Cross-cultural encounters through interpreter

- experiences of patients, interpreters and healthcare professionals

Nabi Fatahi

Institute of Clinical Sciences
at Sahlgrenska Academy
University of Gothenburg
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To my Mother,

My first communication partner

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ABSTRACT

Cross-cultural encounters through interpreter - experiences of patients, interpreters and healthcare professionals

Nabi Fatahi
Department of Radiology, Institute of Clinical Sciences, Sahlgrenska Academy, University of Gothenburg, Sweden.

Background: A mutual understanding between patients and providers has a significant impact on the outcome of healthcare consultations. If the patient and the professional do not share the same mother tongue an interpreter is usually necessary and the contact is facilitated. In order to reach satisfactory communication the competence and neutrality of the interpreter are crucial.
Aims: The overall aim of this project was to study difficulties and possibilities in communication between non-Swedish-speaking patients and Swedish authorities (healthcare providers and social welfare service personnel). Views of refugees (Study I), interpreters (Study II), general practitioners (GPs) (Study III) and nurse radiographers (Study IV) were especially in focus.
Material and method: Individual interviews (I) and focus group interviews (II, III, IV) were carried out with refugees, interpreters, general practitioner and nurse radiographers. A qualitative content analysis method was used in Studies I, III and IV and a phenomenographic method was used in Study II.
Results: ***Study I*** Kurdish war-wounded refugees stressed the value of the interpreters' competence and the patients' confidence in the interpreter. Often the interpreters were selected based on the refugees' citizenship rather than on the mother tongue, leading to a more complex, tri-lingual interpretation situation.
Study II Interpreters experienced a number of difficulties, mainly related to complexity in balancing the triad relation (patient-interpreter-provider). The time aspect of the translation procedure and problems of diverse health beliefs and cultural inequalities were also stated.
Study III GPs stressed the necessity of involving all the persons in the triad situation to enhance the interchange and facilitate the contact. The interpreter has a key role to balance support between the GP and the patient. Adequate length of time was stressed and consciousness as to how to organize facilities was highlighted.
Study IV The need for an interpreter in the radiological examination was strongly associated with the type of examination. For interventional procedures and contrast-enhanced examinations a professional interpreter was needed. Shortage of time and lack of specific knowledge about radiological procedures and cultural aspects were other identified factors that obstructed the communication process. Interpreters' knowledge of terminology and staff training in cultural diversities were suggested in order to improve the quality of radiological examinations.

Conclusions: Interpreters' competence and patient confidence in the interpreter are essential for an adequate cross-cultural health communication. Assignment of interpreters should be based on knowledge of the patient's /client's mother tongue, rather than on citizenship. The interpreters noticed a set of difficulties that need to be highlighted in order to improve cross-cultural consultations. Barriers in these encounters could originate from all the persons involved. Encounters between patient and personnel in radiological examinations are short, and therefore adequate communication is essential. Ways to reduce misunderstandings are suggested.
Key words: Communication, cross-cultural, mother tongue, language barrier, trilingual, refugee, general practitioner, interpreters, radiographer, encounters, radiological examination, focus group.
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Articles I, II, III, IV and Tables and Figures from the aforementioned articles that occur in the Thesis are reproduced with permission.

LIST OF PAPERS

This thesis is based on the following papers, which are referred to by their Roman numerals in the text:

I. **Fatahi N, Nordholm L, Mattsson B, Hellström M**
Experiences of Kurdish war-wounded refugees in communication with Swedish authorities through interpreter
Patient Education and Counseling 2010; 78(2):160-165.

II. **Fatahi N, Mattsson B, Hasanpoor J, Skott C**
Interpreters' experiences of general practitioner-patient encounters
Scandinavian Journal of Primary Health Care 2005; 23(3):159-163.

III. **Fatahi N, Hellström M, Skott C, Mattsson B**
General practitioners' views on consultations with interpreters: a triad situation with complex issues
Scandinavian Journal of Primary Health Care 2008; 26(1):40-45.

IV. **Fatahi N, Mattsson B, Lundgren SM, Hellström M**
Nurse radiographers' experiences of communication with patients who do not speak the native language
Journal of Advanced Nursing 2010; 66(4):774-783.

DEFINITIONS

Asylum seeker*:* A person who has applied for refugee status and is awaiting a decision on the application. In comparison, refugee status (see below) means official recognition by the host nation under the Geneva Convention (1).

Bilingual interpreting (BLI): Communication through an interpreter, when the interpreter and the patient/client share the same mother tongue (two languages are involved in the interpreting process).

Belief: a concept that has been accepted as true by a cultural group, especially as a principle or as a system of belief (2).

Cross-cultural: This concept originates from anthropological research in which cultural groups are contrasted and compared with one another. In this context cross-cultural means diversities across culture groups, which is in contrast to the term transcultural, which means similarity across culture groups (3).

Culture: The way of life that is shared by a group of people regarding beliefs, values, ideas, language, communication, norms and visibly expressed forms such as customs, music, art, clothing and manners. Culture is dynamic and ever changing, it influences people and is influenced by people (4).

Ethnicity: A common culture (language, religion, ancestry, uniqueness etc) that leads to the feeling of kinship and group solidarity. It also could be defined as collective identity (5).

Health: According to the World Health Organisation /WHO) health is*" a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"* (6).

Immigrant: A person born in another country and settled in Sweden, irrespective of citizenship and reason for immigration (7).

Peshmerge**:** A Kurdish term that means a person that voluntarily participated in a war directed towards independence (guerrilla soldier).

Refugee: "A *person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or*

political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or, who not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it" (8).

Trilingual interpreting (TLI): Communication with Swedish-speaking staff through an interpreter when the interpreter and the patient/client (e.g. Kurdish) have different mother tongues (e.g. Kurdish and Persian) but understand a common language (Persian) (three languages are involved in the interpreting process; Kurdish, Persian and Swedish).

INTRODUCTION

During the last five decades millions of people have been forced to leave their own countries and crossed the language and cultural boundaries and resettled in other parts of the world. Every day thousands of them are involved in cross-cultural communication through interpreters while others are void of this possibility. To be able to communicate with other people, to understand and to be understood, is essential for human existence. We create our knowledge, social structure and science through communication together with other people. In this context communication has a significant role in human cognitive development, well-being and health.

The increasing number of immigrants in Sweden during the last decades has brought the healthcare of patients with different ethnic backgrounds into focus. Providing high-quality healthcare and social service to immigrants, requires an adequate cross-cultural communication between personnel and patient.
After gathering various forms of facts from the patient or client, the quality of the healthcare or social service provided is strongly dependent on accurate and valid information. The most common situation of cross-cultural interaction in healthcare occurs when a non-Swedish-speaking patient faces a provider who does not share a language with the patient. The consultation then relies on an interpreter who facilitates the communication process. The fundamental task of an interpreter is to link communication parties that do not speak the same language and do not share the same culture. However, even communication through an interpreter is not always free of problems depending on a number of complicating factors.

To create a successful clinical interaction between healthcare personnel and patients, who do not share the same mother tongue, requires a qualified interpreter who interprets correctly. The interpreter has to listen to the original message in the source language (patient language) and produce a linguistic and culturally equivalent message

in the target language (the language of the healthcare provider), without adding, omitting or destroying the meaning of the original message. Filtering important words or meanings in the interpreting process could lead to misunderstandings that may have negative or even dangerous consequences for the patient. The task of the interpreter is like building a bridge, strong enough and secure enough to transmit information in a neutral and unbiased way in two directions. Impartiality and credibility of the interpreter are essential to reach an adequate communication outcome. To work as a qualified interpreter one needs knowledge of the general subject of the conversation which is to be interpreted (e.g. medical terminology) and ability to express thoughts clearly and succinctly in both source and target languages.

A cross-cultural clinical encounter through an interpreter is a multifaceted situation. Persons involved in the communication process may have different backgrounds. All individual and environmental factors that lead to difficulties in reaching an adequate interaction between the participating persons should be minimized. Due to cultural diversities it may be difficult to obtain an adequate relationship between the patient and the healthcare provider. A symptom of disease may have the same biomedical origin in different parts of the world, but it may be presented in quite different ways in different cultures. When there is a lack of mutual understanding due to differences in cultural background, an open attitude and understanding of other cultures on behalf of the staff may help to overcome some of the cross-cultural communication difficulties.

As primary healthcare usually is the first stage of providing healthcare to immigrant patients, research regarding cross-cultural and cross-lingual clinical encounters often focuses on communication in this area. However, communication difficulties between non-Swedish-speaking patients/clients and Swedish authorities in other healthcare sectors, and in other sectors of public service, have not been studied as extensively.

Background

Refugees and immigrants in an international perspective

The world today is characterised by an enormous migration, either voluntary or caused by force. Migration has been a part of human life throughout human existence. However, the history of forced migration can be traced back to enslavement of defeated enemies during wars already in ancient times and which reached an organised level during the slave trade from Africa to America. The migration of people to America in the 19th and early 20th centuries can partly be considered as a forced migration for people who were escaping from natural disasters, war, economic deficiency and social problems in their own home countries. At that time, the terms “immigration”, and “refugee” were used interchangeably while the label refugee, in its present meaning, was used first after the First World War (7). Although the word immigrant is sometimes used to cover both voluntary immigrants and refugees, the two terms represent different rights to obtain residency. However, in Sweden both groups have the same rights once they have become residents. On the other hand, an asylum seeker is a person who has applied for refugee status and is awaiting a decision on the application.

Practical reasons for migration for refugees and immigrants differ. The refugees have been forced to leave their own countries, while immigrants usually left of their own free will in order to attain better life conditions, better jobs or to join other members of their family. However, both refugees and immigrants may experience the same problems in adapting to their resettlement countries. Migration is not just a change of physical environment and language; it may also mean dramatic changes in religious, moral and cultural environments. Thus, a new social network needs to be built up, at the same time as one tries to protect one’s own old values and networks. To keep a good balance between these two is a difficult task (9, 10).

Due to violence and persecution, the number of refugees has increased rapidly during the 21st century. According to available information at the end of 2007, a total of 67 million people were forcibly displaced from their own homes worldwide. The number

of internally displaced refugees was 51 million, of this some 26 million were displaced as a result of armed conflicts and another 25 million were displaced by natural disasters. Today 34.4 million immigrants and refugees are provided with humanitarian help by about 6,500 staff in the United Nation Refugee Agency (UNHCR) in 116 countries (11).

Migration to Sweden

It is impossible to know who the first migrants to Sweden were or how immigration will be in the future, but it is obvious that the flow of immigrants to Sweden is an ongoing process. Thus, the immigrants' history in Sweden is as long as the existence of Sweden as a nation. In the middle of the 19th century, emigration, especially to North America, dominated over immigration. However, after the Second World War, this changed dramatically and transferred Swedish society from an emigrant to an immigrant country. Labour immigrants from the Northern European countries dominated post-war immigration up to the 1970s. However, later it changed to refugees and asylum seekers mostly from Iran, Iraq and former Yugoslavia (12, 13). Lately, refugees from the African continent have increased, particularly from Somalia. According to Swedish official statistics in May 2009, 17.9 % of the Swedish population of 9.25 million had a foreign background, and 13.8% were born outside the country (14). The Swedish Immigrant Board shows that from the middle of the 18th century when immigration was first registered, 2.5 million people have left Sweden and 2.4 million have come to Sweden (15). The main periods of immigration to Sweden, up to 1989, have been defined as the following (16) (Table 1).

Table 1. Main trends of immigration to Sweden from 1860. Modified from (16).

1860-1917	1917-1945	1945-1970	1970-1989
Free immigration	Restrictive immigration policy	Free labour immigration	Immigration with refugee status

In the last ten years, labour migration associated with European Union regulations and immigration to join family has increased. In 2008, 101,171 immigrants were registered, and of these, 24,342 were asylum seekers and 2,436 were refugees. The

largest groups of immigrants during this year were those joining their families, 34,586 persons, while 6,346 persons were categorized as labour immigrants. The majority of asylum seekers came from the Asian countries, 12,480 persons, of whom 6,080 persons were from Iraq (17).

Migration of Kurds to Sweden

Migration of Kurds to Sweden began in the middle of the1960s, from the Kurdish part of Turkey, within the framework of labour recruitment (18). However, this later changed to mainly asylum seekers from all parts of Kurdistan, because of ethnic conflicts between Kurds and their respective host countries. Kurdistan is a non-state nation or "a nation without a country", since it is not officially recognised as an independent state. Kurds live in the Middle East in an area partly inside Turkey, Iran, Iraq and Syria. The separation of the Kurds and division of the Kurdistan region occurred when the allied countries divided the defeated Ottoman territories among themselves, after the 1st World War. The Kurds constitute a population of some 30 million in terms of ethnic origin. Unlike the Turks and the Arabs they belong to the Indo-European family, as reflected in the Kurdish language and culture.
Since the division of Kurdistan, the Kurdish resistance and fight for an independent Kurdistan has led to an enormous forced emigration from Kurdistan to other parts of the world (19,20).

Thus, approximately 7-8% of all Kurds live outside their region of origin, including 746,000 who settled in Europe (20). It is difficult to give an exact number of the Kurdish population in Sweden, as figures are often based on their citizenship, and not on ethnic background. The figure is estimated at about 50,000-60,000 people (18,21, 22). Among the Kurdish refugees there are many that were involved in guerrilla warfare against the central governments in their respective countries. The literature about refugee migration and war trauma suggests that war-wounded refugees constitute a high-risk group for mental health problems and adjustment difficulties in the resettlement countries (23). Calbucura, who studied the life of 268 disabled

refugees of different nationalities in Sweden, mentioned that most of the refugees in the Iranian group were Kurds (24).

Interpreter service

Language diversity and interpreting in healthcare in Sweden and in Gothenburg

During the year 2006 the Sahlgrenska University Hospital assigned 11,495 interpreter hours, of which about 6% (690 hours) were used by the radiology departments (25). We recently performed a prospective pilot questionnaire study, responded to by patients and staff, regarding radiological examinations of non-Swedish-speaking patients (n=132) in the radiology departments of this hospital. It showed that only 25% of the patients had a professional interpreter in their contacts with the radiology staff. About 39% of the interpreting was carried out by family members or accompanying friends of the patient, 11% was carried out by bilingual staff and 25% without an interpreter (Figure 1).

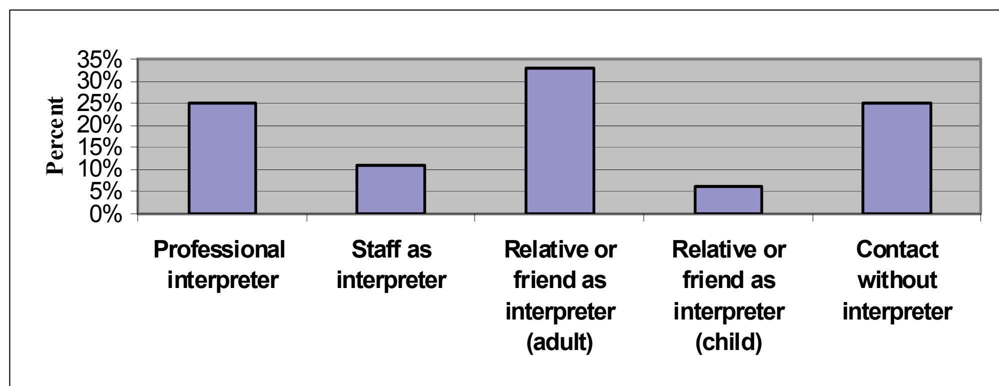

Figure 1. Interpreter alternatives. Use of an interpreter in clinical encounters between radiology staff and non-Swedish-speaking patients (n=132) at the Sahlgrenska University Hospital during a defined period in 2008. (Pilot study by the author, unpublished).

The most frequent languages in these radiological examinations were Arabic, Kurdish, Somali, Serbo-Croatian and Spanish. Sixty-six percent of the total number of communications (n=131) during the registration period were carried out in the five most frequently used languages (Figure 2). The results also indicate that many patients have lived in Sweden for a long period of time, but they still prefer to use an interpreter in contact with healthcare professionals (Figure 3). According to the same survey differences in mother tongue between patient and interpreter occurred in 10 % of the cases and in 23% of cases the patient and the interpreter had different genders. These survey results are preliminary and not fully representative, since compliance and response frequency varied between radiology departments and sections. The results need to be confirmed in a larger group of patients and in different healthcare settings.

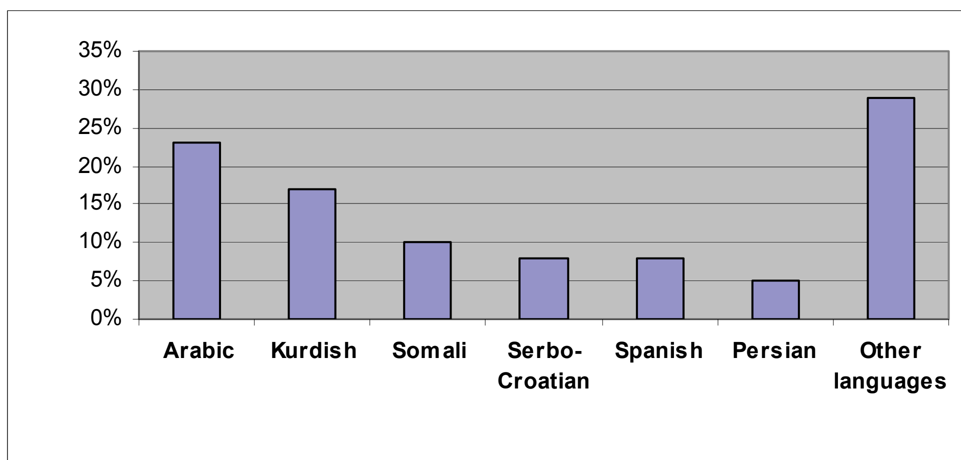

Figure 2. Frequency distribution of the mother tongue of patients from a sample of non-Swedish-speaking patients in clinical encounters between radiology staff and non-Swedish-speaking patients (n=132) at the Sahlgrenska University Hospital during a defined period in 2008. (Pilot study by the author, unpublished).

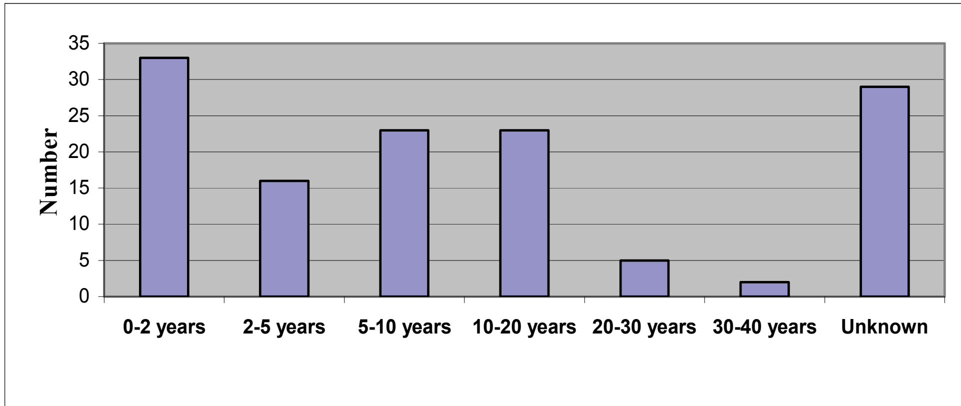

Figure 3. Duration of residence in Sweden of patients in clinical encounters between radiology staff and non-Swedish-speaking patients (n=132) at the Sahlgrenska University Hospital during a defined period in 2008. (Pilot study by the author, unpublished).

The importance of the interpreter in overcoming the problem of bi-lingual and inter-cultural communication in healthcare is obvious (26). To reach the goal of equal healthcare for the entire population, it is the responsibility of society to provide this to both Swedish-speaking and non-Swedish-speaking individuals. According to §8 in the The Health and Medical Service Act (27) a public authority should use an interpreter "if necessary" when dealing with a person who does not speak Swedish.

The Swedish interpreter service has, by international standards, a good standard.

In order to provide healthcare and social service to immigrant patients, the Swedish authorities started interpreter education during the 1960s and established interpreter services in most of the Swedish municipalities. There are about 60 interpreter service agencies in Sweden. Of these, 40 are run by cities and municipalities, while 20 are privately owned. In the last 10 years more than 140 languages have been represented at interpreter training courses. Every day, over 3,000 hours of interpreting are provided, mainly in medical care and social welfare by over 5,000 interpreters in more than 100 working languages (28). However, formal interpreter authorisation exists in only a minority of the languages spoken, and only a minority of the authorised interpreters have special training in healthcare interpreting.

The Gothenburg Interpreter Centre, that provides approximately 90% of the total number of interpreters in the area, provided over 23,000 hours of interpretation in 93 working languages to 581 customers in the Sahlgrenska University Hospital, the Primary Health Care organisation and the Crisis and Trauma Centre during the year 2006 (Table 2). The seven most frequent customers ordered 28.1% of the interpreter service (Angered 8.8%) and 72.8% of the interpretations occurred in the seven most common languages (Figure 4) (29).

Table 2. Interpreter service (number of interpretation occasions and number of hours) provided by Gothenburg Interpreter Centre in 2006 (29).

Institution	**Number of occasions**	**Hours**
The Sahlgrenska University Hospital	9,791	11,495
Primary Healthcare	11,481	10,664
Crisis and Trauma Centre	998	1,045
Total	22,270	23,204

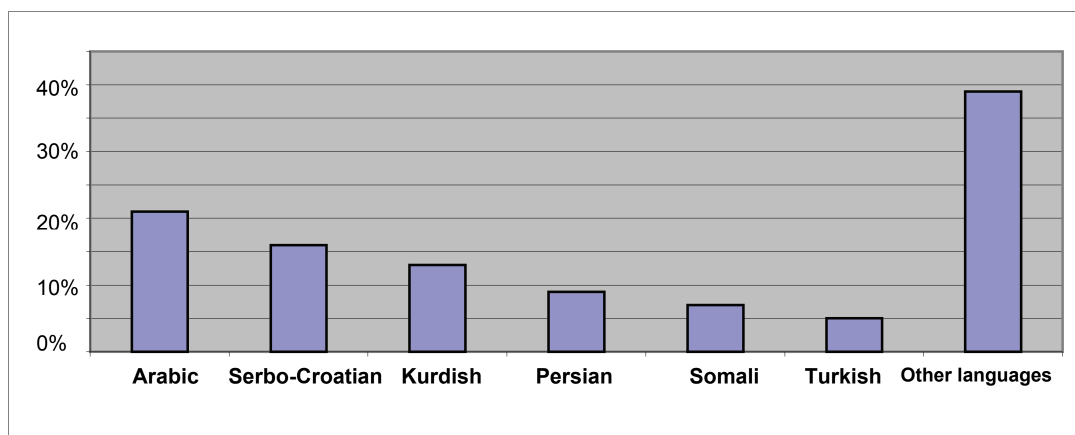

Figure 4. Interpreter service (languages) in order of frequency, provided by Gothenburg Interpreter Centre in 2006 (29).

The healthcare interpreter

The healthcare interpreter is a person who acts as language mediator between a patient and healthcare provider (30). Working as a healthcare interpreter requires a number of skills, e.g. good knowledge of both the source and the target language, knowledge about healthcare terminology, neutrality and an understanding of cultural diversities (31). The formal requirements of an authorised interpreter include impartiality and independence, professional confidentiality, and that all information should be translated as exactly as possible.

The use of professional healthcare interpreters in the contacts with patients who do not share their mother tongue with the healthcare provider, is vital to prevent communication misunderstandings. Physicians perceive communication with patients to be more difficult when using an interpreter, than when one was not needed. They considered professional interpreters to be better translators than family interpreters (32,33), and the development of guidelines for both professional and family interpreters was suggested (32).

In order to improve the quality of the healthcare outcome, not only interpreters, but also healthcare providers trained in communication, are essential (34). There is a strong association between understanding the symptoms of the diseases and the plan to an effective treatment. Factors influencing communication processes should be avoided (35).

The migration process and its effects on health

The process of migration causes various types of stress, which may lead to a number of problems within the cultural, social and psychological spheres for immigrants, which in turn, affects their health and well- being in the resettlement countries (36, 37). Previous studies have indicated a strong association between poor psychosocial well-being and physical health (38,39). Pre-migration experiences of negative life events, such as persecution and political violence, may have a significant impact on immigrants' health. Thus, individual background and the reason for migration are essential (40,41). In this context, there are significant differences between voluntary

migration and migration by force, particularly as a result of ethnic and political conflicts. Not only foreign-born people, but also second generations of immigrants, have an increased risk of impaired health and psychiatric disorders, as compared to native-born inhabitants (42,43). Thousands of refugees from other parts of the world that have been forced to leave their own countries and resettled in Sweden suffer from post-war trauma (44,45). However, if the migration is voluntary and planned, and the goal of migration is reached, it may lead to improvements in mental health.

In order to provide adequate social and health service to refugees with post-war trauma, the needs of war-wounded refugees should be in focus in their resettlement countries (46). Usually, primary healthcare is the first meeting place for refugees and healthcare staff. Adequate communication between the healthcare providers and the immigrant patient or client is therefore of utmost importance. Lack of language links, lack of confidence and trust in the healthcare system may damage the effectiveness of the clinical consultations (47,48). Sundquist et al (49) studied the effects of migration factors on human well-being and health, and stated that life in exile in resettlement countries may be a "beautiful prison in gold". Some factors that were mentioned in this study are social isolation, discrimination, change of social role, social disintegration and low level of control in the resettlement country. The study has indicated that people who are targets for sociological difficulties need more contacts with the healthcare service system. Among identified factors, low level of control and change of identity were considered as central elements that influence all parts of the migration process (49).

Cultural aspects

Culture plays a main role in communication with other people and for behavior during the interaction process. Understanding its role in communication and its impact on the communication outcome is therefore crucial. Communication is also essential for transferring culture from one generation to the next (50). In today's multicultural and multiethnic societies, transcultural healthcare has become an important humanistic and

scientific area of research and practice. In this context sensitivity for cultural beliefs and specific knowledge about these issues are essential (4).

In order to satisfy the fundamental needs of patients with different cultural backgrounds, healthcare information should be adjusted according to the patients' understanding (51). The increased number of foreign-born patients has created difficulties for the healthcare providers to give appropriate linguistic service to all patients with different languages and other cultural and ethnical background than the healthcare staff (52). Helping foreign-born patients to learn about the healthcare system in their resettlement countries, as well as helping healthcare staff to learn about the immigrant patients' cultural values and beliefs is essential for an equal healthcare service to all inhabitants regardless of ethnic background (53,54).

Culture and ethnicity may be considered as factors that may hamper the establishment of a good and satisfactory healthcare provider-patient relationship. There are significant variations in cultural beliefs and understanding and acceptance of the modern biomedical perspective on health and illness. Thus, many traditional health beliefs, practices and terms have no equivalent in biomedicine of the western world. Despite the struggle of the healthcare providers to improve the health and quality of life for every patient, there are still some further factors, e.g. socio-economic barriers, that create difficulties to provide equally high quality of health care to ethnic minorities, in comparison with the native-language-speaking patients. To reduce cross-cultural communication misunderstandings, adaptation of the health care systems to this cultural diversity is essential (55,56). This issue is being discussed in countries that have high rates of immigrant populations, e.g. Canada, Australia and the United States of America (57). As a part of the interpersonal communication, diversity in body language in different cultures should also be in focus when we meet immigrant patients, since the same body language may have a different meaning in different cultures.

Human communication

The phenomenon of communication has been defined as “the sharing of experiences” (58). When talking about human communication language is in focus because verbal language is the most important tool for exchange of messages in interpersonal communication (59,60). Human communication may take place as intrapersonal communication, interpersonal communication, group communication or mass communication, and it may occur within one cultural entity, or constitute cross-cultural communication (61-63) (Figure 5).

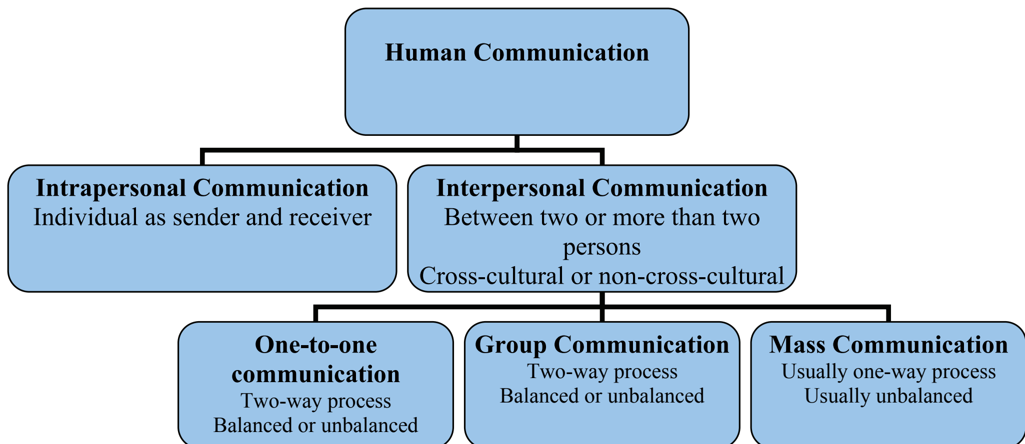

Figure 5. Different forms of human communication

Intrapersonal communication refers to e.g. reflections within oneself, writing or talking to oneself, and contains none or little inter-cultural communication element. While mass communication usually has an unbalanced power relationship between sender and receiver, one-to-one communication and group communications can be balanced or unbalanced. Communicative relationships within hierarchies (such as the military) and in relationships with an element of dependence, such as doctor-patient relationship, tend to be unbalanced as regards power. As this thesis is dealing primarily with cross-cultural interpersonal communication, this issue is in focus.

Cross-cultural communication occurs when people from different cultural backgrounds attempt to communicate. Sociology and psychology have attained an increasing role in clinical settings during the last decades, and the role of cultural factors in the context of communication has become obvious (63-67). Thus, communication influences our everyday life, and to study this issue is none other than a way to study human cultural, psychosocial and psychological issues. Communication is an open system that is influenced by factors such as environmental factors, the context of the interaction, interpersonal relationship, the psychological state of sender and receiver, sex, age of sender and receiver as well as qualifications of both sender and receiver, and the mode of communication (68). In today's modern society studies of our essential means of communication are more important than before, and in this context, development of modern theories on communication is needed (69).

Communication theory

The history of human communication theory can be traced back to the fifth century B.C. Development of communication theories comprises three periods, the historical period (500 B.C.- 400 A.D.), medieval and renaissance periods (400-1600) and the modern period (1600-). The first stage of this development began with Greek and Roman theories, and has been developed into a "five-part paradigm" (70) (Figure 6).

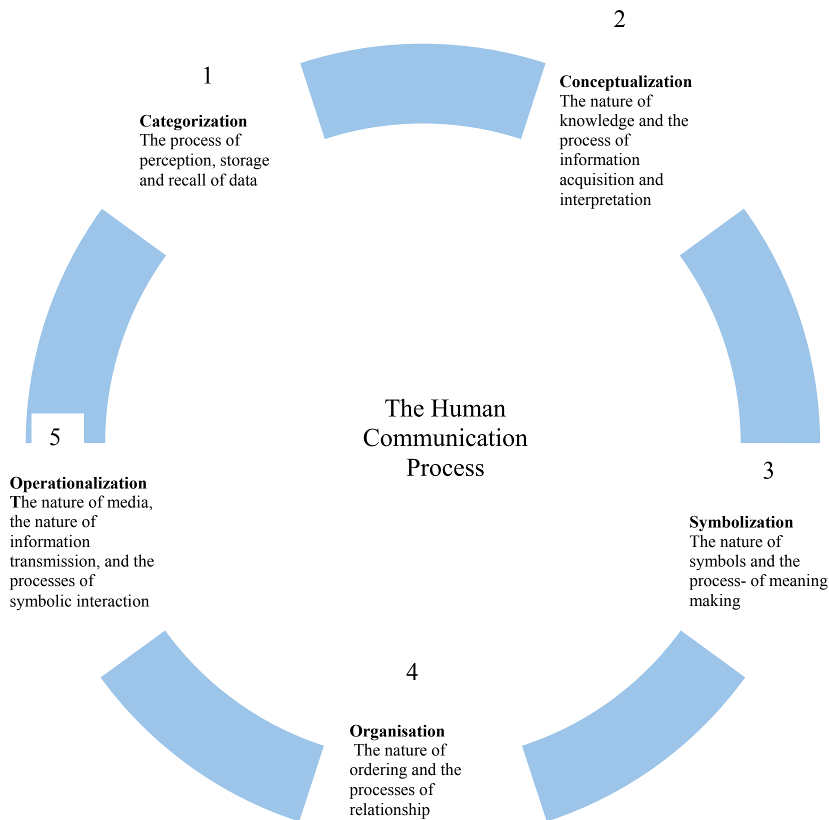

Figure 6. Paradigm of human communication, specified for areas of research and theory construction. Modified from Harper (70).

According to this paradigm, the human communication process contains five phases. The first phase of this process, "categorization" (phase 1, Figure 6) has been considered as a fundamental stage of the process. Through our senses - sight, hearing, touch etc. - we perceive, learn, store and classify data, recalling relevant data and transforming it into information that constitutes the message in the light of the prevailing communication situation. The next phase, "conceptualization" (making sense of data) (phase 2) or the process of discovery of relevant information, is an important phase, since at this stage of the communication process, interpreting of the information takes place. Conceptualization can be considered as both an objective and a subjective process, in terms of discovery of the relevant information and the creation

of information. In the conceptualization process the sender must be aware of the receiver's values, beliefs, attitude and cultural background. This issue should be in focus in cross-cultural clinical communication with immigrant patients. Recalling of relevant data and transferring it into relevant information in the light of the prevailing situation for an immigrant patient is dependent on his/her stored data and the patient's ability to transfer it into information in relation to the actual situation. Cultural diversities and patient healthcare literacy level are two factors that influence the communication process (71,72).

Symbolization, "cognitive representation of ideas in appropriate symbols" (70) (phase 3), has a crucial role in the human communication process, both for the sender and the receiver. This phase contains words, action, and artefacts of symbolic value, i.e. how one speaks, dresses and behaves (e.g. body language). In selecting symbols for interpersonal and intercultural communication, body language has an important role; about 65% of our messages are non-verbal (73).

The process of arranging and organising the information (phase 4) as well as sending a message depends on the communication subject and relationship between the communication partners. The structure of the message that is sent is important; ideally it should have three components, an introduction, a body and a conclusion (70). A well-constructed message makes it easier for the communication partner to understand it. The form of the message plays a significant role in how the receiver understands the message. If the message is sent in a physical form, such as a film or a book, it may be understood differently from e.g. a message delivered by oral communication, or by a combination of oral and visual communication.

In today's society communication in healthcare is more demanding than before. This is due to the increasing frequency of cross-cultural encounters and the increasing role of clinical communication and medical technical development, not only for gathering clinical information but also as support and treatment in psychosomatic, psychological and psychiatric disorders (74). In order to reach an adequate communication outcome,

the form and content of the message must be adjusted to the receiver's situation and background.

During the 19th century a number of communication models have been developed in order to describe and explain the process of human communication. An early model that specified the elements in the communication process is the Shannon-Weaver model (Figure 7), which might be considered a universal model for all forms of communication (75). Based on this model, the communication elements are the source of information (sender's brain), transmitter (sender's vocal organ), channel (receiver's ear), and destination (receiver's brain).

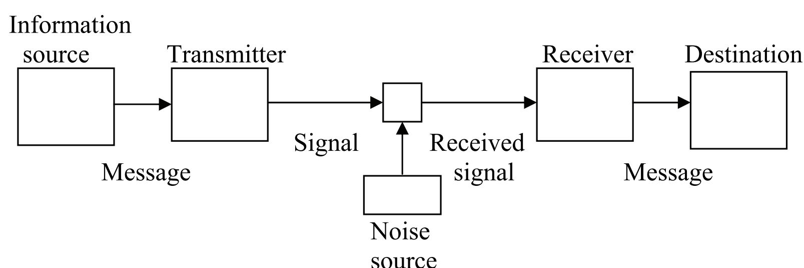

Figure 7. The Shannon-Weaver linear model of communication (75).

The model suggests the interaction between sender and receiver as an active sender with a passive receiver. However the nature of human communication is a more complex process than that provided by the model. Human communication is a mutual activity and the sender is certainly affected by the receiver, both in verbal and non-verbal forms. The linear model has been criticized as an inadequate model for human communication, and an alternative circular model of human communication has been suggested (Figure 8) (76).

In the transferring of this circular model to clinical medical situations the concept of patient-centred medicine will be of interest. This term was originally introduced by Enid Balint as "understanding the patient as a unique human being" and an application

of patient-centeredness requires a constant interchange of communication between provider and patient (77). The patient-centred attitude implies the exploring of both the disease and the illness experience, understanding the whole person and the enhancing of the relationship and finding the common grounds in the consultation. The alternative to patient-centred medicine, a disease-centred medicine, on the other hand, is characterized by a "doctor-centred" style, signifying questioning by the doctor and less of a dialogue in the encounter (78). The doctor-centred style is also labelled as a "police-detective" style (79) which means that the communicative process is mainly pointed in one direction, from the provider to the patient. Patient-centred communication is helpful in building a working alliance with the patient and a tool for mediating the provider's professional competence to the relationship.

In a circular model of communication the path of signals, i.e. the flow of information, is in constant movement in two directions between sender and receiver. So the circular communication model is a more appropriate model concerning medical encounters, because human communication is a process of production and exchange of meaning between speaker and hearer (Figure 8) (80).

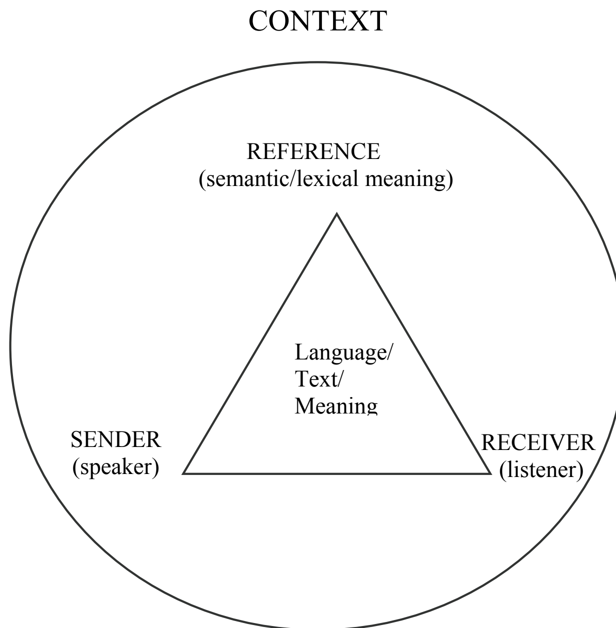

Figure 8. The circular communication model illustrating the interchange between sender and receiver and reference (the message and its meaning) according to Nessa (81).

Furthermore, the main elements in the model are signs and language codes and participants in medical encounters exchange messages specific to this context (81).

Clinical health communication

Due to its multidisciplinary nature, clinical health communication has been defined differently over time. However, its role in improving health outcome in both individual and public perspectives seems to be common to most definitions (82).

"Health communication is a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging and supporting individuals, communities, health professionals, special groups, policymakers and the public to champion, introduce, adapt, or sustain a behaviour, practice or policy that will ultimately improve health outcome" (82).

Clinical health communication may have different forms and it takes place in different situations (Figure 9). One important issue that makes clinical health communication different from many other types of human communication is the inherent unequal communication situation, the patient being dependent on the healthcare professionals and their diagnosis and decisions. Thus, the communication relationship between patient and health professionals cannot be assumed to be equally powered. These difficulties could multiply with other communication barriers, particularly when the healthcare provider and the patient have different ethnical and cultural backgrounds. Thus, efforts to reduce factors that influence clinical encounters negatively may have significant impact on the communication outcome.

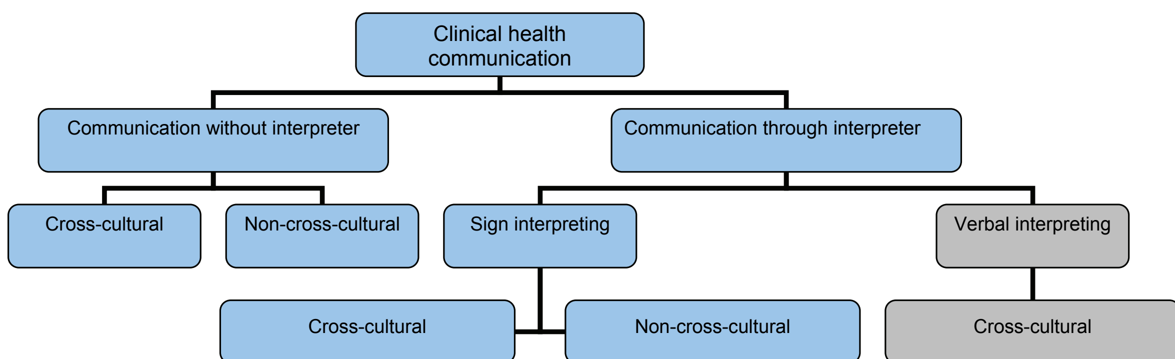

Figure 9. Various forms of clinical health communication principles.

Since communication between healthcare provider and patient has a significant role for the quality of health outcome, research in this area has been in focus during the last three decades. Many published studies (83-89) have indicated that a certain level of healthcare provider-patient communication improves their respective satisfaction, the

patient's quality of life, the treatment processes, as well as the clinical results. Problems arise in the case when the healthcare provider and the patient do not share the same mother tongue. In this situation, communication is often difficult to carry through without the help of a language mediator.

The planning of clinical encounters through qualified interpreters to patients with limited language ability is crucial. Healthcare-provider knowledge regarding the necessity and correct use of an interpreter has a significant impact on the quality of the health outcome (89-91). In clinical encounters, the ability of the healthcare provider to use interpreters in an optimal way requires experience, an open attitude, patient orientation and knowledge about other cultures.

Hermeneutics as interpretation theory

The concept of interpretation has two meanings. In the context of this thesis, it usually means translation, a literal transformation of words and sentences from one language to another. Interpretation also stands for an endeavor for deeper understanding of a statement or piece of text. The latter meaning of interpretation relates to the concept of hermeneutics' theory which can be traced back to the 18th century (92). However, the modern hermeneutic theory that was developed by Schleiermacher at the beginning of the 19th century emerged from Protestant theology. Schleiermacher's arguments started with the critique of superficial interpreting, and he mentioned, in order to prevent misunderstandings, that the meaning must be sought more deeply. The Bible view on human existence and the definition of human conditions were in focus in Schleiermacher's critique. This process of deeper understanding of human existence can be found in more modern philosophers´ and researchers´ work, such as those of Heidegger and Gadamer (93). Heidegger criticized the objectivism of hermeneutics, i.e. the view that considers the human being and all phenomena as objects. He also stated that understanding of a phenomenon is impossible without understanding its particular. It is difficult to make a sense of understanding of a sentence, before understanding all its parts. Finally, according to Heidegger previous experiences play an important role in understanding the meaning of phenomena (94).

This concept, which has a significant impact on the patient-healthcare-provider communication, was in focus in Gadamer's *"Circularity of the process of understanding"* (95). According to the "hermeneutic circle", the whole cannot be understood without understanding its parts, and the parts cannot be understood without understanding the whole. Thus, the understanding process is not mathematical, as in the Shannon- Weaver linear model of communication (Figure 7). Every conversation is influenced by pre-understanding and understanding, its history, culture and language backgrounds. The healthcare provider's knowledge about his/her own historical and cultural background, within previous experiences, is essential to an understanding of the illness history that the patient presents.

As mentioned earlier, the conceptualisation process (Figure 6) of human communication, as both a subjective and objective process, has a vital role in the hermeneutic circle. The hermeneutic approach has had a great impact on qualitative research methodology, including nursing research (96).

On encounters

A clinical encounter between patient and healthcare provider is the first step in the diagnosis and treatment procedure, therefore a satisfactory contact is essential. In this context, attempts to develop an adequate model for clinical consultation generally (97) as well as in specific situations (98), (consultation through an interpreter) have been in focus during the last decades.

Ingredients that are necessary for an adequate encounter are often highlighted and professional and caring attitudes and empathy are frequently mentioned in this context (99,100). A professional attitude refers to the ability of the healthcare provider not to be directed by his/her own needs and feelings, but instead to be focused on issues that benefit the patient. A healthcare provider's need to be popular or to be authoritative can for example be destructive in the relationship and cause problems.

The caring attitude, humanity, implies a talent to bring about respect and esteem to the patient. The patient has usually less power than the provider and is dependent on the

knowledge and competence of a staff member. A trustful cooperation needs to be aimed at and the self-esteem of the patient must not be diminished. The caring attitude also involves common civility like greeting each other in an equal way, introducing oneself properly, keeping in step with the patient in the corridor, taking time and not interrupting unnecessarily. Empathy means the capacity to identify and understand another person's situation, feelings, and motives and then be led by these feelings in caring for the patient. Empathy is a core element in a good encounter, and intellectual components must also be integrated into the process. Empathy is reflected in the adaptation of the treatment or caring of the patient. Understanding the importance of cross-cultural issues in encounters with foreign patients is part of this adaptation.

The short encounter

The scheduled time for clinical consultations in relation to the period of illness experienced by the patient, particularly in cases of chronic disease, is often shorter than the patient's subjective need of communication. This dissertation encompasses mainly studies that are characterized by short meetings between the provider and the patient, in settings requiring cross-cultural communication, often through a third person (the interpreter). This adds complexity to the short encounter, and difficult interactions will therefore easily appear, and these conditions make heavy demands on all participants. If miss-communication occurs initially, it is often difficult to reconsider actions and steps that have been taken, and the consequences may sometimes be long-lasting. A frequent objection to primary care in general today is the shortage of time in the consultations and the lack of continuity in the provider-patient relation (101,102). Yet, primary care consultations in Sweden are comparatively longer than in other European countries, about 15-20 minutes on average (103,104). The quality of the encounter is associated also with the physicians' attitude, the nature of the health problem and factors such as culture, gender, age, environment and level of education. A special case of short encounter is that occurring in the radiology department, where encounters may be limited to less than 10 minutes.

A short consultation implies special requirements of the persons concerned; the possibility to establish a deeper relationship is limited. The starting point in the encounter is often that the persons are unknown to each other. This is especially relevant in a radiological setting, while in primary healthcare it happens more often that the provider and the patient have some knowledge of each other beforehand. Many facts and ideas need to be sufficiently elucidated during a short length of time before decisions are made and actions can be taken. Of course, the possibility of displaying necessary attitudes and empathy are under threat when consultations tend to be hasty. Important decisions, difficult to revise, are sometimes made on insufficient underpinnings.

The provider and the interpreter are the only professional actors in the encounter, while the patient is more of a clean sheet. The professionals have also usually experienced the triad situation (doctor, interpreter, patient) more often than the patient, and obstacles and problems might have been touched upon in collegial meetings and in professional training. Thus, a short triad meeting tends to be more familiar to the interpreter and the provider than to the patient. This lack of equality needs to be noticed and understood.

Gender perspective

A gender perspective is also of interest when terms of equality are in focus. Hierarchical patterns are sometimes very obvious in cross-cultural consultations. Gender bias is defined as an inconsistency between women and men that is rooted in a society and its culture (105,106). Social and cultural dimensions such as ethnicity, age, and social class exist at the same time and these features, including gender, interact and are bound to each other in a dynamic interaction (107). A common position in the consultation is the dominant (male) power, and depending on the other triad persons, certain patterns can be developed. The gender structure sometimes overrides the professional hierarchy and a composition of male patient, female provider and female interpreter implies other settings than the inverse gender composition.

Patient perspective

The patient usually has the most difficult position in the short encounter. A more or less pronounced fear of the illness itself is accompanied by the experience of being in an unfamiliar place, meeting unknown persons among the staff and uncertainties about the treatment and other consequences of the consultation. Thus, giving adequate information, to be honest, respectful and present, to give adequate time and be aware of the power structures are elements of significance for the healthcare provider (108).

A longer consultation would usually result in better knowledge about the communication partner and would enhance understanding. However, for economical reasons, today's clinics are ruled by clock scheduling rather than the patient's actual need for consultation time. Thereby, clinical encounters are characterized by short consultations, in order to see more patients in a defined time period (109). Previous studies showed that consultation times differ between countries and are associated also with the physician's attitude and the nature of the health problem (110,111).
Due to the limited time available in clinical encounters, openness and a good consultation technique are essential in establishing a good relationship with the patient, particularly when linguistic and cultural barriers are present. Time shortage in the clinical encounter often results in stress, a situation that may lead to misunderstanding and mistrust, which are obstacles to establishing a good relationship to the patient. Therefore all additional hindrance factors should be avoided. If something goes wrong in the communication, it is usually difficult to repair during the scheduled time. According to a recent study the mode of communication and staff's behaviour during the clinical encounters has significant impact on the healthcare professional - patient relationship (112). For instance, an encounter associated with a radiological examination may be very short, but the staff member, usually a nurse radiographer, still must transfer important information to the patient, in the absence of an earlier relationship between these two persons (113).

Personal rationale for this thesis

As a healthcare provider, with an immigrant background and my own experience of struggling with multiple languages (native Kurdish, Persian at school, Swedish on arrival in Sweden and English as the scientific language), my own experience of needing an interpreter and my own experience of interpreting for others, I have experienced numerous communication misunderstandings between healthcare providers and foreign-language-speaking patients.

The starting point of this thesis can be traced back to the mid 1980s during my stay in several Red Cross refugee camps (Altash, Sammawe and Hele camps) in Iraq. As a healthcare provider and interpreter between Kurdish and Persian refugees and the English-speaking Red Cross staff as well as between Arabic-speaking healthcare providers and refugees at that time, I became aware of the importance of proper interpreting. According to my experiences, misinterpretations in the clinical communication affected the patients' health both in the short and in the long term perspective. The instant effects of misunderstandings could result in psychological reactions, while long term consequences could appear as inaccuracies in the drug treatment (e.g. a patient who was prescribed antibiotics four times a day and one diazepam tablet a day, did the opposite due to linguistic difficulties). By being close to the patients in the refugee camps it was also evident that many communication misunderstandings between e.g. Arabic-speaking healthcare staff and the refugee patients occurred.

After my arrival in the multicultural Swedish society with over one hundred different languages, a need for research in this topic turned up. Healthcare personnel express much concern over intercultural communication problems. My own experiences have strengthened my belief that more and new knowledge in this field may have an impact on the lives of the parties involved, primarily the patients, but hopefully also healthcare providers and interpreters involved in healthcare.

AIMS

Overall aims

The overall aim of this study was to explore difficulties and possibilities in communication between non-Swedish-speaking patients/clients and Swedish authorities, particularly healthcare providers and social welfare service personnel. The prime focus was the consultation with a physically present interpreter (face-to-face interpreting).

Specific aims

Study I.

The aim was to study experiences of war-wounded Kurdish refugees with respect to cross-cultural communication through an interpreter.

Study II.

The aim of this study was to describe the difficulties and possibilities in the interpreting process in the Swedish primary healthcare system, mainly in the GP-patient encounter, as seen by the interpreter.

Study III.

The aim of this study was to analyse the difficulties and alternatives in the interpreting process in the GP-patient encounter as seen by the GP.

Study IV.

The aim of this study was to explore nurse radiographers' experiences of examining patients who do not speak Swedish. Which are the obstacles and how could barriers be overcome?

ETHICAL CONSIDERATIONS

Ethical discussions and deliberations between the authors have occurred continuously during the accomplishment of the studies. At the time when the research projects (Studies I -IV) were carried out according to Swedish legislation no formal approval and acceptance by the regional research ethics committee was necessary. This was confirmed after consultation with members of the committee. By definition the studies could also be labelled as quality assurance projects. It implies that the patients/subjects were never exposed to any new or untested form of treatment or measure. The researchers' key interest was focused on experiences and views on everyday healthcare performances.

The pilot study presented in the frame story of this dissertation includes however perspectives that need special ethical comments. According to Swedish legislation sensitive personal information must be handled with special discretion and the registration of specific ethnic groups calls for such cautiousness. The information gathered in this brief classifying of patients at the radiological departments focused on the language used by the patient (pilot study). Data on years of residence in Sweden was also asked for but no further personal data, including registration of the ethnic or religious group in question, was recorded. In the future a more comprehensive research approach is aimed at, and more information on the relevant ethnic group will be of interest and a formal application to the research ethics committee will then be passed on.

All of the present studies were performed according to general ethical procedures of good standard. Voluntariness, possibilities to discontinue the participation at any time and written and oral information were part of the initial presentation before the interviews started.

MATERIAL AND METHODS

Data collection

Details on the materials and methods are depicted in Study I-IV

***Experiences of Kurdish war-wounded refugees in communication with Swedish authorities through interpreter* (Study I)**

Semi-structured interviews were conducted with ten men, aged 31-42 years (mean 34.7). All were war-wounded refugees from east Kurdistan and had been involved in guerrilla warfare against the central government in Iran. They had fled to Sweden between 1982 and 1988. Based on information from two Kurdish cultural associations in Göteborg and Eskilstuna, 11 war-wounded, disabled Kurd Peshmerge (guerrilla soldier) were contacted and ten of them could participate in the interviews (Table 3) The participants were informed beforehand about the purpose of the investigation and that a tape-recorder was to be used.

Table 3. Background data of the study group (n=10)

Nr	Age (years)	School education	Type of injury	Residency in Sweden	Civil status
1	37	None	Amputation of lower extremity	14 years	Divorced
2	37	None	Amputation of lower extremity	13 years	Married
3	35	None	Amputation of lower and upper extremity	9.5 years	Married, 4 children
4	28	5 years	Brain injury	9.5 years	Single
5	33	8 years	Spinal injury	13 years	Married
6	42	12 years	Amputation of lower extremity	12 years	Married, 4 children
7	37	5 years	Amputation of lower extremity	13 years	Divorced
8	33	12 years	Hemiparesis	12 years	Single
9	34	10 years	Amputation of lower extremity	14 years	Married, 2 children
10	31	9 years	Amputation of lower extremity	10 years	Single

The interviews, about one hour in duration, took place in the participant's residence and started with an open question: *Could you please explain how you experienced communication through interpreters with the Swedish authorities?*
During the interviews the participants could develop their answers and time was ample to talk about communication difficulties. In the discussion various themes were unfolded such as questions concerning difficulties and misunderstandings because of differences in mother tongue between patient and interpreter.
The interviews were taped, and then transcribed verbatim. The transcripts were read and re-read to find omissions and other transcription errors and they were later translated by NF from Kurdish into English. The interviews were carried out during a nine-month period in Gothenburg and Västerås in Sweden.
A qualitative content analysis method was used for the analysis and interpretation of the interviews.

Interpreters' experiences of general practitioner-patient encounters **(Study II)**
Eight authorised experienced interpreters, six women and two men were contacted through the Gothenburg Interpreter Centre and were asked to participate in a focus group interview. We were interested in persons translating into the most frequently used languages (Arabic, Persian, Kurdish and Turkish) in primary healthcare in Gothenburg. Brief information about the project was sent to the interpreters in advance and all were interested in participating. Five interpreters (mean age 49.5 years; three men and two women) could participate on the interview day.
Three interpreters were Arabic-speaking and two Turkish-speaking and all had participated in interpreter training courses. They were working part-time (about 60 %) but had altogether about 75 years of experience as interpreters.
The group interview took place at the interpreter's office in Gothenburg in 2003 and lasted for 90 minutes. It was chaired by one of us (BM) and started with an open question: "*Please tell us about the problems you meet in your daily interpreting activity*"? In the course of the interview, clarifications were asked for and condensing

was achieved by more detailed questions. The interview was audiotaped, and then transcribed verbatim.
The analysis was undertaken according to a phenomenographic method.

General practitioners' views on consultations with interpreters - a triad situation with complex issues **(Study III)**
Thirty experienced general practitioners (GPs) at nine healthcare centres in an area with a high rate of immigrant patients in Gothenburg were contacted. In advance the GPs received brief information about the project and 13 were primarily interested in participating. Five of the GPs had impediments (practical obstacles) while eight, four men and four women (age 36-65 years, mean 53 years) from five healthcare centres finally took part in the interviews. They had worked as GPs 10-28 years (mean 20.7 years). Two of them had a non-Swedish ethnic background but they had settled in Sweden many years ago and were fluent in Swedish.

Data were collected at two group interviews and three individual interviews. The interviews, focusing on the GPs' attitudes' towards interpreting, took place at healthcare centres in Gothenburg 2003-2005. The GPs (n = 3) who could not take part in group interviews were offered individual interviews.
The group interviews (one with two and one with three GPs) lasted for about 75 minutes and the personal interviews for about 60 minutes. The groups were chaired by one of the authors (BM). The personal interviews were led by another researcher (NF). The interviews started with an open question: "*Could you comment on difficulties and possibilities in daily clinical encounters, including an interpreter*?" During the discussions, deepening of the content, clarifications and condensing were achieved by means of more targeted questions. All participants in the group discussions participated actively. The interviews were audio-taped, and then transcribed verbatim
A qualitative content analysis method was used for the analysis and interpretation of the interviews.

***Nurse radiographers´ experiences of communication with patients who do not speak the native language* (Study IV)**

Through the heads of radiology departments nurse radiographers were asked to participate in focus group interviews. The aim of the study was presented and nurse radiographers with at least two years' of working experiences and who were open to share language problems were especially asked for. Eleven nurse radiographers, two men and 11 women (age between 30-54 years; working experience between two and 30 years) participated. Four had a non-Swedish ethnic background but had settled in Sweden many years ago and were fluent in Swedish.

Three group interviews (two groups with four and one group with three) were carried through in November 2007 and lasted 50-70 minutes each. The groups were chaired by one of the authors and the interviews started with an open question: *"Could you comment on making X-ray examinations on patients who do not understand Swedish?"* Difficulties and possibilities in the examination situation were especially asked for and the participants exemplified their views by clinical examples. The role of the interpretation was in focus and all nurse radiographers were encouraged to participate actively. The interviews were audio-taped, and then transcribed verbatim.
A qualitative content analysis method was used for the analysis and interpretation of the interviews.

Research methods

Qualitative methods

Qualitative research methods were initially mainly applied within the social sciences; however these methods have been more accepted within the realm of healthcare during the last decades and they deal with the exploration of human understanding of everyday life. Usually the results in qualitative methods emerge from verbal and textual data (114,115) and are appropriate in studies aiming at answering questions beginning with "*who, what and where*" (116). In contrast to quantitative methods that focus on empirical and objective analysis, qualitative methods attempt to describe and identify the qualitative features of phenomena through interpretation (117).

In all qualitative methods the analysis and interpretation processes take place in a holistic perspective that is rooted in hermeneutic principles (118). This notion implies that the understanding of the separate parts of a text is dependent on the overall meaning of the whole. Yet, later on the meaning of the separate parts can change the meaning of the whole and this in its turn can change the meaning of the parts and so on (the hermeneutic circle).

To ensure scientific rigour in qualitative research the researcher must be aware of the process of data collection and by using different data collection methods (triangulation) validity can be improved. Critical evaluation and systematic control of the analysis process and a careful audit of the results are necessary in order to reach optimal research quality (119,120).

Criteria for scientific rigour in qualitative research

Criteria for qualitative research vary from those of quantitative ones and features of qualitative research are considered according to: *Credibility, transferability, dependability* and *confirmability*. These concepts correspond to internal validity, external validity, reliability and objectivity, which are notions used in quantitative methods (121).

The idea behind the development of specific criteria for qualitative methods was that the nature of the study topic, methodology, aims and supposition in these methods did not suit the criteria for quantitative research. Furthermore reliability in quantitative research means constancy, which is not relevant to the nature of qualitative research. Reliability implies getting the same result independently of whoever accomplishes the test. In qualitative research two researchers who repeat a similar study may reach resembling experiences; however it may be impossible to reach the same result, as different persons with different understandings of the phenomena cannot reach the same conclusion.

Credibility reflects the ability of the researcher to communicate the validity of the knowledge. Sufficient descriptions of the pre-understanding of the researcher, ways of describing the data collection, sampling, analysis of methods will have an impact on

the credibility of data. *Transferability* in a qualitative study means to what extent the results are transferable to other contexts (122). The researcher does not define the transferability; it is determined by the reader and regarded as reasonable or not. The result should be critically evaluated in relation to previous studies in a similar field. *Dependability* in qualitative research reflects the adaptation to changes in the studied environment and to new inputs obtained during the study. The quality of researchers as well of the technical devices used is in focus. The ability of the researcher to carry out interviews and be flexible to data received also affect dependability. *Confirmability* in qualitative research corresponds to, but is not the same as, objectivity. Neutrality is essential, reality must not be distorted; findings must be rooted in data and not be a result of preconceived assumptions. Verbatim audit of the material and adequate judgement regarding the potential risk for bias are important elements in confirmability of qualitative research.

Due to the multiple nature of qualitative research the need of a systematic audit and reflective evaluation is important (123). This project focuses on the quality of human communication and thus qualitative methods have been used for the analysis and interpretation of data.

Qualitative content analysis (Studies I, III, IV)

Content analysis method is a well-known and recognized method of analyzing both writing and spoken communication between people. Originally the method dealt with a more objective, systematic and quantitative description of a manifest content of communication (124,125). At the beginning the qualitative approach received less consideration, but later it has expanded to include also interpretations of latent content. Two uses of content analysis are apparent; one is a quantitative approach often used in media research. The other is a qualitative approach often applied in medical research and education (126).

One issue in the analysis process is to be aware of the various modes; manifest or latent content. Analysis of what the text says deals with the content aspect and describes the visible elements (manifest content). Analysis of what the text is about involves an interpretation of the underlying meaning of the text (latent content). Both

manifest and latent content deal with interpretation but the interpretations vary in depth and level of abstraction.
In accordance with this method (127) the transcripts were read carefully by several authors in order to identify the informants' experiences and conceptions of communication. The words, sentences or paragraphs containing aspects related to each other through their content and context, i.e. related to the same central meaning and addressing a specific topic, were grouped together into meaning units (127).

When the interviews were completed, the text was read for an overview of the material. Meaning units were identified as a few words or some sentences or even paragraphs, i.e. a constellation of words and statements that relate to the same central meaning. Thus, the units of meaning had aspects related to each other through their content and context. In a number of meetings between the authors the transformed units of meaning were interpreted and condensed to concepts and notions – subcategories - and later grouped into categories and a theme. Finally, the categories were compared with the original text to ensure that they were rooted in the material.

Illustration of the analysis process in various stages (from Study III)

I. Meaning unit.

The first step is to identify the words, sentences and paragraph that have the same essential meaning and contain aspects related to each other through their content and context.

II. Condensed meaning unit description close to the text.

Then meaning units related to each other through their content and context were abstracted and grouped together into a condensed meaning unit, with a description close to the original text.

III. More condensed meaning unit interpretation of the underlying meaning.

The condensed text in the meaning unit was further abstracted and interpreted as the underlying meaning and labelled with a code.

IV. Subcategories.

Codes were grouped together based on their relationship and codes that addressed similar issues were grouped together in subcategories.

V. Categories.

Subcategories that focused on the same problem were brought together in order to create more extensive conceptions.

VI. Theme.

Finally, a theme that covers the analysed text links the categories that appeared and emerged from the text.

Table 4. Examples of meaning units, subcategory, category and theme (from Study III).

Meaning units	Subcategory	Category	Theme
"Sometimes the patient talks for five minutes and it is interpreted in two seconds, or the patient says something and the interpreter is quite silent."… "A female patient once presented unclear symptoms. Two weeks later she comes back with a female interpreter and haemorrhoids were diagnosed	**Neutrality**	**The interpreter – capacity of bridge constructing**	**Intertwined triadic relationship**
"Sometimes the patient says something but the interpreter does not react. If I ask the interpreter what the patient just said the interpreter could reply that the patient just repeated an earlier statement" "…"; I must know what the patient has said".	**Unbiased**		

Phenomenography (Study II)

Phenomenography is a research method that originally was developed by a group of educational researchers at the University of Gothenburg (128). Initially, the research group claimed that phenomenography was an independent empirical approach, without

association to phenomenological thinking. However, later it was stated that the phenomenographic method also obtained impulses from phenomenology and the method was labelled as “practice phenomenology” (129).

The object of study in phenomenography is mainly the various ways in which people experience, understand, conceptualise, and make sense of phenomena in the world around them (130,131). The basic assumption is that people experience phenomena or situations in quite different ways and the aim of phenomenography is to discern and describe these ways in a systematic mode.

In accordance with this method the transcripts from the group interview were primarily read carefully in order to find the participants’ different conceptions of the subject. Then different statements were grouped together based on their similarities and differences. Later the conceptions of a similar kind were grouped in categories based on their relationship. This was done in order to derive a meaningful, structural model of the conceptions. Obtained categories are compared with the original text in order to assure that they originated from the text. Finally every category has been confirmed by an appropriate citation with the intention of upholding external reliability of the study.

Overview of Study I-IV

An overview of the background data and research features of Study I-IV is depicted in Table 5.

Table 5. Background data and research features of Study I-IV (y=years).

Study	Sample	Setting	Data collection method	Analysis method	Gender	Age	Job experience
I	Ten war-wounded refugees	Participants' residences	Individual semi-structured interviews	Content analysis	All men	31-42 y mean 34.7	-
II	Five authorized interpreters	Gothenburg Interpreter Centre	Focus group interview	Phenomeno-graphy	Three women and two men	28-51 y mean 42.2	3-23 y mean 11.8
III	Eight GPs	Primary Healthcare Centres	Focus group interviews and individual semi-structured interviews	Content analysis	Four women and four men	36-65 y mean 53	10-28 y mean 20.7
IV	Eleven nurse radiographers	X-ray department	Focus group interviews	Content analysis	Nine women and two men	30 -54 y mean 40	2- 30 y mean 13

RESULTS

Detailed results are presented in Study I-IV

Experiences of Kurdish war-wounded refugees in communication with Swedish authorities through interpreter (Study I)

Three main categories emerged from the analysis of the interviews, which altogether resulted in a theme (Table 6). Categories cover the problems concerning interpreters` qualifications, differences in language and culture between those involved in the encounters and the importance of fear and its influence on the outcome of the communication.

Table 6. Theme, categories, subcategories and codes that emerged in the interviews (From Study I).

Theme	**Experiences of communication through interpreters**				
Categories	The role of interpreter as a language bridge		Impact of language and culture in clinical encounters		Impact of fear
Subcategories	Interpreters' competence	Confidence in the interpreter	Different sets of cultural values	Differences in mother tongue	Unpleasant experiences
Codes	Misinterpretations Inexperienced interpreters Lack of language knowledge Unqualified interpreters Health terminology deficiency	Safekeeping inability Feeling of irresponsibility Distinguish social life from work life Confidence Neutrality	Health beliefs Conception of diseases in different cultures Handicap in the various cultures Body language Culture competency Ethnic background	Three languages in communication Illiterate refugees Same mother tongue Lack of knowledge in Persian Understanding the interpreter	Suspicion Feeling of fear Feeling of insecurity Fright of revealing identity

The role of the interpreter as a language bridge

The role of the interpreter as a language bridge had significant impact on the quality of contact both regarding encounters with healthcare professionals and social welfare personnel. The diagnostic and treatment process was enhanced if the interpreter was competent. The capability of the interpreter was recurrently stressed and the ability to interpret was closely related to experience. A successful clinical interaction was dependent on the use of the same language by interpreter and patient.

Lack of confidence in the interpreter was an important issue and lack of trust was mentioned as an influential factor on outcome of the consultation. The interpreter must also be characterized by impartiality and accuracy in the translation assignment.

Impact of language and culture in clinical encounters

Cultural differences between patient and healthcare personnel and between patient and interpreter could result in serious consequences for the patients. Bodily symptoms and diagnostic and treatment principles of a disease can easily be judged by the predominant traditions but the understanding of health and illness varies between different cultures. To reach a mutual understanding could be a difficult task.

Differences in mother tongue between interpreter and patient could cause misunderstandings in communication. It was found that if the patient and the interpreter did not share the same mother tongue three languages were involved in the interpretation process (patient's, doctor's and interpreter's languages). There is a risk for misunderstanding both when a Kurdish patient has sent a message in the Persian language to the interpreter as well as when the message is interpreted from Persian to Swedish. This kind of interpreting process is labelled trilingual interpreting process (TLI). Despite the fact that three out of ten of the participants were illiterate and five of ten had difficulty in expressing themselves in Persian, only three of ten had been asked if they wanted to have an interpreter in Kurdish.

Impact of fear

Fear and suspicion dominated the refugees' first contact with Swedish authorities. The first contact with the Swedish establishment bore the stamp of suspicion for many of

the refugees, especially those who entered Sweden illegally. Because of fear that their identity would be discovered and create problems for their families in the home countries, many did not dare to show their identity cards. This, in turn, created problems for them concerning residence permits.

Interpreters' experiences of general practitioner-patient encounters (Study II)

The analysis resulted in three main categories that were related to problems and difficulties as well as future possibilities.

Table 7. Categories and subcategories that emerged from the analysis (From Study II).

Categories	**Subcategories**
I. The interpreter's role	Attitudes among staff The triad problem Patients' demand of the interpreter
II. Lack of time	The time-related stress Information shortage The time and quality problem
III. Cultural aspects	The role of the GP Health beliefs and patient satisfaction Further education

The interpreter's role

The interpreters regarded themselves essentially as part of the healthcare staff in contrast to a frequently demonstrated staff attitude. This difference between self-image and reality created conflicts and dilemma for the interpreters. The balancing of the triad relationship (patient, doctor, interpreter) was another difficulty that was brought to notice. Healthcare providers' ability to focus on the patient obviously varies. Some doctors tried to put the patient at the centre of attention, while some doctors did not, and a desired patient-centredness was lacking. Sometimes the common language and the cultural context automatically guide the patient to turn to the interpreter instead of

the doctor. To find an equilibrium between doctor and patient created difficulties for the interpreters. While sitting in the same waiting room as the patient the interpreters were sometimes asked to do tasks outside the assignment. A sense of irritation easily arose.

Time and cultural aspects

Lack of time was an important obstacle to effective communication. Consultations through an interpreter with three persons involved took longer. Translation cannot be accomplished word by word, and to omit irrelevant words and to find the appropriate words in the target language called for additional time. Cultural aspects had an impact on the patient-GP encounters. Many patients came from countries where the doctor has an authoritarian role and they look upon the GP as the person who knows best. It makes it difficult for the interpreter to convey an approach of a more equal relation and the GP might be recognized as the person who perfectly well understands the condition of the patient. The GP's shortage of knowledge of health beliefs of different ethnic groups and unfamiliarity with the patients' essentials to regain health add to other difficulties. Further knowledge of health beliefs in other parts of the world was desirable.

General practitioners' views on consultations with interpreters - a triad situation with complex issues (Study III)

The data analysis resulted in four main categories and a number of subcategories. Three categories embrace the three members of the consultation (the interpreter, the GP and the patient) and the last category reflects the tangible prerequisites of the session (Figure 10).

Subcategories	Categories	Theme
Neutrality Unbiased Balancing	***The interpreter*** **– ability to construct bridges**	
Cultural openness Acceptance Patient orientation	***The general practitioner*** **– ability to embrace cultural circumstances**	**Intertwined triadic relationship**
Underdog Cooperating Language knowledge	***The patient*** **- ability to participate**	
Spatial orientation Continuity Time Technical support	***Tangible prerequisites***	

Figure 10. Categories and subcategories that emerged in the interviews (Modified from Study III).

The role of the interpreter

The task of the interpreters as a language link should be characterized by neutrality, impartiality and credibility. They should not add or take anything away from the narrative and try to produce an equivalent message from the source language to the target language. If a summary must be presented to the GP or the patient, the key message must not be lost. Otherwise it would lead to misunderstanding. The GPs stated that interpreters should have a balancing role between GP and patient, loyalties to one part in the consultation may affect the outcome of the consultations negatively.

The role of the GP

Ideally the GP's task and qualities is to be open for other cultures and have some experiences of his/her own of cultural differences. The ability of the GP to have an understanding and interest in the impact of body language is essential in cross-cultural

encounters. The need of interpreter in a consultation must also be regarded as a part of the daily work of the GP and not an exception. A patient-oriented style in the consultation must also be something important to aim at.

The role of the patient

In the triad situation usually both the GP and the interpreter were in a safer and more familiar setting while the patient's position could be weaker. This condition involved a tendency for the patient to face the interpreter instead of the GP; the interpreter was from time to time considered as an ombudsman for the patient in relation to the GP. Sometimes it was difficult to establish good cooperation with patients as they had a tendency to hide themselves behind the interpreters. Some patients did not want to use the new language (Swedish) even after residence for decades in Sweden. Immediate appropriate language teaching for immigrants was emphasized.

Tangible prerequisites

Consultations could be facilitated if concrete measures were accomplished. The way the participants were seated in the room could have an impact on the communication outcome. The distance between the GP and the patient should be shorter than the distance between the interpreter and the other two participants in the consultation. The interpreter ought to have an equal distance from the GP and the patient. A mindful placing of chairs and desk can diminish authority imbalance. By using the same interpreter in recurrent visits for the patient (continuity) and more time for the encounter, the quality of the consultation could be enhanced. An interpreter present in the room was preferred to a remote interpreter (by telephone).

Nurse radiographers´ experiences of communication with patients who do not speak the native language (Study IV)

An overall theme, "*The interpreting setting – a variety of scenarios"* was based on four main categories (modes, needs, quality and improvements of interpreting). Categories and the subcategories that support the theme, appear in Figure 11.

Subcategories	Categories	Theme
Professional interpreter Friend or relative as interpreter Personnel as interpreter Without interpreter	**Modes of interpreting**	
Absolute necessary Fairly necessary Not necessary	**Needs of interpreting**	**The interpreting setting - a variety of scenarios**
Interpreter's quality Time aspects Cultural aspects	**Quality of interpreting**	
Specific interpreter training Scheduling of interpreter Employment of interpreters Education of nurse radiographers	**Improvement of interpreter**	

Figure 11. Theme, categories and subcategories that emerged in the interviews (n=11). (From Study IV).

Modes of interpreting

Professional interpreters were the most credible and important persons in the contact with non-Swedish-speaking patients. The use of a professional interpreter implied good quality of the encounter and more confidence and security were experienced by the patient. The use of relatives or friends as interpreters could hamper the outcome of communication. Sometimes a relative could calm the patient, but emotional ties and troubles with impartibility could obstruct a free and optimal conversation.
Bilingual staff members at the hospitals could sometimes be used to establish a contact with a non-Swedish patient. However this option could create additional stress for the staff and influence the work flow.

Needs of interpreting

The need of an interpreter was strongly associated with the type of examination. Injections of contrast medium, for example, entailed a qualified interpreter as side effects of the infusion can be expected. It was also highlighted that imperfect communication increased the risk of misunderstandings and consequently additional examinations were sometimes asked for. This could lead to more radiation exposure for the patient and higher costs for the healthcare system. The participants also emphasized that those examinations without a need for specific verbal communication, such as those of wrist or ankle joints, can be carried out without an interpreter.

Quality and improvement of interpreting

Factors that could influence the quality of communication outcome were; interpreters' neutrality, good knowledge of languages and medical terminology, good discipline and a certain level of compassion for the patient.

Since within many countries various languages and dialects are spoken, the radiographers suggested that interpreter should ideally be assigned according to the patient's mother tongue rather than to the patient's citizenship. Permanent employment of interpreters for the major immigrant languages in the main hospitals was recommended as well. In the absence of an interpreter, telephone interpreting servcice on a 24-hour basis was recommended. In order to improve interpreting quality ample time for the interpretation assignment and the attention of the staff on cultural diversities was emphasized.

GENERAL DISCUSSION

Methodological aspects

Research perspectives

The research perspective of the present study had primarily an empirical-holistic approach. This implies that focus was on an increased understanding of phenomena and incidents that occur in healthcare encounters where language support (often through interpreters) was necessary. Primarily no quantified data were sought for; the aim was to find the essence and quality of the interpreting processes and the choice of qualitative research methods was natural. These methods attempt to generate concepts based on notes and observations and the context is of utmost importance.
The approach depicted entails no calculation of results in advance and no objective outcomes could be predicted. The initial conditions are the established everyday practice in routine healthcare settings and the collection of data is carried out in a holistic rather than in an atomistic way. The aim is to understand more than to explain.

The study design was based on the experiences of the researchers, and the outcome was based on the experiences of the participants. The relation to the informants had a subjective perspective; the objective researcher role was less prominent. The informants were chosen on the basis of their knowledge of the topics studied, and there was less emphasis on the quantity (number of participants), since the richness of data obtained was in focus.

An alternative or complement to an empirical-holistic approach could have been an empirical-atomistic (quantitative) research approach. Large numbers of participants could have been recruited and data then collected by using questionnaires designed to answer pre-determined, structured questions. Questions like “How satisfied are you with communication with your patients through an interpreter?” with fixed response alternatives might have been used. However, such an approach is not in accordance with the overall aim of the project, the endeavour to describe the nature and quality of the interpreting processes. An empirical-atomistic approach is more restricted at this

stage; insufficient knowledge about the basis of the interpreting conditions is the case so far and pre-determined questions by the researchers would be based on scant facts and on general apprehensions. Consequently, we preferred the use of interviews (individual or in groups), where mainly the experiences of the informants contributed to the outcome and the findings.

Nevertheless, in the thesis a small pilot study was added, where a more empirical-atomistic approach was applied. Quantitative measures of some objective facts within the research project were investigated. For example, the number of languages involved in interpreting, nationality of patients and kind of interpreter (relative or professional interpreter) was studied.

Size of material

The number of participants, particularly in study II (interpreters' experiences) was small and the question arises whether the sample size was enough to receive substantial and adequate data. Despite the limited number of participants we believe that the information obtained was rich and informative. All informants (patients, interpreters and healthcare professionals) were very active during the interviews and displayed various examples of difficulties and possibilities in their cross-cultural encounters. In study II altogether 75 years of interpreting experiences were behind the statements presented.

The size of study samples in qualitative research is often discussed and no definitive answers can be given to the question "what is a suitable study group size". Steinar Kvale (132), in his book on Qualitative Research Interview, comments on the question of sample size in interviewing informants:"… *Interview as many people as you need to find out what you want to know…*" (p. 97). The necessary number of informants depends on the aim of the study. If the number is too small it might be impossible to transfer the information to other fields and the applicability of the data would be restricted. If the number is too large it would be difficult to make more thorough interpretations of the data.

“Saturation” is another related concept often discussed in qualitative research, when numbers of interviewees are questioned. The information received in interviews is said to be saturated when further talks are not expected to add any more important information on the phenomena. However this concept is often questioned and the term “pragmatic saturation” is suggested as a more relevant expression (133). It implies that you can impede the collection of data when a rich and interesting material has been gathered, ample enough to allow interpretations and throw some new light on the phenomena studied.
Despite the limited size of the materials, we believe that the information received in the four studies was rich and interesting enough. Of course larger samples and more interviewees could have given some further knowledge. Our results may then be used to design such larger studies in the future.

Three of our studies were carried out in focus group interviews. According to the literature, there is no generally accepted ideal size of a focus group; a sample of four to twelve (134), six to eight (135) or six to twelve (136) participants seems to be adequate, although smaller groups could possibly result in deeper discussions (135). We had planned for 6-8 participants in all focus group interviews, but the actual number of participants was sometimes smaller due to late drop-outs caused by sickness, lack of personnel to substitute for the participants or other practical difficulties for participation. Such difficulties in organising a common focus group schedule for the general practitioners necessitated personal interviews in some cases in Study III. Studies have indicated that selection of the informants and the nature of the discussion process are more important than the actual sample size (120, 134).

Other aspects of focus group methodology were fulfilled (136). Thus, participants were selected in accordance with focus group methodology, representing selected groups with homogeneous backgrounds (interpreters, general practitioners and nurse radiographers, respectively). The interviews were performed during working hours in an open, trusting environment outside their usual workplace (137). The sessions were

moderated by an experienced moderator and co-moderator, representing two different healthcare professions (physician and nurse radiographer, respectively).

Gender perspectives and power balance

Socio-cultural power dimensions such as gender, ethnicity, age, and social class are more or less common in communication in healthcare. These issues are highlighted in a recent study in Sweden (138). Hierarchical patterns can be seen in this context and the importance of gender issues, also in inter-cultural encounters, has been explored (139). Within our focus groups there was no apparent hierarchy or power imbalance among the participating nurse radiographers or GPs; all had similar training and position in the departments/clinics. However, age and professional experience varied somewhat and therefore informal hierarchies can not be ruled out. The interpreters, on the other hand, represented different professions and different social and cultural backgrounds. Although no apparent power imbalance could be noticed during the interviews, such an influence is more likely to occur in this group.

Gender structures could sometimes be very prominent and overshadow more traditional professional hierarchies. A triad composition of a male patient, a female provider and a female interpreter provides another condition than a setting of the inverse gender composition. The awareness of these structural conditions has however not always attracted much attention and the findings in our studies gave just a few indications of power features.

The gender perspective can also be noticed from the viewpoint of representativeness. We tried to obtain samples with both males and females and in Studies II, III and IV both men and women participated. In Study II three of five participants were women, which represents the gender distribution (58.5% female) among interpreters in Gothenburg today (140). In Study III there was an equal distribution of male and female GPs (four of each), which also mirrors the actual proportion of 44% female GPs in Sweden (141). Among nurse radiographers in Sweden, women are clearly over-represented, they constituted about 80% in 2008 (142). In Study IV nine of eleven

participants were women, which is close to the general gender distribution in the country. Thus, we feel that the gender distribution among the informants in Studies II-IV was satisfactory. Furthermore, the participants in Studies II-IV to some extent represented different ethnic backgrounds.

During the group interviews of interpreters, GPs and nurse radiographers, the female as well as the male participants were active in the discussions. It has been suggested that men and women may act and interact differently in group discussions (143). This may have some influence on the content and outcome of the discussions. However, this issue was not the focus of the present study. The moderators of the focus groups were men in all settings. Others (144) used gender-concordant moderators to lead focus group interviews of men and women separately, when ethnical and cultural gender aspects among the participating patients were thought to have a significant impact on the openness of the discussions. In our studies of professionals it seems unlikely that essentials of the interviews would have been much different if females had acted as moderators for females. The attitude and the experience of the moderator probably have a greater impact than his/her gender in such a setting.

In Study III signs of a low patient-status was visible in the subcategory "visible/underdog". The patients were reported in the triad interpreting situation as having a tendency to be invisible and hide behind the interpreter. This was mentioned by the GPs and the observation probably partly reflects the patient's insecurity and power inequality in the setting.

Regarding the content of the interviews, reflecting the views of the interpreters, GPs and nurse radiographers, no clear gender issues or discrepancies were identified. However, specific questions regarding e.g. the situation of male and female patients in need of an interpreter could have been further elaborated upon – this might have added interesting material. Studies of such differences should be the focus of future studies.

In Study I it would have been desirable to include women also. However, at the time of recruitment no women with a similar background as the recruited men, i.e. war-wounded refugees, were available for the study.

Potential sources of bias

The investigator's background and pre-understanding

The background and pre-understanding (145) of the investigator may be considered a risk factor for impartiality in the planning, execution and analysis of the research. The investigator in the present study has a background as a refugee immigrant from the Kurdish part of Iran, a background very similar to that of the Kurdish war-wounded refugees interviewed in Study I. Knowledge of the problems experienced by this vulnerable group and their considerable need of support from social and healthcare authorities on arrival in Sweden was one reason for the selection of this study theme. However, it might potentially also have influenced the performance and outcome of the interviews.

On one hand, the investigator's background and his pre-understanding might have been advantageous, since he was aware of the potential problem areas that Kurdish refugees might be exposed to. Also, the interviews had the advantage of being performed in their native tongue. The interviews were performed by "one of their own", and the material was probably less censored than if a person with a different background had performed the interviews. On the other hand, there is a risk that the interviews took a direction that was influenced merely by the investigator's background and pre-understanding, thus hampering neutrality. In order to minimize such bias the interviews had a semi-structured design starting with a neutral question: ''could you please explain how you experienced communication through interpreters with the Swedish authorities after your arrival in Sweden?''. Although some bias due to the investigator's background and pre-understanding cannot be ruled out, the degree of openness, depth and confidence obtained in the interview situations was probably beneficial.

Regarding Study II (interpreters) the investigator had his own experience as an interpreter in a Red Cross refugee camp environment, and in Study IV the investigator had his own experience as a registered nurse radiographer. Thus, the investigator had a certain degree of knowledge and pre-understanding of the role and problems of interpreters and nurse radiographers, respectively. In both these studies (II and IV) the experiences of the investigator was the incentive for the studies. A potential influence of pre-understanding was minimized in Studies II and IV by using co-authors without such a degree of pre-education to chair the interviews and be part of the data analyses.

In Study III the moderator had the same profession as the participants (GP) and the interviewing of colleagues could be challenging. There is an urge among GPs to do their work in the "right" way, and also a fear of failure according to professional standards (146). As the formal academic head, the interviewer could also be seen as an agent getting an insight into the professional quality of the interviewee and thus preventing honesty and frankness. The discussion, however, seldom touched upon aspects of professional knowledge and the interviewees seemed unbound and straight in their commentaries**.** Awareness of one's own historicity and pre-understanding, and understanding the impact of the "life-world paradigm" (129,147), is probably the most effective measure to minimize bias in the research process.

Location of interviews

The place where interviews take place is of some importance for the outcome, and a neutral site should usually be sought for (137). In our studies interviews were performed in different environments. In Study I (war-wounded refugees) the interviews took place in the participants' residences, which were not quite neutral environments. This was made mainly for practical and economical reasons as it was difficult to conduct the interviews in other places. Yet we think that the home is a place for receiving more information than interviewing in a hospital or a more authority-loaded setting. At home the interviewees are more easily relaxed, less time-pressured and as some were physically handicapped certain home facilities were

needed, thus the homes were the optimal location. In Studies II-IV we were outside the everyday workplace and a neutral place was used.

Audio-recording of interviews

Awareness of the fact that the interviews were audiotaped might have influenced the interviewees. In some cases this was obvious at the beginning. The experience was, however, that after a while the microphone was forgotten and the discussion was seemingly free, relaxed and non-restricted. In some discussions a few comments were given after the tape was turned off. In this case notes were taken and added to the transcripts. An alternative to a tape-recorder would have been to take notes on line during the interviews. This would however reduce the exactness and reliability of the findings and we do not think that the microphone had any significant negative influence on the discussion process (148).

Recall bias

Selection of the data collection method is strongly associated with the type and nature of the problem area to be investigated. In Study I we used a qualitative, semi-structured interview, which is a flexible method with a framework of themes, thus allowing expansion of the interview with more targeted questions as it proceeds. There was a long time between arrivals of the participants and the time of the interviews, and some of the memories from the arrival period might have been forgotten (10-14 years). Yet the participants reported quite well in detail and with seemingly high reliability about events at the time of arrival in Sweden.*" One never forgets such unpleasant moments"* as one participant said. Some of the experiences reported in Study I are also related to more recent experiences in contact with the Swedish healthcare and social services, and the recall bias is less in these cases. Furthermore, communication problems for many of the war-wounded persons have been ongoing and are part of everyday life. Thus, this issue of being reminded of communication hurdles has been a part of the life of the war-wounded Kurdish refugees through the years and it may minimize the risk of recall bias.

We were aware of this bias risk as a long time existed between arrival and interviews. However one of the reasons for choosing these persons was that they had been resident for many years and had now learnt the Swedish language quite well and had become familiar with the Swedish society. It can be assumed that this might have helped to explore the difficulties and put things into perspective.

Interviews

For collection of the data for Studies II, III and IV focus group interviews were used. This method is suitable for collection of data in cross-cultural and health research (149). The focus group method is an appropriate mode for the study of homogeneous groups (149,150) and it was preferable to use this method. The method is cheap and suitable for a small group of participants. Focus group interviews require the participants to be aware of the specific focus of the discussions. Compared to individual interviews, ideas, thoughts and opinions from other members of the group may enrich the discussions and add content.

Problems with focus groups may include hierarchical, cultural and other discrepancies, resulting in diminished confidence and self-censoring among participants. In order to obtain valuable data an experienced interview leader is required. In our studies all group interviews were lead by a physician (BM) with long clinical and research experience. Individual interviews, on the other hand, may add depth and help to keep focus. The relationship between the interviewer and the interviewee becomes more important than in group interviews, and may influence the outcome. The power balance between interviewer and interviewees may be different to that in a group interview. In Study III both group interviews and individual interviews were performed, although it had been the intention to use group interviews in all cases. Similar problems in interpreting situations were mentioned in the individual interviews as in the group interviews, but more depth and detailed examples were presented in the individual interviews, perhaps reflecting the longer time allowed for the participants who were interviewed individually.

Analysis methods

The study aimed at finding qualities of communications in cross-cultural clinical encounters, and a method that describes human conception of this issue was needed. In the first study (chronologically) that was carried out (in this thesis Study II) phenomenography was attempted. This method was originally developed in relation to pedagogic research but over the years the method and its application have been modified; *"the method is dynamically changing"* (151, p 113).

The starting point is that people have different perceptions and understanding of phenomena in the world and phenomenography aims at describing differences and variations of experiences. Perceptions are not equal to attitudes or opinions. You do not choose a perception; you cannot choose how to understand the world. Phenomenography studies the world as it is perceived, and focuses on differences (152). In Study II the selection of language groups was made according to variations of the phenomenon (the interpreting process). We aimed at interpreters from various realms of language but for practical reasons interpreters from only two language groups could participate in the discussion. The variations in perceptions of the interpretation were probably partly lost by this limitation. Also, some researchers propose that at least 15-20 informants are needed to receive a sufficient variation of perceptions (153).

Sometimes in phenomenographic research, the concept of "domain" is used and it comprises the main result. We did not use the specific term "domain", instead we used the terms subcategories and categories. In the domain an accumulation of different description categories emerges and these categories are related to each other through different conceptions of the same content. This forms the basis for a more systematic analysis (154). It might be doubted whether the analysis in Study II fulfilled this obligation. There were limited variations of conceptions among the interpreters. This was probably due to the limited number of participants and limited variation in cultural and ethnic background among the interpreters, although there were variations in age, sex, education and social status.

Furthermore, some personal attitudes and opinions were probably incorporated into the interpreters' statements. This could have influenced the discussion process, and could be considered as a hinder to the disclosure of conceptions that should characterize a phenomenographic analysis. Otherwise, the text analysis process was conducted according to the suggestions in the literature (155,156).

It can be concluded that the analysis in Study II may be considered to be closer to content analysis of the manifest content rather than being strictly phenomenographic in approach. Regardless of the aforementioned critical views of the analysis process of Study II, there was a firm relationship between the clearly described categories and the empirical raw data, indicating credibility of the study (155). Awareness of the limitations of this method in the analysis of our first study (chronologically) resulted in internal discussions within the research team leading to a shift of methods in the subsequent three studies. After an overview of potentially suitable qualitative methods, content analysis was considered the most appropriate method for the studies in question.

Content analysis method is a well-known and recognized method of analysing data collected by different qualitative methods, including focus group interviews (157). This method examines the data at the surface level (manifest content) as well as at a deeper level (latent content). Even though the analysis process often begins at a manifest level and the latent one occurs later, there is no defined ideal timing of the description of the manifest content or interpretation of the latent content. Carlsson (118) suggests that both elements should be in focus from the beginning to the end of the analysis. In this way, the content analysis method may be difficult, but on the other hand it may make it more attractive. Due to the nature of our study (cross-cultural communication) some culturally related expressions in the text required not only interpretation at a manifest level, but also needed latent interpretation. The content analysis method was considered a suitable method for analysis of our data as it can be used as a dynamic form of analysis that stays close to the collected data.

On trustworthiness

The question arises as to whether the studies performed were carried out in accordance with the strictness required in qualitative methods. Objections towards the methods used are depicted in the above sections and some imperfections are present.
The limited size of the material is already mentioned and larger samples of interviewees would probably have enriched the data and further experiences could have been elucidated. The transcriptions of the interviews were sent back to all the interpreters and some of the GPs but no preliminary analysis of the interviews was judged by the interviewees afterwards. By doing a feed-back and control of the participants' own perception of the interviews (clarification of data) information could have been more truthful and possible misunderstandings could have been avoided. However, in many other studies (32-36) similar conclusions are reported, even if cultural settings and languages studied are different from ours. For example, the importance of a competent interpreter, the avoidance of relatives or friends as interpreters, the significance of sufficient time in the interpreting process and the need to be open to cultural diversities have frequently been highlighted. We think that this equivalence to our findings confirms that the trustworthiness of our data is reasonable.

Comments on Results

A shift in Sweden from a monoculture to a more multicultural nation during the last decades has resulted in a great challenge for healthcare professionals regarding cross-cultural clinical encounters. This thesis is aimed at elucidating difficulties and possibilities in the interpreting processes in order to create a better mutual understanding between patients with different cultural and ethnical backgrounds and Swedish authorities, particularly healthcare and social welfare professionals.
According to sociocultural theory our cognitive development is socially related and our consciousness is a product of socialization (158). As we grow up in different sociological contexts, cultural diversity is a significant aspect that occurs between patient and healthcare provider in clinical encounters (159).

Culture has a dynamic nature and changes in time. The role of modern technology (internet, satellite TV), globalization and a better educational situation for many people have reduced cultural diversity at an individual level. However, in an ethnic perspective, particularly in religious issues these differences are still undeniable, mainly in societies where religion influences the country's constitutions and law and rules are often rooted in religion. In this way the entry of every new group of immigrants into Sweden conveys a new challenge to healthcare professionals; to overcome this problem culture competence professionals is needed among professionals. According to the results of Studies II and IV the necessity of culture-related literature in a healthcare professional education program is stressed. However an adequate measure has still not been taken regarding this issue in healthcare.

In the following, the main discussion will be based on the perspectives of the patient, the interpreter and the healthcare provider.

Patient perspective

The patient has an essential role in clinical encounters and her/his problem (illness) is the central element in the consultation. Therefore, active patient participation in the consultation process has a significant impact on the communication outcome. The situation is more complex in inter-cultural communication necessitating an interpreter (160). Although the role of the interpreter and the healthcare provider in clinical communication is important, interpreter-mediated communication is a dynamic process and all participants, including the patient, can influence the outcome of the communication (Study III). We found a tendency of the patient to be invisible and to hide behind the interpreter, using the interpreter as an ombudsman in contact with the healthcare professional (Study III). The importance of patient-centering in medical consultations has recently been emphasized (161). Disease must be looked upon as not only a biological phenomenon, as psychological and social aspects interact. The patient should be seen as an individual, and the patient's own perception of illness is important. There is a shared responsibility and a therapeutic alliance between the healthcare provider and the patient. In the intercultural encounter all or some of these

issues may be challenged. The communication of the illness perceptions and views of the patient can be hampered by insufficient language communication, insufficient interpreting, as well as factors such as physical environment and practical circumstances influenced by cultural differences.

The role of an adequate interpreter service cannot, therefore, be over-emphasized. In short and seemingly simple encounters, such as radiological examinations, patient centering may be reduced due to the impact of the technical part of the examination, and this may be accentuated by difficulties in communication, as exemplified in Study IV.

An important factor in this respect is the trust and confidence in the interpreter, as demonstrated by the asylum seekers in Study I, who feared negative consequences of revealing information and facts to the authorities. Similarly, the patient-healthcare provider communication may be affected by confidence in the interpreter, hampering the communication of the true patient story. The importance of patient confidence in the interpreter has been highlighted in the present study. Thus, our studies and others have confirmed that confidence in the interpreter and a good triad relationship are significant themes in almost all narratives and triad situations. Interpreter openness and neutrality have a significant impact on the triad relationship and makes it easier to communicate (162,163, Study III).

In some circumstances patients who had lived in Sweden for many years did not learn the language, or were reluctant to use Swedish in their healthcare contacts, and required an interpreter. This may be due to a feeling of greater security with their native tongue in situations of illness, or cultural and linguistic isolation in Swedish society. In order to contribute to equality in health care for patients with language difficulties, regardless of ethnic background, factors behind such attitudes should be identified and minimized.

Preparation of the patient through adequate information before a clinical encounter may contribute to satisfactory communication, diminish patient insecurity and establish a good clinical relationship. Sending written information in advance to the

patient in his/her mother tongue concerning the triad relationship and the consultation technique may result in better consultation outcome. In the triad situation the healthcare provider and the interpreter are usually accustomed to the setting while the patient is usually unfamiliar with the situation. Instructions to the patient not to discuss his/her illness with the interpreter in the waiting room, suggestions to face the healthcare provider and not the interpreter during the consultations and encouraging the patient to ask questions and demand clarifications may be beneficial.

Good clinical relationship is an important factor that enhances the patient's condition and contributes to a more active participation. Continuity of care is also known to have significant impact on experiences and outcome of consultations. Having the same provider and the same interpreter on successive visits are important aspects for the patient. If the participants knew each other beforehand the encounters resulted in more confidence and a more relaxed atmosphere which may have had a positive impact on the consultation (Study III).

Interpreter perspective

The interpreter's role in the triad relationship

Working as an interpreter in healthcare is not an easy task. The study revealed that interpreters' daily work comprises a number of difficulties that many times result in role conflicts and anxiety for the interpreters. The problems mainly originate from the triad relationship, because of interpreters balancing role both practically and emotionally. Often the patient and the interpreter share the same cultural and ethnic background. In this way the patient may try to privatize the relationship with the interpreter threatening the interpreter's neutrality. At the same time the interpreter attempts to maintain a professional role leading to role conflicts (Study II). In the case of a common background of the patient and the interpreter the patient may turn to the interpreter instead of to the healthcare provider. Some patients even regarded them as their ombudsmen. This may add to the difficulties in balancing the triad relationship (patient, interpreter and staff).

The interpreters considered themselves as members of the healthcare team, however they experienced that the staff showed a restrictive attitude towards them as shown in Study II and other studies (164,165). The interpreters experienced that they were considered as "a necessary evil" by the healthcare staff as well as an economic load on the healthcare system. However, studies have shown that in the long perspective the use of professional interpreters is economically more beneficial compared to interpreting by relatives or encounters without interpreters (166).

In a previous study, in the eyes of the staff the interpreters were looked upon as immigrants or refugees, and a distance between the native-born staff and the interpreters was clear (164,166). The distance between interpreter and staff is rooted in cultural differences within a society. Although during the last decades a more open attitude towards differences in cultural habits and health beliefs has been accepted, we must still try to understand each other much more. The staff must be more aware of the importance of the interpreters' role and invite them more openly to participate in the caring process. Due to the interpreters' job status (not belonging to the healthcare staff team) they have no office at their workplace. They sit in the patients' waiting room before they start their work and between interpreting sessions. This issue creates many problems for the interpreter. Many times they have been asked for help by patients about tasks not related to their interpretive duty. Additionally a relation between patient and interpreter was often established before they met the GP, which many times resulted in problems for the interpreter and interpretation quality.

Interpreters' competence

Since the quality of clinical encounters is strongly associated with the quality of the communication, the competence of the interpreter has a significant impact on the consultation outcome. Studies have also confirmed that health outcome is improved by use of professional interpreters as compared to non-professional interpreters (167,168). Lack of interpreter competence may originate from insufficient basic language knowledge or shortage of interpreter training. According to "Kammarkollegiet", which

is the authority responsible for interpreter authorisation, the authorisation must be renewed every five years, in order to assure continued interpreter competence (169). As with all other jobs interpreters need to update their knowledge, but the employment policy for interpreters in Sweden is a hindrance in this context. Thus, all interpreters in Sweden are employed on a part-time basis, with no secure long-term employment. In this way there is unwillingness to develop deeper engagement and competence. It may also contribute to the relatively low status of the interpreters' work and their competence in Sweden. Interpreters constitute a heterogeneous group of individuals with varying backgrounds and education, which may make it difficult to create the feeling of a common professional identity. In addition, even large hospitals lack local interpreter service based at the hospital, and the lack of actual physical rooms for interpreters and lack of e.g. identity badges adds to the difficulty of creating a professional identity.

In order to compensate for a lack of interpreters, relatives or friends are frequently involved in the interpreting process. However, they should never be the first interpreter alternative (Study III), as they are often acting as a third participant in the encounters rather than a neutral language link (170).

There are about 200 interpreting languages in Sweden. Authorised interpreters are available in only 40 (20%) of these languages (171). Authorised interpreters specialised in healthcare interpreting are available in only 37 (19%) of these languages. In total, the estimated number of interpreters is about 6000. Less than 800 of these have formal authorisation, and only 95 have special competence in healthcare interpreting (171). In order to satisfy the need of the society regarding communication with non-native speaking inhabitants in Sweden, the involved governing authorities should attempt to improve and increase interpreter education and interpreter service and control, in order to reduce the risk of insufficient interpreting (172).

In Study IV, it was witnessed by the nurse radiographers that even though a professional interpreter was present, optimal consultation outcome could not be obtained. Previous studies have indicated that the competence of the interpreter is

strongly associated with the patients' assessment of quality of the consultation (173). Based on the result of our studies when using relatives or friends, particularly children, as interpreters the quality of communication outcome may be reduced, because of their lack of language knowledge, particularly in medical terminology and lack of impartiality. This issue has also been stressed in previous studies (170,174,175). Studies on cost-effectiveness are needed to indicate the differences in using an incompetent interpreter compared with assignments carried out by a professional interpreter. When the quality of communication is improved it reduces communication barriers. To assign an interpreter according to the patient's mother tongue rather than citizenship is essential (Study I). When the patient and interpreter share the same mother tongue there are two languages involved in communication (in this example Swedish (S) and Kurdish (K)), i.e. bi-lingual interpreting (BLI) (Figure 12). If the patient and the interpreter do not share the same mother tongue, three languages may be involved in the interpreting process (in this example Kurdish (K), Persian (P) and Swedish (S), i.e. tri-lingual interpreting (TLI) (Figure 13). This carries an increased risk of misunderstandings, because of the doubling of the interpreting process. In a difficult situation, such as illness, one may go back to memories of early experiences that are often built into the mother tongue, implying the difficulty of transferring this to a second language, as indicated in a previous study (176). In a worst scenario, the doctor has a foreign mother tongue, different from both the patient´s and the interpreter´s mother tongue, and the communicative language (Swedish) is non-native to all parts involved. This means that four languages are involved in the consultation, leading to potential complications in communication.

The desirable/sought-after interpreter

Without competent interpreters, valid and reliable communication, that is essential to obtain a satisfactory consultation outcome, is difficult to obtain (33,177,178). Based on the results of our studies, the above discussion and my own experience, the image of a "good interpreter" emerges: good language and cultural competence, good interpreting technique, neutrality in relation to the patient and healthcare giver, neutrality with respect to gender, ability to balance closeness and distance to the

patient/client and the healthcare provider, good discipline (time keeping) and correctness, discretion in clothing, attitude, emotions and manners, empathy and mindfulness. Above all, the language and cultural competencies are important; however an evident lack of neutrality could have devastating consequences.
For interpreting in healthcare, it is also important too have knowledge of medical terminology, be familiar with healthcare system routines, have knowledge about hierarchies and know who in the staff is doing what. For specific situations knowledge about e.g. radiology department routines, emergency room, intensive care unit routines, and familiarity with end-of-life situations may be required.

An interpreter with openness, neutrality and impartiality makes it easier to communicate, as shown in Study III. Interpreters' neutrality and safe-keeping is crucial since in many cultures "*...people don't want others to know about their illness"* (179). Thus, the healthcare staff and social welfare personnel should assign competent interpreters, since this is so essential for the exchange of information between patient and professional (180). In particular, tri-lingual interpreting situations (when the patient and interpreter do not share the same mother tongue) should be avoided, as this increases the risk of misunderstandings (Study I) (Figure 12, Figure 13).

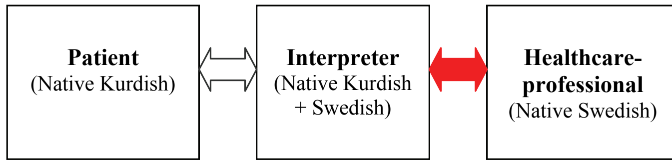

Figure 12. *Bilingual interpreting process*

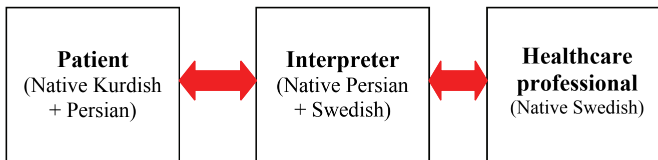

Figure 13. *Trilingual interpreting process*

Healthcare professional perspective

The role of the healthcare professional in achieving an adequate consultation outcome in clinical encounters, with or without an interpreter, seems to be related to an open attitude towards cultural discrepancies and a patient-oriented approach. Therefore, knowledge about other cultures is an essential factor in order to facilitate communication between healthcare provider and patients with different cultural backgrounds. Although it is not necessary to know all details about the patient's culture, a general knowledge and understanding of certain sets of cultural values is crucial. For instance, the attempt of a male physician to shake hands with a female patient from a culture in which this is not customary, or allowed, may hamper a good relationship and reduce trust in the consultation process. The need for further education and knowledge about cultural diversities, in order to avoid such inconveniences, was emphasised by e.g. the nurse radiographers in Study IV.

Lack of knowledge on behalf of the healthcare provider about the patient's culture, "culture blindness" could result in more questions to the patient (181) and need for additional time. With consultation through an interpreter this is added to the time needed for the actual translation (182). Lack of sufficient time in consultations through an interpreter was one of the main issues brought up in our studies (Studies II, III and IV). This situation may lead to time stress and frustration. In recent years cost and cost-effectiveness have become more important in healthcare ("time is money") (183). As long as interpreters and interpreting are not seen as integral parts of the system, this remains problematic (Study II). Thus, it has been demonstrated that important knowledge and information may be lost in clinical encounters through the interpreter (184). This may, in turn, threaten the medical treatment and the rights for equal and high quality healthcare for all individuals (27).

As suggested in Study IV, the interpreters should be scheduled to cover the entire consultation or examination, and not only a pre-defined time slot. Patients often have questions that arise after the actual consultation, to be answered by available staff. Without the interpreter available, this may be impossible and can leave the patient worried or confused. In fact, migrants emphasized and appreciated the role of the interpreter as a guide and practical helper in the healthcare system, in addition to the linguistic aid provided (180). As pointed out by the authors, this has not been clearly addressed in the guide-lines for authorized interpreters (169). In Study II, the interpreters expressed dissatisfaction with tasks that were not related to the actual consultation, because of time constraint and the fact that activities outside the consultation interpretation is not included in the working time. Since the guiding role of the interpreter seems relevant and important for the patients, scheduling of such activities should be considered as part of the interpreter service.

Patient-orientation, both emotional and physical, has a significant impact on the outcome of clinical encounters. Since training and practical education about patient centredness has been shown to improve safety in health care, this issue must be in

focus (185). For example, it is essential that the healthcare provider tries to look directly at the patient and not at the interpreter, during the clinical consultation. This makes the patient feel in focus (Study II). Previous studies have indicated that the patient-centred consultation influences patient satisfaction (186,187). Fulfilment of the above may be difficult in interpreter-mediated consultations. With an interpreter present, both patient and caregiver tend to turn to the interpreter when communicating with each other, as exemplified in Studies II and III.

Physical orientation in encounters has been in focus in other areas of research. For example, a triangle model has been used in educational encounters (188) regarding teacher, patient and medical students. This concept could favourably be transferred to healthcare consultations through an interpreter. Based on the experience from our studies (Studies II and III), we suggest the use of this triangle communication model (Figure 14) that hopefully could result in more patient-centred consultations.
In this model the patient, the healthcare provider and the interpreter are seated physically in a triangle situation. The distance between the patient and the healthcare provider should be shorter than the distance between the interpreter and the patient and between the interpreter and the healthcare provider (Figure 14). This could lead to a more patient-centered consultation, which also encourages the healthcare provider to look at the patient instead of the interpreter. This, in turn, would facilitate the reading of body language, and improve the emotional contact between the two parts. Furthermore, a patient-centered strategy would result in more active listening to the patient, an essential aspect of the clinical encounter (189). Apart from the physical orientation, Figure 14 summarizes some other elements of importance for a successful and patient-oriented, interpreter-mediated encounter.

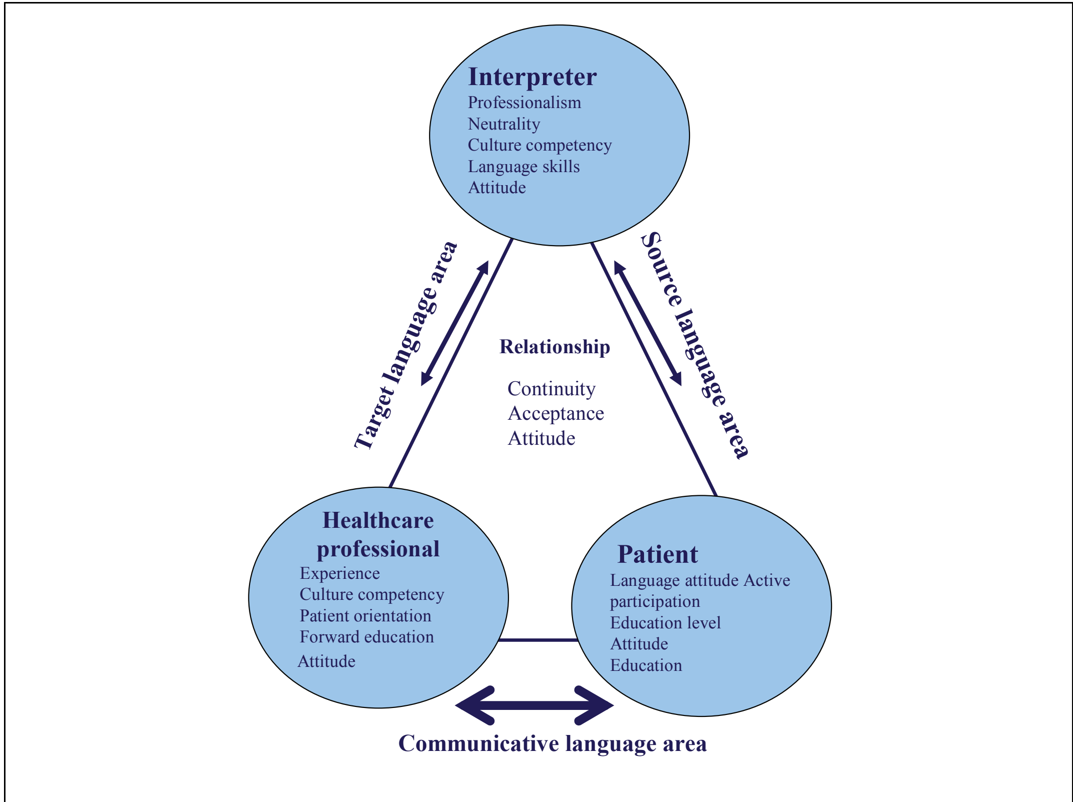

Figure 14. *The triangle communication model, and some factors that influence the communication process.*

General perspective

The importance of a patient-oriented attitude has been discussed above and highlights the fact that the *"spatial orientation"* may have an impact on the outcome of the consultation. Thus, the triad's physical position of the patient, interpreter and healthcare provider in the room is of importance (Studies II, III). An adequate placing of chairs and desk in the room can result in a more patient-oriented approach (Figure 14), facilitating a close relationship between the patient and the healthcare provider, regarding eye contact, reading of body language and emotional interaction.

Study III has indicated that the use of the same interpreter on successive visits (continuity) has significant impact on the communication outcome and improves the patient's trust. *"I usually write the interpreter's phone number in the medical record in order to reserve the same interpreter next time more easily"* said a general practitioner. If both parts are satisfied with the interpreter, there should be an agreement between the patient and the healthcare provider to book the same interpreter for successive visits, although the logistical difficulties with such arrangements are obvious.
One of the most significant problem areas stressed by both the interpreters and healthcare providers was the time aspect, as mentioned earlier. Thus, lack of time might force the healthcare provider to shorten the patient interview, resulting in stress and incomplete information exchange. Clearly, clinical communication through an interpreter requires scheduling of more than average time for consultations. This, in turn, requires that the staff responsible for consultation scheduling are aware of the need of an interpreter well in advance of the encounter.

To judge the need of an interpreter in contacts with non-native-language speaking patients is often difficult, since the needs are individual, difficult to anticipate and no clear guidelines are available. Thus, our survey showed that occasionally no interpreter is available in radiological consultations making mutual understanding impossible. As witnessed by the healthcare providers (Studies III, IV), the absence of an interpreter may jeopardize the consultation outcome, and it can create unnecessary anxiety among patients as well as staff. In particular, this was evident in radiological examinations where intravenous contrast medium is used, as adequate bilateral communication between nurse radiographer and patient is necessary to prevent patient over-reaction to normally occurring side-effects, such as a feeling of heat inside the body, and to facilitate the early identification by the staff of early signs of serious side-effects, such as anaphylactic reactions (Study IV).

In the absence of an interpreter, remote interpreting by e.g. telephone or video conference may be an alternative. Analysis of remote interpreting was not the primary

focus of the present thesis. This method has long been used in the USA in order to overcome language barriers (190) and is now used also in Sweden. However, according to the results of Study III, remote interpreting was considered as a suboptimal model for clinical consultations in most instances. According to the participants in Study III the presence of an interpreter as a physical link to the healthcare system would result in better patient trust and a feeling of security. In a recent similar study in Sweden, immigrant patients preferred “face to face” interpretation, rather than interpreting by telephone (180). It was stressed that the quality of the message decreases in remote interpreting. In the case of political refugees, fear of revealing personal information to an unknown, remote interpreter was a concern (Study I). Remote interpreting may seem attractive for logistical and economical reasons, but should be used with care, taking the above factors into consideration.

In order to improve and secure an adequate interpreter service, the preferred solution suggested in Study IV was employment of interpreters in the most frequently used languages, at least at the larger hospitals or institutions, in order to contribute to an equal healthcare for all patients, regardless of ethnical, cultural and lingual background. Availability of interpreters at nights and e.g. for ambulance service constitutes special problems, that needs to be faced (191).

In the present studies, not only linguistic, but also culture-related communication problems were highlighted. Thus, differences in e.g. values and conception of disease and health, ways of expressing feelings, differences in body language and other factors specific to ethnic or cultural background can influence the communication outcome. It is apparent that knowledge about such cultural differences may increase trust and reduce the risk of misunderstandings in communication. The need for improved education about such issues for healthcare and social welfare providers was stressed (Study I, IV). Knowledge about differences in culturally rooted habits such as e.g. hand-shaking and body-language may thus be helpful. However, any educational efforts should be made with caution to minimize the risk of creating or enhancing

stereotypes that may prevent an open and neutral mind in the encounter with a patient or client with a different cultural background. Openness and acceptance of other cultures, both on an individual and a collective basis, are the fundamental aspects of this issue.

CLINICAL IMPLICATIONS AND RECOMMENDATIONS

Implications

The results of this thesis provide a number of propositions:

- In clinical consultations through an interpreter, involving three persons instead of two, as in normal consultations, allocation of more time is needed.

- In order to avoid tri-lingual interpreting processes (patient and interpreter have different mother tongue), interpreters should ideally be assigned according to the patients´/clients´ mother tongue rather than citizenship. The need for an interpreter, and the native tongue of the patient, should be clearly stated on the consultation request forms and radiology request form.

- With the intention of minimizing misunderstandings related to cultural and ethnic differences interpreters with dual cultural competence are needed. Thus, the cultural and ethnic background of the patient/client as well as that of the interpreter should be taken into consideration in the appointment of interpreters. Intercultural communication in healthcare providers´ training should be enhanced.

- Practical planning has an impact on the quality of consultation. By arranging the chairs and desk in a suitable way in the consultation room, the healthcare provider – patient communication may be enhanced, while less focus is on the interpreter.

- All persons in the triad situation, i.e. the interpreter, the healthcare provider and the patient need to be actively involved to enhance the interchange and facilitate the contact. The patient should not “hide” behind the interpreter, since the patient should be in focus in the encounter.

- Due to the need for impartiality and the lack of language knowledge, particularly of medical terminology, patients´ relatives, friends and especially children should not be the first alternative as an interpreting aid.

- Sending information to the patient in his/her mother tongue concerning the consultation and interpreting routines beforehand could lead to a more fruitful clinical interaction.

Recommendations

Due to factors such as globalisation, natural disasters and human-related factors, migration of people has become an undeniable fact. This issue creates a number of problems regarding cross-cultural communication through interpreters, particularly in the healthcare and social welfare sections. In spite of worldwide studies of this topic additional studies are needed in order to clarify many of the obstacles in cross-cultural communication with an interpreter, including the role of distant interpretation.

Since a clinical encounter through an interpreter is a kind of social interaction, accuracy in the translation is probably just a part in the assessment of the quality of the interpretation enterprise. Experiences of sociologists, psychologists and anthropologists could probably add important inputs into a realm that needs more knowledge. In this context knowledge about cultural diversities in health and illness should be a mandatory subject in the healthcare-provider's training programme.

As interpreters in Sweden mostly work part-time on a consultation basis they have no long-term secure career opportunities, thus recruitment and professional development may be hampered. This creates low interest in this work, which may in turn lead to lack of competence among healthcare interpreters. Employment by the healthcare system of professional interpreters in the most frequent foreign languages seems warranted. Finally, establishing of a 24- hour interpreter service with interpreters in at least the ten most frequent languages equipped with the possibility of tele-interpreting is needed in order to compensate for the lack of a face-to-face interpreter service.

CONCLUSIONS

- Kurdish refugees stressed that interpreters´ competence and patients' confidence in interpreters were essential for cross-cultural communication. Assignment of interpreters should be based on the patients' mother tongue and ethnic and cultural background, rather than citizenship. In particular, tri-lingual interpreting situations (three languages involved) carried a high risk of misunderstandings, as the interpreting process was doubled.

- The interpreters emphasized that shortage of time was difficult to master. The translation itself implied a prolongation of time, which causes stress. The triad situation (three persons involved) was difficult to balance – interpersonal dynamics appear and a desirable patient-centred style could be difficult to maintain. The attitude of the health professionals towards the interpreters was sometimes negative; the role of the interpreter in the healthcare system was questioned and the interpreters expressed that they lack a clear position in the system.

- The general practitioners accentuated the responsibility of all persons in the triad situation to achieve optimized cross-cultural communications. The interpreter was regarded as the key person being a neutral creator of a bridge between the doctor and the patient. An open attitude to cultural disparities was stressed and a patient-centered attitude a necessity. Practical planning of the consultation was recommended; chairs preferably need to be arranged as in an equilateral triangle with a shorter distance between doctor and patient.

- The need of interpreter in radiological examination was strongly influenced by the type and complexity of the radiological procedure. The need varies between indispensable (as in interventional procedures) and not necessary. Professional interpreters were preferred instead of relatives or employees.

Shortage of time was a threat towards quality standards and cultural diversities between interpreter and patients should be in focus. Interpreter training and checklists specific for radiology department routines were suggested, as well as nurse radiographer training in intercultural communication.

SAMMANFATTNING PÅ SVENSKA

Bakgrund

Under de senaste decennierna har varje dag över hela världen tiotusentals människor flyttat mer eller mindre ofrivilligt från sin hemort till andra länder och samtidigt har de passerat språkliga och kulturella gränser. Sverige, som har en generös flyktingpolitik, tar varje år emot ett stort antal flyktingar och invandrare, och landet har omvandlats till ett mångkulturellt samhälle. Många flyktingar har en traumatisk bakgrund och åtskilliga har ett uttalat behov av vård och stöd och det är en stor utmaning för vårdpersonal att bemöta hjälpsökandes önskemål på ett tillfredsställande sätt. Patienter som inte behärskar det svenska språket skall enligt svensk lagstiftning ha samma möjlighet till information som de som har svenska som modersmål. Genom stöd av en god tolkhjälp kan en adekvat kommunikation erhållas och på så sätt kan icke-svensktalande patienters behov att nå optimal hälsa på lika villkor tillfredsställas.

Syfte

Syftet med projektet var att belysa kommunikationssvårigheter mellan icke-svensktalande patienter/klienter och personal inom svensk hälso- och sjukvård och sociala myndigheter. Vidare var avsikten att identifiera hinder och möjligheter i den kliniska kommunikationen och undersöka hur en positiv utveckling av kontakten mellan vårdsökande och vårdgivare kan befrämjas. I fokus var särskilt flyktingar (Studie I), tolkar (Studie II), allmänläkare (Studie III) och röntgensjuksköterskor (Studie IV).

Material och metoder

Fokusgruppsintervjuer och semistrukturerade individuella intervjuer genomfördes med de aktuella aktörerna (krigsskadade flyktingar, tolkar, allmänläkare och röntgensjuksköterskor). I Studie I var huvudfrågan: Vad är erfarenheten av kommunikation med svenska myndigheter genom tolk? Ett centralt och gemensamt spörsmål i Studie II-IV var också: Vilka är erfarenheterna av kommunikation genom

tolk? I samtliga samtal eftersträvades fördjupningar och förtydliganden för att få deltagarnas erfarenheter av dessa möten. Samtalen inspelades på band och en analys av det utskrivna materialet gjordes med kvalitativa metoder (innehållsanalys och fenomenografi) (Tabell 8).

Tabell 8. Översikt av material och metoder i de studier som ingår i avhandlingen.

Studie	Undersökningsmiljö	Datainsamling	Analysmetod
I	Hemma hos krigs-skadade flyktingar	10 semistrukturerade intervjuer med krigsskadade kurder genomfördes	Innehållsanalys
II	Tolkar från primärvården	En fokusgruppintervju med auktoriserade tolkar genomfördes	Fenomenografi
III	Allmänläkare i primärvården	Två fokusgruppsintervjuer och tre individuella intervjuer med allmänläkare genomfördes	Innehållsanalys
IV	På röntgen-avdelningar	Tre fokusgruppsintervjuer med röntgensjuksköterskor genomfördes	Innehållsanalys

Resultat

I samtliga studier framkom betydelsen av kvalificerade tolkar. Kommunikationen underlättades och sjukvårdsarbetets kvalitet förbättrades om tolken kunde vara både språk- och kulturöversättare. Tolken skall också vara medveten om de lagar och regler som gäller inom hälso- och sjukvård och inom socialvård. Att tolkarbete tar extra tid underströks av alla deltagare. Med fler aktiva i konsultationerna blir tidsåtgången betydlig och en tillräckligt väl avsatt tid för möten mellan sjukvårdspersonal och icke -svensktalande hjälpsökande är en nödvändighet för god kvalitet i arbetet.

Vikten av att välja tolk efter det språk som den hjälpsökande har och inte efter nationalitet underströks också. Inom många länder talas olika språk och ett lands dominerande språk behöver inte vara patientens modersmål. Om tolken och

klienten/patienten har olika språk blir kommunikationen ”tre-språkig” vilket innebär att patienten eller tolken själv måste översätta den hjälpsökandes språk till sjukvårdpersonalens språk. Viktig information kan då gå förlorad i jämförelse med en ”två-språkig” kommunikation där tolk och den hjälpsökande talar samma språk.

I **Studie I** (Krigsskadade flyktingar) framkom att på grund av kommunikationssvårigheter hade det uppstått svårigheter hos klienterna att få tillgång till det handikappstöd och den rehabiliteringshjälp som de formellt var berättigade till. Det fanns också en rädsla hos flyktingarna i den formella kontakten med myndigheter. Tolkens neutralitet och tystnadsplikt prövades extra när misstänksamhet och erfarenhet av politisk förföljelse fanns i bakgrunden hos de hjälpsökande. Betydelsen av ett gott förtroende för tolken återkom i flera berättelser. Fanns tidigare erfarenhet av gerillakrig och poliskonfrontationer var misstänksamheten särskilt påtaglig.

I **Studie II** (Tolkar) framkom en osäkerhet som gruppen kände i relation till övrig hälso- och sjukvårdspersonal. Tolkarna upplevde sig som en del av och samarbetspartner i sjukvårdsteamet och även av patienterna sågs de mer som ”personal”. Av personalen själva erfor de dock inte en sådan acceptans. Man efterlyste en större formell behörighet, gärna innebärande ett eget rum att vistas i mellan tolkinsatserna. Att sitta i väntrummet med patienten i avvaktan på konsultationen ville man undvika.

Tolkarna underströk svårigheterna som uppstod med tre aktiva personer i rummet (personal/tolk/patient) – en triad som kunde ge gruppdynamiska problem. Tolkens roll som neutral förmedlare kunde påverkas av patienten (som ibland vände sig till tolken i första hand) eller av läkaren (som också kunde bli för riktad mot tolken). Mötet mellan läkare och patient kom lätt i skymundan. Om patienten hade tidigare erfarenhet av en mer auktoritär sjukvårdstruktur med tydlig envägskommunikation blev det svårt med dialog och ömsesidighet i mötet. Aktiva insatser för att upprätthålla fokus på det centrala mötet läkare-patient behövdes.

Den språkliga översättningen kunde vara komplicerad. Olikheter i kultur och syn på sjukdom och hälsa mellan olika kulturer gjorde att det var svårt med nyanser och begrepp i den språkliga behandlingen. Patienter hade föreställningar och tro på vissa behandlingar och terapier som inte kunde föras över till den svenska kontexten. Tolken kände sig lätt pressad mellan patient och läkare. Ofta underströk man också otillfredsställelsen med de små tidsmarginaler man arbetade under - tidsbrist gav sämre kvalitet.

I **Studie III** (Allmänläkare) framkom att läkarna fäste stor vikt vid tolkens oberoende och neutralitet. Tolken sågs som bäst som en opartisk och stabil brobyggare som kunde balansera mellan närhet och distans till patienten och som översatte och förmedlade det språkliga utan att göra tillägg eller reduktioner. En viktig kompetens var också att ha kulturell sakkunskap och kontinuitet i tolkkontakten var en fördel.

Läkarna underströk vikten av att alla i triaden var aktiva i konsultationen och att tolken hade en väsentlig roll i att balansera stödet i relationen mellan läkare och patient. En eventuell tendens hos patienten att ”gömma sig” bakom tolken skulle uppmärksammas.

För att få en större patientcentrering i konsultationen betonade läkarna vikten av en strategisk placering i undersökningsrummet. Stolarna kan vara satta som i en liksidig triangel med kortaste avståndet mellan patient och läkare. Tolken sitter en liten bit ifrån med samma avstånd till både läkare och patient.

Läkarna betonade också nackdelarna med att ha anhöriga/barn som tolkhjälp. I akuta fall kan det vara acceptabelt men det finns olägenheter med den lösningen. Beroende och ofrihet i relationen kan få anhörigtolken att undvika eller lägga till väsentlig information och förvränga de förhållanden som skall undersökas. Även läkarna beskrev otillräckligheten i tillgången av tid för konsultationerna.

I **Studie IV** (Röntgensjuksköterskor) framkom att behovet av tolk var nära förknippat med typ av röntgenundersökning. Om interventions- och kontrastundersökningar skulle göras var kravet på kvalificerad tolk särskilt stort och undersökningar nödgades

ställas in om språkexpertis saknades. Vid enklare skelettundersökningar var behovet av tolk mindre och tvåspråkig personal kunde t ex vid dessa tillfällen bistå adekvat.

Anhörigtolk var också i princip icke-önskvärt och om tolken hade kännedom om röntgenavdelningens villkor och arbetssätt (ofta korta möten i mörka lokaler, med delvis avklädda patienter) hade det en positiv betydelse med förbättrad kvalitet i det radiologiska arbetet. Även här betonades nackdelen med att ha snäva tidsmarginaler och det underströks önskemål om att tolken kunde stanna kvar på avdelningen tills alla undersökningar var väl genomförda. Röntgensjuksköterskorna angav också förslag på förbättringar; tydliga utbildningsinsatser om kulturella villkor och behovet av fasta och lättillgängliga tolkar inom sjukhusområdet var några idéer.

Slutsatser

Tolkens kompetens är av stor betydelse för kvalitet i kommunikationen och det är viktigt att patienten har förtroende för tolken. Tolkrekrytering skall ske på basis av patientens modersmål och inte efter patientens nationalitet. Det finns ett antal hinder i kommunikationen som sammanhänger med språkförbistring, kulturskillnader, maktförhållanden, praktiska omständigheter i själva undersökningsrummet, kontinuitet och olägenheter med dessa förhållanden bör tidigt uppmärksammas. Alla inblandade i tolksituationen (tolk/patient/ personal) har ett ansvar i att aktivt medverka i kommunikationsprocessen som särskilt i röntgenundersökningar är av kortvarig karaktär. Ökad utbildning av personalen om interkulturella frågor och ökad kännedom hos tolkarna om de medicinska förhållandena föreslogs som förbättringsåtgärder.

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