

Interpreters in Intercultural Health Care Settings: Health professionals' and professional interpreters' cultural knowledge, and their reciprocal perception and collaboration

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Abstract

Aim: To learn how health professionals and interpreters perceive each other and collaborate. Based on this discuss the role of professional interpreters.

Method: Narrative interviews with nurses, focus group interviews and questionnaire studies of medical nurses, psychiatric health professionals, and professional interpreters.

Findings: Communication problems may be caused by language and by different horizons of understanding, medical explanations, expressions of symptoms etc. Many health professionals find it difficult to communicate well with patients through interpreters. They tend to trust professional interpreters to translate everything being said and inform about misunderstandings, while Norwegian interpreters are only authorised for verbatim translations without any additions or comments.

Conclusion: Interpreters are needed who are qualified to act as cultural mediators and who are legally and ethically authorised to do so.

Key words: Interpretation– interpreters – intercultural communication – cultural interpretation – cultural 'bridge building'

Introduction

As conceptions of illness and cure are legion and there may exist a veritable knowledge gap between health professionals and patients in intercultural health care settings, words translated lexically correct may create no meaning in the receiving party. One may therefore need 'cultural interpretation' or mediation to make the material content of the information understandable. This means that the interpreter must have knowledge of western biomedicine and its vocabulary, how the majority society functions etc., as well as of the patient's understanding of the situation to be able to bridge the abyss that may separate the interlocutors. Word for word translation makes it possible to converse without ever realising that one's words create no meaning in the other party, even when communicating through an interpreter.

The importance of using professional interpreters and how to use professional interpreters are discussed by many authors (e.g., Jareg and Pettersen 2006, Pistillo 2004, Hanssen 2002, Dahl 2001). The interaction between health professionals and interpreters is much less studied and described.

The purpose of this paper is to present and discuss empirical data concerning how health professionals and professional interpreters perceive each other and their collaboration. Four such studies are collectively presented (Studies 1-4). Besides findings, interpretation as a vehicle for reciprocal understanding in intercultural health care settings is discussed. The main focus will be on Studies 2-4. Study 1 will mainly serve as a background and contribute examples to underpin the discussion.

Research methods

Study 1 (Hanssen 2002) was a qualitative study with narrative interviews and field observations of nurses in two Norwegian city hospitals with 30-40 % ethnic minority patients regarding working with non-western patients. Strategic sampling of nurses with some intercultural nursing experience. All volunteers were included (23 nurses: 2 men, 21 women. Years of nursing experience: 2-10+). In the interviews (tape

recorded, lasting 20-90 minutes) respondents were encouraged to recount their experiences through the telling of patient stories. Transcriptions were verbatim.

Issues concerning interpretation and interpreters became central. These issues were then incorporated into two studies (Studies 2 and 3) regarding health professionals' competency in caring for minority ethnic patients (Alpers and Hanssen 2009, 2008).

Studies 2 and 3 were conducted at medical and psychiatric wards in one of the hospitals of the 2002 study. As no instrument measuring health professionals' intercultural competence was found, a questionnaire was developed. Three audio recorded focus group interviews were conducted to ensure that the questionnaire questions were pertinent to the respondents' health care practice: two with medical unit nurses (6 + 5 nurses [Study 2]), one with 7 psychiatric health professionals (Study 3). Each group was interviewed once. Participants were recruited through information given at staff meetings. All volunteers were included. Transcriptions were verbatim. Additionally a professor of intercultural cooperation and 12 health professionals (men and women) with Norwegian, Eastern European, African, and Asian backgrounds, were interviewed. Some of these were known experts, others were suggested by these experts ('snow balling'). These latter interviews were not audio recorded, but rich notes were taken.

The resulting questionnaire was divided into six sections: 1. Experience and knowledge, 2. Collaboration, attitudes and conduct, 3. Illness, health behaviour and pain, 4. Communication and collaboration with interpreters, 5. Death and dying, 6. Culture, religion, and diet, with a total of 35 statements. Each statement was given six Likert-type response alternatives: 1: I don't agree at all, 2: I don't agree; 3: I neither agree nor disagree; 4: I agree, 5: I very much agree; and 6: I don't know. Additionally there were four open-ended questions. Two college tutors and an expert on quantitative research read and commented on the questionnaire, causing some changes to be made before a small pilot study was carried out to ensure the questionnaire's validity and reliability. Also the pilot study led to some changes before the study proper was commenced.

Questionnaire respondents: Medical unit: N=139, 90 % of nursing staff (17 men, 122 women. Years of nursing experience: 0-10+). Psychiatric unit: N=195, 64 % of staff: 100 (75.2 %) nursing staff, 26 (13 %) psychologists, 16 (8 %) physicians/psychiatrists, 13 social workers, 10 auxiliary nurses, 30 'others' (61 men, 143 women. Years of psychiatric health care experience: 0-10+).

Comparability between Studies 2 and 3 with a total of 334 respondents was ensured by using identical statements in the two questionnaires where possible. Statements regarding death and dying pertinent in the medical unit (Study 2) were replaced by statements regarding suicide in the psychiatric unit questionnaire (Study 3). During the Study 3 focus group interview things were said about the use of interpreters in psychiatric therapy which we chose to include as two additional statements in that study's questionnaire.

As Studies 1-3 rendered some unflattering descriptions of professional interpreters, we decided to add this group's 'voices'. In Study 4 a focus group interview was conducted with six experienced professional interpreters representing four continents and eight languages. A questionnaire was sent to 30 experienced interpreters invited to participate by the head of the Oslo Municipality Interpreter Service. This questionnaire mirrored the two previous questionnaires concerning interpreters, interpreting, and nurse-interpreter collaboration, reworded to catch the interpreters' perceptions. It was returned by 25 interpreters (75 %).

Data analysis

Study 1: Thematic analysis of interview statements (van Manen 2001) focused on ethical problematics in intercultural nursing. Studies 2-4: the electronic analytical tool SPSS-15 was utilised for the quantitative data. The qualitative data were analysed thematically. The questionnaire statements were used as analytic categories for both the quantitative and qualitative data (statements and open-ended questions/focus group interviews) in all three studies.

Critical remarks

A strength in Studies 2-4 is their being based on knowledge gleaned from a previous empirical study. A weakness is the mismatch of the numbers of respondents in Study 4 compared to Studies 2-3. Six focus group interviewees and 25 questionnaire respondents make for a limited study that cannot be generalised. Even so, we find their responses interesting and well worth considering.

Another weakness is that in questionnaires respondents cannot elaborate their answers. To reduce this problem focus group interviews were conducted before producing the questionnaire and the inclusion of three open-ended questions and an "Other comments" category. A few respondents used this latter category to express frustration that standardised statements tend to 'generalise' human beings.

Ethical considerations

Study 1 was approved by a Regional Committee for Medical and Health Research Ethics. Interviewees were informed orally and in writing and signed a written informed consent form. Studies 2 and 3 were approved both by a hospital Privacy Ombudsman for Research and the respective unit heads. Study 4 was approved by the heads of the hospital's and the municipality's interpreter services respectively. Both focus group interviewees and questionnaire respondents were informed orally and in writing. Neither group signed a consent form but were informed that participation was voluntary.

Studies 2 and 3 respondents put their unmarked, anonymous questionnaires in a communal envelope on the ward, which then was collected. To ensure anonymity, the unmarked Study 4 questionnaires were collected by the head of the interpreter service, who sent them on to us. Interviewee/respondent confidentiality has been ensured throughout the entire research process of all studies, from data collection to publication.

Findings

Lack of communication is very frustrating for health professionals and patients alike. In Studies 2-3 a mean of 54.5 % of the health professionals found some ethnic minority patients more difficult to cooperate with than others. A mean of 38 % did not find this to be so, and the rest did not know. Two of the main issues making patients difficult to cooperate with according to health professionals were:

- patients having different understandings of illness and treatment than the health professionals
- lack of common language/linguistic problems

Also the interpreters found that some patients may be difficult to work with, but in their case causes given were patients' general lack of education or lack of understanding of medical terminology or the health care system. This could frustrate their interpretive efforts. It is furthermore problematic when patients do not understand the interpreter's role and try to pull him/her into the conversation.

Knowledge and intercultural health care communication

Cultural understanding in health care was introduced in the Studies 2-4 questionnaires as two statements: "I have knowledge about illness and treatment philosophies other than western biomedicine" (Studies 2-3)/"Health professionals have knowledge about illness and treatment philosophies other than western biomedicine" (Study 4), and "I have the necessary insight into various medical philosophies to do a good job" (Studies 2-4).

	Medical unit nurses (Study 2)		Psychiatric unit health professionals (Study 3)		Interpreters (Study 4)	
	No. of respond.	Percent	No. of respond.	Percent	No. of respond.	Percent
I don't agree at all	28	20 %	28	9 %	4	16 %
I don't agree	25	18 %	38	19 %	9	36 %
I neither agree nor disagree	40	28 %	53	33 %	8	32 %
I agree	31	22 %	58	33 %	3	12 %
I very much agree	10	7 %	10	4 %	0	0 %
I don't know	<u>9</u>	<u>6 %</u>	<u>7</u>	<u>2 %</u>	<u>1</u>	<u>4 %</u>
Sum total	143	101 %	194	100 %	25	100 %

Figure 1. Health professionals' and interpreters' perception of whether health professionals have knowledge about illness and treatment philosophies other than western biomedicine.

A mean of 33 % of the health professionals more or less agreed or disagreed with the statement that they have knowledge about illness and treatment philosophies other than western biomedicine (Figure 1). A mean of 30.5 % neither agreed nor disagreed.

Among the interpreters only 12 % agreed and 52 % more or less disagreed with the statement that health profession have such knowledge. 32 % neither agreed nor disagreed.

In Study 3 several respondents pointed to communication problems caused by different illness philosophies and horizons of understanding between the interlocutors and that this makes it "easier to misunderstand/misinterpret". Both language problems and the interlocutors' "understanding of psychiatric illness may create a distance." Some immigrants are furthermore "much less schooled than are ethnic Norwegians", and this may also have an effect on communication and reciprocal understanding. If the patient "does not know the language, the concepts, the system" and uses "different concepts" based on a different "horizon of understanding" and "reasons in a different way", patient and therapist lack a "common frame of reference", something which often makes it "more difficult to understand a statement's social context." Different backgrounds may furthermore make it difficult for the therapist to "differentiate between expressions of culture and expressions of symptoms". As one respondent wrote: "I think we 'diagnose' cultural differences as illness. What do patients mean with what they express/what context does it hail from/how should we understand this."

Among the health professionals a mean of 25.5 % more or less agreed that they had "the necessary insight into various medical philosophies to do a good job" and 39.5 % more or less disagreed. A mean of 34 % neither agreed nor disagreed, and 2 % did not know (Figure 2).

	Medical unit nurses (Study 2)		Psychiatric unit health professionals (Study 3)		Interpreters (Study 4)	
	No. of respond.	Percent	No. of respond.	Percent	No. of respond.	Percent
I don't agree at all	15	11 %	18	9 %	0	0 %
I don't agree	47	33 %	50	26 %	2	8 %
I neither agree nor disagree	49	35 %	64	33 %	1	4 %
I agree	24	17 %	48	25 %	11	44 %
I very much agree	4	3 %	12	6 %	11	44 %
I don't know	<u>3</u>	<u>2 %</u>	<u>3</u>	<u>2 %</u>	<u>0</u>	<u>0 %</u>
Sum total	142	101 %	195	101 %	25	100 %

Figure 2. Health professionals' and interpreters' perception of whether they themselves have the necessary insight into various medical philosophies to do a good job.

Among the interpreters 88 % more or less agreed to have "the necessary insight into various medical philosophies to do a good job" and 8 % disagreed. This is in variance with findings in Study 1, where several medical nurses claimed to have worked with professional interpreters who seemed not to understand the message they were to interpret. These nurses held that hospital interpreters ought to know basic medical words and expressions, but that this is not always the case.

Health professional-interpreter collaboration

Lack of common language was the problem most often mentioned by interviewees in Studies 1-3. A striking finding in Study 1 was that many nurses accepted linguistic problems as inevitable, resulting in impaired quality of nursing care if professional interpreters were not called in.

Interpreters tend to be used only for doctor's appointments, while family step in for day-to-day communication needs. A Study 1 interviewee said that "they often think that when the physician is there, that is enough. But, often this is not so, for you have the nursing care actions – information and observations" (Hanssen 2002). This is still the situation today (Studies 2-4). In the medical unit (Study 2) family members tend to be present and available around the clock, while professional interpreters are called in by the hour. The nurses found that they too often resorted to the use of family interpreters, and at times they found it difficult to know where to draw the line – when it is permissible to use family as interpreters and in what situations it is a must to call in professionals.

While many interpreters are highly competent and carry out their work brilliantly, health professionals also experience cooperating with interpreters with inadequate language skills. Study 2 interviewees were at times uncertain whether the interpreter understands what the health professional is saying. They held that many professional interpreters lack the medical vocabulary and understanding necessary. Even when they write "consultation with physician" in the booking form, interpreters may be unprepared for the use of medical expressions. The interpreters held that the booking forms contain inadequate information about content of the sessions to enable them to prepare properly (Study 4). They are at times unimpressed by health professional's collaborative skills; they find themselves interrupted time and again while interpreting, or trying to do their job while several health professionals are talking at once. At times they are even treated rudely, e.g. people saying things like "next time get hold of an interpreter who understands Norwegian" when they know the interpreter can hear them.

According to Study 2 interviewees, some interpreters are unprepared for having to interpret during medical examinations and in treatment settings. Several of these nurses had worked with interpreters unable to stand by patients and interpret while examinations and tests were conducted. Some turned away, others left the room.

The Studies 2-3 questionnaires contained the following three statements concerning working with professional interpreters: "It is difficult to communicate well with patients through interpreters", "I am certain that interpreters translate everything that is being said", and "I am certain that interpreters tell me if misunderstandings arise during the talk." Questions 'mirrored' in the Study 4 questionnaire will be presented together with these statement findings. As mentioned in the method section, two statements were added to the Study 3 questionnaire: "Sometimes it is better to communicate without interpreter present in spite of language problems", and "Language problems make therapeutic sessions difficult without interpreter present."

In Study 3 the importance of language as a treatment tool in psychiatric therapy was stressed. One respondent expresses this thusly: "When poor Norwegian → poor rapport." Both "language and culture barriers" make it "difficult to connect with" some patients. To create good communication becomes "somewhat more demanding", and "it is often difficult to create good alliances." "It is of course more difficult to help those who do not speak Norwegian in a satisfactory way."

It is difficult to communicate well with patients through interpreters

As shown in Figure 3, responses regarding this statement are very similar in Studies 2 and 3:

	Medical unit nurses (Study 2)		Psychiatric unit health professionals (Study 3)	
	No. of respondents	Percent	No. of respondents	Percent
I don't agree at all	16	11 %	23	12 %
I don't agree	29	20 %	46	24 %
I neither agree nor disagree	37	26 %	42	22 %
I agree	29	20 %	48	25 %
I very much agree	12	8 %	10	5 %
I don't know	<u>20</u>	<u>14 %</u>	<u>24</u>	<u>12 %</u>
Sum total	143	99 %	193	100 %

Figure 3. *It is difficult to communicate well with patients through interpreters.*

Among the health professionals a mean of 29 % more or less agreed that it is difficult to communicate well through professional interpreters. 24 % neither agreed nor disagreed with this statement, 33 % more or less disagreed, and a mean of 13 % did not know.

Study 3 interviewees found that language problems may make it very difficult to do diagnostic interviews. And when interpreters are used, the interview takes longer: "Perhaps one gets to ask four questions during the interview instead of the ten one usually have time for". The interpreters (Study 4) found it frustrating that health professionals did not take into account that when everything has to be said twice the interview by necessity will take twice as long.

How do interpreters interpret?

Another statement was: "I am certain that interpreters translate everything that is being said" (Figure 4):

	Medical unit nurses (Study 2)		Psychiatric unit health professionals (Study 3)		Interpreters (Study 4)	
	No. of respond.	Percent	No. of respond.	Percent	No. of respond.	Percent
I don't agree at all	1	1 %	9	5 %	0	0 %
I don't agree	14	10 %	27	14 %	0	0 %
I neither agree nor disagree	27	19 %	45	23 %	0	0 %
I agree	42	29 %	57	30 %	3	12 %
I very much agree	40	28 %	34	18 %	22	88 %
I don't know	<u>21</u>	<u>15 %</u>	<u>21</u>	<u>11 %</u>	<u>0</u>	<u>0 %</u>
Sum total	145	102 %	193	101 %	25	100 %

Figure 4. Health professionals' certainty of interpreters translate everything that is being said, and interpreters' view on the same.

A mean of 44 % of the health professionals more or less agreed while 15 % more or less disagreed with this statement. A mean of 24 % neither agreed nor disagreed, and 13 % did not know (Studies 2-3). All the interpreters (100 %) agreed that they interpret everything (Study 4).

As opposed to professional interpreters, family or 'ad hoc' interpreters may be eclectic in their translations. An example is a narrative about a son who interpreted for his old father, told by a Study 1 interviewee: "And he used three words, you know, to explain everything I had said. And then I had to ask: 'Were you able to say everything I told you in such a short time?' And he just laughed at me. Of course he had not!" (Hanssen 2002:167).

Do interpreters help build cultural 'bridges'?

Responses to the statement: "I am certain that interpreters tell me if misunderstandings arise during the talk" show that health professionals' trust in professional interpreters varies (Figure 5):

	Medical unit nurses (Study 2)		Psychiatric unit health professionals (Study 3)		Interpreters (Study 4)	
	No. of respond.	Percent	No. of respond.	Percent	No. of respond.	Percent
I don't agree at all	4	3 %	7	4 %	8	32 %
I don't agree	11	8 %	26	14 %	4	16 %
I neither agree nor disagree	28	20 %	47	25 %	3	12 %
I agree	44	31 %	58	31 %	3	12 %
I very much agree	36	25 %	28	15 %	7	28 %
I don't know	<u>19</u>	<u>13 %</u>	<u>23</u>	<u>12 %</u>	<u>0</u>	<u>0 %</u>
Sum total	143	100 %	189	101 %	25	100 %

Figure 5. Health professionals' certainty that interpreters tell them if misunderstandings arise during sessions, and interpreters' perception of the same.

Among the health professionals a mean of 51 % more or less agreed with this statement while 14.5 % more or less disagreed. A mean of 22.5 % neither agreed nor disagreed, and 12.5 % did not know (Study 2-3). 40 % among the interpreters more or less agreed and 48 % more or less disagreed with the statement that they tell health professionals when misunderstandings arise. 12 % neither agreed nor disagreed (Study 4).

Study 4 focus group interviewees were asked the following question: When the communicating parties do not understand each other, should the interpreter step in as a bridge builder, or continue to interpret word for word? One of the interpreter answered that "during the session I interpret word for word, but I would perhaps talk with the physician after the session and say: 'Here is a problem, and I am not certain whether you realise there is a problem', as a kind of debriefing afterwards. I would say that that would be in order." All the interpreters present seemed to support this strategy and also that the interlocutors themselves have to figure out if they misunderstand each other. The quoted interpreter admitted however that sometimes he intervenes and informs the parties that they are misunderstanding each other "to save time".

Sometimes it is better to communicate without interpreter present in spite of language problems

While Study 3 interviewees said that sessions with psychiatric patients often are done without interpreters present, they also claimed to use interpreters whenever necessary. Not using interpreters makes it "more difficult to diagnose, but as long as you realise that it demands more time and competence, it works." One of the interviewees held that "the importance of words are overrated" and that "relationships may be at least as important as language." These views were presented as statement to Study 3 (psychiatric unit) respondents: "Sometimes it is better to communicate without interpreter present in spite of language problems" (Figure 6):

	Psychiatric unit health professionals (Study 3)	
	No. of respondents	Percent
I don't agree at all	41	21 %
I don't agree	42	22 %
I neither agree nor disagree	49	26 %
I agree	29	15 %
I very much agree	15	8 %
I don't know	16	8 %
Sum total	192	100 %

Figure 6. Sometimes it is better to communicate without interpreter present in spite of language problems.

23 % among the respondents agreed with this statement while 63 % disagreed. 26 % neither agreed nor disagreed, and 8 % did not know.

Quite a few patients, particularly those hailing from various clans and small immigrant groups, do not want interpreter assistance. This because "interpreters might talk" (break their oath of secrecy). "If you are not already paranoid, you may become so when interpreters are used." Study 4 interviewees firmly stressed the importance of upholding their oath of secrecy and that they always inform patients that they as interpreters are bound by such an oath.

Also Study 2 interviewees said sessions sometimes must be conducted without interpreter present because the patient mistrusts the interpreter in question. Reasons for distrust may according to these nurses be that patient and interpreter hail from different clans, they have been wartime enemies, or the group speaking the language in question is small and transparent, and the patient worries about gossip and stigma. The nurses claimed that they quickly sense whether patients trust the interpreter or not.

Consequences of not having an interpreter present when encountering language problems

What a Study 1 interviewee missed the most when there is no common language, is to be able to ask 'How are you doing?' and be able to "plough a little deeper and learn what goes on in the patient's mind". The assistance of an interpreter may be the difference between understanding or misreading a patient:

"I am thinking about the Pakistani lady; she was quiet – very quiet. But, when we had this interpreter here, the words suddenly just welled forth. ... Because she smiled and did not speak, it was easy for people to think that she had had a stroke, she is a little stupid, she is inattentive. But, when she had an interpreter, I realised ... And when I saw her facial expression while she talked, you saw ... She was totally with it, intellectually adequate – it had no connection with that at all. ... But I did not realise this until the interpreter came" (Hanssen 2002: 177).

The Study 3 respondents were presented with the statement "Language problems make therapeutic sessions difficult without interpreter present" (Figure 7):

	Psychiatric unit health professionals (Study 3)	
	No. of respondents	Percent
I don't agree at all	1	1 %
I don't agree	3	2 %
I neither agree nor disagree	24	13 %
I agree	50	26 %
I very much agree	101	53 %
I don't know	<u>13</u>	<u>7 %</u>
Sum total	192	102 %

Figure 7. Language problems make therapeutic sessions difficult without interpreter present.

Only 3 % of the psychiatric unit respondents more or less disagreed with this statement, while 79 % more or less agreed. 13 % neither agreed nor disagreed, and 7 % did not know.

Discussion

Although Study 2 shows that nurses still use family interpreters more often than they according to themselves ought to, there seems to be a growing consciousness among health professionals regarding the need to call in professionals when language is a problem.

Without professional interpreters health professionals cannot truly learn about patients' feelings, needs and abilities (Spence 1999), and in the case of the quiet Pakistani lady (above), without the interpreter's help the nurse would not have perceived her patient's true mental capacity. Furthermore, Spence (1999) found that

"[n]urses experience greater uncertainty when nursing people from other cultures than when encountering people from their own culture. Thus differences potentially has meaning as difficulty because, when encountering a patient from another culture, the nurse cannot assume that the person will share, or be able to understand, the background horizons that inform nursing practice. People from other cultures are also often perceived to be more vulnerable by nurses. Thus a greater need to communicate and establish trust exists alongside the increased difficulty in doing so" (p. 114).

Knowledge and intercultural health care communication

Only one third of the health professionals found that they have knowledge about other medical philosophies than biomedicine and 25 % evaluated their knowledge and understanding of non-western

illness philosophy and treatment adequate to be able to give good/appropriate treatment/ nursing care to patients who are unfamiliar with western medicine. Lack of knowledge makes it difficult for health professional to understand patients who's description of illness and symptoms is based on medical philosophies other than biomedicine. The risk is that they never realise that they misunderstand or do not understand what their ethnic minority patients tell them.

The interpreters found it difficult to collaborate with health professional who do not realise that patients may have a different medical understanding and/or behaviour other than what is common among ethnic Norwegians. Bradby (2001) stresses the importance for health professionals to be "aware of the peculiarities of their own professional culture" (p. 130).

The purpose of interpreting is traditionally to communicate messages in a faithful manner between people who lack a communal language (Jareg and Pettersen 2006). Professional interpreters tend to be trained to do word for word translations. Norwegian interpreters' code of ethics § 4 states that interpreters are to "interpret everything said, suppressing nothing, changing nothing" (T.Y. 2009). However,

"[t]he challenge is to convey meaning as accurately as possible from one person 'from one culture' to another person 'from another culture'. Due to cultural differences, ..., the transmission may be distorted. The receiver interprets the message differently from what was intended by the sender of the message. In this way, misunderstanding or lack of comprehension arises" (Haus 2006:73).

We will hold that verbatim translations are insufficient to create reciprocal understanding in cases where the interlocutors' respective background horizons are very different. If "[c]ommunication is action aimed at joint understanding" (Nynäs 2006:29), interpretation must needs be more than translation of the lexical meaning of words. If the connotative meaning of the words is not grasped by the receiver of the message, understanding will be frustrated. Studies on interpretation in the Norwegian legal system show that

"there was very often a sustainable lack of understanding, or even direct misunderstandings between the parties in cases involving defendants or witnesses with non-Norwegian backgrounds. This was also often the case in proceedings where the actors apparently understood the linguistic utterances as such, i.e. where the immigrants had fairly good knowledge of the Norwegian language, or even when a professional interpreter was engaged. In other words, in spite of linguistic interpretation, the different social and cultural backgrounds of the actors and their often different ways of communication their messages seemed to result in a lack of sufficient understanding" (Gotaas 2006:241).

Communication needs to be studied within the framework of the social, historical, cultural, and religious context within which it occurs as this constitutes the scope for the interlocutors' interpretation of the meaning of any message (Lewis 2000, Bradby 2001). Wittgenstein (2001) asks what the relationship is between a thing [or phenomenon] and the thing [or phenomenon] named. The hearing of a thing or phenomenon named, he says, must conjure up a picture in a person's mind to be translated into understanding or experience. This is a particularly interesting point when experiential and cultural differences make the picture that is conjured up in the mind of the listener very different from what was intended by the speaker. Maybe no picture is forthcoming at all if the name of the 'thing' or phenomenon, and perhaps the 'thing' or phenomenon itself, is outside the listener's scope of understanding or experience. As Wittgenstein points out (2001:17): a "word has no meaning if nothing corresponds to it", either in reality or in the mind of the listener. A health care related example of this is when a patient is informed about an infection and is unfamiliar with the concept of bacteria (Hanssen 2002).

Language as the vehicle of thought

Communication problems in health care – which include lack of a common language – also comprise different explanations and expressions of symptoms due to understandings of illness at variance with western medical philosophy (Hanssen 2002) as well as different 'languages of emotion' (Bradby 2001). Wittgenstein (2001) points out that language is the vehicle of our thoughts and that the meaning of our words and how we express our meanings are something we take for granted. We tend to forget that although the "physiognomy of a word" may be familiar to us and gives us "the feeling that it has taken up its meaning into itself, that it is an actual likeness of its meaning – there could be human beings to whom all this was alien" (ibid., p. 186).

Bandler and Grinder (1975) state that language is perhaps the most influential socio-cultural factor in human perception. They exemplify this by way of Maidu, a language spoken by a Native American people of northern California. Maidu contains merely three words to cover the total colour spectrum: *lak* represents red, *tit* represents green and blue, and *tulak* represents yellow, orange, and brown. Native Maidu speakers group all colour nuances within these three categories although it is physically possible for human beings to distinguish between about 130 nuances of colour. In most other languages speakers have more categories to choose from because their languages have more words with which to express colour nuances. While a native English speaker, for instance, will describe otherwise identical blue and green cups as different based on colour, a native Maidu speaker will describe them both as *tit*.

Our perception, then, is influenced both by language and by culture. It is influenced by the context of a given situation, and by our thoughts and feelings. Our perception will in its turn influence our communication and collaboration with others. Hence it is difficult to distinguish between a person's cultural background and the environment within which he or she functions. When we for instance in English say that "it rained yesterday", the receiver of this message neither knows how we came to this conclusion nor whether we speak the truth. A Native American Hopi, on the other hand, cannot speak about the rain without clarifying his relationship to the occurrence – whether it is experienced first hand, is a logical conclusion, or based on rumour (Hall 1989). What we choose to focus on and what we choose to ignore, find expression through our verbal communication. Because of this "one human being can be a complete enigma to another. We learn this when we come into a strange country with entirely strange traditions; and, what is more, even given a mastery of the country's language. We do not *understand* the people. ... We cannot find our feet with them" (Wittgenstein 2001:190).

Although 79 % of the psychiatric unit respondent more or less supported the statement that therapeutic sessions are difficult without interpreters present, findings also show that interpreters are often not used. Based on the above we question the professional reasoning behind not always using interpreters. As a Bosnian patient put it:

"When I started in therapy everything was difficult. I sat there and was not willing to say much. I was not able to express my feelings well in Norwegian, but I was never offered an interpreter. I was not able to communicate the nuances of my state of mind. Many times it was very exhausting because I tried to explain as best I could, but I felt that the therapist did not understand me properly" (Rizvic 2005:68).

Sami patients have the same experience when communicating with Norwegian health professionals: "Then the Sami comes to the fore. It is obvious that it is difficult to think in Norwegian then. The mother tongue comes automatically." "Of course I wish to speak Sami about personal issues. I think in Sami!" (NOU 1995.6:56).

The need for cultural and linguistic knowledge

Both interpreters and health professionals need cultural knowledge in their work with ethnic minority patients. Interpreters found it for instance difficult to collaborate with health professionals who do not modify their language according to the patient's needs or who do not realise that patients may have a different medical understanding and/or behaviour other than what is common among ethnic Norwegians. The interpreters claimed to have the necessary knowledge of western biomedicine to do a good job. They also found it difficult when health professionals used medical terminology. These statements are rather conflicting. The latter statement is supported by many health professionals who claim that some professional interpreters lack the necessary understanding of medical terminology etc. to enable skilled interpretation.

In 2000 relatively few of the interpreters working in the public sector were trained and/or authorised as interpreters. Although more interpreters are being trained these days, it is a slow process to build a sufficiently large corps of linguistically and culturally skilled interpreters. Additionally, many do interpretive work only as a sideline (Ørving 2007). The majority of trained interpreters work in the Oslo area (Nilsen 2000). Neither the three largest Norwegian private firms of interpreters nor the public interpreter services have records of qualifications of the interpreters they employ (Ørving 2007, Nilsen 2000). In her study of the Norwegian legal system Nilsen found that interpreters are being used

"who do not have the necessary competence when it comes to linguistic skills and interpretational techniques to cope satisfactory with their assigned tasks of interpreting. Several of the interpreters in the data material may be characterised as bilingual helpers with varied linguistic skills rather than professional interpreters" (Nilsen 2000:13).

Our studies indicate that this is likely also to be true for quite a few professional interpreters within the fields of medicine and nursing. Study 3 interviewees had the impression that "anyone can become an interpreter". And one of the Study 1 interviewees was at times a little doubtful about the quality of interpretations:

"But, it is just a feeling, perhaps, impression – some signal given showing that the interpreter does not feel comfortable, or if he asks about a lot of words, or ... Or at times I have experienced that when I have said 'blood sugar' the interpreter has said 'blood pressure', and then ... So I think ... 'this is not quite right'. And it may be an interpreter who has worked for years" (Hanssen 2002:178-179)..

To distinguish the skilled interpreters from the inapt ones it is necessary to

"establish dependable routines for feedback, so that unsatisfactory interpreters are weeded out of the system. Another point is that the interpreters must be secured a corresponding opportunity to give feedback regarding ... unsatisfactory **users** of the interpreting services, without risking losing out on assignments" (Alpers and Hanssen 2009:105).

Andenæs et al. (2000) maintain that the quality of interpreting as a 'commodity' "is very difficult for the costumer or end user to control" and that there is "a general lack of knowledge about what it takes to hold such a responsible position. Interpreting within the public sector is a rather unregulated domain, and hence it seems difficult to register" (p. 9). This is without doubt a great problem.

Health professional-interpreter collaboration

The importance of facilitating genuine reciprocal understanding cannot be exaggerated. Citing various studies Bradby (2001:132) holds that

"not only is effective communication associated with compliance and patient satisfaction, but also with some improved health outcomes. Conversely, poor service provider communication constitutes a significant barrier to the receipt of good quality health care, and is associated with non-compliance with preventative services ... An inability to speak [the language] is associated with a range of indicators of the inappropriate use of various hospital services and with children's poor health status. Ineffective communication is likely to lead to worsened health outcomes, particularly with complex and/or chronic health problems".

The use of unqualified interpreters – whether professional or not – may cause translation errors which may have clinical consequences regarding dosage, "frequency, duration or mode of administration of drugs and other therapeutic intervention, and omitting relevant clinical information on drug allergies and the past medical history" (Flores 2005:271). The use of inapt or unprofessional interpreters raises additional concerns regarding accuracy, comprehensiveness, impartiality, and confidentiality (Nailon

2006). Family interpreters may furthermore have their own reasons for editing the exchange of information (Gerrish and Fox House 2002, Hanssen 2002).

According to the Norwegian Patients' Rights Act (PRA 1999) it is the responsibility of health personnel to adapt information according to the individual patient's maturity, knowledge, and linguistic ability to ensure true understanding. When this is not done, this responsibility is not met.

It is difficult to communicate well with patients through interpreters

It is understandable that health professionals may find establishing good rapport with patients more difficult when communication goes through an interpreter. One of Spence's (1999) respondents explained that it was difficult to "form any sort of relationship with the client. The communication goes through someone else. It's not a two-way thing" (p. 109). Nynäs (2006:30) finds that

"[t]he relevance of mutual understanding in intercultural communication is observable as an emphasis of interpersonal relatedness in communication. Parties in a multicultural co-operation might e.g. prefer the uncertainty of communication in a face-to-face situation rather than a more certain communication with the services of an interpreter. Such 'middlemen' and 'filters' are easily experienced in a negative way."

As the interpreter is the only person in the setting who understands both languages (and cultures), he/she may find him/herself in a position of power. It is imperative that the interpreter has the skill, knowledge and moral backbone to handle this power in a beneficial way for the interlocutors. The professional interpreters' ethical guidelines state the principle of patient confidentiality. It is a great problem that certain patients may distrust certain professional interpreters. Varvin (2008) holds that this distrust is not unfounded, as there are several examples of interpreters having broken their oath of secrecy causing confidential information to circulate in immigrant groups.

Another ethical principle is that of being impartial and not permitting attitudes, feelings or opinions influence their work (Jareg and Pettersen 2006). The interpreter's demeanour towards the patient is important to the success of the talk. van der Veer (1994) mentions sympathetic, businesslike, authoritarian, and condescending as demeanours which may further or hinder the patient-health professional relationship. An example is an interpreter who became what a Study 1 interviewee characterised as 'unprofessionally involved' because he "almost got angry because [the patient] did not understand." This interviewee found that interpreters sometimes "become embarrassed on behalf of the person for whom they interpret" (Hanssen 2002).

An interpreter's feelings may get in the way of doing a good job in other respects, too. As seen in the findings section, some interpreters are unprepared for the situation in which they may be called in to interpret, for instance in therapeutic settings. To turn away from the patient or leave the room during treatment sessions is rather unprofessional. Pistillo points out that

"[s]uccessful intercultural communication is very difficult to achieve, as it involves a great number of factors, e.g. language (verbal communication), body gestures (non-verbal communication), the use of time, space and silence etc., which differ from culture to culture. For all of these reasons, bridging the gap between two people or groups of people who employ an interpreter 'simply' because they do not speak the same language is a very delicate task" (2004:2).

To achieve such a delicate task successfully we will hold that mediation rather than mere translation is necessary. The interpreters interviewed in Study 3 found it difficult when patients do not understand medical terminology or how the health care system works. As they are not authorised to add anything – e.g. explain what the terminology used mean or how to navigate the 'system' to be able to use the information they are given – they are put in a frustrating position. Their not being permitted when necessary to explain the content of what is being said also frustrates the intent of the Patients' Rights Act to ensure true understanding.

Stolk et al. (1998) found that ineffective communication is particularly unfortunate when it comes to "mental health problems, where the lack of a common language can lead to misdiagnosis, ineffective, harmful treatment and longer admissions" (in Bradby 2001:132). In Study 3 some psychiatric therapists wondered whether they at times 'diagnose' ethnic minority patients' culture rather than their mental

illness because their 'normal' way of behaving and expressing themselves at times can be very different from what is common among ethnic Norwegians.

Do interpreters help build cultural 'bridges'?

While more than half of the total number of Studies 1-2 respondents expect to be told by the interpreter if they and their patients do not understand each other, only 40 % of the interpreters report to give this kind of information, and nearly half of them respond that they donot. In combination with verbatim translations this mismatch of expectations adds to the danger of the interlocutors never realising that their words create no meaning in the other party.

Impartiality is one of the major ethical requirements for professional interpreters, and as a rule they are not supposed to express their opinion or in any way through their translations alter what the speaker expresses. In this mode of interpretation, where the interpreter acts as a 'voice box', "[t]he interpreter is 'used by' the professional, who should 'keep control of the consultation'. The fear that interpreters may step beyond their neutral role and distort communication with patients is not uncommon" (Bradby 2001:142). As seen in the findings section, this is a mode of interpretation supported by all the Study 4 interviewees and by 40 % of the interpreter respondents.

However, "[g]iven that the literal translation is generally not considered advisable (Schäffner, 1996; Katan, 1999), it is essential to find out the extent to which an interpreter can 'mediate' rather than merely 'translate' in order to improve the communication flow" (Pistillo 2004:2). As a mediator the interpreter can contribute more explicitly by mediating between members of cultures having different pre-understandings and expectations (Pistillo 2003). However, this is in conflict with Norwegian interpreters' current responsibility, which according to their code of ethics is to suppress nothing, ad nothing, change nothing (§ 4), and "which only entails translation of what is being said by the communicating parties. ... the interpreter is not delegated a function as cultural informer/interpreter" (Ørvig 2007:28).

The problem is that quite often messages are misunderstood not due to lack of translation, but due to the interlocutors' lack of reciprocal knowledge and communal horizons of understanding:

"Due to the difference in cultural background the Norwegian party do not understand what is being said by the foreigner, even if they seemingly understand the linguistic utterances in a narrow sense. The foreign party does not understand what the Norwegians are saying due to a corresponding lack of understanding of Norwegian society" (Nilsen 2000:18).

As we see it, in health care mediation the interpreter should interpret verbatim and then when necessary explain the meaning behind the words. Both parties need to be privy to such cultural interpretation and explanation, otherwise an unexplained lengthy speech by the interpreter may create uncertainty and suspicion in the person who does not understand what is being said. To mediate thusly will be possible also for Norwegian interpreters. Although it goes beyond a literal understanding of their code of ethics, it is defensible as it will keep the interlocutors informed about everything being said by all parties during the talk. Furthermore, it will be in accordance with the intention of the Patients' Right Act.

This latter stance is in line with how many interpreters function in the UK. In the UK there are different kinds of interpreters working within the health care services with various roles regarding interpreting, information giving and support to patients: There are interpreters who merely work as linguistic translators when the interlocutors do not speak a common language, and interpreters who's work exceeds mere linguistic translation as they also act as cultural mediators. As one of the latter kind of interpreters put it:

"My role is to liaise between the patient and the professional providing a confidential and professional service. It's not just about interpreting word for word, it's about taking it a step further, possibly giving professional cultural advice, giving the patient advice, pointing them in the direction of other services" (Gerrish and Fox House 2004:411).

We do not advocate that interpreters should act as advisors, but in the future we wish to see interpreters who are qualified to act as cultural mediators and who are legally and ethically allowed to do so.

Conclusion

How to cooperate with interpreters – including attitudes, skills and knowledge on the part of health professionals – is a pressing question in combination with whether the interpreter's linguistic, cultural and specialty skills are adequate to perform the task required of him/her.

In this text we have tried to show why successful intercultural communication may be difficult and that it involves more than mere lexical understanding of words. Wittgenstein (2001:108) points out that "[t]here is a gulf between an order and its execution. It has to be filled by the act of understanding". In health care settings communication may necessitate more than mere word for word translation to create true understanding. Where there is a gap of understanding between patient and health professional, the interpreter may be needed as a 'cultural bridge'. So far this is not within Norwegian professional interpreters' job description.

Although the use of interpreters may not be as ideal as communicating one on one, it eases the collaborative processes. We have in this paper shown that interpreters need to possess adequate knowledge of western biomedicine and its vocabulary, how the majority society functions etc., as well as of the patient's understanding of the situation to be able to help build trust and understanding. Pistillo (2003), a professional interpreter herself, holds that interpreters need to be "bi-cultural, that is have a deep knowledge of and strong 'feel' for both cultures, and use this skill to avoid misunderstandings and communication failure" (p. 136). Communication may be compromised by health professionals and professional interpreters alike being culturally incompetent. Both interpreters and health professionals therefore need to be culturally aware and trained to collaborate effectively to secure high quality of communication with patients and hence ensure the best possible health care outcome.

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