

Research paper

Perspective of Professional Interpreters Regarding their Role and Attitude in the Healthcare Encounter

Emina Hadziabdic

Department of Health and Caring Sciences, Faculty of Health and Life Sciences, Linnaeus University, Sweden

Katarina Hjelm

Department of Social and Welfare Studies, Linköping University, Sweden

What is known?

- Language barriers can be diminished and communication in healthcare can be improved by using professional interpreters in healthcare consultations.
- The role of the professional interpreter has previously been described as a conduit, which has been regarded as a controversial view, as the role is experienced as complex and conflicting.
- There is a lack of knowledge concerning how professional interpreters experience their role and attitude before, during and after a healthcare consultation.

What this paper adds.

- The professional interpreters in this study viewed their central role as to transfer information accurately, to keep confidentiality, to remain impartial and to perform duties related to their work assignments and the code of ethics for interpreters.
- The interpreters felt that several factors, such as the form of interpretation, the interpretation environment, their employment conditions and personal characteristics, and the behaviour of the patient and healthcare staff during the interpretation session, could influence their role.
- The employment conditions and training of the interpreters, as well as the information and training of healthcare staff concerning the use of the interpreter service, were identified as challenges to be improved.
- To ensure equality and high-quality healthcare, it is important to develop a functioning role of the interpreter and interpreter service that provides professional interpreters of high quality, in order that language barriers can be diminished and the healthcare of non-native speakers improved.

ABSTRACT

This study aimed to explore how professional interpreters experience their role in a healthcare encounter. An explorative study with semi-structured individual interviews and written descriptions was conducted with a purposeful sample of nine professional interpreters who represented the migrant population in Sweden. Qualitative content analysis was used to analyse data.

The findings showed that the professional interpreters viewed their role as to transfer information accurately, to keep confidentiality, to remain impartial and to perform the duties related to their work assignments. However, the study also found a number of factors and challenges that influenced this role. These were: 1) the form of interpretation, 2) the interpretation

environment, 3) the employment conditions and personal characteristics of the interpreters, and 4) the behaviour of the patient and healthcare staff during the interpretation session. The study found that professional interpreters experienced their role as aligning with the existing guidelines regarding an interpreter's role and ethical attitude. Healthcare service providers, policymakers and interpreter agencies should focus on improving training and support and development opportunities in order to increase the impact of interpretation on equality and quality of healthcare.

Keywords: Communication, Communication Barriers, Cultural Competency, Interpreter Service, Qualitative Research, Transients and Migrants, Translating

Introduction

The central components of healthcare delivery are communication and language. As the number of multicultural and multilingual individuals has increased in recent years due to ongoing global migration and globalization (Irving and Mosca, 2010), it is important to address language barriers in healthcare in order to offer appropriate care of high quality. The use of professional interpreters has been linked to reduced

communication barriers and medical errors, better patient satisfaction, improved health results and better compliance with medical procedures (Karliner et al., 2007, Flores, 2005). The role of medical interpreters is restricted by institutional controls regarding ethics and role description, as well as by the space provided to interpreters in which to work (IMIA, 2008). Most previous studies have generally focused either on the professional/informal interpreter's role (Dysart-Gale, 2005, Hsieh, 2006b, Hsieh, 2006a, Hsieh, 2007, Hsieh, 2008, Hsieh

and Kramer, 2012, Rosenberg et al., 2008, Watermeyer, 2011, Kaufert and Putsch, 1997) or on the interpreter's behaviour during a healthcare encounter (Hsieh, 2007, Elderkin-Thompson et al., 2001, Leanza, 2005). Thus, there is a lack of knowledge concerning how professional interpreters experience their role in the healthcare encounter. It is important to investigate this area in order to develop an affordable organisation of professional interpreter role, and to provide training and development regarding their attitude in order to prevent inappropriate communication, which in turn will prevent negative outcomes from the healthcare encounter.

Previous studies (Dysart-Gale, 2005, Kaufert and Putsch, 1997, Hsieh, 2006a) which have investigated the role of the interpreter have described it as a conduit, which is an interpreting model where the interpreter is seen as a translation machine providing accurate and neutral communication (Dysart-Gale, 2005, Hsieh, 2006a, Kaufert and Putsch, 1997). However, this model was found not to provide consistent guidance in clinical practice and to create considerable distress for interpreters. Distress was perceived because the conduit role does not create space for social interactions between the patient and healthcare staff (Dysart-Gale 2005). As a result, the interpreters experienced the conduit role as complex and conflicting (Dysart-Gale, 2005, Hsieh, 2006a, Kaufert and Putsch, 1997, Butow et al., 2012) and the model was therefore extended to regard the interpreter as functioning as an advocate, a bridge between cultures (Hsieh and Kramer, 2012, Rosenberg et al., 2008, Hilfinger Messias et al., 2009, Butow et al., 2012). In this model, the interpreter may assume a provider's role, take the patient's role and/or engage in other non-interpretative roles (White and Laws, 2009). Previous studies (Elderkin-Thompson et al., 2001, Hsieh, 2007, Leanza, 2005) investigating the interpreter's behaviour in a healthcare encounter found that the mutual interpreter's function is to keep the conversation focused on medical information by interpreting while patients are giving personal information.

Interpreters' working conditions in the Swedish healthcare setting

In Sweden, there are different kinds of interpreters: 1) authorised interpreters and 2) interpreters with lower qualifications (basic training for interpreters) or no training at all. Authorised interpreters are interpreters with a university education, who undertake special tests performed by the Administrative Services Agency (Kammarkollegiet) and have specific skills as medical interpreters or court interpreters. An authorisation is valid for five years and may be renewed after a new test (SOU, 2004:15).

All interpreters are members of the public interpreter service, even those who are non-authorised (in that they have not completed the knowledge test that covers language competence), and adhere to the professional ethics of the official document "God tolksed" (Good Interpreting Practice) developed by the Administrative Services Agency (Kammarkollegiet 2010). The Good Interpreting Practice sets out guidelines for the role and ethical behaviour of interpreters. The main role and ethical rules are to interpret all spoken information into the target language, remain neutral, ensure confidentiality, interpret in the first person form (I-form), only interpret and not to carry

out other activities for either part or to express their own views and values. The interpretation technique that is used is of sequential nature, which means "word by word" and "sentence by sentence" (Kammarkollegiet, 2010). The interpreter should have no relationship to the person being interpreted for, and thus ideally should neither arrive before the consultation nor stay on after the interpretation session has ended, but be present only during the interpretation session.

Until the mid-1990s it was common that interpreters were employed by interpreter agencies run by public authorities in the municipality or county council, whereas during the last 20 years it has been common for them to be employed by privately-owned interpreter agencies, working freelance for one or more public and/or private agencies. Interpreters receive compensation on a time-unit basis and receive some travel and slothful time allowances, and in most cases do not receive compensation for preparation work. Responsibility for calling upon interpreter institutions and obtaining the provision of interpreting services lies with the healthcare service. Thus, the interpreter agency arranges interpreters' jobs and schedules (Norström et al., 2011). According to Swedish law (SFS, 1986:223) interpreters should be used in all contacts with public authorities for people who cannot speak Swedish.

There is no control over interpreter services, and thus interpreter agencies have largely developed without central control (SOU, 2004:15). Some agencies support interpreters with professional guidance, training, authorisation and shared encouragement, while some agencies only invest small sums in interpreters, as a result of the current competitive situation created by the Public Procurement Act (SFS, 2007:1091), which states that contracts must be signed with the most economically advantageous interpreter agency after an assessment based on price and quality criteria.

In summary, a deficit noted in previous research is the lack of studies solely focused on how professional interpreters experience their role and behaviour before, during and after a healthcare encounter. Yet it is important to investigate this area in order to develop an affordable organisation of the professional interpreter role, training and attitude to ensure adequate communication, which in turn increases the likelihood of positive outcomes of the healthcare encounter.

Aim

The aim of this study was to explore how professional interpreters experience their role in the healthcare encounter.

Methodology

Design

This is an explorative study, with data collected from interpreters by carrying out semi-structured individual interviews or obtaining written descriptions (depending on their preferred method of providing data), regarding how they experience their role in the healthcare encounter, in order to investigate the reality of professional interpreter experiences to generate data of depth and complexity (Patton, 2015).

Procedure and participants

In order to ensure a sample with variation, a purposive sampling procedure was chosen (Patton, 2015), with a focus on professional interpreters with different languages, gender, age, educational level and experience of interpreting in a healthcare context.

To obtain approval for the study, the principal investigator (PI; EH) contacted the managers of interpreter agencies responsible for providing professional interpreters in healthcare. They were given verbal and written information about the study and were requested to recommend interpreters with different languages, gender, age and education, who had experience of interpretation in healthcare. At the meeting, the manager wrote a list of interpreters based on these criteria, whom the PI contacted by telephone and gave verbal information about the study and the ethical considerations of participation. For those who preferred individual interviews, a time and place for the interview was arranged, while those who preferred to give written descriptions were sent written information, together with a prepaid envelope, and asked to return their descriptions to the PI. The PI's contact details were included in case the participants had any questions.

The study included nine participants, six of whom were interested in participating in individual interviews and three of whom preferred to write descriptions (see Table 1).

Data collection

Data were collected by the PI between December 2013

and March 2104, by semi-structured interviews and written descriptions. The interview guide and instruction guide for written descriptions were developed based on literature review and experiences described in previous studies of migrants (Hadziabdic et al., 2009a, Hadziabdic and Hjelm, 2014), healthcare staff (Hadziabdic et al., 2010, Hadziabdic et al., 2011) and family members' perceptions and experiences of using interpreters in a healthcare setting (Hadziabdic et al., 2013). Examples of the main interview questions and written instructions are: 1) Please describe the preparation that you do before an interpreting situation in healthcare, and 2) How do you experience your role before, during and after an interpreting situation in healthcare? The informants were asked the following: What do you do? What do you think? How do you react?

A pilot interview and a pilot written description were completed to test the guides (Patton, 2015). The individual pilot interview led to minor corrections of language and ordering of questions and was included in the study. The written description turned out well, with the data found to be of good quality, and was therefore also included in the analysis.

All six interviews were held in secluded venues selected by the informants, where they felt comfortable: four in an office at a university (the PI's work place), one in a participant's home and one in a participant's workplace. During the interviews,

Table 1: Characteristics of the study population.

Variable	persons (N= 9)
Gender (<i>n</i>)	
Male	5
Female	4
Age (years)*	from 26 years to 68 years (Median 42 years)
18–28 years	2
29–39 years	1
40–49 years	1
50–59 years	1
60–70 years	2
Missing	2
Length of residence in Sweden (years)*	from 16 years to 47 years (Median 22 years)
0-10 years	0
11-20 years	1
21- 30 years	5
31-40 years	0
41- 50 years	1
Missing	2
Educational level	
Primary school	0
Secondary school	1
University ≤ 2 years	0
University ≥ 2 years	6
Missing	2
Work experience in current position (years)*	from 1 year to 18 years (Median 10 years)
Authorization	
Yes	2
No	7

Languages	
Arabic	4
Albanian	1
Bosnian/Croatian/Serbian	2
Lithuanian	1
Russian	1
Somalian	1

communication was perceived as unproblematic and free-flowing. Each interview took about one hour. Interviews were audio-taped and transcribed verbatim by a professional secretary employed for the project.

The written descriptions were carried out whenever and wherever the participants felt comfortable and resulted in rich data.

Data analysis

Qualitative content analysis was used to analyse data from the individual interviews and written descriptions in order to carry out data reduction, to identify core consistencies and meanings and to provide knowledge and understanding of the study area (Krippendorff, 2013).

The texts from the interviews and situations described were read thoroughly several times to gain a sense of the whole (Krippendorff, 2013). The texts were then broken into smaller textual units and the codes were developed. During the whole analysis process, authors looked for regularities, contradictions, similarities and patterns, in order to develop sub-categories and categories until the “whole picture” emerged, subsequently returning to the data analysis and re-reading all transcripts until no new information was found.

The concepts of credibility, dependability, confirmation, and transferability were used to guide the planning and process of analysis (Patton, 2015). The PI conducted, transcribed and analysed the data to guarantee credibility. Investigator triangulation was used to validate findings, by the co-author double-checking the content of the codes and categories to confirm their relevance. A triangulated approach using two different sources of data allowed a broad range of issues to be cross-checked, thus ensuring the confirmation of data. Furthermore, in naming categories, concepts as close as possible to the text were used to guarantee the confirmability of the study. Describing the investigation process as visibly as possible was used to guarantee dependability. To guarantee the transferability of findings, a variety of informants with different languages, gender, age, educational level and experience of interpreting in a healthcare context was selected (Patton, 2015). Their characteristics are described in Table 1.

Ethical consideration

Approval for the study was obtained from the Ethics Committee of Linköping University, Sweden. Swedish law concerning the regulation of ethics in research involving persons (SFS., 2003: 460) and the ethical principles stated in the Declaration of Helsinki (World Medical Association Declaration of Helsinki, 2008) were followed. Written informed consent was

obtained from the participants. To preserve the confidentiality of the participants' data, the audiotapes and transcripts were anonymised and coded by number. The analysis and reporting of findings was made in a way that protected the participants' identities. All the data collected were kept in a locked space which was only accessed by the PI.

Findings

In the study, interpreters reported experiencing their role in the healthcare context as: to be professional and to perform work assignments related to the Guidelines for Interpreters. The interpreters felt that there were several factors that could influence their role as interpreters and desired better organisation of the practice of interpretation in the healthcare service.

Performing work assignments and being professional, in line with the guidelines for interpreters

Practical and linguistic preparation

Practical preparation was described as obtaining the information about the time and place for assignments in order to arrive in good time for interpretation sessions. The interpreters' intention was to arrive a short time before the meeting, in order to avoid a situation where they would need to talk with the patient before the session. This was important as it ensured that they would remain neutral during the interpretation session. Because of the need for confidentiality, interpreters are seldom given information about the patient's gender and age or the reason for the meeting before the actual interpretation situation.

“We do not need to be in good time before, five minutes is enough to avoid a situation where we sit and talk to the patient. to remain neutral ... should not have very close contacts, so that I can interpret everything that is said, and that friendship should not affect what I can say or not”(I:2).

Most of the informants felt that it was important when they receive assignments to prepare themselves with medical terminology relating to the specific area to be discussed.

“If I know that the interpreting will be concerning ophthalmology, I can go through certain terminology related to eye disease (in advance) ...”(I:1).

Professional attitude

Having a professional attitude was seen as the most important factor in their role as interpreters both before, during and after the interpretation situation. The interpreters described having a professional attitude as: interpreting in full the information given during the healthcare encounter; remaining neutral, ensuring confidentiality, interpreting in the first person form (I-form), and interpreting without expressing value judgments. Furthermore, a professional attitude included transferring

information in full without becoming emotionally involved or becoming involved with the content of the interaction between healthcare staff and the patient.

“... I interpret everything that is said. ... I function as a machine. I interpret everything and try not to be emotionally influenced by what I hear; no matter how hard may seem to be. My task is not too be lenient or embellish ... unfortunately I have to report the situation as it is. So I interpret everything”(I:2).

On the other hand, most of the informants stated that transferring complete information without getting emotionally involved was difficult to achieve in some situations. These situations were: long interpretation sessions, threatening situations in psychiatric care, assignments that they described as sensitive, such when children are involved, and in the care of patients with ulcers and blood.

“... in certain situations it is long interpretations. When there are a lot of emotions and difficult situations things that have to do with children because I do not think so much about ulcers and blood ... that in some situations it becomes too heavy, too hard ...”

(I:2).

Performing duties that are related to the interpreters' own work assignments

Interpreters stated that the role of the professional interpreter is to transfer complete information during the healthcare encounter. The performing of other duties such as giving information or practical guidance was not viewed as a part of their role. Some interpreters said that they never perform other duties that are not related to their work assignments, and referred to the need to abide by the guidelines regarding the interpreters' role and ethical attitude, while some informants would occasionally help elderly patients to order a taxi or to show them where the pharmacy is located.

“I never do that. Once my requisition is signed then my mission is completed. If healthcare staff want me to go with patients to X-rays and interpret there, then I get healthcare staff to extend my mission. Otherwise, confidentiality is not maintained. Secondly, I as an interpreter am insured under the mandate. If I go to the X-ray and it is not part of my mission, and slip and break bones, then I am completely unprotected in terms of insurance.... If a patients asks me to translate a letter afterwards, I refer them to their social worker.... It is not my task, I could misinterpret or misjudge the letter ...”(I:4).

Factors that influence their role as interpreters

Form of interpretation

All informants preferred interpretation in person. They could see the benefit of telephone interpretation when related to short-term, one-off emergency care situations and in care situations that the patients experience as sensitive, but otherwise, most informants did not prefer telephone interpretation because it is more likely to miss information, as they are unable to see body language, technical equipment is poor, which means that it is hard to hear, and they could be confused about which and

how many people there are in the room. Furthermore, they stated that patients feel unsure whether complete information is transferred if using telephone interpretation, patients are not proactive and ask no follow-up questions, and patients feel alienated by telephone interpretation because of the lack of the shared culture that they would experience with a live interpreter. Informants were in agreement that telephone interpretation is also not a good choice because most interpreters who interpret by telephone are not of a sufficiently high quality to obtain assignments in person because of their low language competency and unprofessional attitude.

Informants reported that the difference between interpreting on short-term assignments in emergency situations and on in-advance time-ordered assignments were that with the latter, they had time for practical and linguistic preparation.

Interpretation environment

It was believed important that interpretation was carried out in a large, secluded room with appropriate acoustics and neutral colours, in order to feel a sense of wellbeing during the session.

“It feels better to interpret in a bigger room, so that there is scope and participants do not sit very close. ...”(I:3).

Interpreters' employment status

Interpreters work as freelancers for one or more interpreting agencies, which could affect their private life and quality of interpreting. Interpreters who have a high level of professional competence and quality in interpreting are usually attached to agencies that support them with further education and professional guidance. Interpreters whose competence and interpreting skills are lower are usually attached to agencies that invest only small sums in interpreters. In other words, the agencies that do not invest greatly in interpreters are the agencies who win contracts with healthcare, as a consequence of the current competitive situation, which is based on low-cost criteria.

“Nowadays, it is rare that interpreter agencies require admission tests for newly-hired interpreters, owing to the high cost of performing these tests ... so they hire people and evaluate if it works or not while they are working”(I:1).

Interpreters' personal characteristics

The interpreter's age, gender, religion and nationality, language or dialect, education, clothes and social group could influence the interpreter situation. Some of the informants mentioned that patients were more ready to trust an older interpreter; however, a few informants said that parents of young children for whom an interpretation session was necessary felt increased trust in younger female interpreters. Shared gender, religion and nationality and language or dialect were important factors in the interpreter situation. Therefore, informants stated that they wore non-provocative and/or neutral clothes and jewellery and used the same language or dialect as the patient in order not to disclose their background. In the Arabic-speaking countries, the interpreter's social class was considered of importance, as was the importance of wealth, which was associated with the interpreter's skills, intelligence and cleverness.

“When patients know that I'm from Lebanon, they feel confidence and relax linguistically because they trust me. But if they know that I am rich ... in the Arab world, to be rich is related to being talented, knowledgeable and smart. They associate wealth with smartness and so ...” (I:2).

Patient and healthcare staff behaviour during the interpretation

The behaviour of the patient and the healthcare staff during the interpretation could influence the interpretation. The behaviour and attitude of the healthcare staff was sometimes perceived as unprofessional because they did not show respect for the interpreter. In some situations, healthcare staff might accuse interpreters of interpreting errors, and did not talk to the patient but instead turned to the interpreter, putting the responsibility on the interpreter to explain for the patient to understand. Healthcare staff did not always inform interpreters about the risks attached to the coming situation, which could lead to interpreters being exposed to contagious and/or aggressive patients. Another aspect was the unfamiliarity of the healthcare staff with the use of interpreters, and in some situations they would break the code of confidentiality by answering the phone and talking about other patients, unaware that everything said in the room was to be interpreted by the interpreter.

“...it feels very hard and it has happened a few times and that's when health professionals do not know how to adapt information so that patients understand. Then they (healthcare staff) say, you cannot explain so that patients can understand” (I:4).

The patient's attitude towards interpreters was sometimes described as regarding the interpreter as an entrance to the community and to obtaining information. In some interpretation situations in psychiatric care, it could happen that patients would injure themselves badly during the interpretation and/or become aggressive towards the interpreter because they blamed the interpreter for an idea expressed by the healthcare staff.

“... they (patients) see you as a putt in the community, you become gladly seen as an information source and more. They (patients) see you as a link to much more” (I:1).

Better organization of interpretation practice in the healthcare service

The interpreters' employment conditions and training

Informants expressed a need for better employment conditions for interpreters. They desire i) to receive the same job benefits as health professionals, such as the provision of rest rooms so that they can rest between assignments, and ii) within major municipalities, the employment in healthcare of interpreters who interpret only in healthcare, in order to specialise in medical terminology, because this leads to increased patient safety as well as quality of healthcare. Furthermore, informants desire ongoing training in medical terminology and the healthcare service, and to be provided with relevant medical literature in order to develop their language competence and to ensure that the information will be correctly interpreted.

“... I would like to have the possibility of frequent training related to the changes that happen all the time ... healthcare to

provide a little bit of literature, because we are not physicians but we need to know the kind of expressions used by the physician ... do not confuse the lungs with the heart. A little more training for interpreters just in this area ... this is extra important” (I:5).

Information and training of healthcare staff concerning interpretation practice

Participants expressed a need for ongoing information and training of healthcare staff in how to use and communicate through interpreters in order to ensure optimal interpreter situations. Healthcare staff need to: 1) speak slowly and in moderate sequences and to avoid using specialist medical terminology, ii) position themselves so that they can see directly into the patient's eyes, iii) respect the interpreters' working methods and inform them when facing contagious or threatening patients, iv) avoid using family members as interpreters and v) involve the patient in the decision process about the form of interpretation. Furthermore, some emphasised that healthcare staff should be able to require interpreter services to authorise competent interpreters and provide feedback to the interpreter agencies.

Discussion

This study highlights important characteristics of the professional interpreter's role in the healthcare encounter. Despite the interpreters experiencing their role as aligning with the current professional guidelines for interpreters, the study found a number of factors and challenges that influenced this role, e.g. the form of interpretation, the interpretation environment, the interpreters' employment conditions and personal characteristics, and the behaviour of the patient and healthcare staff during interpretation.

The study found that having a professional attitude, transferring information accurately, keeping confidentiality and remaining impartial, and performing the duties that are related to their work assignments, which is part of their training, were the interpreters' central goals. These findings were similar to those of previous studies (Dysart-Gale, 2005, Hsieh, 2006a, Kaufert and Putsch, 1997) but in contrast to other investigations of the interpreter's role (Hilfinger Messias et al., 2009, Hsieh and Kramer, 2012, Rosenberg et al., 2008, White and Laws, 2009, Elderkin-Thompson et al., 2001, Hsieh, 2007, Leanza, 2005, Butow et al., 2012) where interpreters described their role as including patient advocacy, cultural brokerage and the provision of emotional support. These contrasting results can be understood as occurring as a result of variations in terms of the regulation of policy guidelines for trained interpreters that exist in Sweden (Kammarkollegiet, 2010). However, informants in this study felt that it was not always easy to manage their own emotions, especially after consultations which involved delivering bad news, diverse family situations and managing threatening patients. This finding highlights the need for recognition of the trained interpreter's professional role according to existing policy guidelines for interpreters, the development of educational opportunities both within interpreters' training programs and the healthcare service, and the provision of support and debriefing in order to prevent stress and burnout (Butow et al., 2012).

An unexpected finding of this study was that factors such

as the form of interpretation, the interpreters' employment conditions and personal characteristics, and the behaviour of the patient and healthcare staff during the interpretation influenced them in the performance of their role. Interpreters did not recommend telephone interpretation because of the lack of body language and the low quality of technical equipment, which is in accordance with previous studies of Arabic-speaking migrants (Hadziabdic and Hjelm, 2014, Hadziabdic et al., 2014), Bosnian/Croatian/Serbian-speaking migrants (Hadziabdic et al., 2009b) and different kinds of healthcare staff (Hadziabdic et al., 2010). However, the second new finding of this study was that most of the interpreters who were on the agencies' telephone priority lists were employed by agencies who only invest small sums in interpreters' authorisation, training development and opportunities, so many telephone interpreters had low-quality language skills and lacked a professional attitude, which negatively affected communication as well as patient safety and quality of healthcare. Despite this, across healthcare settings there is reliance on telephone interpretation (Hadziabdic et al., 2010, Dowbor et al., 2015) due to positive impacts on access to healthcare (Dowbor et al., 2015). Staff in the healthcare service need to be aware of the opportunity to learn from the interpreters' own perspectives when planning to sign a contract with an interpreter agency, in order that they specify requirements for a high level of competence from interpreters for both face-to-face and telephone interpretation, in accordance with the existing Swedish law (SFS, 2007:1091) and the International Code of Ethics for Medical Interpreters (IMIA, 2008). In Sweden, there is a lack of authorised interpreters, and this is expected to continue because there is only a small percentage of individuals who undertake the special tests that examine the skills required to become an authorised interpreter (SOU, 2004:15). A third new finding was that the interpreters' employment status and the behaviour of the patient and healthcare staff influenced the interpreters' role during the interpretation sessions. It is important that these aspects are taken into account, in order to improve interpretation and healthcare by considering not only the form of interpretation, the interpretation technique, the professional attitude of interpreters and their personal characteristics, but also organisational routines and training by interpreter and healthcare services.

This study indicates the necessity for better employment conditions for interpreters and for the development of ongoing training and information for both interpreters and healthcare staff. We agree with Butow et al. (2012) that a model where interpreters could be employed by the healthcare service and thus be part of the multi-disciplinary healthcare team might be optimal, but hard to realise in the existing healthcare system. Another factor that needs to be improved is the development of ongoing training and information for healthcare staff concerning interpretation practice, and also the provision of feedback to the interpreter agency about the quality of interpreters and interpretation. These results confirm those in previous studies of healthcare staff in primary healthcare and emergency care (Hadziabdic et al., 2010, Hadziabdic et al., 2011) and elderly healthcare (Hadziabdic et al., 2015). This study highlights the need to take important steps forward by providing ongoing training and support 1) in medical terminology for interpreters, and 2) in how to communicate with interpreters and to provide evaluation of the interpreter service for healthcare staff, in order to provide safe and high-quality care (SFS,

1982, World Health Organisation, 2005).

The strength of this study was that it included several professional interpreters to collect the collective experiences of interpreting in the healthcare context, and also that investigation was carried out using two different qualitative methods of data collection; individual interviews and written descriptions. Using individual semi-structured interviews and written descriptions allowed the generation of data of depth and complexity about the research topic from the informants' perspective (Patton, 2015). Furthermore, the written descriptions stimulated participants into a reflective attitude, the writing process places certain restrictions on the free obtaining of descriptions undisturbed by the authors and enabled the participants to choose the appropriate time and place to write down their stories (Patton, 2015). However, a limitation of using written descriptions could be that the method gave no opportunity to ask supplementary questions, as would occur during an interview. On the other hand, the professional interpreters live in a stressful environment and this data-collection method made it possible to obtain access to their experiences. Another strength was the use of guides for the interview and instructions to guarantee that all data were held in a standardised structure and that the interviews and descriptions concerned issues aimed at achieving the aim of the study (Patton, 2015). The questions in the guides were in the form of open-ended questions that allowed participants to talk and/or write freely and to respond to questions in their own words (Patton, 2015). The individual interviews and written descriptions gave an opportunity for a deeper understanding of the different experiences and views of several professional interpreters, and the fact that the data was informative and rich in detail showed that the informants were comfortable with their preferred method of data collection.

The backgrounds of the professional interpreters in our sample are the third strength of the chosen method. The participants had similar socioeconomic status and were almost equally divided between genders, but they differed in age, educational level, length of residence in Sweden and languages spoken.

One limitation of the study might be the number of participants; nine people took part. However, the collection and analysis of data was carried out up to the point where no new information was obtained and redundancy was reached (Patton, 2015). When the aim is exploratory, the goal is to generate data which are in-depth enough to illuminate the contradictions, similarities and patterns of the studied area. The data obtained in the study were deep and rich in detail, and the findings offer a deeper understanding of the area studied, which can be transferred to other settings with similar characteristics, as informants described a homogeneous picture of their experiences in order to improve the situation and outcomes for interpreters in the healthcare services.

Conclusion

This study showed that the professional interpreters who took part experience their role to be in accordance with the existing guidelines for the role and ethical attitude of the professional interpreter. On the other hand, the findings suggest that there is an area of dissatisfaction, as there are a number of factors and challenges that influence their role as interpreters.

The implications of the study are that there is a need to develop educational opportunities for interpreters in medical terminology, as well as for the provision of support and debriefing from the healthcare service, in order to prevent interpreters from developing stress and burnout. Furthermore, the healthcare service needs to put demands on interpreter agencies to provide high quality interpreters both for face-to-face and telephone interpretation. These findings align with findings from previous studies (Hadziabdic et al., 2010, Hadziabdic et al., 2015) from the perspective of healthcare staff, who need to be trained in how to communicate with interpreters and to provide feedback to the interpreter agencies, in order to promote equal and high-quality healthcare in healthcare encounters where the support/help of an interpreter service is needed.

Authors' contributions

First author (EH) was responsible for the study conception, design and coordination. Further, the first author carried out the data collection, performed the data analyses and drafted and revised the manuscript. Both authors (EH and KH) performed the drafting of the manuscript.

Acknowledgement

This study was supported by grants from Crafoord Foundation, Sweden.

REFERENCES

- BUTOW, P.N, LOBB E, JEFFORD M, GOLDSTEIN D, EISENBRUCH M, GIRGIS A, KING, M., SZE, M., ALDRIDGE, L. & SCHOFIELD, P. 2012. A bridge between cultures: interpreters' perspectives of consultations with migrant oncology patients. *Support Care Cancer*, 20, 235-44.
- DOWBOR, T., ZERGER, S., PEDERSEN, C., DEVOTTA, K., SOLOMON, R., DOBBIN, K. & O'CAMPO, P. 2015. Shrinking the language accessibility gap: a mixed methods evaluation of telephone interpretation services in a large, diverse urban health care system. *Int J Equity Health*, 14, 83.
- DYSART-GALE, D. 2005. Communication models, professionalization, and the work of medical interpreters. *Health Communication*, 17, 91-103.
- ELDERKIN-THOMPSON, V., SILVER, R. C. & WAITZKIN, H. 2001. When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting. *Soc Sci Med*, 52, 1343-58.
- FLORES, G. 2005. The impact of medical interpreter services on the quality of health care: a systematic review. *Med Care Res Rev*, 62, 255 - 299.
- HADZIABDIC, E., ALBIN, B., HEIKKILA, K. & HJELM, K. 2013. Family members' experiences of the use of interpreters in healthcare. *Prim Health Care Res Dev*, 1-14.
- HADZIABDIC, E., ALBIN, B., HEIKKILÄ, K. & HJELM, K. 2010. Healthcare staffs perceptions of using interpreters: a qualitative study. *Primary Health Care Research & Development*, 1, 1-11.
- HADZIABDIC, E., ALBIN, B. & HJELM, K. 2014. Arabic-speaking migrants' attitudes, opinions, preferences and past experiences concerning the use of interpreters in healthcare: a postal cross-sectional survey. *BMC Res Notes*, 7, 71.
- HADZIABDIC, E., HEIKKILA, K., ALBIN, B. & HJELM, K. 2009a. Migrants' perceptions of using interpreters in health care. *Int Nurs Rev*, 56, 461-469.
- HADZIABDIC, E., HEIKKILA, K., ALBIN, B. & HJELM, K. 2011. Problems and consequences in the use of professional interpreters: qualitative analysis of incidents from primary healthcare. *Nurs Inq*, 18, 253-261.
- HADZIABDIC, E., HEIKKILÄ, K., ALBIN, B. & HJELM, K. 2009b. Migrants' perceptions of using interpreters in health care. *International Nursing Review*, 56, 461-469.
- HADZIABDIC, E. & HJELM, K. 2014. Arabic-speaking migrants' experiences of the use of interpreters in healthcare: A qualitative explorative study. *International Journal for Equity in Health*, 13.
- HADZIABDIC, E., LUNDIN, C. & HJELM, K. 2015. Boundaries and conditions of interpretation in multilingual and multicultural elderly healthcare. *BMC Health Serv Res*, 15, 458.
- HILFINGER MESSIAS, D. K., MCDOWELL, L. & ESTRADA, R. D. 2009. Language interpreting as social justice work: perspectives of formal and informal healthcare interpreters. *ANS Adv Nurs Sci*, 32, 128-43.
- HSIEH, E. 2006a. Conflicts in how interpreters manage their roles in provider-patient interactions. *Soc Sci Med*, 62, 721-30.
- HSIEH, E. 2006b. Understanding medical interpreters: reconceptualizing bilingual health communication. *Health Communication*, 20, 177-86.
- HSIEH, E. 2007. Interpreters as co-diagnosticians: overlapping roles and services between providers and interpreters. *Soc Sci Med*, 64, 924-37.
- HSIEH, E. 2008. "I am not a robot!" Interpreters' views of their roles in health care settings. *Qual Health Res*, 18, 1367-83.
- HSIEH, E. & KRAMER, E. M. 2012. Medical interpreters as tools: dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient Educ Couns*, 89, 158-62.
- IMIA, I. M. I. A. 2008. Code of Ethics for Medical Interpreters 2008 [Online]. International Medical Interpreters Association. Available: <http://www.imiaweb.org/uploads/pages/376.pdf> [Accessed 11 July 2014].
- IRVING, G. & MOSCA, D. 2010. Future capacity needs in managing the health Aspects of migration. [Online]. International Organization For Migration (IOM) Available: http://publications.iom.int/bookstore/free/WMR2010_capacity_needs_health_aspects.pdf [Accessed 18 March 2014].
- KAMMARKOLLEGIET. 2010. God tolksed. Vägledning för auktoriserade tolkar (Good interpreting practice. Guidance for authorized interpreters) [Online]. Kammarkollegiet
- (National Judicial Board for Public Lands and Funds). Available:

- <http://www.sprakservice.se/media/9541/GodTolksed.pdf>
[Accessed 17 December 2013].
24. KARLINER, L., JACOBS, E., CHEN, A. & MUTHA, S. 2007. Do professional interpreters improve clinical care for patients with limited english proficiency? A systematic review of the literature. *Health Serv Res*, 42, 727 - 754.
 25. KAUFERT, J. M. & PUTSCH, R. W. 1997. Communication through interpreters in healthcare: Ethical dilemmas arising from differences in class, culture, language, and power. *Journal of Clinical Ethics*, 8, 71-87.
 26. KRIPPENDORFF, K. 2013. *Content analysis : an introduction to its methodology*, Thousand Oaks, Calif. ; London, SAGE.
 27. LEANZA, Y. 2005. Roles of community interpreters as seen by interpreters, physicians, and researchers. *Interpreting*, 7, 167-92.
 28. NORSTRÖM, E., GUSTAFSSON, K. & FIORETOS, I. 2011. The Interpreter – a cultural intermediary. Behind closed doors. The importance of interpreting for the rule of law and for integration, with special focus on separated minors [Online]. Department of Arts and Cultural Studies, Lund University and Medborgarskolan Syd. Available: http://www.tolkprojektet.se/Report_English.pdf
[Accessed 15 July 2014].
 29. PATTON, M. Q. 2015. *Qualitative Research & Evaluation Methods*, Thousand Oaks, California, SAGE Publications.
 30. ROSENBERG, E., SELLER, R. & LEANZA, Y. 2008. Through interpreters' eyes: comparing roles of professional and family interpreters. *Patient Educ Couns*, 70, 87-93.
 31. SFS 1982. Socialtjänstlag (Social Services Act). https://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Socialtjanstlag-1980620_sfs-1980-620/:
Socialstyrelsen (The National Board of Health and Welfare).
 32. SFS. 1986:223. Förvaltningslagen (Management Act) [Online]. Justitiedepartementet L6. Available: http://www.riksdagen.se/sv/Dokument-Lagar/Lagar/Svenskforfattningssamling/Forvaltningslag-1986223_sfs-1986-223/?bet=1986:223 [Accessed 17 December 2013].
 33. SFS. 2007:1091. Lag om offentlig upphandling (Public Procurement Act) [Online]. <https://lagen.nu/2007:1091:Socialdepartementet>. Available:
<https://lagen.nu/2007:1091> [Accessed 10 April 2014].
 34. SFS. 2003: 460. Förordning om etikprövning av forskning som avser människor (Swedish law: Regulation of ethical research involving humans)
 35. [Online]. <http://www.riksdagen.se/webbnav/index.aspx?nid=3911&bet=2003:460>
Available: <http://www.riksdagen.se/webbnav/index.aspx?nid=3911&bet=2003:460>
(accessed 15 March 2010). [Accessed 15 March 2010].
 36. SOU 2004:15. Tolkförmedling - kvalitet, registrering tillsyn (Interpreter agency- quality, registration supervision). <http://www.regeringen.se/contentassets/2bea5a3cdb034c6197bd335252d8994f/tolkformedling---kvalitet-registrering-tillsyn:Fritzes Stockholm>.
 37. WATERMEYER, J. 2011. "She will hear me": how a flexible interpreting style enables patients to manage the inclusion of interpreters in mediated pharmacy interactions. *Health Communication*, 26, 71-81.
 38. WHITE, K. & LAWS, M. B. 2009. Role exchange in medical interpretation. *J Immigr Minor Health*, 11, 482-93.
 39. WORLD HEALTH ORGANISATION. 2005. World Alliance For Patient Safety. Who draft guidelines for adverse event reporting and learning systems. [Online]. http://www.who.int/patientsafety/events/05/Reporting_Guidelines.pdf?ua=1: World Health Organisation. Available: http://www.who.int/patientsafety/events/05/Reporting_Guidelines.pdf?ua=1 [Accessed 30 June 2014].
 40. WORLD MEDICAL ASSOCIATION DECLARATION OF HELSINKI. 2008. Available: <http://www.wma.net/e/policy/b3.htm> (accessed 19 May 2009).

ADDRESS FOR CORRESPONDENCE

Dr. Emina Hadziabdic, Department of Health and Caring Sciences, Faculty of Health and Life Sciences, Linnaeus University, SE- 351 95 Växjö, Sweden, Telephone: +46 470 70 80 37, Fax: +46 470 363 10. Email: emina.hadziabdic@lnu.se

Submitted: Mar 21, 2016; Accepted: Feb 27, 2016; Published: Mar 05, 2016