpreters. This was also supported by some of the family members (IV), whose desires were contrary to the Swedish Health and Medical Services Act (SFS 1982:763), wishing interpreters to interpret selectively to suit their own purposes. The challenge of healthcare is to provide quality care in encounters where there is a difference between what is stated in healthcare laws which have patient autonomy in focus and the family members’ preferences.

The incident reports (III) have shown also that arranging for an interpreter can be impractical and time-consuming for healthcare staff. At a time when the healthcare sector is facing a financial crisis, it is in the interest of the management department to see that the cost of interpretation services is reduced by sharing resources appropriately. In order to address this problem, there must be first the organizational will to provide high-quality interpreter services (Karliner and Mutha 2010). This could be done through better access to the interpreter service, working effectively and productively in cooperation with healthcare staff to enhance the delivery of healthcare to individuals with limited language proficiency. Healthcare staff in this study were aware of the risks and had the ability to see mistakes, and by writing these incident reports they tried to advocate for improved interpreter service to ensure individuals safety and high-quality, individual-centred healthcare. An effective interpreter service prevents the increase of long-term costs e.g. managing chronic diseases such as diabetes or cardiovascular disease (Jacobs et al. 2004, Bischoff & Denhaerynck 2010). Healthcare is responsible for ensuring safe and effective communication with individuals, and therefore improved quality and availability is needed in the interpreter service.
This thesis found that changes in the form of increased collaboration between individuals, healthcare staff, interpreters and family members are required to facilitate appropriate healthcare for persons of foreign background and not sharing the language of the majority population. However, it has been shown that healthcare staff (IV) expected the accompanying family member and/or bilingual healthcare staff to act as an interpreter and not make individual requests. Healthcare professionals should be better on involving individuals and their family members in the decision process about interpreter use as far as it is possible. However, this is in their area of responsibility for informing and getting individuals and their families involved in care (SFS 1982:763) in order to ensure the provision of high-quality interpretation service to maintain health and put the individual in a central position (Leininger & McFarland 2006, Giger & Davidhizar 2008).

The wishes of individuals (I), healthcare staff (II) and family members (IV) to improve the use of interpreters call for changes that are not difficult to implement through the opportunities created by newer, faster and cheaper communication technologies. This is in order to adjust the unpredictable and urgent requirement for interpretation in healthcare context within an increasingly heterogeneous population. Adaptation of the use of interpreters in healthcare encounters to the possibilities of the context, the characteristics of the patient (culture, age and disability) and the nature of the communication is required in order to achieve individual, culturally congruent healthcare contributing to a strong sense of health (Leininger & McFarland 2006, Giger & Davidhizar 2008).

Conclusion
The findings highlighted high agreement between individuals’, healthcare professionals’ and family members’ perspective of using interpreters; it depended on the healthcare situation and the individual and thus, use of interpreters needs to be individualized. Perceptions differed as to whether the interpreter should interpret literally or not, the type and mode of interpretation and the interpreter’s professional role.

Effective communication by the interpreters depends on much more than the spoken language. The interpreter’s role means more than being a communication aid, also being a practical and informative guide to find the right way in healthcare. Interpreters’ language skills, professional attitude, cultural background and personal characteristics such as clothes, gender and age, preferably in personal contact through face-to-face interaction must also be considered in encounters.

Making interpreter services available to healthcare professionals is not enough: effective cooperation is needed between interpreter agencies and healthcare institutions in order to have a well-functioning interpreter organization to guarantee safe, individual-centred quality healthcare.
Implications

As part of individual care planning it is important to plan for the use of interpreters in accordance with individuals' desires and the need to organize a good interpretation situation on a case-by-case basis and choose the appropriate interpreter based on the individual and the healthcare situation.

The person who is acting as an interpreter should be highly skilled in the medical terminology, in Swedish and in the individual's native language, with an ability to adapt to different dialects, should wear non-provocative or neutral clothes, be of the same gender (at least in sensitive encounters) and have a professional attitude in order to provide good communication and ensure high-quality healthcare.

In the revision of the interpreters' guidelines, the individuals' perspective should be taken into account when changes are made considering the interpreter not only as a communication aid but also a practical and informative guide to find the way in healthcare. The interpreters also need to be trained in developing a professional attitude considering language ability and personal characteristics to improve interpretation and to find ways to guide individuals in the healthcare system.

Healthcare professionals need to be aware of the importance of documenting the individual's language ability and communication preferences for an interpreter in medical records in order to ensure safe, individual-centred, high-quality healthcare.

Healthcare staff need to involve individuals and their families in the decision process about interpreter use and not only rely on one type (professional, bilingual healthcare professionals, family members) and/or mode (face-to-face, telephone) of interpreter. Their challenge is to be able to identify when different types of interpreters are needed. Healthcare staff also needs to develop the use of communication technologies (e.g. web communication with the ability to see the interpreter, making it possible to observe the interpreter's body language) in order to avoid the effects of language barriers, leading to individualized use of interpreters by placing the individual's wishes at the centre.

Providing an appropriate interpreter requires having effective cooperation between interpreter agencies and healthcare institutions in order to fulfil the existing policy of using interpreters to guarantee timely and high-quality care. The interpreter agencies must be able to offer good accessibility with professional interpreters trained in the importance of translating accurately, turning up at the set time and offering appropriate technical equipment. Thus, the interpreter agency must be structured in consideration of the unpredictable and urgent requirements for interpretation within the health service context.

The main aim of the incident reports is to learn from error experience, and reviewing them provides an opportunity to learn from these mistakes and to use them as an aid in healthcare practice, to improve the use of interpreters.
lead to individual safe healthcare. Thus, incident reports should be used in a
systematic way to increase awareness of existing problems, and further they
can be used as a basis for continuous work with improving healthcare practice.

This thesis findings from three different perspectives (the individuals, the
healthcare staff and the families) with using different methods for qualitative
data collection methods (individual and focus group interviews, written
descriptions and review of official documents) and different qualitative data
analysis (phenomenographic, qualitative content analysis and focus groups
analysis) gave a similar picture of participants’ perceptions/experiences and
confirms that the use of interpreters will remain a complex challenge,
deserving empirical and critical reflection and requiring further future
research, with our increasingly heterogeneous population.

Cost-effective, high-quality healthcare can only be developed if limited and
poor communication is prevented, thereby decreasing the risk of
misunderstandings and delayed healthcare. This can best be achieved by
offering and using high-quality interpreters in order to develop individualized
culturally congruent healthcare offered in well-developed organizations.
SWEDISH SUMMARY

Till följd av en omfattande global migration har antalet utlandsfödda personer som inte kan majoritetsbefolkningens språk ökat såväl i Sverige som i andra länder i världen. Därmed har också antalet vårdtagare som har en annan kulturell bakgrund och ett annat språk än vårdgivarna ökat, och som resultat av detta har också behovet av tolkhjälp i hälso- och sjukvården ökat.


Syfte

Det övergripande syftet med avhandlingen är att studera hur vårdgivare samt vårdtagare och deras familjemedlemmar erfar och uppfattar användningen av tolkar inom hälso- och sjukvården. Avhandlingens fyra delstudier har därför följande syften:

- Att beskriva hur vårdtagare från det forna Jugoslavien uppfattar användningen av tolkar inom den svenska hälso- och sjukvården (I).

- Att beskriva hur vårdpersonal erfar och uppfattar användningen av tolk i kontakt med patienter som talar ett annat språk än vad de själva använder (II).
• Att utforska vilka problem vårdpersonal inom primärvården rapporterar om i samband med tolkanvändning och vad problemen leder till (III).

• Att utforska hur familjemedlemmar till vårdtagare med ett annat språk erfar tolkanvändningen inom hälso- och sjukvården (IV).

**Metod och Material**

Avhandlingen är undersöksande och beskrivande och består av fyra delstudier. Olika kvalitativa metoder har använts för att samla i materialet: individuella intervjuer, skrivna berättelser, officiella dokument i form av avvikelserapporter och fokusgruppsintervjuer. Förutom de olika datainsamlingsmetoderna i de fyra delstudierna har tre olika kvalitativa metoder använts för att analysera insamlad data: den fenomenografiska analysmetoden, den kvalitativa innehållsanalysen och en särskild analys utvecklad för fokusgruppsintervjuer.

De individuella intervjuerna genomfördes med 17 serbokroatisktalande vårdtagare för att fänga upp hur de uppfattar tolkanvändningen (I). De flesta intervjuerna genomfördes i vårdtagarnas hem efter deras önskemål. Materialet analyserades enligt en fenomenografisk metod för att finna variationen i vårdtagarnas sätt att uppfatta tolkanvändning.

De skrivna berättelserna fångade upp erfarenheter av tolkanvändning från 24 vårdgivare (II). Avsikten med berättelserna var att stimulera vårdgivarna till att reflektera över sitt förhållningssätt och formulera sina erfarenheter av tolkverksamheten med egna ord och utan påverkan av forskaren. Berättelserna analyserades med en kvalitativ innehållsanalys för att ge kunskap och förståelse av tolkanvändningen ur vårdgivarnas perspektiv samt möjliggöra en bred beskrivning.

De officiella dokumenten består av 60 avvikelserapporter som studerades för att identifiera vilka problem som vårdgivare på en vårdcentral rapporterar om när tolkanvändning inte stämmer med den gängse rutinen eller med det förväntade vårdförloppet och vad dessa problem leder till (III). Samtliga avvikelserapporter är hämtade på en bestämd vårdcentral och speglar på så sätt tolkanvändningen utifrån ett arbetsplatsperspektiv. Även dessa rapporter analyserades med kvalitativ innehållsanalys.

Slutligen genomfördes 3 fokusgruppsintervjuer för att fänga upp vilka erfarenheter av tolkanvändning inom hälso- och sjukvården som familjemedlemmar till vårdtagare har (IV). Fokusgruppsintervjuerna användes för att utforska en rad olika erfarenheter och uppfattningar om tolkanvändningen. Processen med datainsamlingen stimulerade till ökat erfarenhetsbyte och fördjupade kunskaper. I fokusgrupperna deltog totalt 10 familjemedlemmar till vårdtagare med annat språk. Fokusgruppsintervjuerna
analyserades med en specifik metod utvecklad just för fokusgruppsintervjuer som beaktar grupp dynamiken när mönster i data identifieras.

**Resultat**

En kvalificerad tolk ansågs vara det viktigaste för att tolkningen skulle fungera bra. Tolken skulle underlätta i kommunikationen samt ge praktisk hjälp att hitta rätt i vården och hitta rätt information.

Vårdtagare och vårdgivare betonade vikten att tolkningen genomfördes öga-mot-öga av en professionell tolk med goda kunskaper i både svenska språket och vårdtagarnas språk. Tolken skulle kunna den medicinska terminologin samt tolka ordagrant och objektivt. Familjemedlemmarna menade dock att tolkningen inte alltid skulle vara objektiv och ordagrant utan anpassas till vård mötet och den person som var i behov av tolkhjälp. Deltagarna i delstudierna upp fattade att vård mötet blev bra när de hade förtryende för tolken, och förtryendet fick tolken genom sin kompetens i de båda språken och den diskurs som används inom vården, samt ett professionellt beteende som bland annat innebär neutral klädseln. Ett önskemål var också att tolken skulle vara av samma kön och ha samma kulturella bakgrund när den som behöver tolkhjälp är i en utsatt situation. Några vårdtagare beskrev att användningen av tolk också kunde uppfattas som ett handikapp eller hinder.

Granskningen av avvikelserapporterna visade att problemen som rapporterades huvudsakligen var relaterade antigen till tolkens språk eller till organisatoriska rutiner. Avvikelserapporterna beskrev problem som berodde på bristande tillgänglighet på tolkar i ett visst språk, vilket ledde till att tolkar som inte talar vårdtagarnas språk engagerades. De organisatoriska avvikelserna var således relaterade till bristande tillgång till tolk med rätt språk men även till tolk av samma kön som vårdtagaren. Brist på tillgång till tolk förmedling var också ett problem som rapporterades liksom att överenskommen tolkning avbröts i för tid, att tolk uteblev från överenskommen tid för tolkning, att tolkningen genomfördes via telefon med störningsljud i bakgrunden och att de medicinska journalerna saknade uppgifter om patientens språkförmåga. Sammantaget ledde dessa problem till felaktig tids- och resursanvändning genom merarbete för vårdpersonalen, fördröjd behandling av vårdtagare och begränsad kommunikation eftersom vården skedde helt utan tolk eller enbart med stöd av familjemedlemmar.

Familjemedlemmarna påtalade att vårdgivarna inte frågade efter vårdtagarnas och de medföljande familjemedlemmarnas önskemål om att använda tolk utan förväntade sig att medföljande person själv skulle agera som tolk. När medföljande familjemedlemmar agerade som tolkar uppfattade de sin roll som praktiskt och känslomässigt stöd till sina anhöriga, vilket innebar såväl positiva som negativa upplevelser.
För att förbättra tolkanvändningen menade familjemedlemmarna att vårdgivarna ska försäkras sig om att både tolken och vårdtagaren har förstått informationen rätt. Vårdtagarna och deras familjemedlemmar önskade att vårdgivarna ska vara mer flexibla när de planerar och bokar tolkhjälp. För att öka kvaliteten i de tjänster som tolkbyråerna erbjuder ansåg vårdgivarna att tjänsterna ska utvärderas kontinuerligt så att kvaliteten svarar mot kraven på en säker och god vård för dessa vårdtagare.

Slutsats

Avhandlingen visar att det finns en god överensstämmelse i uppfattningen mellan vårdtagare, vårdgivare och familjemedlemmar om hur en tolk ska arbeta och fungera. Tolken ska inte endast göra en språklig översättning utan också guida så att vårdtagarna hittar rätt i vården och finner relevant information. I ett vård möte där en tolk används skall tolkens språkkunskaper och professionella förhållningssätt samt typ av tolk (anställd tolk, tvåspråkig personal eller familjemedlem), kommunikations medel (öga-mot-öga eller tolkning via telefon), klädsel och miljön beaktas men framförallt ska en tolk vara anpassad till vårdtagaren och vårdsituationens behov.

För att underlätta kommunikationen och garantera högkvalitativ individualiserad vård, baserad på en förtroendefull relation mellan vårdgivare, vårdtagare med sina familjemedlemmar och tolkar bör samarbetet mellan dem och tolkbyråerna förbättras i syfte att utveckla en väl fungerande och kostnadseffektiv organisation för tolkanvändning. Som en del av detta kan ingå revidering av vägledningen för auktoriserade tolkar. I den bör vårdtagarnas och familjemedlemmars önskemål beaktas utifrån att tolkens roll både innebär att vara ett kommunikationshjälpmedel och en guide för praktiska frågor och informationshjälp i att hitta rätt i vården.

Inom kontexten för hälso- och sjukvården bidrar avhandlingen till en ökad kunskap om tolkanvändning genom att anlägga vårdtagarnas, vårdgivarnas och familjemedlemmarnas perspektiv på kommunikation inom den vård där vårdtagaren inte kan kommunicera på det egna språket utan behöver använda sig av tolk. Det krävs ett effektivt, produktivt och flexibelt arbete av hälso- och sjukvården och tolkorganisation för att kunna boka och planera en lämplig tolk anpassad till vårdtagaren och behoven i vårdsituationen.
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