

Healthcare staffs perceptions of using interpreters: a qualitative study

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Aim: The aim of this study was to describe how healthcare professionals experience and perceive the use of interpreters in their contacts with patients with whom they do not share a common language. **Background:** Language barriers lead to poor-quality care and fewer medical contacts. To avoid language barriers and their consequences, interpreters are recommended. However, communicating through an interpreter can be difficult. To develop effective interpreter service it is important to study healthcare staff's perceptions of using an interpreter. **Methods:** An explorative descriptive study design was used. The study was conducted in different healthcare settings in Sweden and included 24 healthcare staff, of whom 11 were physicians, 9 nurses, 2 physiotherapists and 2 assistant nurses. Data were generated through written descriptions of the use of interpreters in healthcare service and were analysed using qualitative content analysis. **Findings:** Two main categories emerged from the data: 1) aspects related to the interpreter and 2) organizational aspects. The study showed that having a face-to-face, professional, trained interpreter, with a good knowledge of both languages and of medical terminology, translating literally and objectively, was perceived positively. The organizational aspects that affected the perception were functioning or non-functioning technical equipment, calm in the interpretation environment, documentation of the patients' language ability, respect for the appointed time, and the level of availability and service provided by the interpreter agency. It is important to develop a well-functioning interpreter organization that offers trained interpreters with a professional attitude to improve and ensure cost-effective and high-quality encounters and care.

Key words: communication; healthcare professionals; qualitative content analysis; utilization of interpreters; written descriptions

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Introduction

Communication is an essential part of caring (Leininger and McFarland, 2002) and it is a social process which includes spoken language as well as non-verbal features such as facial expressions and gestures (Watzlawick *et al.*, 1967; Leininger and McFarland, 2002). It is not only a process of

substantive messages between people but also includes the entire field of human interaction and behaviour (Watzlawick *et al.*, 1967). It includes a sender, a transmitting device, signals, a receiver and feedback. An interpreter is an aid in transmitting messages, and communication through a third party exacerbates the problem of sending messages clearly (Giger and Davidhizar, 2004).

Healthcare professionals face particular challenges when caring for foreign-born patients with whom they do not share the same language (Gerrish *et al.*, 2004). Language barriers may lead

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to patients receiving poor-quality care (Rhodes and Nocon, 2003; Gerrish *et al.*, 2004), and the use of an interpreter can reduce language barriers (Bischoff, 2003; Karliner *et al.*, 2007).

When reviewing the literature it has been shown that using an interpreter can be perceived as a barrier to communication (Hadziabdic *et al.*, 2009; Fatahi *et al.*, 2010). Previous studies (Rhodes and Nocon, 2003; Edwards *et al.*, 2005) have found that patients preferred using family members as interpreters, because they trusted them more than professional interpreters. Others (Hadziabdic *et al.*, 2009) have shown that the patients' desire was to have a professional interpreter in face-to-face interaction, who would understand and empathize with them and relate to the situation. An investigation focusing on arranging and negotiating the use of informal interpreters showed that the use of informal interpreters can be experienced as inadequate and problematic (MacFarlane *et al.*, 2009).

In studies of healthcare staff, family physicians described how, in consultation through interpreters, they faced obstacles in establishing optimal communication, and it required all the participants to play an active role to achieve an optimal clinical encounter (Fatahi *et al.*, 2008). All communication tasks were more difficult when an interpreter was used (Rosenberg *et al.*, 2007), and the interpreter had to strive to be a neutral information bridge and have a balancing role between the physician and the patient (Fatahi *et al.*, 2008).

The previous studies are limited to family physicians' perceptions of communication through interpreters. Thus, there is a lack of studies reporting on different caregivers' experiences of communication through an interpreter, yet this perspective is important as several professions in healthcare face the need to use an interpreter in their contacts with patients. This study, together with a previous study (Hadziabdic *et al.*, 2009) from the patient's perspective, can help us to adopt a holistic picture of the use of interpreters in healthcare to develop service and organization of interpreters from the users' perspective.

Aim

The aim of this study was to describe how healthcare professionals perceived the use of interpreters in their contacts when communicating

with patients with whom they do not share a common language.

Methods

Design and method descriptions

As the field has not previously been explored and the study sought to understand the reality, an explorative qualitative method (Patton, 2002) was chosen, using written descriptions of situations experienced by healthcare staff. The descriptions were used to obtain information about respondents' experiences of a phenomenon and the intention was to have as lively accounts as possible (van Manen, 1990). Informants were asked to write down their experiences of using interpreters in their daily work in healthcare as accurately as possible. Writing forced the informants into a reflective attitude, in contrast to interviews in which persons are much more immediately involved (van Manen, 1990).

Setting and participants

A purposive sample was chosen to ensure a sample with maximum variation (Patton, 2002) in age, gender and different healthcare professions. The participants had to have used interpreters in their daily work in healthcare. Managers in different institutions in primary healthcare and hospitals frequently using interpreters were contacted by telephone by the first author and approval was obtained for the study. The managers were requested to invite different kinds of healthcare professions to participate. A time was set at ordinary staff meetings when information (verbal and written) about the study and assurance of voluntary participation was given. It was emphasized that the descriptions of their own experiences were more important than formal literary expression. Written information together with a prepaid envelope was given to voluntary participants. The written descriptions in the prepaid envelope were to be returned to the first author. The first author's contact details were included in case the participants had any questions. Participants did not have to write their names if they did not want to.

The study included 24 persons (19 females and 5 males) of whom 11 were physicians, 9 nurses,

2 physiotherapists and 2 assistant nurses, with experience of work in healthcare from one year to 36 years (median of 27 years). All participants were Swedes.

Data collection

Data were collected between March and November 2007. On the basis of a literature review and experiences from a previous study (Ozolins and Hjelm, 2003) using the same method, an instruction guide was developed. Two pilot studies, included in the study, were carried out to evaluate the instruction guide, resulting in minor corrections of the language with regard to follow-up instructions. The overall instruction was: please describe as thoroughly as possible a positive and a negative situation where you have used (professional or informal) interpreters in the care of foreign-born patients. The participants were asked to describe the situations according to: what happened? What did you/others do? What did you think? What did you feel? How did you react?

Ethical considerations

Written informed consent was obtained from the participants (Declaration of Helsinki, 1996). To preserve the confidentiality of the participants' data, the transcripts were anonymized and coded by number. The analysis and presentation of the

data were performed in a way that concealed the participants' identity. All the collected data were stored in a locked space which only the principal investigator had access to. The procedure was in accordance with Swedish law (SFS, 2003: 460), and approval by an official research ethics committee was not required.

Data analysis

Qualitative content analysis of data was applied. This method refers to qualitative data reduction and attempts to identify core consistencies and meanings, and to provide knowledge and understanding of the phenomenon under study (Krippendorff, 2004).

The texts from the situations described were read thoroughly several times to achieve a sense of the whole. The texts were broken into smaller textual units (see Table 1). The next step was to develop codes from the context of the textual units. The co-authors were open to as much variation in the material as possible and searched for regularities, contradictions and patterns, which then built up sub-categories and categories. Categories were developed, modified and refined until an acceptable system was recognized. In naming categories, concepts as close as possible to the text were used. Analysis of data proceeded until no new information was obtained (Krippendorff, 2004).

To strengthen the rigour the following steps described by Patton (2002) were taken. Credibility

Table 1 Example of analysis steps

Main category	Aspects related to the interpreter		
Sub-category	Type of interpreter		
Code	Professional interpreter preferable	Family member as interpreter not preferred because of insufficient language skills and difficulty in remaining objective	Interpreter on the spot uses body language
Textual units	Professional interpreter best of all	Family member as interpreter... problematic... poor command of the language... difficulty remaining objective	interpreter on the spot can show, point ...
Quote	'Best of all is a professional interpreter who just translates so that the talk goes between me and the patient. The patient should preferably grasp this and have eye contact with me'. (16)	'A family member as interpreter can be problematic because they might not master the language and can find it hard to remain objective.' (15)	'An interpreter on the spot can show, point and explain in simple terms.' (12)

was ensured by the first author conducting, transcribing and analysing the data. The co-authors double-checked the content of the codes and categories to confirm their relevance. The confirmability of the study was further ensured by the way differences and similarities between groups were supported by the empirical data: categories followed in the form of literal citations and naming of categories as close as possible to the text. Dependability was ensured by describing the research process as clearly as possible.

Findings

Two main categories – 1) aspects related to the interpreter and 2) organizational aspects – emerged from healthcare staff's perceptions of the interpretation situation with the respective sub-categories (see Table 2).

Aspects related to the interpreter

Type of interpreter

Healthcare staff said that they preferred using a professional interpreter and that family members should be avoided as interpreters. They felt trust in the professional interpreter's ability to interpret literally, objectively and without having any relation to the patients, and they wanted direct face-to-face communication with the patient.

'The best interpreting situation arises if you have an interpreter who has no relation to the patient. Best of all is a certified professional interpreter who just translates so that the talk goes between me and the patient.' (16)

Family members were perceived as being unprofessional because of incomplete translation and inability to fully grasp the language so that the patient became hesitant and felt hopeless. Using them as interpreters caused feelings of stress for healthcare staff as they perceived it to be more time-consuming, with the result that they needed to book a new consultation with a professional interpreter.

'The family member didn't know Swedish well enough to understand me. ... They talked to

Table 2 Two main categories with the respective sub-categories

Categories	Sub-categories
Aspects related to the interpreter	Type of interpreter The interpreter's attitude to the interpretation situation Personal characteristics of the interpreter Language
Organizational aspects	Technical equipment Interpreting environment Documentation of the patients' language ability in the medical record Time Interpreter agency

each other and I couldn't understand a thing. I felt stress, the patient became hesitant The examination took more time than usual, and the next patient had to wait. ... Then I made a new appointment so that the patient could come back again with a certified interpreter.' (17)

Some of the informants preferred to have personal contact with face-to-face interaction with a professional interpreter, while others preferred interpretation by telephone. Face-to-face interaction made direct communication possible as well as being able to observe body language. In contrast, interpretation by telephone was perceived to improve the direct communication between staff and patient, as the interpreter became only a communication aid. Telephone interpreters were also perceived to be easily accessible and a help to fast orientation about the patients' condition.

'A certified interpreter on the spot is much better than the telephone ... an interpreter on the spot can show, point and explain in simple terms.' (12)

'The other day I had a patient and I had no idea at all what his trouble was. So I called for a telephone interpreter, which is what we use most. The interpreter spoke in a calm and friendly way and I quickly gained an idea of what the problem was. The advantage of using a telephone interpreter is that both the patient and I automatically look at

each other when we talk and the interpreter becomes a tool instead of a participant.’ (22)

Others said that it was important to use interpreters, because it provided an opportunity for patients to express themselves in their native language, which facilitated the examination and treatment. Informants stated that there were guidelines recommending the use of a telephone interpreter as the first option, as face-to-face interpreters were considered expensive. However, some expressed the need to use face-to-face interpreters and felt stress as a result of this recommendation.

‘I have worked in places where they try to avoid a face-to-face interpreter as much as possible because of the high costs. In my work I often need to have access to a face-to-face interpreter and the pressure from the management means that the stress on me increases if I have to use an interpreter. ... It’s important that the use of a face-to-face interpreter is accepted if it’s necessary.’ (9)
 ‘Being able to express yourself in your mother tongue means that examinations and understanding of treatments can be much better....’ (12)

Continuous use of a particular interpreter was experienced as leading to feelings of security for both the interpreters and healthcare staff, but this occurred rarely.

‘I think that interpreting is actually better if I have had the same interpreter before and both the interpreter and I are secure in the situation that it works as it’s supposed to. With the present interpreter agency we rarely have the same interpreter, so it’s mostly a new interpreter each time.’ (7)

The interpreters’ attitude in the interpretation situation

Participants described how interpreters having a professional attitude could lead to positive experiences of the interpretation situation. This attitude included an ability to translate like a communication aid, being highly skilled in language, informing about their role as a formal translator and the code of confidentiality, keeping themselves in the background so that the conversation could flow between the staff and the

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patient, and finally that they turned up at the agreed time and were present during the entire consultation.

‘The interpreter just translates what you say, doesn’t seem to add any explanations for the patient, stays in the background and lets me and the patient carry on the conversation, knows the language well, including medical terms, doesn’t interfere, arrives on time, and isn’t in a hurry to get away ...’ (18)
 ‘... inform me and the patient that the interpreting would be done through him and that he had to respect professional secrecy.’ (9)

The interpreter’s attitude was sometimes perceived as unprofessional when the interpreter for example talked to the family or staff instead of the patient or when background noise could be heard and disturbed the consultation when using the telephone interpreter.

‘The husband accompanied the patient, a woman. The interpreter mostly turned to the husband. The interpreter spoke almost without interruption to the husband in their own language ... The woman became uncertain when he spoke to her. It felt as if the patient and I [a nurse] weren’t there.’ (24)
 ‘In some cases sounds or voices in the background had caused disturbance. ... Telephone with disturbance/interpreting by mobile phone.’ (8)

Personal characteristics of the interpreter

This sub-category described the interpreter’s personal characteristics especially in face-to-face interaction. Some of the informants felt that the same gender and ethnic origin shared by patient and interpreter was important. Other essential factors were the interpreter’s education, language skills, behaviour and attitude. Non-provocative and/or neutral clothes worn by the interpreter inspired respect in the respondents. Informants’ trust in the interpreter increased with the interpreter’s language skills. The interpreters’ professional attitude shown by the respect and interest demonstrated was perceived as pleasant and courteous to all involved.

‘The sex of the interpreter is often significant for the patient but not for me personally. ...

Dress can be important. Not all styles of dress are suitable. The interpreter's behaviour and attitude are of great importance. Once again, you have to be professional and respect both parties for whom you're interpreting, just as the parties must respect the interpreter. Education is important, of course, you have to be able to understand both parties.' (9)
 'Good knowledge of the language is very important!' (12)

Language

The interpreter's language skills, knowledge of medical terminology and translation ability were perceived as important by the informants. The interpreter should translate completely and objectively and also be able to make a fast translation and be able to adapt the language to the patient and/or to health professionals. Further, to facilitate the translation it was viewed as important that an interpreter talked the same dialect as the patient. Participants wanted a 'literal' interpretation because it could lead to feelings of mutual understanding between them and their patients. They also described how the conversation could be positively facilitated if the interpreter kept them informed as to whether there was something that might influence the interpretation.

'... Must have a good knowledge of both languages...' (10)

'... trained to interpret in a health-care situation.' (15)

'The interpreter must say immediately if he notices that the patient speaks a different dialect that he can't translate.' (11)

'I had an interpreter with a patient and the interpreter had a dialect the patient didn't understand.' (6)

'Translates everything that I or the patient/family member says. Even the dialogue that takes place between children and parents (patient/family member) without putting any personal judgements into the words, as I see it.' (19)

Sometimes informants described how interpreters could put in their own opinions and give their own suggestions for medication and even talk to the patient without translating for healthcare staff. Then the healthcare staff feared that they would lose something in the story and

they mistrusted the interpretation. The participants had also experienced interpreters having inadequate knowledge both of Swedish and medical terminology.

'She [the interpreter] inserts her own judgements and suggested measures, which can be downright wrong as well.' (10)

'[Interpreters] find it hard to understand what I mean when I explain different things. They can't find the right words in the language they're interpreting in.' (19)

Organizational aspects

Technical equipment

The informants perceived that well-functioning technical equipment was crucial for communication in telephonic interpretation. The equipment must be of good quality, and a mobile phone must be placed appropriately or a speaker telephone should be used.

'The telephone is portable, of good quality, the sound is good. The telephone [a loud-speaker phone] can be placed in the room so that both the patient and I can hear well.' (11)

Further, it could happen that there was no mobile phone coverage, resulting in more time needed for the consultation and thus other patients having to wait.

'Dialled the number which was a mobile number, we introduced ourselves and then there was silence. No signal ... I had to dial again, which meant that the case took longer and others had to wait.' (21)

Interpreting environment

The sub-category described how the place where interpretation occurred could influence the interpretation. The informants felt that a secluded room and no interruption during consultation were important to ensure a good environment for interpretation. It was essential that the interpretation was carried out in a peaceful atmosphere and that the interpreter could sit near the patient.

'...important to be able to close the door and not be disturbed, along with the interpreter and the patient.' (12)

‘There should be no interruptions during the consultation.’ (14)

‘The discussion took place in peace and was calm. The interpreter was able to explain to me and to the patients. He sat close to the patient and took an interest.’ (17)

The participants found that interpretation by telephone could lead to disturbance in consultation because of background noise, for example the doorbell or other telephone rang, and the interpreter could be speaking on another phone at the same time.

‘The interpreter interrupts the conversation twice, the doorbell rings or another phone rings, you hear voices in the background.’ (6)

Documentation of the patients’ language ability in the medical record

The staff felt it important to document the patients’ communication status in the medical record, including the appropriate language and dialect, as there were many languages and dialects spoken. This was important to book a relevant interpreter and to be able to plan for the consultation. It also took more time for preparation if the patient spoke an unusual language or dialect for whom few interpreters were available.

‘In view of the fact that there are so many languages and dialects, it’s important that it says in the records not just which language the patient speaks but also if there is some special dialect, since some patients speak and understand only their own dialect.’ (6)

Time

Informants felt that it was important that an interpreter was available at the appointed time and throughout the whole consultation. However, this was not always the case.

‘The interpreter is available exactly at the agreed time... The interpreter must have allocated enough time for the conversation and not suddenly say, “I have to stop now because of another appointment.”’ (11)

If the interpreter did not turn up at appointed time, an untrained interpreter often replaced him/her, which resulted in feelings of insecurity among healthcare staff, and the consultation was limited

in content. A new appointment with a professional interpreter was needed, which increased the workload.

‘...when the interpreter didn’t come and I had to interpret via a family member instead [who was not a trained interpreter]. I felt uncertain as to whether the right information was put across. Had to make an appointment for a new visit, this time with an interpreter...’ (18)

Sometimes, the interpreter did not turn up at the appointed time and/or broke off the consultation prematurely. In telephone interpretation, if the coverage was bad this also required more time. Then other patients had to wait. From healthcare staff’s point of view it was also important to have enough time set aside. According to the booking system, the same amount of time was reserved for all consultations, but the participants found that communication through an interpreter took longer and thus the disrupted schedule led to other patients having to wait.

‘I think it helped a lot to have the double time that we had saved in the timetable for patients with an interpreter because it takes more time than usual.’ (17)

Interpreter agency

Good accessibility to the interpreter agency and continuity in the use of interpreters resulted in feelings of security. It was faster to get an interpreter by telephone than a face-to-face interpreter. However, informants found difficulties in access to the interpreter agency. This led to more work for healthcare staff and required someone else, such as family members, to interpret, which was not always perceived as good for patients.

‘What is often a problem for us is that you can’t always get an interpreter. This means a lot of extra work for us and causes problems for the patient. Family members sometimes have to interpret, and that’s not always good.’ (9)

Interpreter services should be evaluated to improve the quality and ensure a professional attitude among the interpreters. The staff also wished that the agency would ask the staff to

evaluate the interpreters, the service and the accessibility.

‘There should be some evaluation by interpreter agencies so that you don’t have to phone to complain. In evaluations you can emphasize positive things.’ (9)

Discussion

This study is unique as it illustrates the perceptions of using interpreters from the healthcare professionals’ perspective. The main findings are that the healthcare staff desired to have a professional interpreter who translated literally and objectively, and a functioning interpreter organization. This is a possibility to prevent effects of poor communication due to language barriers, leading to poor quality care and misunderstandings about care received (Watzlawick *et al.*, 1967; Giger and Davidhizar, 2004). The results contrast with a previous investigation where family physicians described how the relationship could be seen as frustrating and instrumentalized when using professional interpreters (Rosenberg *et al.*, 2007). Healthcare staff in our study wanted to communicate on equal terms as they did with the patients with whom they share the same language, enlisting the aid of a professional interpreter. The findings indicate that the choice of interpreter should be made in agreement between patient and healthcare staff and thus individualized. This is in accordance with the Swedish Health and Medical Services Act (SFS, 1982: 763), in which the main goal is individualized care of high quality delivered on equal terms to the whole population. It is important to be aware of this because previous studies (Rhodes and Nocon, 2003; Edwards *et al.*, 2005; Hadziabdic *et al.*, 2009) have shown that different patient groups prefer different kinds of interpreters. European migrants in Sweden (Hadziabdic *et al.*, 2009) and Ireland (MacFarlane *et al.*, 2009) preferred professional interpreters while mostly Asian-born respondents in the UK preferred family members as interpreters (Rhodes and Nocon, 2003; Edwards *et al.*, 2005).

Healthcare staff in this study did not reflect on the use of bilingual healthcare professionals as interpreters. They were aware of how to access interpreter service and recognized that a professional

interpreter contributes to better communication, leading to better care. Interpretation errors occur frequently when bilingual nurses act as interpreters (Elderkin-Thompson *et al.*, 2001). Patients, when asked about this in an open-ended question, would consider using bilingual healthcare professionals as interpreters if no professional interpreters were available (Hadziabdic *et al.*, 2009). The dissimilarities might be due to differences in methods used for investigating the area. However, the use of bilingual healthcare professionals as interpreters was not the focus of this study, but it needs to be further studied.

The importance of interpreters’ personal characteristics for healthcare staff has not been described in other studies. However, they did describe, in accordance with patients’ preference, the language competence of the interpreter, their attitude and appearance, and the qualities of a good interpreter (Edwards *et al.*, 2005; Hadziabdic *et al.*, 2009). This highlights the need to develop interpreter service considering not only interpreters’ language skills but also their personal characteristics. Communication includes not only spoken language but also the entire field of interaction and behaviour (Watzlawick *et al.*, 1967; Giger and Davidhizar, 2004).

Our results showed that working with an interpreter in a consultation requires more time as the same information has to be given twice, which is a new finding. Consultation with an interpreter requires a three-fold interaction between healthcare staff, patient and interpreter. This should be considered in all medical communication (Rosenberg *et al.*, 2007) where there are plans to work through an interpreter, when more time is needed for consultations. Routines must be adequately resourced in healthcare. Changing a routine includes also a change in resources such as money, knowledge, command over things and people, trust and respect for skills and expertise. Those resources are often lacking, and this makes it difficult to change routines using and planning for the use of interpreters (Greenhalgh *et al.*, 2007). Our findings showed that healthcare staff felt it necessary to document the patient’s language ability in the medical record. It would also be beneficial for the consultation if a preferred interpreter could be noted in the records, which would mean that enough time could be given for preparation to book a relevant interpreter.

Another new finding was that interpreters did not always come at the appointed time. To avoid this problem, it is important that there is direct communication between healthcare staff and interpreter services, and feedback to the interpreter agency, as participants proposed in this study.

Informants pointed out that disturbance in technical equipment in telephonic interpretation could affect the consultation. The disturbance in communication could be overcome by being aware of how to organize the interpretation and by both interpreters and healthcare staff using well-functioning phones. Sometimes, however, telephone interpreters were preferred to face-to-face interpretation as they were easier to access, and the interpreter acted as a communication aid in the background. These results are in contrast to Fatahi *et al.*'s study (2008), where personal attendance was usually preferred. Our proposal is that interpreters who use mobile phones should behave professionally and work from a place where no sound is heard and have full mobile coverage to avoid disturbances in communication. This is supported by a code of ethics for interpreters (Kaufert and Putsch, 1997; Kammarkollegiet, 2004).

Strengths and limitations of the study

A limitation of this study was that data collection through written descriptions gave no opportunity to ask follow-up questions, as can be done during an interview (van Manen, 1990). However, the chosen method gave the respondents an opportunity to reflect upon their daily work in a calm and non-stressful environment. The intention was to describe the meaning of the text in context and to ascertain the informants' perceptions. In analysing the data the researchers depended on the written text, which should be analysed in the same way as interviews through qualitative content analysis. Written descriptions also gave the possibility to explore contradictory comments on a given topic (Välimäki *et al.*, 2007) and authors drew conclusions on the basis of the texts as a whole.

Another weakness of written descriptions can be that many people find it difficult to write down their thoughts (van Manen, 1990). The participants were persons who were educated and were used to documenting data in medical records in

their daily work. The first author's personal contact with participants enhanced motivation and gave them a chance to ask questions about the descriptions. The fact that the data we received were rich and gave a consistent picture indicated that the informants were comfortable in their descriptions. The selected method also encouraged the participants to choose the appropriate time and place they wanted to write down their stories and could thus more easily fit it into their daily work schedule in a time-strained situation.

The sampling procedure of contacting managers in healthcare to get into contact with informants could be seen as a limitation (Patton, 2002). However, information meetings about the study were set at ordinary staff meetings including all kinds of healthcare staff, which minimized the risk of bias.

The findings are contextual and cannot be generalized due to the qualitative methods, but as several professional groups in several workplaces gave similar perceptions, the results can be transferred to other contexts with similar characteristics (Patton, 2002). However, the most important benefit is the deeper understanding of the studied area.

Conclusions and implications

In conclusion, the results point out two important aspects of interpreters in relation to healthcare staff. These were the desire to have professional interpreters who translate literally and objectively, and the desire to have a well-functioning interpreter organization.

The implications of the study are the importance of cooperation between healthcare staff and interpreter agencies, which needs to be illuminated and improved to develop a well-functioning interpreter organization. The interpreter agency must be able to offer good accessibility, with professional interpreters trained in the importance of translating accurately, turning up at the appointed time and offering appropriate technical equipment to facilitate communication. Thus, evidence-based knowledge in communication techniques to avoid misunderstandings needs to be included in the education and training of interpreters in healthcare. The healthcare service must consider that consultation through an

interpreter requires more time both for preparation and during the consultation. Healthcare staff need to feel comfortable in consultation when they use interpreters, which facilitates the examination and treatment of patients. The consultation must be based on individualized care and adjusted to healthcare staff's perceptions to develop cost-effective and high-quality care of patients who use the service of an interpreter.

Author contributions

Emina Hadziabdic and Katarina Hjelm were responsible for the study conception and design and Emina Hadziabdic, Katarina Hjelm, Björn Albin and Kristiina Heikkilä were responsible for the drafting of the manuscript. Emina Hadziabdic performed the data collection and data analysis under the critical scrutiny of Katarina Hjelm, Björn Albin and Kristiina Heikkilä. Emina Hadziabdic and Katarina Hjelm made critical revisions to the paper. Katarina Hjelm, Björn Albin and Kristiina Heikkilä supervised the study.

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