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ORIGINAL ARTICLE

Difficulties in using interpreters in clinical encounters as experienced by immigrants living in Sweden

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Aims and objectives. To study a group of immigrants' experiences regarding interactions with primary health care through an interpreter.

Background. Approximately, 230 million people are resettled outside of their own home country. Thus, more than 3% of the world's population are migrants. It is a major challenge for health care providers to satisfy immigrants' needs for individualised health care services.

Design. Qualitative study.

Methods. Focus group interviews were conducted with four groups of immigrants (n = 24) from Bosnia and Herzegovina, Croatia, Kosovo and Somalia. The group interviews were audio recorded, transcribed and analysed, and the text was categorised using the content analysis method.

Results. Participants' expectations of the interpreter-mediated consultations were high, but not always fulfilled. Interpreters being late, lacking professionalism or lacking knowledge in medical terminology and the use of health care professionals or relatives as interpreters were some of the problems raised.

Conclusion. A well-organised, disciplined interpreter service with professional and competent interpreters is needed to overcome problems regarding clinical consultations involving interpreters. A satisfactory language bridge has a significant impact on the quality of communications.

Clinical implication. Interpreter services should be well organised, and interpreters should be linguistically, culturally and socially competent, as these factors may have a significant impact on consultation outcomes. Using relatives or staff as interpreters can sometimes be a solution but often results in an unsatisfactory clinical consultation.

What does this paper contribute to the wider global clinical community?

- Immigrants face several obstacles in establishing optimal communication when using an interpreter during interactions with the health care system.
- To obtain optimal health care outcomes, a professional interpreter and **a** correct interpretation are needed.
- Using a staff member as an interpreter can be a solution when there are no other alternatives, but this approach has its own disadvantages.
- A well-organised health care system has a significant impact on providing better health care to immigrant patients.

Key words: encounter, health care, immigrant, interpreter, organisation professionalism

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Introduction

Due to an increase in the number of patients from immigrant backgrounds, interpreter-mediated clinical consultations are now part of daily clinical work for health care professionals in many European countries (Hudelson *et al.* 2013). According to official Swedish statistics in 2013, 23·3% of the total 9·7 million population of Sweden had a foreign background, and of these, 15·4% were born outside of the country. These immigrants represented 171 nationalities (SCB Statistics Sweden 2012). Based on Swedish health care laws and regulations, equal health care for all inhabitants should be provided, regardless of whether they master the Swedish language. In this context, those who do not master the Swedish language should receive assistance from a professional health care interpreter in all contacts with public authorities (Kärrström *et al.* 1999). To provide the same level of satisfactory health care service for all patients, the interpreter's qualifications and communication outcomes must be considered (Gill *et al.* 2011).

Background

The role of the interpreter as a language link in clinical consultations should be characterised by impartiality, credibility and neutrality. Interpreters should not add or remove anything from the patient's story and should try to produce an equivalent translation of the source language to the target language (Fatahi 2010). Assigning the interpreter based on the patient's mother tongue, rather than the patient's citizenship, is one way to minimise communication misunderstandings between the patient and the health care provider (Fatahi *et al.* 2010b).

A previous study has indicated that the language barrier between health care providers and patients can induce discrimination and prejudice, negatively affecting care (Carnevale *et al.* 2009). The interpreter thus has an important role in communicating between health care providers and patients with language difficulties. The lack of use of an interpreter may cause the patient's basic needs to be unacknowledged, which may lead to incorrect diagnoses and lack of compliance from the patient (Black 2008). According to a previous study, the practical issues that arise when providing interpretation services may be problematic because of organisational aspects (Hadziabdic *et al.* 2010). Another study has indicated that immigrants were not satisfied when the interpreter did not arrive at the scheduled time without any explanation from the health care professionals (Hadziabdic *et al.* 2009). A study in Ireland (MacFarlane *et al.* 2009) showed immigrants' anxiety about misunderstandings in communication with health care that could lead to misdiagnosis. Furthermore, cultural diversity between patients and interpreters and a lack of trust in the interpreter are factors that may cause misunderstandings in communication (Fatahi *et al.* 2010b). The present study aimed to explore immigrants' experiences regarding use of interpreters in contacts with the health care system.

Methods

All contacts with the informants were arranged in collaboration with one key person in the Bosnian and Somali cultural centre associations of Gothenburg respectively. Information concerning the aim and background of the study was sent to the informants before the interviews in their native tongues. There were initially 29 persons interested in participating in the group discussions; however, five persons did not attend the discussions and did not provide an explanation for their lack of attendance. The final sample consisted of 24 persons who participated in focus group discussions. Twelve participants were men aged between 41–76 years (mean 60·9 years), and 12 were women 44–76 years of age (mean 62·8 years). The participants had lived in Sweden for between 16–40 years, and all but three of them were unemployed (Table 3).

Four focus group interviews (McLafferty 2004) were conducted by one of the authors (FK) between February 2013 and January 2014. The group interviews were semi-structured with open-ended questions in accordance with Kvale (1997). The main question in the group interviews was, *"Could you please describe your experiences regarding the use of an interpreter during your meetings with the health care system"?* More targeted questions were discussed in the course of the group interviews.

The interviews were held in the Bosnian and Somali cultural association centres. Each of the four group interviews included six participants, and all were led by one of the authors. Group interviews in Bosnian and Swedish were conducted by the first author (FK), who is bilingual. In the group interviews with Somalian or Albanian participants who did not speak Swedish (five from Somalia and three from Kosovo, respectively), the author was assisted by a native Somalian or Albanian professional interpreter respectively. All participants were active during the discussions, and they used their mother tongue and own words and expressions without interruption. All group discussions were audio taped and transcribed into Swedish. The transcribed text was then checked for correctness by the professional interpreter who had been present at the group

interviews. The duration of the interviews varied between 90–120 minutes. A qualitative content analysis method (Graneheim & Lundman 2004) was used for analyses and interpretation of the collected data.

Analysis process

The analysis was based on the content analysis method presented by Graneheim and Lundman (2004). The analysis started by extracting meaning units consisting of one or several words, sentences or paragraphs that contained aspects related to each other, addressing a specific topic, throughout the collected text data. Meaning units that related to each other through their content and context were abstracted and grouped together to transfer them into condensed meaning units. The next step was to condense the text into a more abstracted form, labelled with a relevant code. Then codes that addressed similar issues were grouped together, with the intention of identifying subcategories. Subcategories focussing on the same problem were brought together into categories addressing an obvious issue (Graneheim & Lundman 2004). As a last step, categories were summarised as one or several themes. The results were supported by the presentation of direct quotations from the interviews (see Table 1).

Ethics approval

As there was no physical intervention and as no information on individual health issues were involved in the study, there was no need for formal approval from the ethical board, according to Swedish law (Swedish Health Care Act 2007). The World Medical Association Declaration of Helsinki (1964) was, however, considered carefully. The informants' identities were protected, that is, their names and personal identity numbers were not stated on the recordings, transcriptions or on any publications. The audiotapes used for the interviews were stored in a safe at the hospital. Thus, the identity of the participants could not be traced. Prior to data collection, oral and written information about the study was provided to the participants in Swedish or, when necessary, in their native language through professional interpreters. The study information given to the participants included its voluntary nature, and that they could withdraw at any time without experiencing penalties or loss of access to services. All participants provided signed informed consent before the interviews.

Results

Three main categories, seven subcategories and an overall theme that included all categories and subcategories emerged in the analysis of the data (Table 2).

Discrepancy between interpreter service and patient expectations

Being late

The results indicated that the participants' expectations of the interpreter-mediated consultation were high. Their expectations included conveying the correct interpretation,

Table 1 Illustration of the analysis process in various stages (Modified from Lundestam *et al.*)

Steps	Description
I	Meaning unit
	The first step is to identify the words, sentences and paragraphs 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 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
VII	Direct quotes
	Presentation of result with direct quotes from the interviews

Table 2 Categories, subcategories and themes that emerged from analysis of the data

Subcategories	Categories	Theme
Being late Lacking professionalism Problems with medical terminology	Discrepancy between interpreter service and patient expectations	
Health care professionals as interpreters Relatives in the interpreter's roll	Consequences of dual roles	Practical and organisational difficulties in clinical encounters through interpreters
Organisation from health care services Service from the interpreter agency	Organisation of interpreter services	

a high degree of professionalism as well as accuracy. However, these expectations were not met in reality. The actual situations involved the interpreter being delayed, not arriving at the scheduled time, misinterpreting information, exhibiting a lack of professionalism and even being arrogant. Participants described the absence of an interpreter as something that made them sad, angry, disappointed and frustrated, all accompanied by stress and anxiety.

Table 3 Participants' background data

Informant	Sex	Age	Years in Sweden	Employment	Country of birth
1	F	44	14	No	Somalia
2	M	63	13	No	Kosovo
3	M	49	23	No	Bosnia and Herzegovina
4	F	56	18	No	Kosovo
5	M	71	17	No	Somalia
6	F	63	15	No	Somalia
7	F	66	33	No	Croatia
8	M	73	15	No	Somalia
9	M	53	20	No	Somalia
10	M	59	16	No	Kosovo
11	F	72	27	No	Croatia
12	F	70	13	No	Bosnia and Herzegovina
13	F	58	18	No	Croatia
14	F	73	13	No	Kosovo
15	M	58	14	No	Bosnia and Herzegovina
16	F	64	8	No	Croatia
17	M	46	11	No	Bosnia and Herzegovina
18	M	68	15	No	Somalia
19	F	46	12	Yes	Kosovo
20	M	41	16	Yes	Croatia
21	M	57	24	No	Bosnia and Herzegovina
22	F	66	20	No	Bosnia and Herzegovina
23	F	76	17	No	Kosovo
24	M	70	32	No	Croatia

"I had individual care planning at a health care centre, and we waited for an interpreter. More than 15 minutes passed, but the interpreter did not attend, and we were forced to call the interpreters' centre to assign another one, but none was available. My daughter was with me, but she was not able to interpret in this case. It was a sad moment".

"I was in an emergency situation and supposed to be operated on as soon as possible. The interpreter who had been assigned to help me was quite late. The staff talked around me; I understood nothing. It was a very hard situation for me. I was afraid and anxious. I thought I was going to die".

Lack of professionalism

The participants related that some interpreters not only lacked professionalism but also occasionally acted inappropriately and angrily. It seemed that some interpreters had insufficient interest in their job. Participants claimed that sometimes they could not express themselves freely because they were afraid to do so. In these situations, they did not receive adequate help from the interpreter because of the interpreter's negative reactions and irresponsibility.

"My interpreter was delayed about 20 minutes. When he arrived, he was very tired and harassed. I did not know how I could talk to him".

"Once I had an interpreter whose telephone rang all the time throughout the entire interpretation period. It bothered me and the doctor".

Problems with medical terminology

In addition to the interpreters' lack of professionalism, participants highlighted problems regarding interpreters' lack of knowledge of the Swedish language as well as of medical terminology. According to the participants' experiences, sometimes the quality of interpretation was so poor that that the consultation was stopped by the caregiver and a new appointment was scheduled.

"I do not know Swedish, but I have repeatedly felt that the interpreter did not interpret correctly. When the doctor noted that he was not satisfied with the interpretation, I was sure of my suspicions".

"I was in a meeting with five doctors. The interpretation process went well until he came to medical terms, and then the problems started to occur. We were forced to seek help from another interpreter".

"I had pains in my gynaecological organs; the interpreter did not know the term for this kind of disease, so he turned to me and asked, "How do you say that in Swedish?"

Consequences of dual roles

Health care professionals as interpreters

The majority of the participants in this study reported that they sometimes had to cope by themselves with the problems that arose during interpretation. Participants reported that they had to engage health care professionals and family members to help with the interpretation; however, in many cases, this approach had drawbacks. In the event that an interpreter was late or did not come to interpret, the majority of participants engaged health care personnel when possible. However, when the personnel acted as interpreters, it caused stress to both parties.

"Although she was very busy, she wanted to help me. She acted as the interpreter, but she was looking at her watch the whole time. During the consultation, she went to see whether her patient was ok. It was an unpleasant situation both for her and for me".

"Once, my interpreter did not come. I wanted to talk with the head of the department about it; one nurse who had the same mother tongue as me acted as the interpreter, but I was not sure that she interpreted everything I said".

Relatives in the interpreter's role

This study shows that using family members as interpreters is often an inappropriate alternative. One participant stated that a lack of neutrality and of language knowledge influenced the communication outcome. The most frequently mentioned problem, experienced by the majority of the participants, occurred with relatives acting as interpreters, as, based on the participants' experiences, they lacked adequate knowledge of the language.

"My grandson is studying in Lund. Once he was with me in order to help me with a meeting with my doctor. I did not understand what they were talking about, but I think my grandson did not understand either".

"Once I went to my gynaecologist. My daughter acted as the interpreter. The doctor talked, and my daughter interpreted, but suddenly she stopped interpreting for a moment and then she continued in a low, abnormal voice. A few days later I made a return visit and got an interpreter who found out what was going on".

Organisation of interpreter services

Many of the participants were older and had a high number of health care needs. Some of them visited the hospital or health care centre on a regular basis. Accordingly, they had information about how the health care organisation, as well as the assigning of an interpreter, works in Sweden. The experiences of the participants in terms of their access to an interpreter were conflicting, and in some cases, the organisation was not effective or was insufficient.

Organisation from health care services

Most participants were satisfied with the organisation of getting interpreters to the ward or to other places where they were needed. There were no apparent differences between hospitals and health care centres regarding the assignment of an interpreter. Some of the participants emphasised that their mother tongue, and even its dialect, had been asked for by the health care personnel when an interpreter was needed. These participants reported that they had also been asked about the interpreter's gender (if they preferred an interpreter to be male or female) for sensitive topics such as a gynaecological disease.

"Very good organization and services, beyond all expectations." "I felt honoured to be a patient".

"I was grateful that they asked me about my language and dialect as well as the gender of the interpreter when I reserved an appointment at the health care centre".

"I often got a female interpreter when I needed to visit a gynaecologist".

Service from the interpreter agency

According to the results, for an organisation to do the job successfully, all parties had to cooperate. However, although the organisation at the hospital and health care centres was generally considered to be very good, our study identified major problems concerning how the correct interpreter was assigned. Although some of the participants stated that they had been asked about language and dialect, there were some contradictory opinions on this issue:

"In my language, there are a number of different dialects". "I ordered an interpreter with one dialect and got an interpreter who did not understand me in general".

"My language is Croatian, but I often get an interpreter who has another mother tongue, an interpreter from Montenegro or Macedonia".

"Once the interpreter agency sent the wrong interpreter. The nurse called them, and they said that the Croatian and Serbian languages were the same; what professionalism!"

Discussion

As the present study explored immigrants' experiences of interpreter-mediated communication, a qualitative research approach was needed to analyse the data. We found focus group interviews and subsequent content analysis to be appropriate methods to obtain, analyse and interpret the data. The content analysis method includes audio recording, categorisation and classification of speech and text, which allows possibilities to analyse not only the evident content but also the underlying meaning, i.e. the latent content, of the text (Graneheim & Lundman 2004). The method is also appropriate for interpreting culturally related conceptions, relevant to the present study. We believe that basic study requirements concerning credibility, transferability, dependability and confirmability were fulfilled in our study (Mays & Pope 1995). As two of the authors of the present study were immigrants themselves, some degree of preunderstanding among them might have influenced the research process. However, this understanding may also have helped to conceptualise the study.

A well-organised health care system can have a considerable impact on providing better health care for immigrant patients. Although the majority of the participants were satisfied with the health care organisation regarding the need for, and requisition of, interpreters, but they highlighted that the interpreter service was commonly not effective or was insufficient. The results showed a number of other difficulties related to practical issues and the interpreters themselves. Tardiness, lack of professionalism, a lack of knowledge of medical terminology and the use of health care professionals or relatives as interpreters were some of the problems. Assigning an interpreter according to the patients' mother tongue and gender has an important impact on communication outcome. The results of the present study showed that participants were frequently asked by the health authorities about their mother tongue and were sometimes asked about gender when reserving an interpreter. However, despite this, the interpreters assigned to them from the interpreter service did not to always match these requirements. A previous study by Hadziabdic *et al.* (2010) indicated that to prevent communication misunderstandings in clinical consultations with interpreters, the patient's mother tongue should be prioritised, rather than her/his citizenship.

Providing an interpreter with the same gender, particularly for a sensitive examination such as a gynaecological appointment, had an important effect on the consultation outcomes. The following citation from a previous study confirms this issue: "*A female patient once presented unclear symptoms. Two weeks later, she came back with a female interpreter and haemorrhoids were diagnosed*" (Fatahi *et al.* 2008). The aforementioned study also addressed the fact that many dialects may exist in the same language. It is essential to consider the diversity of the different dialects within the same language to minimise misunderstandings. To optimise the clinical consultation, the choice of interpreter must be based on the patient′s individual needs.

According to the participants in the present study, interpreters often cancelled or did not appear at the scheduled time. This issue was mentioned as a major problem by the participants, which often led to the interpretation being performed by health care staff. This solution is frequently suboptimal because staff usually lacks an interpreter's professionalism (Fatahi *et al.* 2010a,b) and is usually not trained to act as interpreters. Furthermore, as clinical consultation is the first step in diagnosis and the treatment process, adequate communication is crucial (Fatahi *et al.* 2008).

The importance of an interpreter's competence in clinical consultation has been confirmed by previous studies (Haffner 1992, Dysart-Gale 2005). The results of the present study highlighted the frequent lack of professionalism and sometimes lack of knowledge of medical terminology among interpreters. Using a relative or a friend as the interpreter is often problematic and may have a negative impact on the quality of the communication outcome. A previous study reported that relatives and friends who act as interpreters often lack impartiality, neutrality and language knowledge (Gerrish *et al.* 2004). To provide equal health care services to all patients (Kärrström *et al.* 1999), a professional health care interpreter of high quality is needed. Using staff and family members as interpreters is a solution in cases where there are no alternatives, but it has its own disadvantages (Hadziabdic *et al.* 2014).

In interpreter-mediated consultations, all parties involved have an impact on the communication outcome. In the

clinical patient–doctor encounter, the physician's ability to consider the patient's emotional and psychological issues is essential (Rosenberg *et al.* 2011). This requires a deep understanding of not only the spoken language but also of culturally related nuances that are easily missed in interpretation. Thus, the physician's awareness of when and how to use an interpreter is important (Hsieh *et al.* 2013). When there is no interpreter and a provider is forced to act as the interpreter in a consultation, this can have a negative impact on communication outcomes because the ability to balance the two roles at the same time has been shown to be challenging (MacFarlane *et al.* 2009). Thus, there is a responsibility for all parties to contribute to suitable circumstances in clinical encounters with immigrants, both at an organisational level and in the clinical consultation situation (Fatahi *et al.* 2008).

The study's strengths and limitations

There have been many studies regarding clinical consultation, but it is often language or cultural problems that have been studied. Our study not only discusses issues concerning language problems but also how the organisation of the interpreter's services influences the consultation outcome. The interpreters' irresponsibility towards the patients, for example by not attending at the scheduled time, resulted in many patients feeling that the interpreter had not paid enough attention to their needs.

The diversity in ethnic backgrounds, age and gender in this study's participants can be considered as strength of the present study. However, the lack of common background among participants may also have contributed to reduce participant openness, which is an important requirement for focus group interviews, although this was not evident. Another potential limitation of our study was that eight participants could not speak Swedish, and we were thus forced to use an interpreter in the focus group interviews. Although professional interpreters were used for this purpose, culturally related expressions may have been translated literally instead of being interpreted correctly.

Conclusion

Regarding the use of an interpreter when in contact with the health care system, immigrants face obstacles in establishing optimal communication. Mutual understanding is essential to provide adequate health care to patients with limited language abilities. In this setting, a satisfactory language bridge has a considerable impact on the quality of the communication. Adequate interpreter service is facilitated by laws and regulations that allow and provide such help to citizens and immigrants. At the next level, interpreter services need to be well organised and disciplined, directed to specific societal services such as health care, the legal system, etc. Interpreter services need to work close to the health care system, using interpreters familiar with such issues. Interpreter availability, assigning of suitable interpreters according to language dialect, ethnic background and gender are crucial for communication outcome and patient safety. Although the use of a relative as interpreter is sometimes employed as an alternative to overcome language barriers in clinical consultations, this approach frequently results in communication misunderstandings or an incomplete transferral of information. Lack of language knowledge, impartiality and lack of neutrality were found to be factors that influenced communication outcomes.

Clinical implication

Health care providers need to be aware of the needs of immigrants. Interpreter services must be well organised, and interpreters should be linguistically, culturally and socially competent, as these factors may have a substantial impact on consultation outcomes. Using relatives or staff as interpreters can sometimes be a solution but often results in an unsatisfactory clinical consultation.

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Study design: FK; data collection and analysis: FK; and manuscript preparation: FK, NF, SS, MH and MB.

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Conflict of interest

No conflict of interest has been declared by the authors.

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