

From Centre for Family Medicine,  
Department of Neurobiology, Care Sciences and Society,  
Karolinska Institutet, Stockholm, Sweden

# HEALTH CARE ON EQUAL TERMS FOR IMMIGRANTS IN SWEDEN

Eivor Wiking



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Supervisor: Jan Sundquist

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Coverpicture: Vincent van Gogh, *Drawbridge at Arles*

“One measures the carrying capacity of a bridge by the strength of its weakest pillar. The human quality of a society ought to be measured by the quality of life of its weakest members. And since the essence of all morality is the responsibility which people take for the humanity of others, this is also the measure of a society’s ethical standard.”

Zygmunt Bauman  
2001

*In memory of my dear parents,  
Ingrid and Per-Gösta Eriksson,  
and with love to my sons, Rafael and Daniel*

## ABSTRACT

**Background** There is limited knowledge about immigrant patients' lower self-reported health (SRH) in relation to acculturation and discrimination and about immigrant patients', interpreters' and GPs' experiences, reflections, and strategies during the triangular meeting.

**Aims** *Study I:* to analyse the association between ethnicity, acculturation, discrimination and poor SRH. *Study II:* (i) to explore patients' experiences and reflections pertaining to primary health care (PHC) consultations in Stockholm and to study whether demographic or migration-related factors are associated with patients' satisfaction with the consultation and the feeling of consolation provided by the GP; (ii) to analyse whether patients' satisfaction with the consultation and feeling of consolation are related to the time from the booking to the consultation, SRH, symptoms and patients' experiences of the consultations; and (iii) to explore these experiences and reflections.

*Study III:* (i) to describe some aspects of each of the three perspectives in the triangular meeting between immigrant patients, interpreters and GPs, including their experiences, reflections and interactions during the consultation in PHC; (ii) to analyse patients' satisfaction with the consultation; whether satisfaction is influenced by respect for patients' culture, personality and wishes; and (iii) whether interpreters or GPs experience any ethical conflicts during the consultation. *Study IV:* to gain insights into the participants' perceptions and reflections of the triangular meeting by means of in-depth interviews with immigrant patients, interpreters, and GPs.

**Methods** *Study I:* Immigrants from Poland (n = 840), Turkey (n = 840), and Iran (n = 480) and of Swedish-born persons (n = 2250) participated in 1996 in the cross-sectional Swedish National Survey of immigrants. *Study II:* A questionnaire was distributed to 78 immigrant patients from Chile (n=17), Iran (n=22) and Turkey (n=39) at 12 primary health care centres around Stockholm. *Study III:* By using questionnaires, immigrant patients, their interpreters and GPs were asked about their opinions of the communication, their experiences and reflections during the consultation and the patient's satisfaction. In studies II and III content analysis was used for open-ended questions. *Study IV:* A total of 29 participants – 10 patients, 9 interpreters, and 10 GPs – participated in face-to-face interviews. Content analysis was used.

**Results** *Study I:* Men from Iran and Turkey had a threefold increased risk of poor SRH than Swedes while the risk was five times higher for women. When socioeconomic status was included in the logistic model the risk decreased slightly. *Study II:* Most of the answers concerned communication problems because of language and cultural differences between the GP and the patient and the GP's ability to listen. Background facts, including demographic and migration-related factors, health status and factors related to the consultation did not seem to be associated with the patient's satisfaction and the feeling of consolation. *Study III:* Of the 182 respondents, 52 were patients, 65 GPs and 65 interpreters. A matched group of answers from patients, GPs and interpreters was present in 40 consultations. Eighteen of the patients experienced language difficulties. Twenty-six experienced respect for their culture; 32, respect for their personality; and 33, respect for their wishes. Ethical conflicts were rare. All three categories reported that the majority of patients were satisfied with the consultation. *Study IV:* Six themes were generated and arranged under two subject areas: the interpretation process (the means of interpreting and means of informing) and the meeting itself (individual tailored approaches, consultation time, patients' feelings, and the role of family members).

**Conclusions** There was a strong association between ethnicity and poor SRH which seems to be mediated by socioeconomic status, poor acculturation, and discrimination. Feelings including frustration and insecurity for patients, interpreters and GPs when interpretation and relationships are suboptimal were reported and strategies were developed. To achieve successful consultations and PHC on equal terms for immigrants in Sweden our results indicate a need for professional interpreters, for GPs to use a patient-tailored approach, cultural competence, and sufficient consultation time.

**Key words** Immigrant patients, interpreters, GPs, triangular meeting, consultation, self-reported health, patient-centred strategies, satisfaction, primary health care, quantitative, qualitative, Sweden



## LIST OF PUBLICATIONS

This thesis is based on the following original articles, which will be referred to in the text by their Roman numbers.

- I Wiking E, Johansson S-E, Sundquist J. **Ethnicity, acculturation, and self reported health. A population based study among immigrants from Poland, Turkey, and Iran in Sweden.** J Epidemiol Community Health 2004;58:574– 582. doi: 10.1136/jech.2003.011387.
- II Wiking E, Saleh-Stattin N, Johansson S-E, Sundquist J. **Immigrant patients' experiences and reflections pertaining to the consultation: a study on patients from Chile, Iran and Turkey in primary health care in Stockholm, Sweden.** doi: 10.1111/j.1471-6712.2008.00622.x Scand J Caring Sci; 2009.
- III Wiking E, Saleh-Stattin N, Johansson S-E and Sundquist J. **A description of some aspects of the triangular meeting between immigrant patients, their interpreters and GPs in primary health care in Stockholm, Sweden.** Family Practice 2009; 26: 377–383.
- IV Wiking E, Sundquist J, Saleh-Stattin N. **The consultation between the immigrant patients, their interpreters, and their general practitioners, is it just an encounter or a real meeting? A qualitative study in primary health care in Stockholm, Sweden.** (submitted)

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## ABBREVIATIONS

CI	Confidence Interval
GP	General Practitioner
Inv-ULF	The Survey of Immigrant Living Conditions (Swedish)
IP	Interpreter
n	Sample size
OR	Odds ratio
P	Patient
PHC	Primary health care
PHCC	Primary health care centre
SCB	Statistics Sweden
SD	Standard Deviation
SRH	Self-reported health
ULF	The survey of living conditions (Swedish)
WHO	World Health Organization

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# INTRODUCTION

## BACKGROUND

The first international declaration underlining the importance of primary health care (PHC) was taken at the Alma-Ata Conference in Kazakhstan 1978. The Declaration of Alma-Ata adopted an affirmation that health is a fundamental human right (World Health Organization and UNICEF, 1978). The World Health Organization's (WHO's) 2008 World Health Report and World Health Assembly (WHA) resolution 62.12 (the WHA is the governing body of the WHO) applied the values pursued in the Declaration of Alma-Ata: social justice, the right to health for all, participation, equity and solidarity (World Health Organization, 2008). The policy directions for PHC aim to achieve universal access and social protection.

Since the 1970s, it has been the policy in Sweden to offer all citizens and residents health care on equal terms, regardless of sex, socioeconomic status (SES), geographical region of residence, and national, ethnic, cultural, religious and linguistic background, as stated in the Swedish Health and Medical Services Act (SFS) (1982:763). This means that all patients have the right to equal access to health care that meets their individual needs.

The main reason for this political decision was the importance of the participation, civic involvement and equal treatment of everyone in society. It is important for individuals to feel that they are full citizens, completely integrated in society. Unemployment and ethnic segregation in housing may impede the social integration of immigrants in Sweden.

Foreign-born persons (including foreign-born children who are adopted and/or have Swedish-born parents and people who have "re-immigrated") accounted for 15% of all residents of Sweden at the end of 2011 (Statistics Sweden, 2012a); however, the figures for 2004 provide a more relevant context for studies II and III. In 2004, 12% of people in Sweden were foreign-born (*foreign background* defines as two foreign-born parents; definition changed at the year 2002) (Statistics Sweden, 2012a). Of the 346,195 foreign-born persons in Stockholm County in 2004, those from Chile accounted for 4%; those from Iran 6%; and those from Turkey 5% (Statistics Sweden, 2005). At that time, these were among the largest non-European groups of immigrants in Sweden. In order to be entered into the population register as an immigrant, one must intend to remain in Sweden for 12 months and have either the right of residency or a residency permit. This does not apply to Nordic citizens. Only persons that are entered into the population register are counted as immigrants (Statistics Sweden, 2010).

Since immigrants from Chile, Iran, Turkey and Poland are the focus of this dissertation, a description of their conditions is needed. Characteristics of immigrants from these countries will be described using information from a report published in 2000 by the Swedish National Board of Health and Welfare (*Socialstyrelsen*), a government agency in Sweden run by the Ministry of Health and Social Affairs (National Board of Health

and Welfare, 2000). The figures are from The Survey of Immigrant Living Conditions 1996.

### **Immigrants from Chile**

In 2004 and 2011, Chileans constituted the largest group of Latin Americans in Sweden. The first period of immigration from Chile started after Augusto Pinochet's coup d'état in 1973 and continues until around 1978. This immigrant group is dominated by political immigrants with varying degrees of experience of persecution. The second period ran from 1978 until 1989 and was dominated by "political-economic" refugees (National Board of Health and Welfare, 2000). Immigrants who arrived in Sweden as a result of the Chilean economic crisis that culminated in 1982 have some important features in common. About 80% of them had at least secondary (high school) education. Later immigrants from Chile came as refugees, but the real reasons for their immigration were both political and economic (National Board of Health and Welfare, 2000).

### **Immigrants from Turkey**

Before 1960, Christian groups from Turkey emigrated to Lebanon, the Soviet Union, Western Europe and the United States. From about 1960 until 1970, Turkey was the source of a massive wave of labour migration to European countries, including Sweden. After that period, family-related reasons for immigration dominated. It was especially common for the wives and children of earlier immigrants to come to Sweden. A large number of Christian immigrants from Turkey arrived in Sweden after 1975. A new wave of refugees came after the military coup in 1980. These people were mainly trade unionists, politicians, and activists who belonged to various "ethnic minorities" or who were ethnic Turks (National Board of Health and Welfare, 2000). Many of them were Kurdish. Immigration of family members from Turkey still occurs. Only 40% of immigrants from Turkey had at least secondary (high school) education (National Board of Health and Welfare, 2000).

### **Immigrants from Iran**

The number of Iranians in Sweden has increased significantly since the Khomeini regime came to power in Iran 1979. At the time of the Iranian Revolution, most of the immigrants were guest students who settled in Sweden for political or other reasons. Many young men emigrated from Iran to avoid involvement in the war between Iran and Iraq. Others were refugees or had family-related reasons for immigration. For many immigrants from Iran, personal identity is based more on ethnic, religious or political background than on Iranian nationality (National Board of Health and Welfare, 2000). The largest group is the Persians, whose native language is Persian. The second largest group is the Azeri-Turks (Azerbaijanis), whose native language is Persian or Azeri-Turkish (National Board of Health and Welfare, 2000). The third largest group in Sweden is the Kurdish group, whose native language is the South Kurdish dialect. More than 90% of immigrants from Iran have at least secondary (high school) education (National Board of Health and Welfare, 2000).

## **Immigrants from Poland**

Looking back in history, the relationship between Poland and Sweden has been political, religious and cultural. An increasing number of refugees arrived during the second half of the 1950s, and a new wave of immigration took place after an anti-Semitic campaign in the wake of the 1967 Six-Day War. Between 1970 and 1980, the number of Polish women who came to Sweden increased and many marriages occurred across national borders. During the “solidarity period” from 1979 to 1981, both refugees and “tourists” from Poland immigrated to Sweden. Immigrants from Poland typically came to Sweden for political, religious or family reasons. More than 90% have at least secondary (high school) education (National Board of Health and Welfare, 2000).

## **Definitions and theoretical considerations**

A large number of labour immigrants came to Sweden between the end of the Second World War and the 1960s, but since the 1980s immigration has been dominated by refugees and/or relatives of persons already resident in Sweden. Conditions for immigrants and their experiences of Swedish society vary from group to group and between individuals, depending on social and demographic factors as sex, age, family relationships, education, occupation, exposure to different risks, and cultural and ethnic differences. The circumstances of migration are also of great importance. Being a refugee or having chosen to emigrate, having language difficulties, feeling accepted in Sweden and feeling that one is the victim of xenophobia may also be of importance for integration and living conditions in Sweden. Knowledge about the extent to which ethnic and cultural factors are significant for individuals and how such factors affect our health in the long term is increasing because of research efforts (National Board of Health and Welfare, 2000).

The word *ethnicity* is derived from the Greek word *ethnos*, which translates as “nation”, and is defined by Max Weber as “belonging to a group of individuals who feel kinship with each other because of a subjective belief in a common origin, in some cases a common language, the same rites and ritual actions, and a specific common dignity, a sort of “collective consciousness” (Massenehre) shared by everyone in the group regardless of social position” (Weber, 1983; Sundquist, 1994). Ethnic identity corresponds to a “state” in which the citizens have characteristic cultural features. An ethnic group may exist within a national group, in which case the ethnic identification is a definite act of will, or it may exist as a national group living in a foreign country (Tägil, 1984; Sundquist, 1994).

### *Migration and health*

A migration process that is more or less forced upon someone is a major change that can affect the individual psychologically and/or physically for the rest of their life. When a person emigrates, he/she must be sufficiently physically and mentally strong to struggle through different situations that arise as part of the migration process. This leads to the “healthy migrant effect”, in which people who migrate tend to be healthier than people who do not migrate (Pérez, 2002). For instance, a study from Canada showed that recently immigrated middle-aged men reported better health than middle-

aged Canadian-born men (Kobayashi and Prus, 2012). This effect tends to decrease over time as the health of immigrants declines due to a variety of factors, some of which may be related to migration (Fuller-Thomson et al., 2011) (Williams, 1993). In the Canadian study by Fuller-Thomson et al., it was found that among recent immigrants who reported a decline in health in the first 4 years after arriving in Canada, characteristics associated with worsening health included initial health status, age, gender, marital status, place/region of birth and experience of discrimination (Fuller-Thomson et al., 2011).

For immigrants, health-related risk and protective factors can be divided into three categories: 1) factors linked to the society and the population in the country of origin; 2) factors related to the migration process itself and how it was handled in Sweden; and 3) factors related to life in Swedish society after the immigrants received their residence permits (National Board of Health and Welfare, 2009).

Previous studies on psychological adaptation have focused on psychiatric diseases such as anxiety and depression (Sam and Berry, 2010). Since mental health is defined as “*a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community*” (World Health Organization, 2007), it is clear that the absence of illnesses is not sufficient to achieve wellness. To achieve good mental health, there is also a need to acquire socio-cultural skills for integration in the new society (Sam and Berry, 2010).

*Culture* was in 1871 defined by the anthropologist Edward Burnett Tylor as: “That complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of a society”. An ideational aspect devised by Keesing is expressed as: “systems of shared ideas, systems of concepts and rules and meanings that underlie and are expressed in the ways that human beings live” (Helman, 2001).

*Acculturation* is defined as the process of psychological and cultural change that follows the meeting between two cultures; i.e. intercultural contact (Sam and Berry, 2010). It results in changes at both the group and individual levels in both cultures (i.e. intercultural changes). It is a multidimensional process involving the integration of members of a minority group into the social structure of the majority group. This process may be reciprocal, as the dominant group may also adopt certain aspects of language and/or culture from the minority group. It is a multidimensional process involving the integration of members of a minority group into the social structure of the majority group.

In this process, members of one cultural group adopt the language, cultural beliefs, values and behaviours of another group to at least some extent (Berry, 1992). Cultural and psychological changes may lead to alterations in collective activities and social institutions at the cultural level and changes in an individual’s daily behaviour at the psychological and possibly practical level. Changes in diet, clothing and language are examples of group-level acculturation effects. For instance, Chilean and Turkish immigrants respectively have higher and lower frequencies of food-related allergy than

the rest of the population (National Board of Health and Welfare, 2009). Differences in the ways in which individuals acculturate are revealed by differences in the way their daily behaviour and psychological and physical well-being change, and differences in psychological stress. There is large variation in how people acculturate. The different ways of acculturating have been identified as *integration*, *assimilation*, *separation* and *marginalisation*. Integration means that someone is engaged in both the culture of their heritage and in the larger society. Assimilation is defined as being engaged in the larger society. Separation means to be only engaged in the culture of one's heritage. Finally, marginalisation occurs when people orient themselves to neither culture. These definitions can be used to link psychological well-being to being "socio-culturally competent", since those who integrate are often better adapted than persons in the other groups (Sam and Berry, 2010).

The term "*refugee*" was defined in the United Nations Geneva Convention of 1951, which Sweden has ratified. The definition states that a refugee is a person who "*As a result of events occurring before 1 January 1951 and owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it*" (United Nations, 1951 and 1967).

*Illness* is a person's experience of being unwell and the meaning he/she attaches to this experience (i.e., illness is defined on the basis of the perspective of the person experiencing it). The presentation of this illness to a doctor may, after translation of sometimes diffuse symptoms and signs, result in the diagnosis of "pathological entities", that is to say the conversion of an illness into a *disease* (with disease being defined on the basis of the doctor's perspective [Helman, 2001]). Sometimes an illness exists without a disease – the patient feels something is wrong, but the results of a physical examination and investigations are normal. Sometimes a disease exists without an illness. The person does not feel ill, but investigations show abnormalities at the biochemical or cellular level (e.g. HIV infection, high cholesterol levels, cancer). Disease without illness is a common phenomenon in modern medicine, in which the evolution and application of diagnostic technology has yielded great advances. Illness without disease and disease without illness may be frustrating for both patients and doctors. The level of frustration may be affected by patients' and doctors' personal experiences and by what they have been taught during studies undertaken from the perspective of just one culture (Helman, 2001).

*Self-reported health (SRH)* is defined as the answer to a question about how a person experiences their health, for example "How is your general condition?", with alternative responses: 1, very good; 2, good; 3, tolerable; 4, poor; and 5, very poor. But is SRH comparable across cultures? In a study from Finland, Jylhä et al. found that in Tampere, Finland and Florence, Italy SRH was significantly associated with number of diagnosed diseases and number of experienced symptoms (Jylhä et al., 1998). However, cultural and linguistic factors may affect how people use the scale when they re-

port SRH. Therefore, direct comparisons of SRH between different cultures should be made with caution (Jylhä et al., 1998).

In a Swedish study comparing the impact of various factors on long-term illness reported by immigrants, researchers found that ethnicity was an independent social dimension comparable to social class (Sundquist, 1995). When immigrant patients are asked to describe their own health in questionnaires in medical studies, the importance of SRH as an independent social dimension and cross-cultural and linguistic differences in the use of the SRH scale must be taken into account.

SRH is a major predictor of morbidity (Gadd et al., 2003) and mortality (Miilunpalo et al., 1997; Sundquist and Johansson, 1997) and may also be used to estimate future health service use (Krakau, 1991; Umar et al., 2011). In a multi-ethnic Swedish population, life satisfaction was found to be the strongest predictor of poor perceived health. Other significant predictors of poor perceived health included country of birth, number of symptoms and depression (Al-Windi, 2005). As in the general population, poor SRH is a good predictor of poor health in immigrants (Bischoff and Wanner, 2008; Setia et al., 2011). Moreover, several studies have shown that immigrants have lower SRH scores than non-immigrants (Bischoff and Wanner, 2008).

## **PREVIOUS STUDIES IN THE RESEARCH FIELD**

Previous studies from Europe have shown that foreign-born people are overrepresented in health care (Balarajan et al., 1989; Gilliam et al., 1989; Sundquist, 1993), while studies from North America showed that patients with low proficiency in English were more often admitted to hospitals than those who were proficient in English (Lee et al., 1998) and that such patients stay in the hospital longer (John-Baptiste et al., 2004). A study of heart failure patients in Sweden showed that more immigrant patients than Swedish patients had ischaemic heart disease when they were admitted to hospital. Also, more immigrants were referred to heart failure clinics for follow-up visits after discharge (Hedemalm et al., 2008). A possible explanation for these results is that the nurses perhaps recognised immigrant patients' individual needs and tailored their treatment accordingly (Hedemalm et al., 2008). Foreign-born people in Sweden have an excess risk of cardiovascular disease (CVD) or coronary heart disease (CHD) compared with Swedish-born persons, even when SES is taken into account (Gadd et al., 2003). There is also evidence of an increased risk of mental disorders in first-generation immigrants (Bayard-Burfield et al., 2001; Steiner et al., 2007; Taloyan et al., 2008), which seems to influence second-generation immigrants (Leão et al., 2005; Leão et al., 2006). Furthermore, country of birth seems to be associated with suicide rate. A follow-up study in Sweden revealed that the risk of suicide was highest among men from Finland; among women, the risk of suicide was highest among immigrants from Finland, Poland and Eastern Europe (Westman et al., 2006).

Previous research has shown that migration itself can be a stressful experience, and that individual responses to the migration process are influenced by personal, cultural and social factors (Bhugra et al., 2011). Migrants have lower rates of health problems during the initial stages of migration than during the later stages. During the initial

stages, migrants are typically young and may even be healthier than those who do not migrate. Moreover, they have not yet experienced the stresses of acculturation and potential discrepancies between goals and achievements (Bhugra, 2001).

Acculturation, defined as “functional integration with mainstream society, value placed on preserving Mexican cultural origin, and attitude toward traditional family structure and sex-role organization”, was found to have a more powerful influence than SES on outcomes including obesity and diabetes in a study in Texas, USA (Hazuda et al., 1988). The researchers who conducted this study concluded that cultural factors have a more pervasive influence on obesity and diabetes than socioeconomic factors (Hazuda et al., 1988). Sundquist and Winkleby (Sundquist and Winkleby, 1999) studied a large national sample of Mexican-American men and women and found that US-born Spanish-speaking men and women had the least healthy CVD (cardiovascular disease) risk profiles due to weakened ties with their traditional Mexican culture and poorly established ties with American culture, indicating a loss of protective influences of their native culture before gaining protective influences associated with the dominant English-speaking culture (i.e. not acculturated using language as a proxy for acculturation).

To explore the relationship between acculturation and health, items were evaluated in a survey of Arabic-speaking general practice patients (Rissel, 1997). Patients were asked about their language habits and preferences in their daily life, including TV/radio habits, food preferences, and frequency of attendance at recreational and/or religious events (Rissel, 1997). The researchers found that education was independently associated with acculturation, but that age and sex were not. They concluded that more formal education may facilitate language skills and exposure to other cultures and Western ideas.

The clinical importance of acculturation and stress among refugees in Sweden was shown in a study based on raw data from 1996 from the Swedish National Board of Health and Welfare (Sundquist et al., 2000). The researchers found a link between migration status and psychological distress in male and female refugees with economic difficulties, low sense of coherence and poor sense of control, and in male refugees with poor acculturation (Sundquist et al., 2000).

There are some problems with different definitions of acculturation and different scales measuring acculturation. For example, acculturation is only measured at the time of interview, and values and attitudes are not separated from behaviour. To correctly define and estimate acculturation, the measurement should include “behaviour, attitudes towards cultural values, preferences” (what is defined by the researchers as a special form of attitude) and “level of confidence of subjects when dealing with different aspects of the two different cultures” (Mavreas et al., 1989). In an attempt to improve acculturation scales, Mavreas et al. conducted a study in London and found that two highly correlated factors, “cultural identification” and “language mastery/ethnocentrism”, explained 28% of the variance in the acculturation scale (Mavreas et al., 1989).

Lack of participation in society is higher among immigrants in Sweden than among native Swedes. Immigrants often settle in residential areas with low SES, may be socially vulnerable because of discrimination, and are either unemployed or have jobs with low pay (National Board of Health and Welfare, 2009). Non-European immigrants rate their health as poor three to four times more often than Swedish-born people (National Board of Health and Welfare, 2009). In a 2007 study from Sweden, Wamala et al. reported that perceived discrimination was associated with psychological distress, and that lack of participation in society, lack of social relations and other contextual factors were possible mediators (Wamala et al., 2007).

Researchers in Norway found that depression and to some extent psychosomatic symptoms were related to integration and feelings of marginalisation among young immigrants. These feelings might be the result of problems with acculturation (Sam and Berry, 1995). The situation for undocumented migrants in Denmark has been documented as a challenge for health professionals, since there is a lack of official policies, which leads to poorer access to primary care for migrants compared to Danes (Jensen et al., 2011). In a study in the USA, one-third of Iranian immigrants reported nervousness or a lack of peace of mind (Lipson, 1992). Only some reported mental health problems among these immigrants were related to immigration status (e.g. paranoia, somatic symptoms and “diffuseness of difficulties”). This is in contrast to the findings of a study from Sweden, which compared mental health problems in immigrants to Sweden and native Swedes and Finns, and which found that Finish immigrants in Sweden had more mental health problems than native Swedes and Finns living in Finland (Haavio-Mannila and Stenius, 1977).

The most vulnerable group of immigrants may be refugees. Rates of common mental disorders such as depression and anxiety are twice as high in refugees compared to economic migrants (Lindert et al., 2009).

### **Perceptions of health and patient-centred care**

Elderly immigrants have been found to be more vulnerable to different diseases than immigrants of other ages (Lipson, 1992). However, different perceptions about health may influence how they report their health status. For instance, Emami et al. found that elderly Iranian immigrants in Sweden perceived health not only as absence of a disease or illness, but also as continuity and balance of life. Elderly immigrants reported that a feeling of well-being is an important component of health. For this reason, they could feel healthy even when they had a disease or perceive health problems when they did not have a disease (Emami et al., 2000).

In a study concerning beliefs about health and diabetes, Swedes and Arabs described health as “freedom from disease”, in contrast to individuals from the former Yugoslavia, who defined health as “wealth and the most important things in life” (Hjelm et al., 2005). The participants in the study, especially the non-Swedes, stressed the ability to be economically independent and occupation/employment as important factors for health.

When confronted with cross-cultural issues in primary health care, it is important for the GP to elucidate the patient's "explanatory model" for his/her symptoms (Rothschild, 1998), i.e. the way the symptoms have been explained to patients before, and the way patients explain their symptoms to themselves in the present situation (Kleinman et al., 1978). If the GP tries to understand the patient's cultural background, the result may be improved access to health care, increased patient satisfaction and greater clinical effectiveness (Rothschild, 1998). Cultural sensitivity is needed to elicit this background. Cultural sensitivity is also needed to make effective use of information about the patient's cultural background (including cultural values) in cross-cultural situations (Kundhal, 2003). Researchers have shown that intercultural differences between GPs and parents of child patients may result in reduced mutual understanding and less adherence, as can educational and linguistic limitations (Harmsen et al., 2003). Patients' perception of finding common ground during consultations was strongly associated with positive outcomes, such as less discomfort, less concern, and better mental health. Finding common ground is made possible by patient-centred care (Stewart et al., 2000).

A patient-centred approach "takes into account a patient's desires for information and for sharing decision-making and responding appropriately" (Stewart, 2001). In a study about patients' preferences for consultation in general practice by Little et al., it was found that patients who were especially vulnerable or who felt particularly unwell expressed a strong desire for a patient-centred approach in communication, partnership and health promotion (Little et al., 2001). A patient-centred approach enhances patient autonomy and results in more positive consultations from the patient's perspective (Fossum and Arborelius, 2004). Shared decision making is an important element in the patient-centred approach, although Siriwardena et al. found that patients place higher value on being listened to and given information they can understand (Siriwardena et al., 2006). A group of researchers in the United Kingdom investigated how well a UK postgraduate exam assessed GPs' consulting skills in general and the involvement of patients in decision making in particular. They used an independently validated measure and found that the postgraduate exam assessment was valid. The researchers concluded that shared decision making may indicate "a more generalized level of global competence" (Siriwardena et al., 2006).

### **Communication, cultural awareness and interpreters in health care**

*Cultural competence* in health care service delivery is present when "individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each" (Mizrahi et al., 2001).

By comparing conceptual models of patient-centredness and cultural competence, Saha et al. found that cultural competence is needed to achieve more patient-centred care (Saha et al., 2008). Adopting an "ethno-sensitive" attitude in which the patient is considered unique, i.e. seeing the patient's illness through their eyes, increases the chance of finding common ground and improving the quality of health care (Saha et al., 2008). To individualise care, it is necessary to take into account the patient's values and preferences and remember that each patient is unique, while making care more equi-

table is dependent on improving care for disadvantaged populations. By contrast, doctor-centredness and having an “ethnocentric” attitude risks hindering effective cross-cultural care (Juckett, 2005). The importance of well-functioning communication and cultural awareness was stressed in a report by the UCLA School of Medicine in USA (Williams, 2007). The report’s author concluded that when the patient is satisfied that a collaborative partnership has been established, it is a confirmation that the health care provider is culturally competent and that successful and satisfactory health care has been provided (Williams, 2007).

Cultural competence means addressing individual patients’ preferences and goals to improve equity and reduce disparities, which in turn means that care should become more patient-centred at the interpersonal level as well as at the health system level (Saha et al., 2008). In a literature review, Betancourt et al. concluded that socio-cultural barriers to care can be identified at three different levels: “the organizational level (leadership/workforce), structural level (process of care), and clinical (provider-patient encounter) level” (Betancourt et al., 2003). By identifying these three levels, intervention programs, such as programs designed to improve interpreter services and to provide education on cross-cultural issues, can be improved (Betancourt et al., 2003).

Several research articles have addressed language barriers in health care. Topics have included access barriers, comprehension, and need for and costs of interpreter services (Brach et al., 2005); interpreter practice, preference, evaluation, and errors; and consultation time and patient satisfaction (Jacobs et al., 2006). In a review of the literature, Jacobs et al. found that limited English proficiency negatively affected not only patients’ comprehension, but also access to health care, adherence and quality of care, as well as patient and provider satisfaction (Jacobs et al., 2006). Language barriers hinder communication and in one study of native English-speaking GPs who were treating Spanish-speaking patients resulted in significantly lower scores for patient-centredness, independent of ethnicity (Pérez-Stable and Nápoles-Springer, 2000; Rivadeneyra et al., 2000). Language barriers are not only important during consultations, but also during the rehabilitation process, as was shown in a study from Switzerland in which immigrant patients with low-back pain were not only experiencing and coping with pain, but also poor job satisfaction and other work-related factors. The need to use professional interpreters was therefore stressed (Scheermesser et al., 2012). In a questionnaire study conducted in Oslo, nurses and physicians reported under-utilisation of interpreters, and the researchers pointed out that it is the legal responsibility of health care providers to ensure a sufficient level of communication during the consultation (Kale and Syed, 2010). When assessing the success of communication during the consultation, it is important to consider who is making this assessment. It is important to assess the quality of interpretation using a variety of approaches that include both patients and providers.

A group of researchers in the United States conducted an observational study of 13 Spanish-speaking families in out-patient clinics, their interpreters and their care providers to evaluate the quality of interpretation (Laws et al., 2004). They coded segments of transcripts from audio-taped consultations for characteristics of the translation and found that in 66% of the translated segments, errors or omissions were made or words were not translated at all. In about 30% of all segments, interpreters engaged in speech

that was not related to interpretation. Such speech was associated with a higher rate of errors. Omission was the most common type of error (Laws et al., 2004). An analysis of incidents concerning the use of professional interpreters in primary health care in Sweden showed that the main problems were related to the health care centres' access to interpreter agencies, availability of interpreters, a lack of interpreters for particular languages and organisational issues, e.g. absence of the interpreter at the appointed time (Hadziabdic et al., 2011). Consequences of these problems included limited opportunities for communication, incorrect use of time and resources, delayed treatment and an increased workload. Because of limited possibilities to communicate, use of family members instead of professional interpreters increased (Hadziabdic et al., 2011).

Interpreters' work can be challenging in many ways. The next section provides some reflections on an investigation of interpreters' work that was conducted by a group of American researchers. The researchers explored the work of 27 formal and informal interpreters (McDowell et al., 2011) and found that being a bilingual "voice" in the room during consultations includes interpretation; attention to nonverbal communication; taking into account cultural frameworks, emotional status, and educational levels; and helping to establish trust between patients and care providers (McDowell et al., 2011). The researchers concluded that interpreters' work is often invisible, complex, challenging and exhausting (McDowell et al., 2011).

In a review of medical interpreter use in the literature and a report from a week-long audit of interpreted consultations at a PHCC in New Zealand, Gray et al. found that untrained interpreters, mostly family members, were used in 49% of all interpreted consultations. Physicians rated these interpreters as working well 88% of the time in "on the day" clinical work and 36% of the time in booked consultations (Gray et al., 2011). In-house interpreters worked well 100% of the time, according to the physicians (Gray et al., 2011).

Discussing the use of family interpreters from an ethical point of view, Ho (Assistant Professor of Philosophy at the University of British Columbia in Vancouver, British Columbia) argues against four common reasons for not using family interpreters: (1) potential risk of misinterpretation, (2) concerns over autonomy, (3) confidentiality and concerns over privacy, and (4) risk of altering the hierarchical structure of the family (Ho, 2008). She claims: that 1) no statistically significant differences in the frequency of errors between hospital and ad hoc interpreters were found in studies (Flores et al., 2003; Jacobs et al., 2001); 2) the assumption that neutrality is possible and always necessary to promote patient autonomy is questionable since there can be many versions of the truth; 3) the patient may consider confidentiality familial rather than individual, which means that patients may voluntarily give family members access to medical information; and 4) interpretation may be seen as a part of family members' collective responsibility for each other's care (Ho, 2008). Ho argues that patients' feelings of "clinical safety" include understanding the presented information, for which the quality of interpretation is important. However, it is also important that the patient feels "culturally safe" in relation to his/her environment. A "culturally safe environment" is one that "facilitates and engages in respectful practices as well as delivers safe services" (Ho, 2008).

The use of children as informal interpreters may be acceptable, depending on the nature of the consultation. For instance, it may be acceptable if the consultation is likely to be “straightforward”, i.e. if it concerns common conditions and is not complex or sensitive (Cohen et al., 1999). Childhood may be seen as a time of innocence, during which children should not be placed in challenging and complex situations.

When professional interpreters are not available, there is a need for ad hoc interpreting. Bilingual staff may fulfil this need. The experiences of ad hoc interpreters, Latino patients and staff members in the USA were explored in a study by Larrison et al. (Larrison et al., 2010). The researchers found that training staff in interpreting may afford them professional status and leave clients satisfied with their interpretation. Because of differences in expectations, there was some friction between the interpreters and the medical staff (Larrison et al., 2010). Using bilingual GPs for immigrant patients is sometimes a good solution. In a study from New York, researchers found that Hispanic patients recalled more information and asked more questions when they were seen by a bilingual physician than when they were seen by a monolingual physician (Seijo et al., 1991).

When no interpreter or bilingual GP, staff member or family member is available, it may be possible to turn to an innovative medical interpreting strategy such as remote simultaneous medical interpreting (RSMI). RSMI was tested in New York in a study by Gany et al., who found that patients using RSMI were more likely to perceive that they were treated with respect by the GP and were more satisfied than patients who received normal interpretation (Gany et al., 2007). However, patients in both interpretation groups reported less comprehension and satisfaction than patients who had language-concordant consultations.

In the USA, GPs’ concerns about language barriers were studied by Schenker et al., who found that four factors must be considered when calling an interpreter: “clinical situation, degree of language gap, available resources, and patient preferences” (Schenker et al., 2008). It is essential to involve the patient in the decision to call an interpreter and it is also important to train physicians in how to work with an interpreter. Specific training for primary care physicians was found to improve the quality of communication reported by patients (Bischoff et al., 2003).

### **The physician and the primary health care consultation**

Studies from around the world indicate that physicians’ behaviour during consultations is a key to building partnerships with patients and establishing trust. Two researchers from Stanford University in the USA used focus groups to explore patients’ experiences of trust in the late 1990s (Thom and Campbell, 1997). Seven different categories of physician behaviour were found, of which two were related to technical competence (evaluation and treatment) and five were related to interpersonal skills (“understanding patient’s individual experience, expressing caring, communicating clearly and completely, building partnership/sharing power and honesty/respect for patient”) (Thom and Campbell, 1997).

The triadic consultation is a medical consultation that includes an interpreter and that has six linked trust relationships between the patient, interpreter and GP involving three different kinds of trust: voluntary trust, the kind of trust that is for instance built upon relationships over time; coercive trust, where there is no choice but to trust; and hegemonic trust, where “a person’s propensity to trust, and awareness of alternatives, is shaped and constrained by the system so that people trust without knowing there is an alternative”(Robb and Greenhalgh, 2006). One of the conclusions of a study of primary care consultations in North London by Robb et al. was that allowing patients to book their own interpreters may increase their feelings of trust in the interpretation.

However, in a 2006 Cochrane review, McKinstry et al. concluded that there is insufficient evidence to conclude that any intervention may increase or decrease trust in doctors (McKinstry et al., 2006). One training intervention tested on 20 GPs with the aim of improving communication behaviours showed no effects on trust. In another intervention, it was shown that disclosing physician incentives to patients did not diminish trust. However, a third intervention that investigated the effects of induction visits on new Health Maintenance Organisation (HMO) members found that patients’ trust in doctors rose compared with controls following group induction visits (McKinstry et al., 2006). The effects of specific training for GPs concerning patient trust are therefore unclear.

In a U.S. study that evaluated the impact of racial disparities in patient-physician relationships, Saha et al. found that both satisfaction and use of health services were lower among Hispanics and Asians than Blacks and Whites. Racial differences explained the difference in satisfaction, but not use of services (Saha et al., 2003). However, another researcher working in a different part of the USA during the 1980s found that race, sex, age, educational level and income did not affect patient satisfaction statistically significant (Weiss, 1988). Predisposing factors such as confidence in the care system, having a regular source of care, and satisfaction with life in general were more important.

The interpreter’s role and importance with regard to patient satisfaction have been highlighted in many studies. However, despite the positive effect of interpreters on patient satisfaction, having a language-concordant care provider is even better for patient satisfaction (Ngo-Metzger et al., 2007).

In a patient survey in California, it was found that levels of patient satisfaction with primary care in a large health maintenance organisation differed according to race and ethnicity (Murray-García et al., 2000). For instance, Asians rated physician performance less favourably than Whites, and Latinos rated physician accessibility less favourably than Whites. The researchers behind this study suggested that these findings could be due to differences in patients’ perceptions, expectations and/or questionnaire response styles (Murray-García et al., 2000).

Eight experts in the field of immigrant health identified 11 “top factors” (best practices) in the delivery of health care services in Denmark. They considered that access to interpreters and the quality of interpretation, adherence to medication, and sufficient consultation time were the most important factors (Jensen et al., 2010).

## IMMIGRANT PATIENTS IN SWEDEN

Sweden is nowadays a multicultural society, 15.1% of whose total population as of December 2011 was foreign-born (Statistics Sweden, 2012a). Most immigrants in Sweden live in or near big cities such as Stockholm, Gothenburg and Malmö, primarily because of better job opportunities in these areas. As of December 2011, 22.6, 22.8 and 30.5% of residents in Stockholm, Gothenburg and Malmö, respectively, were foreign-born (Statistics Sweden, 2012b).

Although Sweden is a multicultural society with a generous immigration policy compared with other EU countries, risk of unemployment is twice as high for non-European immigrants as for native Swedes (Arai and Vilhelmsson, 2004). This may increase the risk of marginalisation and social exclusion. It is serious because there is an association between poverty and poor health (“the poor have poor health”) (Marmot, 2006). The higher the social position, the better the health has been labelled by Marmot as “the status syndrome” (Marmot, 2006). Unemployment may effect the health for both native-born and immigrants, but seems to affect immigrants more powerfully (Beiser, 2005).

For example, previous research has shown that immigrants had longer periods of sick leave, felt more disabled, reported more job strain and were more emotionally distressed than Swedes (Soares and Grossi, 1999). Immigrant patients live under more difficult psychosocial conditions than Swedes, and pain has a greater impact on their lives (Soares and Grossi, 1999). In Sweden, including Stockholm County, the highest risk of ill health is in socio-economically vulnerable residential areas, where the number of immigrants is higher, educational levels are lower, unemployment is higher, and a higher percentage of the population receives social welfare benefits compared to elsewhere in the county (Malmström et al., 1999; Winkleby et al., 2007). Life expectancy is also lower in these residential areas, and mortality is higher (Winkleby et al., 2007).

In 2008, the Health and Medical Care Board of Stockholm County started a project in primary health care to promote better and more equal health. Results from this project indicated a need for further education and competence training for health care staff in health literacy and cross-cultural communication (Bakshi and Bokedal, 2011).

In Lund, Sweden it was shown in the beginning of the 1990s that foreign-born people tended to visit the emergency department more often than Swedes. Latin Americans visited PHCCs more often than expected; immigrants from Asia and Africa less often (Sundquist, 1993). In another Swedish study, it was reported that immigrants visit PHCCs more often than Swedes (Tomson and Lichtenstein, 1988).

Immigrant patients have the right to ask for an interpreter whenever needed during consultations. Furthermore, using a skilled interpreter may have a positive influence on the patient’s ability to participate during the consultation (Björk Brämberg et al., 2010). To enable patient participation it is also important for the caregiver to act in a professional manner, which means to increase the patients’ opportunities to take part in the consultation (Björk Brämberg et al., 2010). It is not enough for the caregiver to be

culturally competent (Mizrahi et al., 2001; Saha et al., 2008) if patients' perspectives and points of views are not in focus (Saha et al., 2008; Björk Brämberg and Nyström, 2010).

An interpreted meeting may be important in a participant's integration into society (Norström et al., 2008–2011). For instance, interpreters may give patients different impressions of and new information about Swedish society. At the same time, patients may be able to express who they are and their vision of the world. Before a patient can express himself in this way, however, he/she must trust the interpreter's role and professional ethics (Norström et al., 2008–2011).

The authors of a research study in which experts from sixteen European countries (Sweden included) evaluated whether there is a consensus in Europe about health care stressed the importance of easy access and equal rights. "Good practice" was defined as high-quality individual care whenever needed and as empowering migrants by providing "culturally sensitive health care adapted to migrants' needs of communication, attitudes, empathy, and non-discrimination" (Devillé et al., 2011).

From a Swedish perspective, the authors of an interview study of refugees in need of long-term health care concluded that the refugees perceived health care as equal to the care received by other Swedish citizens. The main problem expressed by the refugees was lack of information from care providers when the refugees received care at various levels. The refugees had a feeling that no one took overall medical responsibility (Razavi et al., 2011).

## **INTERPRETERS IN SWEDEN**

In Sweden, all patients have the right to equal access to health care that meets their individual needs, including the right to interpretation when needed (The Swedish Health and Medical Services Act 1982:763). During consultations in primary health care, the care provider or the patient may request an interpreter. It should be noted that there is a difference between interpreters and translators. An interpreter translates speech, whereas a translator translates written documents (The Legal, Financial and Administrative Services Agency [Kammarkollegiet]; [www.kammarkollegiet.se/english](http://www.kammarkollegiet.se/english)).

In Sweden, interpreters work in 170 languages, but there are only authorised interpreters for 38 languages (Norström, 2010). In January 2011, there were 1,023 authorised interpreters (Norström et al., 2008–2011). Not all languages have certified court or medical interpreters.

In the Stockholm County Council health care system, interpreters work in about 100 different languages and dialects. There are authorised interpreters for about 30 languages. Fifty-six authorised interpreters have special authorisation for medicine, which means that they have special competence in medical terminology (Sweden's Legal, Financial and Administrative Services Agency). A total of 95% of all instances of language interpretation in Stockholm County Council take place in the health care sector and 70% of all instances of interpretation are carried out by interpreters who are not authorised (Malmefeldt, 2009).

Sometimes there is a need to interpret a language or dialect for which no authorised interpreter is available. One solution is to use ad hoc interpreters such as bilingual health care staff or relatives/friends.

Interpreters are authorised by Sweden's Legal, Financial and Administrative Services Agency, which operates under the aegis of the Ministry of Finance. The purpose of authorising interpreters is to meet society's needs for qualified interpreters and translators.

The Legal, Financial and Administrative Services Agency authorises persons who interpret between Swedish (including Swedish sign language) and other languages. It defines *authorised interpreters* and *translators* as those who "have taken a proficiency examination arranged by the Agency. Authorised interpreters interpret oral conversations and speeches. An individual interpreter may be authorised in several languages" (The Legal, Financial and Administrative Services Agency).

The proficiency test set by the Legal, Financial and Administrative Services Agency for the authorisation of interpreters consists of written tests, oral tests and role play. The interpreter must demonstrate good reading comprehension, literacy, and mastery of Swedish and the interpretation language. He/she must also be well versed in the expressive possibilities, vocabulary and grammar of both languages. The interpreted information must be both correct and understandable to everyone in the meeting. Good knowledge of social issues, health care, social security, the labour market and various social laws is also required. Finally, the interpreter must understand how Swedish society is organised.

An additional test can be taken to receive a certificate of specialist competence as a medical services interpreter from the Legal, Financial and Administrative Services Agency. This test provides evidence of specific qualifications in health care and includes written tests, oral tests and role play. It requires good knowledge of medical terminology and practical application of this knowledge in medical situations.

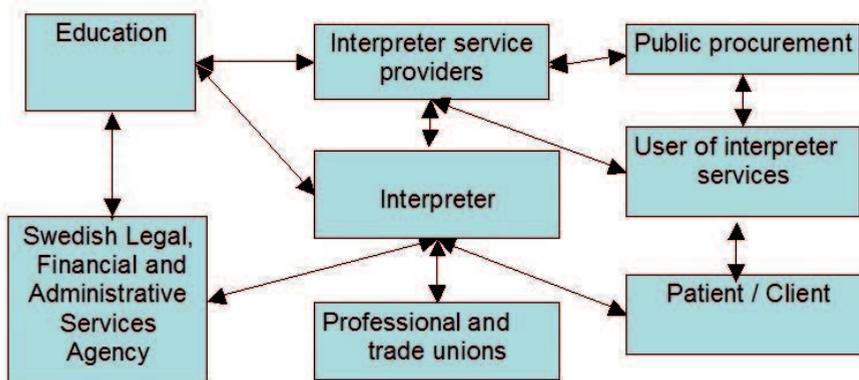
The Legal, Financial and Administrative Services Agency also oversees the activities of authorised interpreters. Anyone who is dissatisfied with an interpreter can notify the Agency.

Terms other than *authorised interpreter* are sometimes used to describe interpreters. A *certified interpreter* is one who has taken and passed an examination administered by a knowledgeable authority such as the Institute for Interpretation and Translation Studies, which has overall responsibility for educating and training interpreters and translators for the needs of society. *Professional interpreter* is a widely used term, but no special definition can be found in the literature. Therefore we may define it as someone who is actively working as an interpreter, hopefully after education in interpretation at Stockholm University and authorisation by the Legal, Financial, and Administrative Services Agency.

There is a set of rules that regulates the activities of authorised interpreters. It includes rules about the confidentiality of interpreted information, rules for the authorisation of

interpreters (regulations for the authorisation of interpreters and translators [1985:613]; amended in 1994 [SFS 1994:413]), and guidelines for interpretation (KAMFS 2004:1; Kammarkollegiet, 2010). The Public Access to Information and Secrecy Act (2009:400) (Law 2009:400) applies to all interpreters, authorised or not, when they are hired by a public authority. The law closely defines and regulates matters that are considered confidential. Matters related to state security and the prevention and prosecution of criminal offences are secret, as are individuals' personal and financial circumstances. Provisions related to secrecy are also meant to protect individuals' personal and financial circumstances. The Obligation to Secrecy of Certain Interpreters and Translators Act (Law 1975:689) applies only to authorised interpreters when they are hired by a person other than a public authority. However, all interpreters have a duty of confidentiality, irrespective of who hires them.

Figure 1 shows interpreters' relationships and connections with society.



**Figure 1.** Interpreters and their connections. Adapted from Norström, Gustafsson and Fioretos (“Tolkprojektet”) with the authors’ permission

An authorised interpreter in Sweden can either work privately outside of health care or be employed by an interpreter service office, which is often run by the municipality. To book an interpreter, users of interpreter services (for example health care staff) contact the different service providers. Interpretation services are procured and are paid for by the state or the municipality, just like services provided by other representatives of public organisations. Procurement is of the simplified kind described in chapter 15 of the Swedish Public Procurement Act (2007:1091). The Health and Medical Care Board of Stockholm and Stockholm County Council most recently procured language interpretation services in 2009. Assessment of interpreter services was based on the interpreter services’ economic situation, technological capacity, price and quality. Particular emphasis was placed on quality.

Professional and trade unions play an important role for interpreters, giving them the opportunity to discuss issues concerning their professional work and to obtain support if needed.

Interpreters are assumed and obligated to be neutral but are also witnesses to what happens during the meeting and may be active agents because of their presence and way of interpreting. They may become a “cultural brokers”, i.e. brokers in a multi-cultural situation (Szasz, 2001; Gustafsson et al., 2011) involving government officials and individuals who cannot communicate in Swedish. This “cultural broker” role has been studied by Norström et al. (Norström et al., 2008–2011). They found that users of interpreters did not have enough knowledge about interpreters’ various professional roles and competencies. In addition, the users did not know about the organisations to which interpreters belong; the working conditions of interpreters; or the kinds of things that a user may reasonably request of interpreters. The interpreters lacked sufficient back-up support, including opportunities and forums for discussing ethical dilemmas or frustrations (Norström et al., 2008–2011). Because of this lack of support, interpreters may occasionally experience conflicts between their right and need to talk about problems or issues they encounter in their work and the need to adhere to confidentiality law.

An individual interpreted meeting may be seen as a minor encounter that is not relevant to larger social issues, but the individual patient’s right to express his/her views is a basic democratic right, and professional interpretation is an important tool for ensuring this right (Norström et al., 2008–2011). Patients’ rights to express their views might thus be an issue of democratic rights and therefore also a question for the government (Statens offentliga utredningar, 2006).

The Legal, Financial and Administrative Services Agency has published a guide for authorised interpreters working professionally. It is called “Good interpreting practice” and provides ethical guidance (Kammarkollegiet, 2010). The principles of information transmission during interpretation found in the guide can be summed up using the same words used to take an oath in court, i.e. “do not comment on, add or alter” or “tell the truth, the whole truth, and nothing but the truth”. The interpreter should use the first person singular during the interpretation, be neutral, not express personal values or views, translate all information word by word or sentence by sentence, ensure confidentiality and “stay in the background” during the interpretation process. The persons in the meeting should talk to each other and not to the interpreter. Force of expression, emotional expression and body language should not be toned down by the interpreter.

Sometimes, it is difficult to achieve interpreter continuity. A few PHCCs in Stockholm County directly employ interpreters in the most common languages, for instance at Fittja PHCC in the southern part of Stockholm. This may result in better continuity and certainty for both the patients and the medical staff, since it gives them a better opportunity to get to know the interpreter. In a Swedish study by Fatahi et al., researchers found that interpreters perceived themselves as part of the health care staff, but that the staff had a more restrictive attitude to the interpreter which sometimes created anxiety and feelings of conflict on the part of the interpreters (Fatahi et al., 2005). The researchers’ recommendation was to include the interpreter as a member of the health care team in order to improve communication (Fatahi et al., 2005).

Wadensjö et al. studied communication in meetings at which an interpreter was present. They found that such meetings are complex situations that can be influenced by a variety of factors depending on the participants' different frames of reference. Culture has been found to be one of many factors of importance during communication (Wadensjö, 1998). The messages that are interpreted are conveyed and understood in a specific situation characterised by interruptions, feedback and interdependence. The context, which includes the place, the participants and their relationships, is of great importance to how the consultation works (Wadensjö, 1998).

When interpreters are booked, it is important to remember that authorised interpreters can be held responsible for their interpretation, whereas this is not necessarily the case for other types of interpreters (e.g. family members and/or medical staff). Ad hoc interpreters may not be neutral and impartial and may therefore be placed in a conflict-of-interest situation. They may interrupt the conversation between the patient and the GP and may not interpret everything. An additional advantage of using interpreters who are specially authorised in medicine is their special competence in medical terminology.

## **GENERAL PRACTITIONERS IN SWEDEN**

Primary health care in Sweden provides all basic health care in both urban areas and more sparsely populated areas. Overall responsibility for primary health care rests with the Federation of County Councils. Each county is responsible for local PHCCs, where GPs, nurses and medical secretaries work in teams, sometimes with physiotherapists and social workers or psychologists. These local PHCCs are responsible for providing medical care to families and individuals of all ages. They treat a wide range of diseases and in some parts of Sweden have primary responsibility for child and maternal health care services, health care in schools and medical care for elderly persons living in sheltered housing in the area. PHCCs also provide rehabilitative and preventive care to local inhabitants.

People may register as patients of a specific doctor at a PHCC. A special allowance is given to the PHCC for each registered person. The size of the allowance depends on how old the person is (it is higher for the youngest and oldest patients).

Continuity (having the same doctor each time one visits the PHCC) is sometimes a problem. Opportunities for patients to see the same doctor every time they visit the PHCC vary depending on the health status in the area and the number of patients on the GP's list, i.e. whether the GP sees few or many persons in need of health care often and regularly. During epidemics, when doctors' schedules are overloaded, or during holidays, the PHCC may hire extra doctors for several days or weeks, and patients may not be able to see their regular GP. Another reason for insufficient continuity is that there are too few GPs to achieve an optimal GP-to-patient ratio in most areas of the country. Sweden's population was 9,113,257 in 2006 (Statistics Sweden, 2012c). The goal is for each GP to be responsible for 1,500 inhabitants (Wiborgh, 2006), but in 2006 there were only about 3,900 GPs below 65 years of age in Sweden (equivalent to full-time workers), and just over 200 GPs were 40 years or younger (Ståhlberg, 2006).#

A long-term strategy is needed to ensure continuity and access for patients who frequently consult GPs (Andersson et al., 1995). A study from the 1990s showed that continuity was higher among older frequent attendees than among younger ones. As far as I know, there have been a limited number of scientific studies on continuity. A substantial part of the work with frequent attendees consisted of contacts other than medical consultations; consultations of this kind can be time-consuming. Musculo-skeletal symptoms, psychological problems, and social problems – often in combination – were the most common complaints among frequent attendees (Andersson et al., 1995).

GPs are expected to have broad competence in many areas; less than 10% of visits to PHCCs result in referrals to specialists at hospitals for secondary and even tertiary care. GPs are expected to make examinations, conduct investigations, give prescriptions and take responsibility for rehabilitation programs, sometimes in cooperation with the Swedish Social Insurance Agency, the Swedish Public Employment Service and those responsible for social welfare services, a set of services organised by each municipality in Sweden. The Swedish health care system strives to provide preventive care, medical treatment and rehabilitation on equal terms, independent of the patient's living conditions and background (The Health and Medical Services Act [1982:763]). The main goal of each GP is to meet the needs of all patients concerning their medical treatment, preventive care and rehabilitation.

To become a certified specialist in general medicine (i.e. a GP) requires at least five years of work as a doctor after the award of a medical degree. During this time, doctors are known as specialist trainees (residents). They work under the supervision of a tutor but deal with medical problems by themselves. After this training period, the doctor may voluntarily sit an examination.

Employment terms are negotiated by the Swedish Medical Association – a professional organisation (something like a union) for doctors, membership of which is voluntary – and the Federation of County Councils. GPs are expected to undergo continuing professional education and training throughout their entire working life. The Swedish Union of General Practitioners is a trade organisation within the Swedish Medical Association for GPs. It is a national independent professional and trade association promoting external education. The scientific organisation for the Swedish medical profession, the Swedish Society of Medicine, promotes research, education and development in the health care sector. Membership is voluntary but provides opportunities for further training and education. At the local level, GPs in different areas are regularly offered lectures on current medical issues and problems by different organisers, for example local pharmaceutical companies and local medical associations.

Since immigrants in Sweden reside in varying numbers in different areas, the composition of immigrant patient groups vary greatly between different areas of Sweden. Moreover, working as a GP in Stockholm County is quite different from working in the countryside or in a city such as Malmö. The availability of professional interpreters varies over time and from place to place. At least one PHCC in Stockholm County with a high frequency of immigrant patients has daily access to interpreters. This means that

GPs can get authorised interpreters who speak patients' languages, even for unscheduled emergency medical consultations. The number of immigrant doctors in Sweden has also increased, which means that immigrant patients are now more likely to have the opportunity to meet a language-concordant doctor. If a professional interpreter (or language-concordant doctor) is not available, it is common for relatives to act as interpreters, particularly during unplanned visits for acute problems.

GPs' abilities to identify themselves as a person belonging to a specific culture, their knowledge about the migration process itself and their ability "to recognize idioms of distress, family structure, and patients' explanatory models of illness" (Löfvander, 2008) are important tools for achieving satisfactory consultations with immigrant patients. GPs therefore need to have a high level of interest in caring for immigrant patients, adapting to their needs and understanding their psychosocial contexts (Hudelson et al., 2010). In one study of GPs and medical students, caregivers with a greater proportion of immigrant patients and those who had received previous training in cultural competence had greater interest in caring. The study concluded that both personal characteristics and professional experience are associated with attitudes towards caring for immigrant patients (Hudelson et al., 2010). In a study conducted in Canada, Papic et al. reported that only a minority of physicians received specific cross-cultural competence training, but that such training seemed to improve physicians' abilities to provide better care to immigrant patients (Papic et al., 2012).

Another group of researchers found that GPs were less satisfied with "ethnic" patient visits than with the visits of control patients (Kamath et al., 2003). This lower satisfaction with "ethnic" patient visits was especially obvious in the context of patients' efforts to prevent diseases and to manage chronic diseases. In contrast, smaller differences were found for issues concerning communication, cultural beliefs and practices (Kamath et al., 2003).

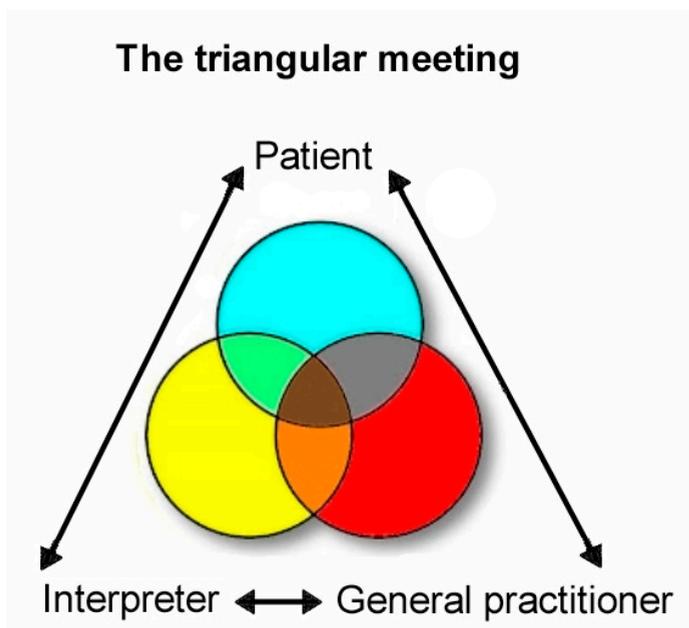
In the international scientific literature, one can find guidelines for appropriate care when meeting immigrant patients. Suzanne Salimbene, PhD, president of Inter-Face International, a company that works with cultural and linguistic competence in health care, has concluded that becoming a competent caregiver is an ongoing process that leads to improved patient satisfaction and health outcomes (Salimbene, 2006). According to R L Pullen of the Department of Nursing at Amarillo College in the USA, a practical guide for communicating with immigrant patients (Pullen, 2007) should include the following components: building confidence in patient-provider relationships, minimising misunderstandings, making more effective use of time, increasing patient satisfaction and decreasing patient stress. Pullen also emphasises the importance of silence during communication to ensure that the patient has time to reflect on what has been said.

It is important for GPs to remember that body language differs from culture to culture. For example, direct eye contact is impolite or even aggressive in many American Indian, Indo-Chinese and Arab cultures. Sitting close to the patient may be right in some cultures, for instance, those in Latin America, Japan, and the Middle East, but people from North America and Great Britain require more personal space (Pullen, 2007). Obtaining patients' permission before touching is also important when the

patient has covered different parts of his/her body, the recommendation being to expose only one part of the body at a time (Pullen, 2007). GPs should focus on the recommendations mentioned above in order to achieve patient-centredness and cultural sensitivity. Such recommendations are important for improving the quality of health care at the individual, community and population levels (Saha et al., 2008).

## THE TRIANGULAR MEETING

In primary care, a triangular meeting is a consultation that includes three participants: an immigrant patient, an interpreter and a GP. This means that three persons with backgrounds that might differ in terms of culture, language, SES and/or educational level meet each other during the consultation. The intention is to discuss patients' symptoms and issues, and if the communication and interpersonal relationships are satisfactory, the encounter will be successful. An overall aim of the triangular meeting is for each participant to feel satisfied afterwards. To gain better insight into triangular meetings in terms of feelings, experiences and strategies, it is important to look at the various relationships between the three participants, all of whom have different roles. In the triangular meeting, three different mutual relationships arise with regard to communication: patient-GP, patient-interpreter and GP-interpreter (Figure 2).



**Figure 2.** The triangular meeting.

Normally, but not always, the roles of the three participants are clear. However, one or more of the participants may adopt an expanded role to bridge the gaps between the provider and the patient depending on the circumstances (Beltran Avery, 2001). All

participants have, and hopefully also take, responsibility for the success of a consultation, which depends on the quality of the interpretation process and of the patient-doctor meeting.

In one study in Switzerland, physicians felt that consultations with immigrant patients took more time and were less effective and less satisfactory than consultations with non-immigrant patients (Hudelson, 2006). Interpreters reported that medical questioning styles may be more or less incomprehensible to patients, and that misunderstandings between GPs and patients may occur in three different domains: 1) ideas of a patient's health problems, 2) expectations of the clinical encounter, and 3) verbal and non-verbal communication styles. Such misunderstandings are related to a "mutual lack of awareness of those differences" (Hudelson, 2005).

### **The patient's role**

The patient's role is to describe his/her symptoms, including how and when they started, their nature, factors that reinforce and relieve them, their background and the patient's own thoughts about possible explanations. Patients need to trust that GPs will put patients' needs above all other considerations. Immigrant patients may trust their GPs less than non-immigrant patients because of "racial/ethnic discrimination in health care" and because of the "social distance between the patient and the GP" (Stepanikova et al., 2006).

The quality of communication in the triangular meeting is of great importance to patients. Immigrant patients who need an interpreter need to trust that the interpreter will convey to the GP completely and correctly what the patients want to say. Otherwise the language barrier may hinder communication, as has been found in previous studies. For instance, in California, USA, Fernandez et al. reported poor glycaemic control in patients with diabetes who had limited English proficiency and language-discordant physicians. They did not find such poor glycaemic control when the GP and the patient spoke the same language (Fernandez et al., 2011). The importance of the quality of communication was also highlighted in a study from the USA. The study found that assessments of communication and quality of health care were similar for Asian immigrant patients who participated in consultations involving interpreters and those who consulted language-concordant GPs (Green et al., 2005). However, the researchers who conducted the study concluded that interpreter use may compromise certain aspects of communication and that the quality of perceived interpretation is important for patients' assessments of quality of care (Green et al., 2005).

Gender may also be an important issue for patients. For instance, a previous study found that patients preferred gender-concordant professional interpreters to family members (Ngo-Metzger et al., 2003). Moreover, gender concordance seems to be important for the quality of communication in the patient-GP relationship, but the presence of a professional interpreter overcame gender-related communication barriers in one study (Bischoff et al., 2008).

In addition to establishing the reasons for the visit and making the right diagnosis, which are important to both patients and GPs, it is also important that patients are able

to express their ideas, concerns and expectations. Matthys et al. found that ideas and concerns were expressed more often in consultations for new reasons than in follow-up visits, and that expectations were more often expressed in follow-up visits (Matthys et al., 2009). They stressed that if patients are able to express concerns and/or expectations, fewer prescriptions will be made (Matthys et al., 2009). Moreover, meeting patients' expectations seems to be important for improving patient satisfaction (McKinley et al., 2002).

It is also important for GPs to communicate with patients about culture-based health beliefs and practices. In a previous study, patients felt that it was important that their traditional health beliefs and practices were respected, and that GPs ought to know more about non-Western medical practices (Ngo-Metzger et al., 2003).

### **The GP's role**

The GP plays a multifaceted role in the consultation. The GP's primary responsibility is to elicit and evaluate the patient's medical history. If the nature of the medical problem to be evaluated is not obvious, achieving an understanding of the problem can be challenging. In consultations in general, patient-centredness is important for identifying the patient's real problems. It is perhaps even more important in triangular consultations. Rivadeneyra et al. found that Spanish-speaking patients visiting an English-speaking physician with an interpreter present made fewer comments and were more likely to be ignored if they made a comment. They concluded that communication difficulties could result in lower adherence rates and poorer medical outcomes (Rivadeneyra et al., 2000).

After an "opening phase" in which the patient explains his/her reasons for the visit, it is important for the GP to confirm the patient's experiences and feelings. A patient-centred approach (Stewart, 2001) includes giving patients enough time to tell their stories without interruptions. Telling their story at the beginning of the consultation constitutes "the patient's part" of the encounter (Nystrup et al., 2010). The GP is then responsible for eliciting information about the patient's ideas, concerns and expectations (Matthys et al., 2009). One research group investigating patient expectations at a multicultural outpatient clinic in Switzerland found that physicians were poor at identifying patients' expectations and therefore needed training in general communication skills (Perron et al., 2003). To achieve satisfactory patient-physician communication, it is important for GPs to be aware of the real reasons that may lie behind the patient's current problems and the patient's main reason for the visit. A patient-centred approach can help GPs to achieve such awareness.

The Latin word "consulere" means to consult and/or seek advice. The patient comes to the GP to seek this advice, and it is therefore important for the GP to adopt a patient-centred approach in order to achieve a satisfactory consultation. It is important for GPs to view themselves as consultants rather than paternal or maternal authority figures. This is consistent with the Swedish Health and Medical Services Act (1982:763).

After the "patient's part" of the consultation, the GP is responsible for eliciting and evaluating the patient's medical history, performing a clinical examination, undertaking investigations and considering alternative diagnoses. This is known as the "physician's

part” of the consultation (Nystrup et al., 2010). In the final “common part” of the consultation (Nystrup et al., 2010), the GP tries to answer the patient’s questions and gives his/her assessment. Achieving a common understanding is the basis for further planning of health care.

A useful approach for GPs in the triangular meeting might be to use open questions at the beginning of the consultation; to not interrupt when patients are describing their medical histories; to remember to consider the patients’ ideas, concerns and expectations; to affirm what patients say during the conversation; to provide emotional feedback; to give summaries of what has been said; and to not be afraid to pause for reflection (Larsen et al., 1997). This approach takes both patients’ and GPs’ autonomy into account and leads to more effective communication and a stronger patient-doctor relationship. The GP’s respect and empathy will also result in a more integrated understanding of the patient’s life and circumstances. Patient-centred communication creates a good platform that enables patients and GPs to make decisions together.

Proper use of the GP’s power is an important part of the GP’s role in the triangular meeting, as in all consultations. From an ethical point of view, respecting patients’ autonomy requires that physicians always share decision-making power with patients (Brody, 1992). This means that physicians must use their power on behalf of patients and not to patients’ disadvantage. Physicians must also be prepared to show how they have used their power. Power in this context can be divided into two parts: to fight against illnesses and to fight for the patient’s rights. The GP must be a “moral user of power” in all circumstances (Brody, 1992).

In summary, a patient-centred approach on the part of the GP is useful during the triangular meeting. Patients who feel that the GP took them seriously and answered their questions might adhere better to treatment, which may result in better health outcomes. A patient-centred approach is associated with fewer unnecessary investigations, fewer follow-up visits, reduced prescription of drugs, reduced need for referrals, improved mental health and physical functioning, improved adherence and increased patient satisfaction (Stewart et al., 2000).

### **The interpreter’s role**

The interpreter’s primary role or function is as a *conduit* (a semantic channel consisting of a sender and a receiver – a bridge between two persons). This role involves transferring information between the patient and the GP. The interpretation must be thorough, accurate and faithful, as prescribed in interpreters’ ethical codes (Diversity Rx, 2002). The conduit role is necessary to provide the patient and the GP with trust and confidence that communication will be satisfactory. The conduit role may prevent “interpreter malpractice”, but in practice does not always provide sufficient and consistent guidance for interpreters, because communication is more than just transmission of information; it also involves the participants’ views and beliefs (Dysart-Gale, 2005).

Technical, semantic and lexical difficulties may need to be overcome before the interpreter can provide clear and correct interpretation. If misunderstandings occur, all

three participants must seek to clarify what they are saying and use various strategies to overcome the misunderstandings.

In addition to the interpreter's role as a conduit, the interpreter sometimes has other roles. One of these is to act as a *clarifier* (Beltran Avery, 2001) when it is difficult to decide which of two possible translations is more accurate. The interpreter may also feel that he/she is responsible to act as the patient's *advocate* to improve both communication and health care quality (Diversity Rx, 2002). Finally, interpreters may also act as a *culture broker* when it is necessary to provide a cultural framework during interpretation in order that the GP can better understand the information provided. Interpreters may also broker other kinds of information. For instance, in a qualitative study that involved interviews of medical interpreters, researchers found that interpretation may include information about the patient's family and relationships, decision-making structures and immigrant patients' culturally determined health beliefs and practices (Dysart-Gale, 2007). It may therefore also be helpful if the GP is more culturally sensitive (Dysart-Gale, 2007). In another study, video-taped encounters between patients, physicians and interpreters showed that in addition to mediating between two cultures, interpreters may also create a safe environment for patients and maintain professional boundaries (Rosenberg et al., 2008). However, it should be noted that interpreters are not always closer in terms of background to immigrant patients than they are to GPs. In Germany, Sleptsova et al. found that Turkish-speaking interpreters' socio-demographic characteristics resembled those of health professionals much more closely than those of Turkish patients. This means that their position during consultations was closer to that of the health care provider than to that of the patient. Sleptsova et al. recommend word-for-word translation, instead of letting the interpreter act as a cultural mediator (Sleptsova, 2007).

In reality, all these roles – conduit, clarifier, advocate and culture broker – may sometimes be performed at the same time, the aim being to provide interpretation that is satisfactory to all three participants. However, research shows that assuming multiple roles may sometimes lead to problems for interpreters. For instance, in a study on communication about end-of-life care, Norris et al. reported that interpreters may experience a conflict between different roles and expectations. They wanted GPs to warn them before bad news was to be delivered and to discuss whether cultural brokering would be needed in addition to a strict interpretation (Norris et al., 2005). In the same study, interpreters said that physicians' awareness of the sometimes conflicting roles of interpreters would improve communication and understanding and therefore also the quality of care. Another group of researchers wrote that interpretation work in health care may be "complex, challenging, exhausting, and often invisible" (McDowell et al., 2011). Their interviews with formal and informal interpreters showed that being the voice of patients and GPs involved mental attentiveness, memory and processing work that was rarely acknowledged.

The international literature presents complementary communication aspects and traditions: "the transmission view" and "the ritual view" (Carey, 1992). According to the transmission view, communication is regarded only as a way to transport "messages, information and commands on space" (Carey, 1992). The ritual view is more closely related to the broader word communication itself. This view refers to shared

beliefs and views communication as “a symbolic process whereby reality is produced, maintained, repaired, and transformed” (Carey, 1992). Although both the transmission and ritual views of communication are relevant to the triangular meeting, it could be argued that the ritual view is the more relevant of the two. The ritual aspect of communication is necessary when using a patient-centred approach, in which it is important to determine the patient’s beliefs (Dysart-Gale, 2005).

### **Patient-interpreter-physician relationships**

The presence of an interpreter may negatively influence the relationship between the patient and the GP. It may lead to reduced and revised speech and changes in content, meaning and “small talk” (Aranguri et al., 2006). The GP may then struggle to gain a comprehensive patient history, get relevant information and engage emotionally in treatment (Aranguri et al., 2006). When information from the patient is reduced, revised or omitted, the result can be misdiagnosis and incorrect treatment. GPs may need to use various strategies to overcome these difficulties and to provide a correct diagnosis and appropriate treatment (Aranguri et al., 2006).

A Swedish study of GPs’ views on consultations with interpreters highlighted the participants’ different abilities: the interpreter’s ability to build bridges; the GP’s ability to embrace cultural circumstances; and the patient’s ability to participate (Fatahi et al., 2008). The consultation in these situations is a balancing act with many possibilities, but also potential difficulties. Strategies for managing these difficulties may be needed.

For the patient, it is important to be an active participant, expressing intentions, concerns and expectations, whereas the GP has to be open to different cultural views. During the triangular meeting within this framework, strategies are sometimes needed to achieve a real encounter and a satisfying consultation. In a qualitative study by Rosenberg et al. (Rosenberg et al., 2007a), 25 GPs reported three types of strategies in intercultural clinical encounters: insistence that patients adapt to local behaviours, adaptation of physicians to assumed patient’s desires, and negotiation of a mutually accepted plan. Physicians used a patient-centred model of care but did not have a framework for eliciting patients’ cultural views during the consultations. For instance, they did not ask the interpreter to act as a culture broker (Rosenberg et al., 2007a).

Because their bilingual and bicultural positions give them opportunities to identify communication barriers, interpreters recommend “cultural competence training” for GPs (Hudelson, 2005). According to one source, cultural competence training should include information about the countries from which patients come, how to work with different styles of communication, and kinds of misunderstandings that might occur. Moreover, health care practitioners should be made aware of the basic problems interpreters face when working in medical situations (Hudelson, 2005).

### **Cultural competence**

Cultural competence development teaches GPs the importance of basic knowledge about patients’ countries of origin (geography, politics and religion). It also includes achieving an awareness of differences in patient/provider perspectives, recognising

difficulties in the translation of medical concepts and terms (even word-for-word interpretation can be a source of miscommunication), and adopting a more narrative approach when providing information (Hudelson, 2005). In one study, in which cultural competence was defined as motivation to learn about other cultures, awareness of privileges, acceptance of different customs and values and GPs' clinical behaviours that reflect cultural competence, the quality of relationships between patients and their physicians was rated more highly by patients if the physicians' cultural competence was more developed (Paez et al., 2009). Patients' satisfaction, trust in their physician, perceptions of being respected and participation in care were included in the ratings (Paez et al., 2009).

The opposite of cultural competence is the concept of *cultural blindness*, defined by Lecca et al. as "the belief that culture actually makes no difference and that all cultures are essentially the same. A system or agency that is culturally blind believes that the 'helpful' approaches used by the dominant culture are universally acceptable" (Lecca et al., 1998).

In the literature, *cultural sensitivity* and *cultural awareness* are used to describe a process with different steps for becoming culturally competent. The first step is to become "culturally sensitive," which means "to reduce resistance and defensiveness during interactions, acknowledging bias that may influence one's behaviour" (Rhymes and Brown, 2005). The second step is achieving "cultural awareness," which is defined as appreciating and accepting "differences between individuals as well as cultures." The third step is to acquire knowledge about different cultures, including by deliberately seeking out a variety of world views and explanatory models of a situation. It is important to obtain information about the patient's language, culture, history and experiences. Reading about different cultures does not, however, mean that one will learn all the relevant facts about each patient's cultural background. Acquiring "cultural skills", including learning how to culturally assess a person to avoid relying solely on written or preconceived "facts", is the next step (Rhymes and Brown, 2005). The final step is to achieve "cultural competence," an attitude that includes "empathy for others, an openness to feeling what the other feels; curiosity, a willingness to ask questions in order to better understand; and a basic respect for self and others, an acknowledgement of the intrinsic value of all humans" (Rhymes and Brown, 2005). There may be a continuum in developing cultural competence, which is described by Lecca et al. as "a cultural competence *continuum* scale", and which includes the following stages: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence and cultural proficiency (Lecca et al., 1998).

Finally, viewed from a broader perspective, cultural competence includes respect for the patient and for the interactions with primary health care and society, and letting people know what you as a health care provider want and what kind of behaviour you cannot accept in relation to your professional rules and recommendations. This approach is important for avoiding conflicts, incorrect assumptions and resentment. When planning for cultural competence development, it is important to bear in mind that situations differ and that training should take into account the challenges relevant to local PHCCs (Hudelson, 2006).

## The role of family members

Patients have the right to decide whether a relative or a companion is present during the consultation. A relative of the patient may sometimes be an invited or uninvited guest in the consultation, which is then no longer a triangular meeting. The presence of this relative may alter the dynamics of the consultation and make it even more complex. Moreover, the relative may have different roles. In acute situations and situations in which there is a need for interpretation but no professional interpreter is available, they may assume the role of the interpreter. If the patient has a special dialect that the interpreter does not completely understand (e.g. if you have a Kurdish-speaking patient from Turkey and a Turkish-speaking interpreter from Turkey), it may also be necessary to use the relative as an inter-interpreter to interpret between the interpreter and the patient.

Relatives who know Swedish may also take on the task of checking the accuracy of the interpretation. This task consists of listening to the interpretation and sometimes even correcting it. Having a relative present who can check the interpretation might give patients a feeling of certainty that their medical histories have been completely interpreted and that they have received the right information from their GPs. However, if the relative interrupts and provides his/her own interpretation it can hinder communication between the patient and the GP. The information provided by the relative and to the GP might be incorrect and incomplete in such cases. In USA it is the professional interpreter's duty "to convey all messages faithfully and completely" during the consultation (National Council on Interpreting in Health Care, 2004).

Family members may provide information about the patient's social and cultural context, which can add another layer of information to the interpretation. This, in turn, increases the GP's understanding of the patient's medical history and life situation and enables the GP to adopt a more patient-centred approach. Empowerment and increased patient satisfaction may be the result. Additionally, when the patient is given bad news, such as a diagnosis of cancer or a chronic illness, the relative may support the patient. It is important for GPs working in Sweden to remember that in some cultures it is not customary to immediately give patients complete information about the nature and seriousness of a diagnosis of cancer or a chronic illness. Instead, patients are informed more gradually to ensure they do not lose their will to fight. Family members who act as interpreters (e.g. sons, sons-in-law, daughters, granddaughters, brothers and husbands) may perceive their role as facilitating understanding, but also ensuring that the diagnosis is correct and the treatment appropriate. They may interact with the health care system as an advocate for their relative. During the consultation, they may become a third or fourth participant, speaking from their point of view as an independent interlocutor (Rosenberg et al., 2007b). The fact that relatives may play multiple roles does not always have positive effects on communication in the consultation. Rosenberg et al. found that physicians treated family interpreters as if they were caregivers, but followed communication rules when using professional interpreters (Rosenberg et al., 2007b).

It is important, however, to consider the involvement of the family in the consultation as an asset or at least a potential asset. Some GPs already do so. In an Australian study, 55% of GPs preferred to use family members instead of professional interpreters, in

spite of the fact that the Royal Australian College of GPs' standards for GPs (RACGP Standards for general practices: a template for quality care and risk management) state that GPs should use professional interpreters (Atkin, 2008). It can be advantageous to have a relative present to achieve understanding and reach a consensus. In a study in UK primary care, Greenhalgh et al. found that family members are generally trusted and have better knowledge about patients' lives (Greenhalgh et al., 2006). The power balance during the consultation was also found to be altered in the patient's favour (Greenhalgh et al., 2006).

### **Use of staff members as interpreters**

In some cases, when neither interpreters nor relatives are available, a member of the staff who knows the patient's language may act as an interpreter. For instance, in an area with great ethnic diversity in California, staff members were used as ad hoc interpreters in 20% of consultations (Hornberger et al., 1997). The use of staff members as interpreters is cost-efficient. Moreover, the staff member may be familiar with medical terminology and have no personal relationship to the patient. However, interpreting may conflict with other work and the interpretation itself may not be accurate. In a study from California, frequent errors were reported when untrained nurse-interpreters were used in consultations with immigrant patients. Misunderstanding of patients' complaints occurred as a result of 1) GPs not always processing contradictory information provided in the interpretation; 2) nurses sometimes providing information that they thought the GPs expected but that the patient did not necessarily provide themselves; 3) patients' comments being ignored and the nurses sometimes failing to ask them to clarify their comments; and 4) patients' symptoms being interpreted literally without explanation in relation to patients' beliefs (Elderkin-Thompson et al., 2001).

### **Use of different kinds of interpreters**

In Northern California, GPs reported that trained medical interpreters were used in less than 6% of encounters, no interpreters in 11% (despite access to trained interpreters), a staff member in 20%, and a family member or companion in 36%. In the remaining 27% of encounters, the GP spoke the same language as the patient (Hornberger et al., 1997). The GPs reported higher quality patient-physician communication when using trained interpreters. Factors other than quality, including costs, seem to influence the choice of interpreter (Hornberger et al., 1997).

### **The need for increased knowledge**

The above review of the literature reveals gaps in our knowledge about associations between ethnicity and SRH and the communication process in the triangular meeting. This thesis aims to increase our knowledge about associations between ethnicity and SRH. It further aims to increase our understanding of the triangular meeting in terms of the experiences, reflections and strategies of patients, interpreters and GPs.

# AIMS

## GENERAL AIM

The *overall aim* of this thesis was:

- To obtain knowledge of the triangular consultation in primary health care where an immigrant patient, an interpreter and a general practitioner are present, to describe their experiences, reflections and strategies.

## SPECIFIC AIMS

The *specific aims* for studies I–IV were:

### STUDY I

- To analyse the association between ethnicity and poor self reported health and explore the importance of any mediators such as acculturation and discrimination.

### STUDY II

- To explore the patient's experiences and reflections pertaining to primary health care consultations in Stockholm;
- To study whether demographic or migration-related factors are associated with the patient's satisfaction with the consultation and the feeling of consolation given by the GP; and
- To analyse whether the patient's satisfaction with the consultation and feeling of consolation given by the GP are related to the time from the booking to the consultation, self-reported health (SRH), symptoms and the patient's experiences of the consultations.

### STUDY III

- To describe some aspects of each of the three perspectives in the triangular meeting between immigrant patients, interpreters and GPs, including their experiences, reflections and interactions during the consultation in primary health care; and
- To analyse patients' satisfaction with the consultation; whether satisfaction is influenced by respect for patients' culture, personality and wishes; and whether interpreters or GPs experience any ethical conflicts during the consultation.

## STUDY IV

- To gain insights into the participants' perceptions and reflections of the triangular meeting by means of in-depth-interviews with immigrant patients, interpreters, and GPs.

## AN OVERVIEW OF THE FOUR STUDIES

	Study 1	Study 2	Study 3	Study 4
Title	Ethnicity, acculturation, and self-reported health. A population based study among immigrants from Poland, Turkey, and Iran in Sweden	Immigrant patients' experiences and reflections pertaining to the consultation. A study on patients from Chile, Iran and Turkey in primary health care in Stockholm, Sweden	A description of some aspects of the triangular meeting between immigrant patients, their interpreters and GPs in primary health care in Stockholm, Sweden	Consultations between immigrant patients, their interpreters, and their GPs: are they real meetings or just encounters? A qualitative study in primary health care
Data source	Swedish National Survey of Immigrants 1996	Questionnaire	Questionnaire	Face-to-face interviews
Outcome	Self-reported health	Satisfaction with the consultation and consolation given by the GP	Patients' satisfaction with the consultation and consolation given by the GP	Experiences and reflections pertaining to the triangular meeting
Sample	840 Polish group 840 Turkish group 480 Iranian group 2250 Swedish-born group	17 Chilean group 22 Iranian group 39 Turkish group	78 patients 78 interpreters 78 GPs	10 patients 9 interpreters 10 GPs
Study design	Cross-sectional	Quantitative and qualitative	Quantitative and qualitative	Qualitative
Study period	2002–2003	Sept 2002 – Febr 2004	Sept 2002 – Febr 2004	2004, 2008–2009

# METHODS

## QUANTITATIVE METHOD IN STUDY I

In order to analyse the association between country of birth and poor self-reported health and explore the importance of mediators such as acculturation and discrimination, a population-based cross sectional study was conducted in 1996 and used as the basis for study I.

### Study population

From the Swedish population register in a survey made by Statistics Sweden in 1996, a simple random national sample of Swedish born persons (n=2250), immigrants born in Poland (n=840), Turkey (n=840), and Iran (n=480), aged between 27 and 60, was drawn. Response rate was about 68% for the immigrants in the study group and 80% for the Swedes in the control group. About half of all non-respondents refused to participate and the other half could not be located. The high proportion of missing persons may have its explanation in that many of the immigrants had been repatriated but had not informed the Swedish authorities (that is, the population registry) of their departure. Age distribution was about the same among respondents and non-respondents. In big cities non-respondents were overrepresented compared with respondents.

Face-to-face interviews with participants took place in the participants' homes and were conducted by trained interviewers from Statistics Sweden and professional Swedish interpreters, or by a family member chosen by the participant. The Turkish group had the highest need for an interpreter (20%) and the Polish group the lowest need (2%).

### Questionnaires

Questionnaires were culturally adapted and translated into Polish, Turkish, and Persian by authorised translators.

### Explanatory variables

The socio-demographic factors age, sex, marital status, education level, and economic conditions were investigated. Immigrants were also asked about their migration background, knowledge of Swedish, and perceived discrimination in different situations in society or their neighbourhood.

*Age* was classified in three groups: 27–39, 40–49, and 50–60 years.

*Marital status* comprised four groups: unmarried, married, divorced, and widowed. The variable was dichotomised according to whether the informant was living alone or married/cohabiting.

*Education level* was categorised into three groups: low (less than 10 years' attendance in school), medium (between 10 and 12 years), and high (more than 12 years).

*Poor economic resources* Participants were asked if they could raise \$1750 (14000 SEK) within a week if they were in economic difficulties. The answers were dichotomised as "yes" or "no".

*Ethnicity and migration background* Two groups in the sample were born in non-Westernised countries, namely Turkey and Iran; the two reference groups were from Poland and Sweden. Reasons for immigration for Iranians were political, religious, or war-related. For Polish immigrants, the reasons were more related to family circumstances than to political factors.

*Knowledge of Swedish* The immigrant participants answered one question each on:

- (1) ability to understand news reports on radio and television;
- (2) speaking Swedish in meetings;
- (3) communicating with authorities over the telephone (for instance, calling the health department, social security office, or unemployment centre);
- (4) reading books in Swedish; and
- (5) completing a written job application.

On each question, there were four alternatives for answers (1 very good, 2 pretty good, 3 fairly bad, and 4 very bad). Based on the answers to the questions, they were dichotomised with 1 including alternatives 1 and 2. The dichotomised variables were summed and categorised according to knowledge of Swedish into three levels; low level (sums lower than 3), medium level (sums 3 and 4), and high level (sum 5).

#### *Discrimination*

In the questionnaires, the immigrants answered questions about discrimination; i.e. if they had been treated better, worse or equal as Swedes at the employment agency, by the housing agency, by landlord or by neighbours, at the bank, in the health service, in the insurance agency, by social services, by the police, and at restaurants. For answering the questions there were six different alternatives (1 much better, 2 somewhat better, 3 equal, 4 any worse, 5 much worse), where 1 was the least discrimination and 5 the greatest; the final alternative was "not relevant". By dichotomising, the answers 1 and 2 were given 0 point and the others 1 point. The dichotomised variables were summed and categorised according to discrimination into three levels; low level of discrimination (sum zero), medium level (sums one and two), and high level (sums higher than two).

#### *Outcome variable*

Questions concerning health in ULF survey questionnaires covered the following: self-reported health (SRH), SRH compared to others of the same age, occurrence of prolonged illness, occurrence of prolonged illness which has a significant impact on working ability, complaints after accidents, need of medical treatment and/or regular medical control, presence of pain, hearing/sight problems and/or mobility needs, mental well-being issues (e.g. fatigue, anxiety, uneasiness, and fear), physical activity, smoking, alcohol consumption, admission to hospital, need of care, need of care (not

sought), dental health, and confidence in Swedish health services and Swedish health care.

The respondents were asked in the questionnaires: “How is your general condition?” The alternative answers were: 1 very good, 2 good, 3 tolerable, 4 poor, and 5 very poor. The answers given by the respondents were categorised in two groups: (1) very good, good, or tolerable and (2) poor or very poor.

### **Statistical analysis**

The outcome variable self-reported health (SRH) was one of the questions the informants were asked about. By using a logistic regression model (Hosmer and Lemeshow, 2000; Bjerling and Ohlsson, 2010), the odds ratios of poor SRH for the different immigrant groups were estimated. The explanatory variables were included stepwise.

I wanted to estimate the odds ratios (OR) with 95 % confidence interval (CI) for each predictor variable.

The odds ratios of having a poor SRH for the different countries, Poland, Turkey, and Iran were estimated with Sweden as a reference group. Our results were presented as OR with a confidence interval of 95%. The fit of the model was considered satisfactory if the deviance was about the same as the degrees of freedom ( $p > 0.05$ ). First, I estimated an age-adjusted logistic model and then successive main effect models by including one by one of the explanatory variables stepwise in two separate analyses, one for each sex. Except marital status, all included variables improved the previous model when Poland was used as reference group. As significant test I used likelihood ratio test. Model improvement ( $p < 0.05$ ) was measured as the difference in  $-2X$ log-likelihood and degrees of freedom between the smaller model and the extended model.

### **COMBINING QUANTITATIVE AND QUALITATIVE METHODS IN STUDIES II–III**

To acquire more knowledge of what happens in a consultation when an interpreter is present, I used a combination of quantitative and qualitative methods; i.e. a mixed model study (Tashakkori and Teddlie, 1998). By using a triangular approach (Patton, 1999), I wanted to explore experiences made by immigrant patients, their interpreters, and their GPs experiences of consultations. One of our expectations was that migration does not interfere with the patient’s feelings of satisfaction and consolation, defined as “alleviation of suffering, grief or disappointment by comforting” (Webster Dictionary). It includes empathy and may involve a shift of perspective for the suffering. In a model of consolation by Norberg et al. the importance of availability and listening is stressed to make a communion and consoling dialogue possible (Norberg et al., 2001).

A questionnaire, specifically developed and culturally adapted for this study, was used for three groups of immigrant patients booked for consultations (Chilean, Turkish, and Iranian), their GPs, and their interpreters. Patients received the questionnaires and information about the study in their native language (Spanish, Turkish or Persian) at the reception desk at the PHCC. Their interpreters and GPs also received questionnaires and written information about the study before the consultation. All three groups of

participants were asked to answer the questionnaires directly after the consultation at the PHCC and to leave them with the receptionist. The questionnaires for all three groups consisted of yes/no questions, multiple choice questions, and open-ended questions. Participants were also asked to comment and give reflections on their answers. The respondents' comments and answers to the open-ended questions were translated from the patients' native languages back into Swedish, before translation into English.

Questionnaires for patients, interpreters and GPs in Swedish are presented in the appendix.

**Patients' questionnaires** included multiple choice questions about background and health status, open-ended questions about their reflections and comments on the consultation, and comments about multicultural consultations in general.

### ***Background variables***

- *Demographic factors*: age, gender, marital status, number of children and persons in the household, number of relatives in Sweden, country of birth, religion, and culture/ethnicity.
- *Socioeconomic factors*: educational status, divided into three categories according to duration of school attendance (low, <10 years of schooling; medium, between 10 and 12 years; and high, more than 12 years), and professional status before and after immigration (previous work in country of origin, occupation in Sweden, and seeking of employment), divided into three categories: employed, unemployed, and at home/other (e.g. student).
- *Migration-related factors*: reasons for immigration categorised into three groups: political, social/family, and other reasons (e.g. religious, work-related, and economic reasons).

Other factors were time of patients' first visit to Sweden, total time in Sweden after immigration (years since arrival), and number of relatives in Sweden.

- As a proxy for *acculturation*, I asked about language spoken at home and length of residence in Sweden.
- *Self-reported health (SRH)* was assessed using the question: "How is your general condition?", for which there were five alternative answers (very good, good, tolerable, poor, and very poor). The results were categorised into two groups: (i) very good/good/tolerable and (ii) poor/very poor.
- *Reasons for consultation* were explored by asking about the patients' symptoms, which were categorised into five groups: musculoskeletal, circulatory, psychological, others, and multiple symptoms.
- *Time from booking to consultation* in days was categorised as 0–7, 8–15, and 16–90 days.
- *Patients' experiences of the consultation*. Questions covered language difficulties (e.g. comprehension during the consultation), feelings of relevance (if said the most important to the GP), whether or not the GP understood the patient's problems and reasons for GPs' non-comprehension, and respect for personality, wishes, and cultural background.

– Patients were also asked, in *open-ended questions*, about their reasons for non-comprehension, dissatisfaction, their beliefs about health promotion, and reflections on difficulties with cross-cultural communication (see appendix).

### **Outcome variables**

*Patients' satisfaction* with the consultation and the PHCC, and their feelings of *consolation* (“comfort/encouragement” in questionnaires) from the GP, were explored.

**Interpreters' questionnaires** included multiple choice-questions about the interpreters' backgrounds and open-ended questions asking for comments about their experiences and reflections concerning the communication in the consultation and cross-cultural communication in general.

### **Background variables**

- Mother tongue.
- If they interpreted the patient's language/dialect.

### **Outcome variables**

- *Special interpreting problems* during the consultation
- *Communication and experiences of the consultation*. If the patient had been able to say the most important during the consultation and if there had been sufficient consultation time. The questionnaires also included questions concerning whether the GP seemed to understand the patient's problems and reasons for non-comprehension. The interpreters' experiences regarding patient satisfaction and whether the patient's personality, wishes, and cultural background had been respected were also explored, as were ethical problems between the GP and the patient or for the interpreters themselves, solutions to the problems, desire for ethical support, and where they feel their values are rooted in. The interpreters were asked about their satisfaction with their own interpretation, as well as reasons for dissatisfaction.
- *Reflections about cross-cultural communication* in general were explored using open-ended questions, which asked the interpreters to describe and comment on their experiences.

**GPs' questionnaires** included multiple choice questions and yes/no questions about their backgrounds, consultation times, and communication, as well as open-ended questions about communication, experiences of the consultation, and reflections on cross-cultural communication.

### **Background variables**

- *Mother tongue*.
- *Language spoken at home*.

### **Outcome variables**

- If the *consultation time* was sufficient
- If the GP had been *able to say what was most important for them*
- If a *serious diagnosis* was given to the patient, and if relatives were present in such cases
- *Communication and experiences of the consultation*

Other questions asked for comments about the communication and experiences of the consultation, e.g. whether the GP thought that the patient had understood the information, ordinations, viewpoints, advice, and reasons for misunderstanding.

GPs' opinions about *patient satisfaction* and reasons for dissatisfaction were also explored.

Whether GPs' views of a healthy life, health were in line with patients' perceptions was also covered, as was the experience of a personal connection during the consultation.

Other questions asked whether the GP's cultural background was congruent with the patient's, and whether cultural differences had had a negative influence during the consultation. If a conflict had occurred, the GPs were asked to comment on whether they wanted ethical support and their opinions about the form it should take.

– *Reflections on cross-cultural communication* in general were asked for using open-ended questions and GPs were also asked to describe and comment on their experiences of ethical issues when meeting immigrant patients.

### **Data analysis of studies II–III**

The answers from the questionnaires distributed to immigrant patients, interpreters, and GPs were analysed by performing descriptive statistical analyses. I used the software package STATA, Stata Corp. 2003. Stata Statistical Software Release 8.0 (StataCorp LP, College Station, TX, USA). Because of the small sample sized I did not make significance tests.

Answers to the open-ended questions and comments to the multiple choice questions were analysed by using Content Analysis (described in a separate paragraph) (Graneheim and Lundman, 2004).

## **QUALITATIVE METHOD IN STUDY IV AND IN STRATEGIES DURING THE TRIANGULAR MEETING**

One of the researchers (EW) made visits to each PHCC when a patient from one of the three selected countries was booked for a consultation with an interpreter. All three potential participants received both verbal and written information and provided informed consent before a booking for an interview with EW was made. For the patient interviews, professional interpreters who were not included as participants in this study were booked separately.

In two cases, all three persons who participated in the same consultation agreed to participate in the study; in another case, a patient and his GP agreed to participate; and in a further case, the interpreter and the GP agreed to participate. A total of 30 face-to-face interviews were booked and conducted with a total of 29 individuals: 10 patients, 9

interpreters, and 10 GPs. The interview time for these semi-structured interviews was 45–60 minutes. A research nurse made notes during a few interviews in the beginning of the study period.

A special interview guide designed for the study was used during the interviews after the participant had been asked to describe experiences and reflections concerning consultations in which interpreters had been present. More generally, reflections on primary health care for immigrants were also investigated (see appendix for the interview guide).

## **Content analysis**

Content analysis in the 1950s dealt with “the objective, systematic, and quantitative description of the manifest content of communication” (Berelson, 1952). Since then, it has gradually been an expansion to include interpretations of latent content as well. The quantitative approach is used in media research and the qualitative approach more in education and nursing research. Diversities of opinions about concepts, interpretation and the procedure itself may be explained due to various beliefs of the nature of reality (Graneheim and Lundman, 2004). The interpretation of reality is subjective, which is important to remember while discussing trustworthiness.

When interpreting the data itself from interviews for instance, it is important to remember that they are contextual, mutual, and value bound (Lincoln and Guba, 1985). The visible, obvious components are referred to as the “manifest content”. When an interpretation has been made of this; i.e. the meaning of the text, it is referred to as the “latent content”. The units of analysis are the objects of the study, for example a person or a whole interview. A meaning unit may thereafter be condensed, interpreted, and aggregated in three different steps to “sub-themes” and finally by abstraction to a “theme”.

In the literature one can also find other definitions in content analysis, as “code”, which is the label of a meaning unit. A “category” is a group of content that shares a commonality and answers to the question “What”; i.e. a descriptive level of content (Krippendorff, 1980). A “theme” answers to the question “How”, and may be seen as an expression of the latent content in the text.

**Table 1.** Content analysis: examples of a meaning unit, a condensed meaning unit, a sub-theme, and a theme from content analysis of a patient’s experiences and reflections pertaining to a consultation.

Meaning unit	Condensed meaning unit Description close to the text	Condensed meaning unit Interpretation of the underlying meaning	Sub-theme	Theme
<i>“I want the interpreter to translate or convey exactly how I feel, in other words, my feelings, emotions, and experiences, i.e., not only the verbal thing.” (P10)</i>	The patient says that she wants to have not only an exact verbal translation, but also a translation with feelings, emotions, and experiences.	The patient has a need for interpretation with words, feelings, and experiences.	Need for verbal and emotional interpretation	Professional interpretation

## ETHICS

To participate in the studies II, III, and IV was voluntarily for the participants. Oral informed consent was given by all participants. Confidentiality was ensured for all informants. All informants were anonymous to the study team, except for EW, who made the bookings and the interviews in Study IV. The regional ethical committee of the Karolinska Institutet (Stockholm) approved the different studies with following approval numbers:

- Study I: 11/0
- Study II: 199/02
- Study III: 199/02
- Study IV: 04-309/2

## **MATERIAL**

### **PARTICIPANTS IN STUDY I: The Survey of Immigrant Living Conditions (Inv-UJLF)**

In 1996, Statistics Sweden performed a large national survey of immigrants' living conditions in cooperation with and funding from different national authorities, including the National Board of Health and Welfare, the National Institute of Public Health, the Swedish Immigration Board, and the Swedish government. Simple random samples of Swedish-born persons (n=2250) and immigrants born in Poland (n=840), Turkey (n=840), and Iran (n=480) were drawn from the Swedish Total Population Register. Inclusion criteria for the Polish and Turkish groups were to have settled in Sweden between 1980 and 1989 and to have been aged 20 to 44 years at the time; to reside in Sweden in 1996; and to be aged 27 to 60 at the time of the interview. The immigrants from Iran had settled in Sweden between 1985 and 1989 and were aged 27 to 55 when they were interviewed. Country of birth was used instead of ethnicity because Swedish law prohibits registration of ethnicity. As a control comparator, data on Swedish-born adults aged 27 to 60 years were added from the 1996 Survey of Living Conditions.

### **PARTICIPANTS IN STUDIES II–III: Questionnaire study in Stockholm**

To obtain information and deepen knowledge about the experiences and reflections of immigrant patients and their interpreters and GPs regarding consultations in primary health care, a mixed model study (combining both quantitative and qualitative methods) was started in 2004. At the time of the commencement of study II, the total number of foreign-born persons in Stockholm County was 346 195, of whom 4% had been born in Chile, 6% in Iran, and 5% in Turkey.

Twelve primary health care centers (PHCCs) around Stockholm with high percentages of immigrant patients from Chile, Turkey, and Iran were selected. Patients from Chile, Turkey, or Iran who had been booked for a consultation and needed the assistance of an interpreter were eligible for participation. The main reason for selecting these three immigrant groups was that, at the time of this study, they were among the largest non-European groups of immigrants in Sweden.

### **PARTICIPANTS IN STUDY IV: An interview study**

To obtain the maximum amount of information about triangular consultations, a purposeful sampling procedure was used. Purposeful sampling is used in qualitative studies such as study IV and involves the intentional selection of a sample on the basis of the study needs (Coyne, 1997). To further examine and explore the results of studies II and III, including the experiences and reflections of immigrant patients from Chile, Turkey, and Iran, I selected five PHCCs in Stockholm County which served areas with

high proportions of these immigrant groups. Selection of patients, interpreters, and GPs was based on participation in the same consultation. As in studies II and III, another criterion for selection was the need for an interpreter's assistance during the consultation.

Of the ten **patients** who participated in the study, four were from Chile, three from Turkey, and three from Iran; nine were women and one was a man. Eight patients were less than 65 years old and two were more than 65 years old.

Of the nine participating **interpreters**, seven were women and two were men. It should be noted that one interpreter was interviewed twice: first in 2004 and again in 2009. At the time of the second interview, this interpreter had moved to a new location, changed her last name, and did not inform the researcher about the original interview. Because the content of the interviews differed, both were included in study IV. Four interpreters were less than 50 years old and five more than 50 years old. Countries of origin of the interpreters were Syria (n=1), Iran (n=3), Turkey (n=2), Uruguay (n=2), and Sweden (n=1). Three interpreters spoke Spanish, three Persian, and three Turkish. Six had worked as interpreters for more than ten years. The participating interpreter with the least experience had been an interpreter for two months. Seven of the interpreters were authorised by *Kammarkollegiet*, the Swedish Legal Financial and Administrative Services Agency and at least two were trained in health care.

Of the ten **GPs**, seven were women and three were men. Three were less than fifty years old and seven more than 50 years old. Countries of origin of the GPs were New Guinea, Iran, Iceland (n=1 in each case), and Sweden (n=7). All GPs had many years of experience working with immigrant patients.

# RESULTS

## STUDY I

About half of the men from Iran and Poland had a high level of education. In contrast, about a quarter of the Swedish-born men had a high level of education. Approximately 70% of women from Turkey had a low educational status. Being able to raise \$1750 (= 14000 SEK) within a week was possible for half of the Iranians and Turks and about 75% of the Polish immigrants. Only one in three Turkish-born women had a good knowledge of Swedish, while men from Iran and Poland and women from Poland had a high level of knowledge of Swedish. Feeling discriminated against was most common in the group of Iranian men and women.

Women from Turkey and Iran had higher odds of poor health than did Polish and Swedish women. Men born in Iran and Turkey had threefold higher odds of poor SRH than Swedish-born men did (**Table 2 Age adjusted logistic model**). These odds decreased slightly after the inclusion of poor economic resources into the model. Turkish-born women had fivefold higher odds of poor SRH than Swedish women did. The odds decreased by 130% after the inclusion of educational status and by a further 60% after the inclusion of poor economic resources. For Iranian-born women, the odds decreased after the inclusion of poor economic resources.

Turkish- and Iranian-born men had higher odds of poor SRH than Poles did (**table 3 Successive main effect models**). The odds decreased after inclusion of SES in the model and decreased further after the inclusion of knowledge of Swedish. For Turkish-born women their higher odds of poor SRH than Polish women (OR=2.73) decreased after stepwise inclusion of education (OR=1.89) and poor economic resources (OR=1.70), and were no longer significant (OR=1.32) after the inclusion of knowledge of Swedish. Thus, the high risks of poor SRH among Turkish-born women were explained by low SES, poor acculturation, and discrimination (table 3b). For Iranian-born women, their high risks of poor SRH were also explained by low SES, poor acculturation, and discrimination (table 3b). When inclusion of knowledge of Swedish was made, the large differences between the SES groups in odds of poor SRH in both men and women decreased to non-significant level.

### Commentary on the results

Feeling discriminated against was most common in Iranian men and women. The perception of discrimination was also rather common among Turkish women. Despite the fact that about 80% of men and women from Poland had a good knowledge of Swedish, many patients in the Polish group still reported that they experienced high or medium levels of discrimination: nearly half the women and more than half the men perceived a high or medium level of discrimination.

**Table 2a.** Odds ratios (with 95% confidence intervals) for poor SRH in men, as determined by the stepwise inclusion of explanatory variables in logistic regression models: Sweden reference group (n=2,150)

Variable	Level	Model			
		Age + ethnicity	Age + ethnicity + education	Age + ethnicity + education + poor economic resources	Age + ethnicity + education + poor economic resources + marital status
Ethnicity	Sweden	1 (ref)	1 (ref)	1 (ref)	1 (ref)
	Poland	1.62 (1.35–1.95)	1.88 (1.28–2.77)	1.72 (1.16–2.54)	1.72 (1.10–2.69)
	Turkey	3.36 (2.93–3.85)	3.07 (2.28–4.13)	2.46 (1.81–3.33)	2.61 (1.84–3.72)
	Iran	3.41 (2.91–3.99)	3.94 (2.81–5.52)	2.95 (2.09–4.17)	2.92 (1.96–4.35)
Educational level	Low		1.99 (1.48–2.69)	1.92 (1.42–2.59)	1.91 (1.36–2.70)
	Medium		1.58 (1.22–2.05)	1.49 (1.15–1.94)	1.49 (1.10–2.00)
	High		1 (ref)	1 (ref)	1 (ref)
Poor economic resources	Yes			2.54 (2.01–3.20)	2.46 (1.88–3.22)
	No			1 (ref)	1 (ref)
Marital status	Single				1.35 (1.03–1.78)
	Married/cohabiting				1 (ref)
Model improvement	<b>-2*log likelihood</b>		19.1	49.7	4.9
	Degrees of freedom		2	1	1
	P-value		<0.0001	<0.0001	0.0027

**Table 2b.** Odds ratios (with 95% confidence intervals) for poor SRH in women, as determined by the stepwise inclusion of explanatory variables in logistic regression models: Sweden reference group (n=2,260)

Variable	Level	Model			
		Age + ethnicity	Age + ethnicity + education	Age + ethnicity + education + poor economic resources	Age + ethnicity + education + poor economic resources + marital status
Ethnicity	Sweden	1 (ref)	1 (ref)	1 (ref)	1 (ref)
	Poland	1.83 (1.61–2.07)	2.03 (1.63–2.52)	1.94 (1.51–2.51)	1.90 (1.42–2.53)
	Turkey	5.00 (4.33–5.76)	3.69 (2.82–4.84)	3.09 (2.24–4.26)	3.13 (2.18–4.51)
	Iran	5.12 (4.24–6.19)	5.28 (3.81–7.32)	4.24 (2.88–6.26)	4.25 (2.74–6.60)
Educational level	Low		2.17 (1.70–2.78)	2.08 (1.56–2.78)	2.11 (1.53–2.93)
	Medium		1.46 (1.20–1.78)	1.42 (1.13–1.79)	1.44 (1.11–1.86)
	High		1 (ref)	1 (ref)	1 (ref)
Poor economic resources	Yes			2.16 (1.74–2.68)	2.02 (1.57–2.59)
	No			1 (ref)	1 (ref)
Marital status	Single				1.41 (1.11–1.81)
	Married/cohabiting				1 (ref)
Model improvement	<b>-2*log likelihood</b>		25.9	41.9	8.5
	Degrees of freedom		2	1	1
	P-value		<0.0001	0.0001	0.004

**Table 3a.** Odds ratios (with 95% confidence intervals) for poor SRH in men, as determined by the stepwise inclusion of explanatory variables in logistic regression models: Poland reference group (n=645)

Variable	Level	Model						
		Age + ethnicity	Age + ethnicity + education	Age + ethnicity + education + poor economic resources	Age + ethnicity + education + Poor economic resources + marital status	Age + ethnicity + education + Poor economic resources + marital status + knowledge of Swedish	Age + ethnicity + education + Poor economic resources + marital status + knowledge of Swedish + discrimination	Age + ethnicity + education + Poor economic resources + marital status + knowledge of Swedish + discrimination
Ethnicity	Poland	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)
	Turkey	2.03 (1.61–2.57)	1.60 (0.96–2.67)	1.40 (0.85–2.33)	1.47 (0.79–2.72)	1.31 (0.71–2.41)	1.29 (0.69–2.44)	1.29 (0.69–2.44)
	Iran	2.05 (1.59–2.64)	2.11 (1.28–3.50)	1.74 (1.06–2.89)	1.72 (0.93–3.16)	1.61 (0.88–2.93)	1.31 (0.70–2.46)	1.31 (0.70–2.46)
Educational level	Low		2.14 (1.30–3.52)	2.10 (1.28–3.44)	2.11 (1.17–3.84)	1.60 (0.86–2.97)	1.77 (0.93–3.36)	1.77 (0.93–3.36)
	Medium		1.63 (1.07–2.47)	1.59 (1.05–2.41)	1.58 (0.96–2.60)	1.46 (0.89–2.39)	1.52 (0.92–2.53)	1.52 (0.92–2.53)
	High		1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)
Poor economic resources	Yes			2.37 (1.69–3.35)	2.32 (1.53–3.52)	2.29 (1.52–3.45)	1.98 (1.29–3.04)	1.98 (1.29–3.04)
	No			1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)
Marital status	Single				1.31 (0.80–2.15)	1.34 (0.82–2.18)	1.27 (0.77–2.09)	1.27 (0.77–2.09)
	Married/cohabiting				1 (ref)	1 (ref)	1 (ref)	1 (ref)
Knowledge of Swedish	Low					2.32 (1.21–4.43)	2.34 (1.20–4.57)	2.34 (1.20–4.57)
	Medium					1.63 (1.00–2.64)	1.61 (0.98–2.65)	1.61 (0.98–2.65)
	High					1 (ref)	1 (ref)	1 (ref)
Discrimination	High						2.54 (1.45–4.45)	2.54 (1.45–4.45)
	Medium						1.46 (0.80–2.68)	1.46 (0.80–2.68)
	None						1 (ref)	1 (ref)
Model improvement	<b>-2*log likelihood</b>		19.5	22.0	1.5	9.6	15.0	15.0
	Degrees of freedom		2	1	1	2	2	2
	P-value		<0.0001	<0.0001	0.22	0.008	0.006	0.006

**Table 3b.** Odds ratios (with 95% confidence intervals) for poor SRH in women, as determined by the stepwise inclusion of explanatory variables in logistic regression models: Poland reference group (n=764)

Variable	Level	Model						
		Age + ethnicity	Age + ethnicity + education	Age + ethnicity + education + economic resources	Age + ethnicity + education + resources + marital status	Age + ethnicity + education + poor economic resources + marital status + knowledge of Swedish	Age + ethnicity + education + poor economic resources + marital status + knowledge of Swedish + discrimination	Age + ethnicity + education + poor economic resources + marital status + knowledge of Swedish + discrimination
Ethnicity	Poland	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)
	Turkey	2.73 (2.23–3.33)	1.89 (1.28–2.77)	1.70 (1.08–2.67)	1.72 (1.04–2.84)	1.32 (0.76–2.28)	1.25 (0.72–2.17)	1.25 (0.72–2.17)
	Iran	2.80 (2.17–3.60)	2.64 (1.83–3.80)	2.25 (1.46–3.47)	2.28 (1.40–3.69)	1.95 (1.17–3.25)	1.59 (0.94–2.68)	1.59 (0.94–2.68)
Educational level	Low	1.99 (1.30–3.03)	1.99 (1.30–3.03)	1.82 (1.11–3.00)	1.86 (1.07–3.24)	1.12 (0.60–2.11)	1.23 (0.65–2.32)	1.23 (0.65–2.32)
	Medium	1.34 (0.98–1.83)	1.34 (0.98–1.83)	1.26 (0.87–1.82)	1.26 (0.84–1.90)	1.08 (0.70–1.66)	1.13 (0.73–1.75)	1.13 (0.73–1.75)
	High	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)
Poor economic resources	Yes			1.94 (1.41–2.65)	1.88 (1.32–2.67)	1.85 (1.28–v2.67)	1.75 (1.20–2.53)	1.75 (1.20–2.53)
	No			1 (ref)	1 (ref)	1 (ref)	1 (ref)	1 (ref)
Marital status	Single							
	Married/cohabiting			1.25 (0.86–1.82)	1.25 (0.86–1.82)	1.27 (0.86–1.87)	1.23 (0.83–1.83)	1.23 (0.83–1.83)
Knowledge of Swedish	Low							
	Medium							
	High							
Discrimination	High							
	Medium							
	None							
Model improvement	-2*log likelihood							
	Degrees of freedom	7.2	15.9	15.9	1.6	20.9	12.9	12.9
	P-value	2	1	1	1	2	2	2
		0.027	<0.0001	<0.0001	0.21	<0.0001	0.0016	0.0016

## STUDY II

### Background variables

In all three groups (n=52), including Chilean (n=16), Turkish (n=27) and Iranian (n=9) patients, age distribution was between 23 and 88 years, with an overrepresentation of women in all groups (**Table 4**). Married/cohabiting patients were also in majority. In the Chilean group, low educational level was reported in 28%, where corresponding figures were 78% for the Iranians, and 84% for the Turkish group. Professional status (employed, unemployed or at home/other; e.g. student) was almost the same before (41%) and after (33%) immigration. For all participants mother tongue was spoken at home and about a third of all participants had no relatives in Sweden. The majority of Chileans reported political reasons for immigration, while social reasons were reported by the other two groups. The immigrant patients had been in Sweden for a range of 2–34 years.

**Table 4.** Distribution in number and percentage of demographic, socioeconomic, acculturation and migration-related variables by ethnicity (n=52).

	Chile	Iran	Turkey	Total
<b>Variable n (%)</b>	16 (31)	9 (17)	27 (52)	52 (100)
<b>Age</b>				
23–50	5 (31)	1 (13)	16 (64)	22 (45)
51–88	11 (69)	7 (87)	9 (36)	27 (55)
<b>Sex</b>				
Male	7 (44)	1 (11)	3 (11)	11 (21)
Female	9 (56)	8 (89)	24 (89)	41 (79)
<b>Marital status</b>				
Single	7 (44)	6 (67)	7 (27)	20 (39)
Married/cohabiting	9 (56)	3 (33)	19 (73)	31 (61)
<b>Education</b>				
Low	4 (28)	7 (78)	21 (84)	32 (66)
Medium	5 (36)	0 (0)	3 (12)	8 (17)
High	5 (36)	2 (22)	1 (4)	8 (17)
<b>Professional status before immigration</b>				
Employed	9 (64)	3 (33)	8 (31)	20 (41)
Unemployed	0 (0)	0 (0)	3 (11)	3 (6)
At home/other	5 (36)	6 (67)	15 (58)	26 (53)

	Chile	Iran	Turkey	Total
<b>Professional status after immigration</b>				
Employed	8 (57)	0 (0)	8 (31)	16 (33)
Unemployed	2 (14)	2 (22)	2 (8)	6 (12)
At home/other	4 (29)	7 (78)	16 (61)	27 (55)
<b>Reasons for immigration 1)</b>				
Political	11 (69)	1 (11)	3 (12)	15 (29)
Social	4 (25)	8 (89)	13 (50)	25 (49)
Other 2)	2 (13)	1 (11)	12 (46)	15 (29)
<b>Length of stay</b>				
Years since first arrival (SD)	15 (6)	14 (3)	19 (10)	17 (8)
(range)	(2–25)	(8–19)	(2–34)	(2–34)
<b>Language spoken at home 3)</b>				
Mother tongue	15 (100)	8 (89)	24 (89)	47 (92)
Swedish	2 (3)	2 (22)	3 (11)	7 (14)
<b>Relatives in Sweden</b>				
None	4 (27)	0 (0)	10 (48)	14 (31)
Median value	4	3	1	2
(range)	(0–30)	(1–25)	(0–200)	(0–200)
2) Religious, employment, economic, other.				
3) Both alternatives possible.				

SRH was reported to be poor/very poor by about one third, where the Turkish group had the highest figure, followed by Iranians and Chileans (**Table 5**). Half of the immigrants had musculoskeletal symptoms and about a fourth had psychic problems. Time from booking to consultation was for one third of the patients 0–7 days. Fifty-four per cent expressed language problems despite the presence of an interpreter. Nevertheless, respondents were sure that GP had understood the patient's problems in 85%. To have been respected for personality, wishes, and culture by the GP was expressed by the majority of the participants.

**Table 5.** Prevalence in number and percentage of self-reported health, symptoms, distribution of time from booking to consultation and patients' experiences of consultations.

	<b>Chile</b>	<b>Iran</b>	<b>Turkey</b>	<b>Total</b>
<b>Variable n (%)</b>	16 (31)	9 (17)	27 (52)	52 (100)
<b>Self-reported health</b>				
Very good/good/moderate	12 (80)	5 (56)	14 (54)	31 (62)
Poor/very poor	3 (20)	4 (44)	12 (46)	19 (38)
<b>Symptoms 1)</b>				
Musculoskeletal	7 (50)	4 (44)	12 (50)	23 (49)
Circulatory	1 (7)	5 (56)	0 (0)	6 (13)
Psychic	2 (14)	2 (22)	7 (29)	11 (23)
Other	7 (50)	4 (44)	11 (46)	22 (47)
Multisymptoms	3 (21)	4 (44)	9 (38)	16 (34)
<b>Time from booking to consultation</b>				
Days				
0–7	1 (10)	4 (44)	8 (40)	13 (33)
8–15	4 (40)	1 (12)	7 (35)	12 (31)
16–90	5 (50)	4 (44)	5 (25)	14 (36)
<b>Language difficulties during the consultation</b>				
Yes	5 (38)	5 (56)	15 (63)	25 (54)
No	8 (62)	4 (44)	9 (37)	21 (46)
<b>Doctor understands the patient's problems</b>				
Yes	15 (100)	7 (78)	18 (78)	40 (85)
No	0 (0)	0 (0)	2 (9)	2 (4)
No idea	0 (0)	2 (22)	3 (13)	5 (11)
<b>Satisfaction with</b>				
<b>a) the consultation</b>				
Yes	14 (93)	6 (67)	21 (81)	41 (82)
No	1 (7)	3 (33)	5 (19)	9 (18)
<b>b) the primary health centre</b>				
Yes	5 (100)	4 (57)	11 (79)	20 (77)
No	0 (0)	3 (43)	3 (21)	6 (23)
<b>Consolation given by the doctor</b>				
Yes	14 (93)	6 (67)	16 (61)	36 (72)

	Chile	Iran	Turkey	Total
No	1 (7)	3 (33)	9 (35)	13 (26)
No need	0 (0)	0 (0)	1 (4)	1 (2)
1) One patient may have more than one symptom.				

### Outcome variables

The majority was satisfied with the consultation (82%) and with the PHCC (77%), with a tendency for lower satisfaction if time from booking to consultation had been more than 16 days, but without relation to different symptoms (**Table 6**). To have been consoled by the GP was expressed in 72%. In relation to the outcome variables satisfaction and consolation, regarding whether the patient had been able to say what was most important, the GP's understanding, and the occurrence of language problems, there were no connections. Among background variables as marital status, relatives in Sweden, educational level, professional status before and after immigration, different religions and cultures, no associations were found in relation to the outcome variables.

**Table 6.** Associations between satisfaction with the consultation, consolation given by the doctor and time from booking to consultation, self-reported health, symptoms and patient's experiences in numbers and percentages.

	Satisfaction with the consultation	Consolation given by the doctor
<b>Variable n (%)</b>	52 (100)	52 (100)
<b>Time from booking to consultation (days)</b>		
0–7	11 (85)	10 (77)
8–15	11 (92)	9 (75)
16–90	9 (64)	9 (64)
<b>Self-reported health</b>		
Very good/good/moderate	28 (93)	25 (83)
Poor/very poor	13 (68)	11 (58)
<b>Symptoms</b>		
Musculoskeletal	17 (74)	16 (70)
Circulatory	4 (67)	4 (67)
Psychic	7 (64)	6 (55)
Other	17 (77)	15 (68)
Multisymptoms	9 (56)	9 (56)

	<b>Satisfaction with the consultation</b>	<b>Consolation given by the doctor</b>
<b>Able to say what was most important</b>		
Yes	35 (83)	30 (71)
No	4 (67)	4 (67)
<b>Doctor understands the patient's problems</b>		
Yes	35 (88)	31 (78)
No	2 (100)	2 (100)
No idea	2 (40)	2 (40)
<b>Language difficulties during the consultation</b>		
Yes	20 (80)	16 (64)
No	19 (90)	18 (86)
<b>Respect for personality</b>		
Yes	36 (90)	32 (80)
No	3 (38)	2 (25)
<b>Respect for wishes</b>		
Yes	37 (90)	34 (83)
No	3 (50)	1 (17)
No idea	0 (0)	0 (0)
<b>Respect for culture</b>		
Yes	32 (97)	30 (91)
No	1 (17)	1 (17)
No idea	5 (63)	2 (25)

### **Open-ended questions**

Forty-three patients answered one or more of the open-ended questions. Communication problems were commented in patients' answers to the open-ended questions due to language and cultural differences between the GP and the patient, as well as the GP's ability to listen to the patient.

### **STUDY III**

Total number of respondents was 182, 52 patients, 65 GPs and 65 interpreters. In 40 consultations, there was a matched group of answers from patients, interpreters and GPs, who had participated in the same consultation.

## **Patients' backgrounds**

Patients' backgrounds including background variables and outcome variables are presented in "Results Study II". By using Fisher's exact test, I found that background facts for the patients, including demographic and migration-related factors (such as reasons for immigration, length of stay in Sweden and number of relatives in Sweden), health status and other factors related to the consultation, did not seem to be associated with the patient's satisfaction. With few exceptions, the P values were non-significant (respect for the patient's personality, respect for the patient's wishes and respect for the patient's culture).

## **Communication and experiences of the consultations**

Language difficulties were reported from nearly half of the patients; 18 of 40 matched consultations. Patients' abilities to say what was most important were answered positively of 34 patients and 37 interpreters (**Table 7**). All GPs answered that they had abilities to say what had been most important and 35 GPs thought that the patient had understood their viewpoints and advice. The majority of the patients (32 of 40) and of the interpreters (36 of 40) answered that the GP understood the patient's problems. Consultation time had been sufficient according to 36 of the interpreters, but only 25 of the GPs thought so. The patients answered positively that they were respected for culture (26 of 40), personality (32 of 40), and wishes (33 of 40). A majority of the interpreters answered also positively to these questions; namely patient respected for culture and personality (33 of 40), and for personality (38 of 40). Thirty three patients, 35 interpreters, and 34 GPs expressed that patients were satisfied with the consultation.

**Table 7.** Distribution of a number of different variables for patients, interpreters and GPs who participated in the same consultation (n=consultations).

<b>Variables</b>	<b>Patient (matched) (n = 40)</b>	<b>Interpreter (matched) (n = 40)</b>	<b>GP (matched) (n = 40)</b>
<b>Patient able to say what was most important</b>			
Yes	34	37	–
No	4	0	–
Don't know	0	2	–
<b>GP able to say what was most important</b>			
Yes	–	–	40
No	–	–	0
Don't know	–	–	0
<b>GP understands the patient's problems</b>			
Yes	32	36	–
No	1	2	–
Don't know	4	0	–
<b>Patient understands the viewpoints and advice</b>			
Yes	–	–	35
No	–	–	2
Don't know	–	–	3
<b>Consultation time sufficient</b>			
Yes	–	36	25
No	–	3	15
Don't know	–	0	0
<b>If patient was shown respect for his/her culture</b>			
Yes	26	33	–
No	5	2	–
Don't know	5	5	–
<b>If patient was shown respect for his/her personality</b>			
Yes	32	38	–
No	3	1	–
Don't know	2	1	–

Variables	Patient	Interpreter	GP
<b>If patient was shown respect for his/her wishes</b>			
Yes	33	38	–
No	3	1	–
Don't know	1	1	–
<b>If patient was satisfied with the consultation</b>			
Yes	33	35	34
No	6	4	1
Don't know	0	1	5

Of the open ended questions, 43 patients, 36 interpreters, and 31 GPs of all participants (n=182) answered at least one question and/or made comments at the end of the questionnaire. These answers and comments will be described under different themes in next paragraph.

### **Interpretation and consultation time**

Language difficulties were reported by 25 of 52 patients despite the presence of an interpreter. On the other hand, nearly all the interpreters were satisfied with their interpretations, where their intentions were to interpret in a neutral and correct way. Concerning consultation time, a majority of the interpreters answered that it had been enough, but stressed the need for it, in contrast to the GPs. They expressed that consultation time often is insufficient in relation to the patients' problems, and pointed out the need for professional interpreters. However, all GPs also reported that they had been able to say what was most important for them.

### **A patient-tailored approach**

The importance of listening to the patients including encouraging them to discuss their problems was commented by the interpreters. GPs inability to listen to the patient could create communication problems. The importance of listening to the patient was expressed as a very important message to the GP. Information must be adjusted to the patients' level of education and wishes, not always culturally related, as one of the interpreters commented.

### **Respect for culture, personality and wishes**

The results indicated that patients' personality, wishes and cultural background are associated with the GPs' personality and his willingness to understand his patient. Different cultural frameworks and the need for respect for patients' cultures were commented as well of 65 GPs, 56 reported that patient and GP had different cultures, but added that this might have a negative effect on the communication in only a third of

consultations. The interpreter was reported as a bridge maker between two cultures. Despite different cultures, a majority of the GPs had experienced a personal connection with their patients (56 of 65 GPs). However, to meet the patients' expectations could be difficult due to different cultural frameworks.

### Patient's satisfaction

**(Table 8)** In 25 of 33 matched consultations where the patients reported **satisfaction**, both the interpreter and the GP experienced patients were satisfied. In two cases, the interpreters and the GPs reported patients were dissatisfied. In three cases interpreters expressed that patients were satisfied, but the GPs expressed the opposite; i.e. that the patients were dissatisfied. In another three cases three interpreters reported that the patients were dissatisfied, but the GPs reported that the patients were satisfied.

**Table 8.** Matched consultations\* in which the patient reported satisfaction (n = 33 of 40 total matched consultations).

Interpreter's opinion	GP's opinion	
	Patient dissatisfied	Patient satisfied
Patient dissatisfied	2	3
Patient satisfied	3	25

\*Matched consultations are consultations for which questionnaires were completed by all 3 participants (patient, interpreter, and GP).

**(Table 9)** In 6 of 33 matched consultations, i.e. in a very limited number of cases, patients expressed **dissatisfaction** with the consultation. In one of these cases, the GP agreed with that, but the interpreter expressed that the patient was satisfied. In another case the GP agreed with the opinion that the patient was dissatisfied, but the interpreter thought the patient was satisfied. In five cases, the patients expressed dissatisfaction, but interpreters and GP expressed that the patients were satisfied.

**Table 9.** Matched consultations\* in which the patient reported dissatisfaction (n = 6 of 40 total matched consultations).

Interpreter's opinion	GP's opinion	
	Patient dissatisfied	Patient satisfied
Patient dissatisfied	0	0
Patient satisfied	1	5

\*Matched consultations are consultations for which questionnaires were completed by all 3 participants (patient, interpreter, and GP).

Satisfaction with the PHCC in general was reported by 20 of the 52 patients and consolation provided by the GPs by 36 patients.

## Values, ethical conflicts and support

The interpreters reported that their values were rooted in humanism and some of them expressed that their values were more related to their profession. Ethical conflicts were rare. Only 4 of the 65 GPs and 1 of the 65 interpreters reported a conflict of values between the patient and the GP, despite the presence of cultural differences between the patient and the GP. In case of ethical conflicts, half of the interpreters reported that they have support when face with this kind of conflicts, either from the linguistic bureau or from interpreter colleagues. For the GPs, ethical support could be from colleagues, from a medical social worker, or from an interpreter. It was also expressed from some of the GPs that they wished to have a medical social worker and a family counselling bureau within the primary health care system.

## STUDY IV

When content analysis was made, six themes were generated from interviews of the three groups of informants; i.e. patients, interpreters, and GPs. I categorised them into two subject areas: the interpretation process (*the means of interpreting and means of informing*) and the meeting itself (*individual tailored approaches, consultation time, the patient's feelings regarding interpretation, and the role of family members*).

### Interpretation process

Two different components were found: linguistic and cultural interpretation. Linguistic interpretation included translation between two languages, as well as explicit explanation of medical terms, for example "migraine". In cultural interpretation the patient's cultural perspective was taken into account.

#### *Means of interpreting*

All three groups commented on means of interpreting, defined as either mere translation or communicating patients' wishes and feelings, with or without body language.

The majority of the patients felt that having a professional interpreter was important for a good patient-GP relationship. The interpreter's role included establishing trust and creating a good atmosphere during the consultation.

Some interpreters described different ways of interpreting; to translate every word precisely; to be neutral and not to disrupt the dialogue between the patient and the GP, while others elaborated on the difficulties when the GP did not know how to work with an interpreter.

The variation in the techniques used by different interpreters was commented by the GPs.

#### *Means of informing*

The means of informing include the importance of professional interpretation in both directions between the patient and the GP. To adjust the information to patients' culture

and level of knowledge about body functions were commented by the patients, as well as the importance of translating medical terms into everyday language. Both interpreter and GP in collaboration are responsible for this adaptation of language.

Information about patients' illnesses and prognoses must be adjusted to patients' cultural framework. In some cultures the family members are more informed than the patient, in an attempt to not let the patient lose the desire to live and struggle. The explanation behind not telling patients is often a wish to support them. This situation might become an ethical dilemma for the GP, since he/she is obliged by law (Hälsö- och sjukvårdslagen [1982:763]: 2 b §) to provide the patient individually compromised information about his disease, investigations, and treatment.

## **The meeting**

Participants in this study expressed that achieving a successful meeting between the patient and the GP during the consultation requires adaptation to the individual patient. They also mentioned consultation time, the patient's feelings, and the role of family members as important factors.

### *Individual tailored approach*

The importance of individual tailored approach was stressed by all three groups. This included for instance a kind response from the GP, a polite and respectful treatment and a focus on the patient as a whole person.

The majority of the interpreters pointed out that the GP's approach to the patient ought to be individual, including listening, patience, respect, and responding to the patient's needs and wishes. However, they added that in some cultures, patients are used to medical authority, and thus find decision sharing strange to deal with.

Mutual understanding with the patient, to see the patient as an individual, and to listen and try to determine the main reason for the consultation were reported from the GPs, as well as showing professionalism, respect for patients' autonomies, and to take into account patients' earlier experiences. Despite the presence of an interpreter one GP expressed that she gets better contact with the patient if she can speak directly with her patient.

### *Consultation time*

It takes time to establish good contact and a good relationship, as well as to exchange information between the patient and his GP through an interpreter, as the participants commented. Patients' expectations and needs of the consultation are important to fulfil. At the first visit there is a need to tell the GP about everything, to be properly examined and to be able to ask questions. Of the patients, three participants commented that the consultation time was insufficient. In agreement with this, seven interpreters felt that the consultation time was never sufficient. They may be frustrated since to establish a relationship with the patient when the GP is stressed will be difficult to accomplish. Respect for patients' needs of presenting their stories properly was stressed.

Also a majority of the GPs felt that it was desirable to have longer consultation times because the interpretation takes time. To adjust the information to match the patient's level of knowledge about the body and obtain knowledge about the association between symptoms and psychosocial factors takes time.

#### *The patient's feelings regarding interpretation*

To have a third person in the room may be stressful for the patient and give feelings of uncertainty and even frustration. Some patients and even interpreters expressed hesitation even if the interpretation is complete and correct. Half of the GPs commented patients' expectations to have a professional interpreter for an interpretation without any judgment.

#### *The role of family members*

All three groups commented on three different roles family members may assume during the consultation: taking over the interpreter's role, checking the interpretation, and supporting the patient. If a family member speaks Swedish, this may also provide a sense of security for the patient. To act as an interpreter in acute medical situations and to support the patient in their treatment are other important aspects of this role.

However, five interpreters expressed that family members may interfere during the communication and interpret incorrectly or provide incomplete information. This can create a dilemma for the interpreter to deal with sometimes. For example, in Sweden GPs must inform patients about cancer diagnose. The family members may choose not to tell the patient the whole truth.

All GPs commented on the importance that patients have confidence in the interpreter's professional confidentiality and their translation. If the family members know Swedish, they may be able to check the interpretation and support the patient. In other cases, patients' uncertainty may result in patients' refusals to have an interpreter.

Variations in the quality of the interpretation and the relationship between the patient and the GP can affect the outcome of the consultation, as illustrated in Figure 3.

**Figure 3.** Effects of the interpretation process and the quality of the patient-GP relationship on the success of a consultation.

(P = patient, IP = interpreter)

1.

Good interpretation (P+IP)	Yes*		Successful
Good patient-GP relationship (P+GP)	Yes**		consultation

\*GP10: *“A good interpreter who has extensive experience translates quickly; uses shorter sentences, not very long explanations ... without the medical content being compromised.”*

\*\*IP7: *“... the doctor’s trust towards his patients and patients’ confidence in their doctor ... it requires a great deal of patience on both sides ...”*

2.

Good interpretation (P+IP)	No***		Less successful
Good patient-GP relationship (P+GP)	Yes		consultation

\*\*\*P4: *“It has not gone well the times we have had an interpreter. The interpreter could not translate into Swedish.”*

3.

Good interpretation (P+IP)	Yes		Less successful
Good patient-GP relationship (P+GP)	No****		consultation

\*\*\*\* P4: *“If I see that the doctor does not understand, then I say that I can see that you don’t understand ... in that case I have to go to another doctor...”*

4.

Good interpretation (P+IP)	No*****		Unsuccessful
Good patient-GP relationship (P+GP)	No*****		consultation

\*\*\*\*\*IP7: *“... To give a fast interpretation and perhaps over-interpret ... due to be flexibility ... a tendency to make what patient says better or to over-interpret it...”*

\*\*\*\*\*GP5: *“... but is it the case when the interpretation is not working you lose the touch...”*

A successful consultation embraces good interpretation *and* a good meeting between patient and GP, and may therefore be defined as a real meeting and not just an encounter.

## EXPERIENCES, FEELINGS, AND STRATEGIES IN THE TRIANGULAR MEETING

The triangular meeting is a dynamic process between the patient, the interpreter, and the GP that influences the relationships and mutual understanding among the three participants and the outcome of the consultation (see Study IV). The overall goal of the triangular meeting is to have a satisfactory interpretation and meeting for all participants. All participants in the triangular meeting have their own perspectives. Moreover, circumstances vary, as do the ways people experience circumstances and the feelings they have as a result of these experiences. Therefore, different strategies may be needed for the three groups of informants during the consultation. Each strategy may be applicable during different phases of the meeting.

When content analysis was made, six themes common to the three groups of informants were found in two subject areas, namely: 1) themes that are related to the interpretation process (*the means of interpreting and means of informing*) and 2) themes that are related to the meeting itself (*individual tailored approaches, consultation time, the patient's feelings, and the role of family members*). Strategies for coping with experiences and feelings related to some theme therefore fell into the two following categories: 1) strategies related to interpretation process, and 2) strategies related to the meeting. However, other strategies not related directly to the themes but to the meeting categories emerged as well and will be presented below. These were grouped under: *structuring the consultation* and *gender effects*. General strategies for improvement of the triangular meeting were also commented from the participants in the study and are presented at the end of this chapter.

### Interpretation process

Two different components were identified in the interpretation process: linguistic and cultural interpretation. Linguistic interpretation includes both interpretation between two languages and interpretation of medical terms, for example “migraine”; i.e. translation and explanation. Cultural interpretation includes that the patient’s cultural perspective has been taken into account.

#### ***Means of interpreting*** (linguistic interpretation and cultural interpretation)

The means of interpreting includes both a verbal translation and an interpretation of patients’ wishes and feelings, with or without body language. The informants from all three groups commented on the different means of interpreting.

#### LINGUISTIC INTERPRETATION

##### **Repetitions/explanations/check questions**

Difficulties in understanding what is translated, despite the presence of an interpreter, may mean that the patient needs further explanation or repetition.

P 10: “*If I do not understand anything when an interpreter translates for me, then I say, ‘Yes, but I do not understand what you said. Can you explain or can you ask the doctor again?’*”

It is important that the interpreter has the same linguistic background as the patient to facilitate mutual understanding. One of the patients commented on what happens when the interpreter has a Kurdish or Assyrian background and the patient speaks Turkish.

P 10: “... when you get a Turkish interpreter with a Kurdish background. Then it gets a little difficult, or when you get a Turkish-speaking interpreter with an Assyrian background that has a different pronunciation, so then it’s like the interpreter understands like this, so it can be a little hard sometimes. But anyway, we understand each other, but we have to go back and forth ... I ask for an explanation or ask them to repeat the question through the interpreter...”

It is imperative that interpreters understand everything the GPs say. If they do not, then they ask the GP about the meaning of the words and expressions.

IP 9: “Maybe a word or if the doctor says some medical term I don’t understand, then I ask the doctor the question again: ‘what do you mean by that?’ Because as an interpreter, I have to understand what the doctor says to translate it...”

When GPs do not get the answers they are expecting from patients, they repeat the question or change it.

GP 1: “... when I don’t get an answer that’s really an answer to my question, then of course I have to repeat the question, and I usually modify the question ... I sometimes ask leading questions. Otherwise I’ll never get out of this...”

When the GPs do not understand what has been translated, they may wonder if the interpreter has translated everything and if the translation is correct.

GP 8: “... you don’t understand what the interpreter says, but sometimes you feel like the patient talks for a long time, many words, and then the interpreter only says something short. And sometimes ... some interpreters don’t seem to interpret everything the patient says, I think. I think some look like they think what the patient is saying is embarrassing ... the interpreter can think the patient has unreasonable expectations and then it seems like he doesn’t translate everything the patient says ... You have to ask the interpreter—did they say anything else?”

### **Selection/omission of words of different shades of meaning**

It is the interpreter’s prerogative to choose words with the same strength and shades of meaning in both languages when translating.

IP 10: “... you know how these cultures that these words, they’re translated as another word. If the meaning is stronger than what the person really intends, then that’s the power I have as an interpreter.”

### **Adaptation of language**

A reflection made by one of the GPs about professional interpretation was that a really good interpreter does not translate verbatim, but adapts the language somewhat.

GP 10: *“A good interpreter who has extensive experience translates quickly; uses shorter sentences, not very long explanations ... without the medical content being compromised.”*

### **Language competency**

Uncertainty about whether the interpretation is correct or not may pose problems for patients and GPs, for example that patient’s history is not complete. Some knowledge of Swedish may help patients check whether interpreters are interpreting correctly.

P 5: *“We don’t know whether the interpreter’s translation is exact, either, but I can understand a little Swedish, so I can tell if the interpreter is translating wrong ... or if she said everything.”*

### **Body language**

Body language and guessing are useful strategies; for example, when performing a physical examination.

GP 1: *“I have to rely on body language when I examine the patient’s abdomen ... you have to guess a little bit...”*

The GP may observe body language as a way of making sure the interpreter is not just making things up.

GP 3: *“... if the interpreter consistently sits and just makes things up ... I don’t believe that either ... anyway, you notice a lot from body language.”*

One strategy for improving communication is to use body language much more and point to different parts of the body.

GP 6: *“Yes I do that ... point body parts it becomes much more ... try to get my point across even without language ...”*

### **Choosing to use an interpreter**

Either the GP or the patient may request an interpreter. Patients may feel uncertainty regarding their command of the Swedish language and may therefore choose what they want to be translated or not.

IP 9: *“... it’s happened that patients or clients sometimes can speak Swedish. They know a little. They understand a little and sometimes they say ‘yeah, I understand’, and then they respond right to the doctor ... tell me when I need to interpret then and then I’ll tell the doctor, too ... Some can speak a little Swedish. They’re uncertain. They’re not sure they understand everything ... and then the patient has the right to say to me as the interpreter, ‘I don’t want you to interpret this’, and so I don’t interpret.”*

### **Bilingual GP**

Some patients prefer having bilingual doctors because it is easier to express their stories and feelings in their own language.

P 9: “... I ask for an Iranian doctor because I can explain in Persian and then they get how I feel.”

P 6: “... when I’ve had a Spanish doctor who speaks Spanish, if I don’t understand something, I usually ask ... and then he explains for me in detail ... I feel more comfortable because we speak the same language.”

Others feel it easier to tell their problems to a Swedish doctor.

P 5: “It’s also like this, that maybe you can’t explain to a Turkish-speaking doctor, but you can tell your problems to a Swedish doctor.”

## CULTURAL INTERPRETATION

### **Interpreter’s “cultural competence”**

Showing respect for both patient and GP is one of the features described by one interpreter to be part of what she called “cultural competence”. The interpreter emphasised the importance of using this technique which helps both the patient and the interpreter in their communication.

IP 4: “... I try to use my cultural competence, which I’ve developed really well ... here and now. In this meeting get ... achieve ... true communication even if it leads to conflict, but sometimes, for the most part, it doesn’t. Instead for the most part, patients are interested in getting better. And for the most part, doctors are interested in helping patients with this ... I try to be with my body, my culture and my respect, show respect for both of them so that they start to respect each other ... It’s catching, this respect thing.”

Sometimes when the patient has many different symptoms and has his own ideas about them, for instance, ways of expressing pain learned in childhood, the GP may guess and interpret bodily signals to better understand the patient.

GP 8: “They often come in for many things, not just one thing ... women from Turkey and Iran don’t have the same notions of how the body works as we do. They have ideas about things ... maybe they’ve learned that it works this way when they were children, like we learned from our mothers, that when you have pain, you say this ... I think it’s culturally conditioned ... you have to guess and read that. Find out in other ways ... simply how you interpret signals ... it depends on who takes care of the child.”

### **Adaptation of language**

Sometimes the interpreter does not interpret only what is said but what is meant as well, which the interpreter is not sure if he should do or not. Sometimes the patients and GPs may start to say something and then add something else.

IP 8: “... that I take into consideration on the first hand is the language from the doctor ... like not overinterpreting what they say and instead interpreting something else, something they actually mean, but don’t really say. It’s hard ... They start to say something and then they decided that I have to put something back. This is usually

*patients if you compare with doctors .... sometimes they start a sentence but don't finish ... you guess what they want to say ... You add words yourself and that's probably OK ... Really you're supposed to mirror ... the patient's language and speak in partial sentences ... to give the context. But that's the way most people say things, but this is what they really mean ... then you have to resist the temptation to keep going on and let the doctor use his questions and knowledge to make sense of it ... I've translated slips of the tongue ... Then I apologise or if I'm not sure I ask, did you say this or ... And then I translate it."*

### **Means of informing**

Professional interpretation is needed in both directions between the patient and the GP when giving information to the patient. The informants expressed the need to adjust the information to the patients' culture and their level of knowledge about body functions. It is also important to translate medical terms into everyday language.

## LINGUISTIC INTERPRETATION

### **Adaptation of language**

When providing information to patients, GPs sometimes have to adjust their language so the patients can understand. The information may be too difficult, and simplified language may therefore be needed. The interpreter helps the GP adapt or modify the way to convey the message or information both to the patient and even the relatives.

IP 2: *"Here we give so much information; so many times they don't really understand ... You might have to use the kind of language you'd use with a child. That's actually true for me when I interpret ... Sometimes I'm forced to say it. That this is ... he's not educated or she's educated ... the whole family comes and wants the information."*

One GP said that her strategy is to be very concise and choose her words more precisely.

GP 3: *"... when you're going through an interpreter you have to be really concise, you're actually a little abrupt, you choose your words."*

Other strategies for not stressing or worrying patients were also used as providing information in shorter bits eventually letting the interpreter explain, and making sure that the patient has understood which is important.

GP 9: *"... I use shorter segments. I speak in a special way ... so the interpreter can translate one sentence at a time ... Sometimes it's the case that you even, like, need the interpreter to explain, and that's good because then you understand, aha, they didn't really understand what I mean ... I subconsciously adjust my word choice a little. Sometimes, if it's a woman from the Turkish countryside, for example, I ... adjust and explain a little more simply. I don't go into details because I've noticed that then I just stress them. It gets too complicated and the risk is that they don't understand but just get upset by what I say. I think I just simplify."*

Another GP expressed interpretation in "a logical way." He repeats himself in an effort to become clearer and uses simpler language.

GP 6: “... what we say in Swedish doesn't have the same meaning in another language, and then you have to do a logical translation anyway ... I repeat a lot more and I think become a lot clearer. I think that's an advantage. I think I actually need to do that more even otherwise ... I use simpler language, clearer ... I think I try to explain more, maybe not more simply but I try to be clearer. I try to explain more thoroughly for some reason ...”

### **Extra information and explanations**

The need to provide information to the patient through an interpreter may give the GP the feeling of a need to give extra explanations, especially if the symptoms may be psychosomatic.

When the patient is given prescriptions and instructions, the interpreter may feel that the patient is uncertain and takes over the responsibility of providing extra information on how the medication should be taken.

IP 1: “... for example, the doctor says: ‘You should take the tablets.’ ... I try to explain to them ... They say, ‘Yes, I understood.’ ... they're not 100% sure ... they know that I'm a little suspicious ...”

It may also be important to check whether and how the patient has taken the medication during the follow-up visit.

IP 6: “When it comes to medications, maybe we need to ... give a little more information or check if the patient really took ... ask more. ‘Have you taken ...’”

The GP is satisfied after having asked several times the patient if everything is clear and ends the consultation with a summary.

GP 6: “Yes, we have an overall perspective, but ... we do something with the patient, we're satisfied when the patient leaves here. I am, anyway. Ask five times before I'm satisfied. Whether the patient understood ... the summary then comes at the end of the appointment.”

If the patient is afraid of the results, the interpreter tries to convey this to the doctor and that this patient needs more information or reassurance.

IP 6: “... If the patient is afraid of some results and if I am a good interpreter, I will try to at least get this across to the GP so he might understand that this is a patient who is ill, or believes himself to be ill and may need a bit more information or security.”

### **Correction of information provided**

The interpreter sometimes corrects information given to the patient by relatives who are present during the consultation.

IP 1: “... they, they receive information from everyone who ... is here ... aunts and I don't know what all ... They also want, they want to interpret ... I say that they for

*example interpret and say what they understood, but I, I say that's wrong and then I correct what they said."*

### **Follow-up visits**

One of the GPs reported that when an interpreter is present, he feels less secure in his understanding of the conversation than during other consultations. Such a feeling leads the GP to use more investigations and more follow-up visits.

GP 6: "*... I have more visits with interpreters than without interpreters where I sit and scratch my head afterward, and 'what's this really about' ... I don't really feel sure about what I'm dealing with ... that can lead to doing more tests. But I don't know if I do that.*"

### **The meeting**

Different strategies were suggested by the informants that contribute to a successful meeting between the patient and the GP. Some were related to the structure of the meeting, a patient-tailored approach, consultation time, the patient's feelings, the role of family members, and gender effects.

#### ***Structure of the consultation***

A medical consultation has different moments including to establish a good relationship with the patient and sometimes also with relatives. Due to limited consultation time; our informants stressed the need for a good structure of the consultation as well as different techniques on how to use an interpreter to insure that all moments are included.

#### **Structuring the consultation**

One GP explained that she uses a more structured interview format and keeps more structured records when she has patients with interpreters to ensure that the consultation stays within the allotted amount of time. She limits the number of problems discussed and books follow-up visits if needed.

GP 10: "*... when I use an interpreter, I have a more structured template for the consultation and try to keep to it strictly, because time is limited and patients often want to take up a lot of other things, and then I try to keep to what we're supposed to discuss that day. So you just have to book a new time if they want to discuss something else.*"

#### **Prioritising symptoms**

Another GP said that when one does not speak the same language as the patient, something disappears from the consultation. She added that language differences and time constraints make it difficult to achieve the deeper emotional contact that facilitates understanding.

GP 9: "*... something's lost a little bit. I think so. Absolutely. Language is still the most important tool we have ... Maybe that you try to ask more questions about the topic at hand, so to speak. That they just say that they have pain somewhere ... This is too*

*much. It's not reasonable that we can manage to talk about this. So I prioritise and I say so."*

### **Interruption**

In an attempt to structure the consultation the GP might need to use interruption as a strategy to limit the interference of relatives or when time becomes a stress factor especially when an interpreter is present.

*GP 7: "So it takes approximately more than twice as much time ... the doctor gets stressed, so it can be transferred to everyone. The interpreter gets stressed and we easily interrupt each other to keep on schedule. I interrupt."*

*GP 7: "... an Arabic-speaking man and his son were and they had an interpreter. Then suddenly the son and the interpreter start to talk with each other a lot and I say, 'Stop, stop! I have to participate. I'm the one who has to steer this conversation', and then the son apologised in Swedish afterwards because he spoke perfect Swedish. And he said that the interpreter translated totally incorrectly. 'I had to correct him.'"*

### **Limit the interpretative content**

When the consultation time is insufficient, the interpreter may adapt the strategy of interpreting only the most important parts of the patient's story and excluding details. Professional interpreters need imagination and presence in such situations.

*IP 6: "... Even if the doctor is under stress and doesn't want to hear everything the patient says in detail, or is not listening the whole time, the interpreter has to do what is needed. The brain isn't a factory for transforming words from one language to another. You need a lot of imagination and undivided presence to convey the intended message in the best way."*

### **Consultation time**

The need of sufficient consultation time was commented by all three groups for establishing good contact and a good relationship. Different strategies on how to use the interpreter were employed to ensure enough time for the consultation.

### **How to use an interpreter**

One of the interpreters explained that sometimes she has to give patients instructions on how to work with an interpreter.

*IP 2: "Those who are beginners, they haven't worked with an interpreter. They look at me. And you have to explain to look at each other; I'm a machine. And then they start to talk with me instead ... you should use the first person when you talk with the patient."*

A technique expressed by one of the GPs is to ignore the interpreter as a person and instead think of the interpreter as a voice in the room which is similar to using a telephone interpreter.

GP 3: “... ignore the interpreter and just have the interpreter as a voice in the room and make eye contact with the patient ... get used to not thinking of the interpreter as a person ... I choose my words in a different way ... I become more concise with language and ask very distinct questions... a telephone interpreter ... speaker phone where you just have a voice in the room and I actually think that it feels like that works better...”

Another GP described differences between interpreters. If the answer does not seem to match the question, he explains and clarifies the question itself.

GP 6: “You notice a real difference between interpreters ... some don’t interpret clearly ... they don’t say what I said ... If the answer comes back and there’s something wrong, the interpreter needs to repeat ... but then you get the feeling that it’s maybe a little that they are trying to help or trying to explain something the patient hasn’t understood, and I think I prefer ... when I get an answer that doesn’t make any sense I then can clarify my question myself. I think that feels better.”

One interpreter commented that when the patient mumbles course words, they do not need to translate them, unless the GP asks what the patient said. In that case, the interpreter would ask the patient for permission.

IP 10: “... used something that was rude and mumbled. Then I hear but I decide that no, this doesn’t need to be translated, unless the doctor we’re visiting asks, ‘What was that you said?’ ... Then I ask the same question again to give the patient another chance. ‘Do you want to say that? OK?’ And most, I can’t say all, decide not to.”

### **Follow-up visits**

When the reasons for booking an appointment do not match the patient’s actual problems, a new time booking will be required. The interpreter may take the initiative to ask for a new appointment.

IP 7: “... then we say to the doctor or to the nurse: ‘you would not be able to give a new time straight away, or be able to organise so that the patient can come back?’”

### **Patient-tailored approach**

Patient-tailored approach was defined here as the GP’s approach to the patient as individual, including listening, patience, respect, and responding to the patient’s ideas, concerns, and expectations.

### **GPs’ professionalism**

Many patients may want to feel that the GP is on their side. One GP commented that she has to act on the basis of the medical facts in the situation.

GP 7: “... Many patients like the idea that I should be on their side ... No matter how much I want to help you, I have to use the medical situation as the basis and act based on it.”

### **Book a new GP**

Mutual understanding between the patient and the GP is important in achieving well-functioning communication. If mutual understanding does not exist, the patient's strategy may be to book a new GP.

P 4: *"If I see that the doctor does not understand, then I say that I can see that you don't understand ... in that case I have to go to another doctor ..."*

If the patient is dissatisfied with his doctor, then the interpreter conveys the patient's wish to book a new doctor to the present GP.

IP 8: *"... if the patient is dissatisfied and maybe wants to switch doctors. It's happened a few times and feel poorly treated. Since I haven't seen the situation or the background to the patient's dissatisfaction, what, but in the end I have to translate the patient's wish to change doctors simply because, it doesn't, like, work ... I don't think that's strange. Because that right exists."*

### **The patient's feelings**

Patients may find it difficult to explain their feelings for a variety of reasons. For instance, using an interpreter, either in person or by phone, means that a third person is present in the consultation. This can cause feelings of stress, uncertainty, and frustration, including the worry that what one says to the GP is being judged.

### **Establish a relationship with the interpreter and the GP**

It seems important for the patient to feel security and trust with the interpreter and the GP. One strategy used by patients is meeting and talking with the interpreter before the consultation to give the interpreter an idea of his/her feelings and symptoms.

P 3: *"... talk with the interpreter before ... prepare him for the visit, reflect somehow my feelings and my complaints better ... start a little personal relationship ... achieve trust."*

### **Emotional contact**

Emotional contact is a strategy expressed by one patient who reported that the environment became favorable for communication when she could laugh together with the GP and the interpreter.

P 6: *"... the last time I met a doctor, I laughed with him during the conversation and the interpreter, too in a way, and we laughed together, and that gives an 'inter-communication,' you could call it a good environment, which was interactive between us."*

### **Interpreting using body language**

If a patient does not understand the GP's questions or acts like he/she does not want to be there, the interpreter may indicate this via his own body language.

IP 4: *"... I can try to let the doctor know that ... your interview, medical interview isn't working ... by taking on the same nonverbal attitude like I did now ... I mumbled"*

*instead of answering like many patients do to show that I don't want, I actually don't want to talk with you even though I'm sitting here ..."*

### **Choosing to use an interpreter**

To have a third person present during the consultation may be stressful for the patient and discussing personal or intimate issues can make the situation even more difficult. Patients can decide whether or not they want an interpreter.

P 9: *"I think that I myself explain my problems better than in front of an interpreter."*

### **Information about patients' feelings**

When the patient is upset during the consultation, one interpreter tells the GP how the patient feels before she begins to interpret.

IP 7: *"Then I say that the patient is upset and say, and so then I explain what the patient said."*

### **Interpreter defines his role**

The interpreter and his interpretation should be neutral, but the interpreter may adapt his voice to convey the patient's feelings, for instance if the patient is angry.

IP 4: *"... they have to solve this the way they want ... I can't interfere. I don't try to help the patient and prettify what the patient says and claims, and if the patient gets angry, I don't need to get angry, but I can use a bit of a different tone so that the doctor can understand that this patient is angry now."*

One interpreter reported that she does not think of herself as a judge or mediator. When patients have strong opinions and views, their body language speaks for itself and she does to need to say anything.

IP 10: *"... I'm not there as a judge or mediator or whatever, but naturally I'm a still a human ... it's said that an interpreter should work like a machine ... that doesn't have any feelings. That doesn't work ... body language that expresses powerful opinions; you don't need to say anything ... you don't need to interpret that ..."*

### **Interpreter as mediator**

Different strategies were suggested among which were: to mediate by putting end to yelling or angry words or consoling to avoid conflicts.

IP 2: *"... we're not allowed to interfere in anything. The only thing I could do, I could comfort her by saying, 'he's ignorant, there's not much you can do, you'll just get into a quarrel' ..."*

If the patient is screaming during an examination, the interpreter tries to help achieve calm in the room so the GP can try to solve the problems. The interpreter may attempt to create a good atmosphere to help and support the patient so the examination can be completed.

IP 7: “... if my patient yells a lot as soon as you palpate her a little during the exam, I usually try to be as calm as possible ‘to create a stone in the room’ so the doctor can give advice and try to get over this on her own ... maybe I can create this calm so that these people ... can meet and that the patient can also feel supported by me and for example allow herself to be examined.”

The interpreter may also try to calm the mood when needed, without interfering with how people behave.

IP 10: “... I can’t, like, interfere with how people act. Yes, of course I can try to soften and calm down, like, the mood ...”

### **Interpreter as supporter**

When the GP has to deliver bad news to the patient, support may be needed. If no relative is present, the interpreter may take this role.

IP 5: “... it has worked much better when they have a relative ... when there is no relative, then I go a little over my role as an interpreter ...”

### **Feeling of threat**

It can be a major problem if the doctor refuses a patient’s request for a prescription for painkillers or to be sick-listed. Patients can become aggressive in these situations and require follow-up visits with different GPs. One GP felt that, as the patient’s doctor, she ought to help them with their problems. A strategy reported by this GP was to reflect about what went wrong after the consultation and refer the patient to a colleague.

GP 9: “... sick listing is the hardest or when they want analgesics ... they get very insulted when I say that I won’t sick-list ... Verbally aggressive and sometimes in body language, too ... ‘you’re a doctor, you’re supposed to help me with this.’ They say it in a way that you feel, yes, I’m really inadequate. You always sit and think ... for most I have booked a follow-up visit with another doctor before they leave the health care centre.”

Another GP described that if she feels scared, it may adversely affect the meeting. Fear affects the clarity of her thinking. She may feel blocked and unable to continue the consultation in the way she otherwise would have done.

GP 9: “... you could say it’s a kind of fear that I think is always a tremendously negative precursor for going into a meeting ... I think you can’t really think clearly. I think that I can even become blocked, when confronted with certain things. And I’ve even felt really threatened, then I actually refused to meet those patients again ... If you’re afraid ... you’re not a good doctor. You have to feel relaxed and somehow open, and I don’t if I’m afraid. Then I’m blocked and stymied both in thought and action ... It’s the exception, actually ...”

### **Management of anxiety by regular visits**

One GP said that she has many patients who want to come to the primary health care centre regularly, according to a schedule, where she helps them cope with anxiety.

GP 8: “... many patients who come regularly ... it’s a kind of anxiety that you need to take care of and help them control. So it worked for a bit and then they came back. And many of these patients came a lot before we made this schedule. They don’t any more ... we have regular times ...”

If the GP is dissatisfied or if the patient is dissatisfied with the GP and/or the diagnosis, the doctor suggests another doctor and might talk with the head of the primary health care centre.

GP 2: “If I’m not satisfied I usually do like this: I try to book a new visit or book a new interpreter if the problem is related to the interpreter. If the patient is not satisfied with the visit or with my assessment, I try to explain to them that ... Yes, is my evaluation of this case – if you are not satisfied with the consultation, you may book a new appointment with another doctor ... I also talk with the head of the centre.”

### **Shorter or longer consultation time**

Reducing contact with PHCC is one strategy used by the patient when he is not satisfied by the meeting.

P 9: “This doctor did not treat me nicely and was in a hurry ... Then I try to contact them less. Then I only call and tell about my husband and then I ask for some medicine over the phone...”

### **The role of family members**

Informants from the three groups commented that family members and relatives may assume different roles in the consultation such as interpreter, supporter, and controller of accuracy.

### **Interpreter**

Asking relatives to help with interpreting is used as a strategy when a patient and a GP do not understand each other and communication does not work, especially if the interpreter does not appear to the consultation.

P 10: “If the interpreter does not show up. I try to tell my doctor myself... If we don’t understand each other and communication isn’t good, then I or the doctor usually phones my son, who helps.”

Using relatives during acute or emergency medical consultations when an interpreter is not available is a rather common strategy.

P 5: “... when we make an appointment in an acute situation and no interpreter is available ... then either my daughter or someone else from the family who knows Swedish accompanies me and helps to interpret ...”

If the patient speaks a dialect that the interpreter does not know, it may be necessary for a relative act as an interpretation between the interpreter and the patient.

P 10: “... they order an interpreter, and instead my daughter has to go in and translate for me, then I answer, and the interpreter interprets back again.”

Five interpreters felt that relatives may interfere by interpreting incorrectly or providing incomplete information. Both the GP and the interpreter sometimes face certain moral as well as legal dilemmas, as delivering a cancer diagnosis is a situation where some relatives may choose not to tell the patient the whole truth.

IP 2: “... In Sweden, the doctor tells the patient directly that he has got cancer. But we do not do that in our countries. It is a difficult situation for an interpreter. We have to tell the patient what you see ... one tells the relatives and they explain gradually for the patient. Especially elderly patients ... they may lose the desire to live and do not struggle anymore.”

All GPs commented on the roles of relatives. Some patients may refuse to have an interpreter because they are concerned about confidentiality. Family engagement becomes an important resource.

GP 10: “... the patients do not always have confidence in the interpreter’s translation. In that case, it may be nice to have a relative in the situation with them.”

### **Supporter**

After the consultation, the patient may be uncertain and afraid of taking medications correctly. A strategy is that the patient asks a relative to contact the PHCC.

P 7: “I feel a little fear afterward ... If I haven’t understood correctly... I take it the right way or not ... if I forget, then I turn to my son. If my son can’t, then he calls here and asks.”

IP 1: “Patients say ‘my son will help me’ or ‘my daughter will help me’.”

### **Controller of accuracy**

The patient may also feel fear and uncertainty that something may go wrong during the medical investigation—for example regarding the assessment about the need for an operation.

P 8: “When the interpreter said I would have another operation, then I got scared and started to cry, because I’d already had an operation ... So my daughter told the doctor the interpreter translated wrong.”

### **Gender effects**

In some cultures, it is important for patients to have GPs and interpreters of their own sex.

### **Sex of patients, interpreters, and GPs**

Five female patients described their need to have a female interpreter when intimate issues were to be discussed or during physical examinations while two female patients mentioned preference for a GP of the same sex.

P 7: *“It is much easier to speak through a female interpreter, especially if one needs to undress. If there is a male interpreter, it is of course rather difficult to do.”*

Five GPs felt the need to have a female interpreter for female patients, especially during examinations.

GP 7: *“Female patients cannot take off their clothes in front of a male interpreter, and therefore the possibility of good communication with the patient vanishes ...”*

Four of the interpreters made comments similar to those of the patients. They commented that for women with gynaecological disorders and men with urological disorders, it is preferable that the GP's sex matches that of the patient.

IP 3: *“... in particular if they go to a gynecologist ... they prefer a female interpreter ... urologist ... they prefer a male interpreter or if they are talking about, yes impotence problems ... 90% of the patients prefer female doctors but often their men, I would not say demand, but prefer that their wives are examined by a female doctor ...”*

### **Parts of medical history omitted**

If the GP is of the opposite sex, the patient may not give a complete medical history and may not say everything they otherwise would have said.

P 5: *“If it's a male Turkish doctor, maybe we can't explain all our problems, but if it's a female Turkish-speaking doctor, we would tell her everything.”*

### **Leave the room**

It is common for male interpreters to leave the room during examinations of female patients and afterwards return and continue the interpretation after the examination.

P 8: *“Male interpreters usually go out ... I have the exam and the interpreter comes in and then the doctor explains to the interpreters and the interpreter translates.”*

### **General strategies for improvement of the triangular consultation**

Informants from all three categories commented and made reflections about improvements for the triangular meeting concerning information and prescriptions for instance, and interpreter continuity. Some of the other strategies are already mentioned above, as follow-up visits and sufficient consultation time for getting a higher degree of continuity; i.e. to have the same GP the whole time. Interpreter continuity is also important for the patient's feelings of security.

### **Written information**

Patients may need written information in their own language, which makes it easier and guarantees that everyone receives the same message.

IP 5: *“... Perhaps written information would be easier, since everyone will get the same information. They have the right to read it.”*

One GP was of the opinion that it would be better for the patient to read the information in their native language than to hear it translated orally.

GP 2: *“... read this information in a language you understand ... yes I think that you understand better than getting the information from, from a translator or someone else.”*

### **Paper prescriptions**

Today most prescriptions are sent to the pharmacy electronically. Patients are told that their prescriptions have been sent electronically, but one interpreter said it would be better if the patient was given a paper prescription.

IP 6: *“... hand the prescription to the patient.”*

### **Interpreter competency and continuity**

One of the patients said she wanted to have a more competent interpreter and the same interpreter every time.

P 8: *“... I'd like it to go better ... better interpreter ... same interpreter every time.”*

One GP expressed the wish that interpreters would receive medical training, as she otherwise has to explain some words and sometimes there are no words, for example The Swedish Social Insurance Agency.

GP 7: *“... that they'd received training in medical interpretation. Many of them ask me for words. What does that mean, and I have to explain to them. Sometimes there aren't words ... for instance 'The Swedish Social Insurance Agency'.”*

### **Cultural awareness**

One GP expressed a desire to learn about different cultures to cultural adapt her behaviour.

GP 1: *“... courses or lectures where you can learn how to act when you have patients from different cultures.”*

### **Medical social workers, counselors, and psychologists**

If the patient has poor knowledge of the body, a medical social worker or a psychologist could support their knowledge.

GP 7: *“... sum of all the symptoms was constant ... moved a little, whereupon we investigated ... medical social workers or maybe psychologists could talk about understanding the body ... it's based on lack of knowledge. On the one hand they ... plenty of time ... acquaintances and friends ... it's both good and bad.”*

**Table 10.** Strategies used by patients, interpreters and GPs to deal with feelings of uncertainty or frustration.

<b>Strategies used by patients, interpreters and GPs to deal with feelings of uncertainty or frustration</b>		
	<b>Uncertainty</b>	<b>Frustration</b>
<b>Patient</b>	<ul style="list-style-type: none"> <li>- control interpretation</li> <li>- getting to know IP/GP</li> </ul>	<ul style="list-style-type: none"> <li>- bilingual GP</li> <li>- relatives</li> </ul>
<b>Interpreter</b>	<ul style="list-style-type: none"> <li>- check questions</li> <li>- adaptation of interpretation</li> <li>- simplify words</li> </ul>	<ul style="list-style-type: none"> <li>- go beyond the role</li> <li>- cultural interpretation</li> <li>- empty container</li> </ul>
<b>GP</b>	<ul style="list-style-type: none"> <li>- investigations</li> <li>- follow-up visits</li> <li>- body language</li> <li>- consultation time</li> <li>- GP continuity</li> <li>- interrupt/lead conversation</li> <li>- IP continuity</li> </ul>	<ul style="list-style-type: none"> <li>- priority</li> <li>- medical role</li> <li>- IP continuity</li> </ul>

**Table 11.** Patients' experiences, feelings and strategies during the consultation.

<b>Patients' experiences, feelings and strategies during the consultation</b>	
<b>Experiences and feelings</b>	<b>Strategies</b>
not knowing language	language course
uncertainty if correct interpretation	controlling
misinterpretation	call daughter
difficulties express feelings	speaking yourself
	Iranian GP
	trust IP
difficulties to understand	explanations
uncomfortable	Spanish GP
lack of understanding	new GP
insecurity	get to know the IP/the GP
do not tell secrets	no IP
dissatisfaction	call PHCC
lack of interpreter	try yourself/son
desorientation	no strategy
without trust	"
need of integrity	"
self confidence	"
security	"
frustration	"
barrier	"
a feeling of being hindered	"
frightened	"
embarrassed	"
stress	"
a feeling of shame	"
lack of confidence	"

**Table 12.** Interpreters' experiences, feelings and strategies during the consultation.

<b>Interpreters' experiences, feelings and strategies during the consultation</b>	
<b>Experiences and feelings</b>	<b>Strategies</b>
get caught up, tears	need to empty emotional container
ignorant dr./ uncomprehending pat	comfort patient
family crisis	console the relatives
dr. needs consolation	console dr.
gynecological examination	become invisible
patient afraid	hold patient's hand
in need of mentoring	colleagues/friends
patient does not understand doctor's questions	indicate through body language/ voice quality
patient angry	different tone
lack of communication between doctor and patient	act with extra respect in hope that the others will copy this behaviour/ use cultural competence
patient unwilling to take medicine	explain afterwards the reason for the ordination
patient uses the wrong word	add words to translation for doctor
patient worried	create calm
patient upset	inform dr., create calm, soften words and tone/ refrain from mimicking patient's body language, tone, etc.
dissatisfied patient	translate patient's requests
need to explain to dr.	cultural interpretation/
interpret patient's feelings	IP's authority to control the conversation by using voice, facial expression, and choosing words
doctor's need of help for understanding the patient	avoid looking into the doctor's eyes/ show with hands
need to interpret the patient's role	voice and body language
need for speed	over-interpret, embellish
slip of the tongue translated	apologise and/or ask and answer questions
incorrect interpretation	translate in detail
IP doesn't understand	ask the GP
too few or too many words	to make a conclusion of what has been said
patient has too many problems to cover in the allotted time	assist in booking [alt. arranging] new time
dr. has not recognised that patient feels fear	convey to dr. patient has fear/ increased information

<b>Interpreters' experiences, feelings and strategies during the consultation</b>	
<b>Experiences and feelings</b>	<b>Strategies</b>
no rapport between the patient and the dr.	help each other
patient feels strong emotions	mirror the doctor's attitude
patient may not understand information	use child-level language, inform dr.
the word "cancer"	use "dangerous" instead as an euphemism
difficult words	explain one word at a time
relative notices an error in interpretation	correct the interpretation
bad news for patient	step outside interpreter's role and support the patient
doctor late	not present all time/
	only provide and interpret absolutely necessary information
instructions for drugs	explain to patient
convey the intended message	use imagination and be truly present
experience extra load	no strategy
experience stress	"
experience frustration	"
accountable for	"
sit on pins and needles	"
feel that quality of work is worse	"

Table 13. General practitioners' experiences, feelings and strategies during the consultation.

<b>General practitioners' experiences, feelings and strategies during the consultation</b>	
<b>Experiences and feelings</b>	<b>Strategies</b>
uncertainty	more investigations/ more visits/ longer time/ continuity/ experience
unsatisfaction, frustration	medical role
discomfort, inconvenience	IP continuity
flat visits, no body language	body language
obstacles not knowing if you can trust the IP	IP continuity
a feeling of safety	correct interpretation/ information about secrecy
uncertainty in the use of relative interpreters	professional IPs interrupt/ tighten the conversation/ IP continuity
misinterpretation/ no IP unpleasant	question everything properly translated
lack of time/many issues	limit the number of issues/ prioritise/longer time/ structured file template
different opinions and beliefs	isolate from the given treatment/ compromise
uncertainty about expectations about the role	cultural information
frustration/ anger to go beyond its mandate	limitation, the medical role
inability to understand the patient completely	learning about different cultures
uncertainty about giving advice	language concordant GP
time constraints, stress	interruption/ extensions of time follow-up visits
difficulty obtaining proper case history	repeat/modify the question/ leading question/ control question/ conclusion
examination	body language/ guesses
GP dissatisfied	follow-up visits/

General practitioners' experiences, feelings and strategies during the consultation	
Experiences and feelings	Strategies
	another IP/
	another GP
patient dissatisfied	information to head of PHCC
conversation technology	concise, short spoken, choose words/
	neglect IP/
	phone interpretation
uncertainty about interpretation	read body language
non-compliance/rough treatment	control/
	more follow-up visits/
	more explanations
lack of communication	clarify
lack of information	pictures
question and answers do not match	explain and clarify the issue
language has not the same meaning	clearer language/
	repetition/
	explanations/
	point to body parts
risk to get away from the disorder	controlling the conversation
facilitate communication	get to know the IP/
	IP continuity
difficult to interpret the symptoms	guess and read
bad response prior to the visit	please/kindness
create safety information gone forward	shorter sections/
	explanations to IP/
	simplify information/no details/
	logic interpretation
excited/scared patient	promise investigations
misunderstanding	rebook with another IP
difficult, barriers, takes time	general experience
patient's desire to have GP on his side	medical term
patient's aggressiveness for medicine and sickness certification	help on problem/
	reflections/
	follow-up visit to another GP
uncertainty if communication satisfying	learning by time
compliance problems	ordinate/control/motivate
observed	no strategy
do not work as well	"
wonder	"
utilised, irritated, feels wrong	"
overcome differences	"
not the same expectations	"

<b>General practitioners' experiences, feelings and strategies during the consultation</b>	
<b>Experiences and feelings</b>	<b>Strategies</b>
comfortable with/trust	no strategy
the stress, be stressed	"
difficult psychic issues/trauma	"
body veil makes it difficult to interpret body language	"
irritation, feeling of being utilised	"
patient unrealistic expectations about certification	"
cultural conflicts concerning ordinations	"
limitations for the mission difficult	"
a feeling of fear/blocking/threatened	"
wrong sex troublesome	"
difficult to justify for preventive advice	"
difficulties with explanations	"

# DISCUSSION

## GENERAL CONSIDERATIONS ON THE RESULTS

**Study I** examined whether there is any association between ethnicity and poor SRH and further explored the importance of mediators such as acculturation and discrimination. The null hypothesis – that ethnicity is not associated with SRH – was rejected. However, SES could not completely explain the relationship between ethnicity and SRH. This means that my second hypothesis – that SES could fully explain the relationship between ethnicity and poor SRH – could not be confirmed. The third hypothesis – that poor acculturation and discrimination explain the association between ethnicity and poor SRH – proved to be right. Thus, I conclude that besides SES, acculturation and discrimination are two important mediators in the pathway between ethnicity and SRH.

### Comparing the findings in study I with other studies

When analysing the results, I found that the big differences in the risk of poor SRH between the different SES groups in both sexes could be explained by poor acculturation. My finding of a relationship between ethnicity and poor SRH is in congruence with studies from four countries: the United States (Ren and Amick, 1996), Sweden (Sundquist, 1995; Lindström et al., 2001), the Netherlands (Reijneveld, 1998) and Israel (Baron-Epel and Kaplan, 2001). In Swedish (Lindström et al., 2001) and Dutch (Reijneveld, 1998) studies it was also found that SES explained only a part of the association between ethnicity and poor SRH. Acculturation was shown to be related to health status and use of health care services (Sundquist and Winkleby, 1999). As a proxy for acculturation I used knowledge of Swedish, but the concept of acculturation is more complex than that. The reasons for the increased risk of poor SRH in Turkish-born men and women and Iranian-born men were low SES and low acculturation. The high risk of poor SRH in Iranian-born women was explained by low SES, poor acculturation and discrimination. Thus, acculturation and discrimination are in the pathway between ethnicity and poor SRH.

I also found that Iranian men commonly felt they were discriminated against, in spite of good knowledge of Swedish. One can speculate that they are highly educated but have problems gaining employment that matches their education. Polish women probably face the same problem and also have good knowledge of Swedish. This is in contrast to Turkish women, who felt discriminated against, probably due to that they have a low level of Swedish knowledge.

Poor health among Turks and Iranians in this study is probably explained to a limited extent by genetic and biological factors. In addition, the “healthy migrant effect”, according to which people who immigrate to another country are generally healthier than those who do not emigrate from their native country, tends to wear off over time (Williams, 1993).

**Study II** examined whether patients' satisfaction with consultations and the feeling of consolation given by the GP are associated with demographic and migration-related factors, time from booking to consultation, SRH, symptoms and the patients' experiences of the consultations.

My principal findings in the quantitative part of study II were that demographic and migration-related factors were not related to the outcome variables satisfaction and consolation given by the GP. Time from booking to consultation, SRH, different symptoms and patients' experiences, including their personality, wishes and culture being respected, were not related to the outcome variables either. The respondents needed interpreter assistance in spite of the fact that they had been residents in Sweden for a rather long time. An explanation for this may be that speaking Swedish at home was not very common and the level of education was rather low. The sample size was small and the non-response rate was high. Therefore, the results should be interpreted with caution.

### **Comparison of the findings of study II with the findings of other studies**

Patients' satisfaction has been found to differ according to whether or not their expectations of the consultation have been met for understanding and whether they received explanations and emotional support (Zebiene et al., 2004). In a study from the USA, Murray-García et al. found significant differences by race and ethnicity in levels of patient satisfaction because of variation in patient perceptions, expectations and/or questionnaire response style, and differences in quality of care (Murray-García et al., 2000). Elsewhere, Liu et al. found that Chinese Canadians were less satisfied with physicians than white Canadians (Liu et al., 2007). Limited English proficiency and short length of residence in Canada were risk factors for lower satisfaction (Liu et al., 2007).

### **Communication and cultural competence**

Despite the presence of an interpreter, many patients reported language and cultural differences and difficulties. The interpreter's role in bridging these differences was emphasised. A review by Brach et al. (Brach and Fraser, 2000) found evidence in the literature of increased patient satisfaction when interpreter services were used, and identified interpreter services as one of nine major cultural competency techniques (Brach and Fraser, 2000). Using cultural competence techniques can change both physicians' and patients' behaviour not only by improving communication, but also by increasing trust, and improving knowledge and understanding of patients' cultural behaviours and environments (Brach and Fraser, 2000).

Baker et al. also found that use of an ad hoc interpreter resulted in lower patient satisfaction ratings than having a language-concordant physician (Baker et al., 1998). If no professional interpreter was available, using an ad hoc interpreter was better and resulted in higher patient satisfaction than not using an interpreter at all (Baker et al., 1998).

In my study, patients attributed misunderstandings to inability to either explain or communicate their problems despite the presence of a professional interpreter. One patient said: *"I doubt that my problems are well conveyed"*.

### Patient-centred communication

Eighty-five percent of the patients reported that the GPs seemed to understand their problems. However, some patients described the GP's inability to listen to them. There is a need for sensitivity for listening to the underlying reasons for patients' symptoms. One patient expressed it thus: *"It is important that the doctor will be able to listen to and understand what I tell him"*. The GP's willingness to understand and his/her personality seemed to be associated with patients' feelings of having been respected in terms of their personality, desires and cultural background. Narrigan et al. found that patients' independence might be difficult to maintain if respect and deference are required from the patient's side in a culture that values a social hierarchy (Narrigan, 2004).

A patient-centred approach requires sufficient time for patients to express their symptoms from their perspective, with an interpreter being needed for better medical outcomes (Rivadeneira et al., 2000). In one study in the USA in which patients' and physicians' opinions about the importance of different factors for quality of care were evaluated, both groups reported that clinical skills were the most important factor. However, while patients reported that delivery of health-related information was the second most important factor for their satisfaction, physicians only rated it the sixth most important factor (Laine et al., 1996). Therefore, sufficient time is needed and patients should be partners during the medical dialogue and not merely reporters of symptoms. Many studies have shown that a patient-centred approach may have a positive impact on patient satisfaction (Lewin et al., 2001; Hornsten et al., 2005).

Different perceptions of problems encountered by patients and staff were reported in a study from Sweden on immigrant patients with diabetes. The patients wanted to be understood with regard to their own perceptions of the problems relating to living with diabetes, while the health care staff felt that language and cultural differences were the primary reasons for non-adherence (Saleh-Stattin, 2001). It is important to understand self-care practices and care-seeking behaviours in cultural and religious contexts (Hjelm et al., 2003).

With regard to the promotion of health, the patients in my study stressed the importance of family, the ability to visit their country of origin and exercise. One patient wrote: *"...to feel usefulness and experience happiness in life"*. Emami et al. found that elderly Iranian immigrants perceived health as a sense of well-being, continuity and balance in life (Emami et al., 2000). They concluded that reflections on meanings of health can be interpreted as cultural understanding of health. In another study, they presented "a socio-cultural health model for late-in-life immigrants" by analysing ways in which Iranian immigrants perceive, experience and explain their health situations (Emami et al., 2001). Perhaps there is a need for more cultural competence and more "culturally sensitive care" (Emami et al., 2000).

**Study III** examined whether patients' satisfaction with the consultation is influenced by respect for patients' culture, personality and wishes, and whether interpreters or GPs experience any ethical conflicts during consultations. Furthermore, the aim was to describe some aspects of each of the three perspectives in the triangular meeting between immigrant patients, interpreters and GPs, including their experiences of, reflections on and interactions during consultations in primary health care.

The main findings of study III were that communication difficulties may even exist when interpreters are used. Reasons for these difficulties may include technical problems, insufficient consultation time, difficulties in expressing patients' problems or explaining medical terms, and problems in the relationships between patients, interpreters and GPs.

### **Comparison of the findings of study III to the findings of other studies**

Previous research indicates that professional interpreters are preferable to other interpreters and have positive effects on communication, increase comprehension, reduce errors and improve use of clinical services, clinical outcomes and satisfaction with care (Karliner et al., 2007). They can also increase delivery of health care to patients who speak limited English (Jacobs et al., 2001; Jacobs et al., 2004). However, my data do not provide evidence that authorised interpreters are preferable. Studies have shown that relatives and friends are not always ideal interpreters (Laws et al., 2004). "Role exchange" has been defined by Laws et al. as "any occurrence in which the interpreter performs a speech act which does not consist of interpretation and is not evidently intended to further or facilitate interpretation". Role exchange was found to be associated with a higher rate of errors, of which omission was the most common (Laws et al., 2004). The interpreter's role is to be an observer of the interaction between the patient and the GP, to be a participant in the relationship, and to translate important information. It is important to not take over the interviewing role, nor project feelings onto the patient or advocate for the family's interest (Laws et al., 2004). However, while the use of relatives, children or ad hoc interpreters is sometimes necessary and can be informative, in general it is standard practice to use professional interpreters.

Consultation time must be sufficient since interpretation takes time. Interpreted consultations involve special elements. For instance, the GP has to repeatedly check that the patient has not misunderstood anything. In a time-motion study by Tocher et al. (Tocher and Larson, 1999), physicians spent nearly the same amount of time with English-speaking patients as with non-English-speaking patients during 5 months of observation (25.8 vs. 26.0 minutes). Physicians' perceptions of time use were also measured (Tocher and Larson, 1999). Physicians thought that they had spent more time providing care to non-English-speaking patients than they actually had. The researchers concluded that reasons for this were "the challenges of language and cultural barriers" (Tocher and Larson, 1999).

My results support the use of a patient-centred strategy. Perron et al. emphasised the need to strengthen GPs' general communication skills, including the ability to identify patients' expectations, before more specific cross-cultural communication training is provided (Perron et al., 2003). Wachtler et al. found that GPs perceive consultations as

meetings between individuals, where cultural differences are only one of many kinds of individual factors that influence the communication (Wachtler et al., 2006). It is important for GPs to understand the meaning of patients' behaviours and ideas (including conceptions of health and illness) within their cultural context. One of my findings was that patients reported that they were shown respect for their culture. I would like to stress the importance of cultural sensitivity and awareness of patients' needs for well-functioning communication. The definition of cultural competence includes health professionals' ability to function effectively "within the context of the cultural beliefs, behaviours, and needs presented by consumers and their communities" (Howard et al., 2001). Fernandez et al. found that physicians' self-rated language ability and cultural competence were associated with elicitation of/responsiveness to patients' problems and concerns, explanations of conditions and patient empowerment in the primary care of Spanish-speaking patients in the USA (Fernandez et al., 2004). A patient-reported measure of physicians' cultural competence was developed and validated by Thom et al. It provides information about associations between cultural competence and health care outcomes (e.g. decreases in blood pressure among hypertensive patients) (Thom and Tirado, 2006).

In terms of ethical conflicts, informants expressed a need for psychological support and/or conflict resolution. Ethical guidelines for health care staff, including interpreters and GPs, are important, but must be interpreted in relation to the actual situation and cultural context.

**Study IV** was conducted to gain insights into the participants' perceptions of and reflections on the triangular meeting by means of in-depth interviews with immigrant patients, interpreters and GPs.

The main findings from the interviews of immigrant patients, interpreters and GPs were that the dynamics of the triangular meeting influence the patient-physician relationship and therefore also mutual understanding. To achieve a successful consultation in which all three parties are satisfied there was a need for both good interpretation and a good patient-GP relationship, in congruence with the international literature (van Wieringen et al., 2002).

### **Comparison of the findings of study IV with the results of other studies**

Achieving good interpretation may necessitate the use of a professional interpreter. GPs may ask for one if the communication does not work. Patients may also ask for an interpreter. In a previous study, the possibility of communicating through an interpreter was found to be related to patient satisfaction (Baker et al., 1998). Despite that, patients may find using an interpreter frustrating and may sometimes feel uncertain as to whether the interpretation of information in both directions is correct or not. Patients may also feel uncertain about the interpreter's professional confidentiality, even when they have been given information and assured about it. It is important for the patient's trust in the interpreter and trust in the interpreter's confidentiality to listen to their wishes concerning the interpreter's behaviour, including respect and professional attitude (Hadziabdic et al., 2009). In general, it is therefore standard practice to use professional interpreters, which may increase patient satisfaction and improve medical

outcomes. Access to a well-functioning interpreter services organisation offering professional interpreters is needed to ensure that care is cost-effective and of high quality (Hadziabdic et al., 2010).

My results also indicate that by using family members as interpreters, the GP can obtain valuable additional information, which can facilitate the consultation and help to establish a relationship with the whole family. Family members' engagement and language skills may be important resources (Rosenberg et al., 2007b). As the three parties commented during the interviews, family members assume different roles in the consultation: taking over the interpreter's role, checking the interpretation, and supporting the patient. They may take the role of a regulator to ensure correct interpretation when the patient is uncertain about the interpretation quality. Another role of family interpreters is care-giving. They may have their own agendas and GPs may treat them as caregivers and partners, the result being that they may not act according to official rules for interpretation (Rosenberg et al., 2007b). More interpreter errors of clinical significance occur when "untrained ad hoc interpreters" are used (Flores, 2005). These errors can include incorrect or inadequate interpretation of the medical history (Flores, 2003). This may leave GPs uncertain as to whether information has been lost or mistakes made.

The need to use a professional interpreter is also important for enhancing the patient-care provider relationship and patient-centredness (Rivadeneira et al., 2000). The definition of a patient-centred approach includes an exploration of the patient's main reason for the visit, concerns, and need for information (Stewart, 2001). It seeks an integrated understanding of the patient's world – his/her whole being, emotional needs and life issues. It enhances the continuing relationship between the patient and the health care provider and helps them to identify the problem and take decisions together (Stewart et al., 2000). My study highlights the importance of a patient-centred approach for supporting patient self-management, including increased patient participation in discussing and setting goals for treatment. This is in agreement with studies by Lewin et al. (Lewin et al., 2001) and Kinnersley et al. (Kinnersley et al., 1999).

My participants also expressed the importance of awareness of the patient's cultural views, in accordance with a previous study by Harmsen et al. (Harmsen et al., 2008). This is particularly important when the patient has more or less adapted to their new culture socially and psychologically. To achieve more patient-centred care and respond to patients' preferences and goals, there is a need for cultural competence at two different levels: the interpersonal level (during the consultation) and the health care system level (Saha et al., 2008).

Another finding of the study was the need for sufficient consultation time to introduce a third person to the communication and to establish trust. It is important also for obtaining a correct and complete medical history and for adopting a patient-centred approach in which decision-making is shared.

## METHODOLOGICAL CONSIDERATIONS

Quantitative methods are used to answer “what?”, “how much?”, and “why?” questions. Qualitative methods are more focused on “why?” and “how?” questions (Kuper et al., 2008). When using quantitative methods, there may be an assumption that there is an “absolute truth”, a “reality”, which the researcher wants to discover (Kuper et al., 2008). The researcher’s belief about knowledge is called “objectivism” and the theoretical framework “positivism”. This is in contrast to qualitative research, where belief about knowledge (epistemology) is called “constructivism” (according to which, the reality we perceive is constructed by individual, social, and historical contexts, and so there can be no absolute shared truth) (Kuper et al., 2008).

By using an *inductive* approach (i.e. allowing meaning to emerge from data), rather than a *deductive* one (a hypothesis-centred approach favoured in quantitative research), a theory-based analysis can be performed. The analysis includes moving in both directions between empirical findings from interviews, for example, and conceptual frameworks (Kuper et al., 2008). The findings of qualitative studies are not intended to be generalisable, but instead transferable to other contexts. *Transferability* is defined as “the extent to which the findings can be transferred to other settings or groups” (Polit and Hungler, 1999) or “the range and limitation for application of the study findings, beyond the context in which the study was done” (Malterud, 2001).

Strategies for ensuring trustworthiness in qualitative studies, according to Guba and Shenton (Guba and Lincoln, 1994; Shenton, 2004), are:

- *Credibility*, which “deals with the focus of the research and refers to confidence in how well data and processes of analysis address the intended focus” (Polit and Hungler, 1999). Credibility of research findings also deals with how well categories and themes cover data (Graneheim and Lundman, 2004).
- *Credibility or trustworthiness*. Terms used to describe the extent that findings generated from qualitative research are believable to others; quantitative researchers often refer to this as internal validity (Kuper et al., 2008).
- *Transferability* (defined above)
- *Dependability*, which “seeks means for taking into account both factors of instability and factors of phenomenal or design induced changes” (Lincoln and Guba, 1985) or which may also be expressed as: “the degree to which data change over time and alterations made in the researcher’s decision during the analysis process” (Graneheim and Lundman, 2004).
- *Confirmability*, which reflects “participants’ recognition of the findings” (Graneheim and Lundman, 2004).

*Triangulation*, defined as “a research technique in which a researcher compares findings obtained using different methods and the perspectives of different people or groups to help produce a more comprehensive set of findings” (Kuper et al., 2008), is a method “for reducing the effect of investigator bias” (Shenton, 2004). “It is not the same as inter-rater reliability, and does not necessarily require more than one researcher” (Kuper et al., 2008).

*Reliability* is defined as meaning that if the work were repeated, in the same context, with the same methods and with the same participants, similar results would be obtained. The positivist employs techniques to show this during the research process (Shenton, 2004).

The influence of participants' and researchers' perspectives on research questions and findings cannot be avoided. This is in contrast to "bias" in quantitative research, where "true reality" cannot be seen because of interference by certain factors. In qualitative research, the researcher believes that reality "is only a construction". The goal in such research is not to erase a perspective, but rather to describe different perspectives (Kuper et al., 2008).

There are four types of triangulation methods: data triangulation, investigator triangulation, theory triangulation and methodological triangulation. In studies II and III, I applied methodological triangulation by using quantitative and qualitative methods and data to study the same phenomena.

By using both quantitative and qualitative approaches in this research project, I hoped to describe *and* understand different perspectives. These methods can be combined at different levels in the research process: sampling, data collection and data analysis. Mixed methodology (combining qualitative and quantitative approaches) is a method for pragmatists, whose approach is to use whichever methods works. Tashakkori and Teddlie define their position as "cautiously optimistic pragmatism", in which values play a large role in the interpretation of results and there is no reason to be concerned about their influence (Tashakkori and Teddlie, 1998). This position is the basis of the approach in this research project.

Patton's opinion is that it is possible to combine different kinds of qualitative methods and to include multiple perspectives, for instance by triangulation (Patton, 1999). Triangulation is a way of enhancing the quality and credibility of qualitative analysis (Patton, 1999). However, Sandelowski has objections to mixing quantitative and qualitative methods at three different levels. First, she argues that at the paradigm level the researchers may have different viewing positions (ways and places from which to see). To see a phenomenon in a certain way is to change the phenomenon (Sandelowski, 2000). Second, she argues that at the method level a neopositivist researcher and a constructivist researcher may use methods in different ways. For the neopositivist, concepts emerge or are discovered; for the constructivist, concepts are made or invented from data. Third, she argues that at the technique level many different techniques are used for different purposes, including triangulation (to corroborate or validate data), complementarity (to clarify, explain or elaborate results), and development (to guide the use of additional sampling, and data collection and different analysis techniques) (Sandelowski, 2000). Farmer et al. conclude that "triangulation is only as strong as the study's underlying theoretical, methodological, and analytical paradigms and the researchers' skills and abilities" (Farmer et al., 2006).

## Study I

Statistics Sweden is a government agency that produces statistics and has a coordinating role when presenting official statistics for Sweden. Their data are used for decision-making in society, for research and in debates. The sample in study I is representative of immigrants from three countries living in Sweden. The questionnaires are validated and have a high degree of reliability (Wärneryd, 1991).

A logistic regression model was used to estimate the risk of poor SRH by ethnicity for men and women. In logistic regression, the odds for each predictor or interaction term are computed. The *natural logarithm* of the odds is computed to obtain the logit. A linear regression analysis is conducted on the predicted values of the logit, and then the *exponential function* of the logit is used to compute the *odds ratio*. The advantages of logistic regression (Hosmer and Lemeshow, 2000) are that it is not based on a linear relationship is linear and there is no requirement for a standardised distribution (Muntaner et al., 1996). The fit of the model was considered satisfactory if the deviation was of a similar size to the number of degrees of freedom, an approach based on accepted statistical principles. To estimate the risk of poor SRH in men and women, an age-adjusted logistic model and then an effect model were created. The main effect model was created through stepwise inclusion of the explanatory variables, with Sweden and Poland as reference groups.

## Study II

The sample consisted of patients from the largest non-European groups of immigrants in Sweden on which previous studies have been based (see study I). By using these groups I hoped to be able to compare my results with the results of previous studies in other countries to increase my confidence when interpreting my results.

The questionnaires were developed specifically for this study. They were translated and culturally adapted by professional interpreters in the hope of achieving a better answer frequency and obtaining more valuable information. During the distribution of the questionnaires to the participants, the receptionists at the different PHCCs and the interpreters booked for the different consultations were able to offer more information to patients who did not understand the written information given to them. By asking the participants to fill in the questionnaires directly after the consultation, I hoped to obtain information on their experiences without distractions due to subsequent experiences.

A reference group comprising specialists in ethics, statistics and methods for developing questionnaires reviewed the questionnaires for validity. Also, to evaluate the questionnaires and test their clarity, two interpreters and one GP completed them before the study started.

The data collection period was long (September 2002 to February 2004) in order for us to obtain as many respondents as possible and to have as many consultations as possible in which patients, interpreters and GPs were present at the same visit. Another reason for the long data collection period was a shortage of staff in the reception area

and a lack of time for them to distribute the questionnaires and inform patients about the study.

Open-ended questions were used to capture patients' experiences, thoughts, expectations and feelings regarding the consultations. I used professional translators to translate the information from the patients' native languages into Swedish before further analyses were made in order that the material was as authentic and precise as possible.

### **Study III**

The sample consisted of patients from Chile, Turkey and Iran (presented in study II), their interpreters and GPs. My aim was to get insights into the triangular meeting from three perspectives.

I have not found any similar studies in the literature. Previous research concerning immigrant patients' visits to PHCCs have obtained information on one or two of the three participants in the triangular consultation using questionnaires (Taira et al., 2001), a combination of video recording, questionnaires and interviews (van Wieringen et al., 2002), interviews (Hudelson, 2005), focus groups (Fatahi et al., 2005) and reviews (Ferguson and Candib, 2002).

In study III, I used a triangulation method because I wanted insights into the three groups' experiences and feelings. This method can be used to obtain a more comprehensive set of findings. The questionnaires were distributed at the same time to all three participants at the PHCC's reception desk in order to avoid disturbing the communication during the consultation. The patients, interpreters and GPs were asked to answer the questionnaires directly after the consultation to avoid distractions due to subsequent experiences.

The questionnaires for interpreters and GPs were validated by a reference group, as mentioned above. Two interpreters and one GP evaluated them for clarity. As I wanted the questionnaire to include relevant questions covering my areas of interest, but at the same time not be too time-consuming for the participants, the questionnaires for the different participant groups did not include the same questions. This is of course a limitation that makes it harder for us to draw conclusions.

It was not possible to assess the reliability of the questionnaires, as mentioned above.

As also mentioned above the data collection period was long in order for us to obtain as many respondents as possible and to have as many consultations as possible in which patients, interpreters and GPs were present at the same visit.

There were 40 matched consultations, but since I wanted to analyse as much data as possible, I have also presented material from non-matched consultations. The high non-response rate may be partly due to interpreters and GPs being overloaded and having a lack of time. While I do not wish to speculate about the content I may have missed, I have drawn conclusions from the data with caution.

I conducted the descriptive statistical analyses using the software package STATA (Stata Corp. 2003, release 8.0), a widely used statistical software package that has high security. With one exception, I did not conduct any significance tests, due to the small number of informants. The exception was my use of Fisher's exact test to better understand which variables may have influenced patient satisfaction.

Content analysis to evaluate open-ended questions and comments is a well known method used in international health care research. Two researchers analysed the data independently before comparison and discussion of the results.

#### **Study IV and strategies during the triangular meeting**

The selection of participants for interviews was purposeful, that is to say they were "intentionally selected according to the needs of the study" (Coyne, 1997). Patients were from the same countries as in studies II and III (Chile, Turkey and Iran). In order to obtain as much information as possible about GPs' experiences, feelings and strategies, they were selected based on their long experience of working with immigrant patients and interpreters. For the same reason, nearly all interpreters were selected based on their being authorised and having extensive primary health care experience. Sampling continued until no new information was forthcoming (Patton, 2002), as determined by the researchers when the analyses were conducted.

The data collection period was divided in two periods due to the interviewer's personal situation. It is not possible to speculate about differences in circumstances between the participants in 2004 and those in 2010 that may have influenced the information given during the interviews. There were too many influencing factors during this period in terms of psychosocial conditions for the participants and working conditions for interpreters and GPs.

Professional interpreters were used when the patients' were interviewed. Kapborg argues that since the interviewer is not able to control the responses, "the interpreter should not only have linguistic abilities, but also be trained in the research field" (Kapborg and Berterö, 2002). It seems difficult to feel certain that no information was lost, since the interpreter's personal and cultural perspectives may influence the interpretation. In a review, Wallin et al. concluded that it is important to consider the interpreter's role in the research process, competence and impact on the findings (Wallin and Ahlström, 2006). The same is true for the interviewer. In the present study, the interviewer's experiences as a GP and as a priest, including prior knowledge, personal experiences, preconceptions and expectations, may have had some influence during the interviews and analyses (Chew-Graham et al., 2002; Coar and Sim, 2006).

## LIMITATIONS AND STRENGTHS

### Study I

Since study I was cross-sectional, causality must be assigned with caution. The large number of non-respondents is also a limitation. A possible explanation for this is that repatriated immigrants may not have informed the Swedish authorities about their departure. Since the non-response rate was higher in the immigrant group than in the Swedish control group, it is difficult to draw conclusions about ethnicity. It was not possible to determine whether non-respondents would have reported better or worse SRH than respondents. The non-response rate was higher in younger immigrants from Turkey and Iran. The risk of poor SRH in these younger immigrants is probably lower, because they also have lower rates of morbidity and mortality.

The response rate was fairly good, being about 68% for immigrants, an acceptable figure for evaluation according to the international literature (Harzing, 1997). The figure for Swedes in the control group was 80%.

SRH was used instead of disease diagnoses. It has previously been used in different European (Krause and Jay, 1994; Fernandez de la Hoz and Leon, 1996; Heistaro et al., 1996; Power et al., 1998) and American (Kaplan and Camacho, 1983; Grant et al., 1995) studies. Perceived combined physical and psychological health may be influenced by cultural differences between ethnic groups (Shetterly et al., 1996). The rating of SRH may reflect a person's general perception of quality of life. SRH varies with age, sex and social context (McCallum et al., 1994). It is also an important independent predictor of mortality (Kington et al., 1997; Miilunpalo et al., 1997). A strong association between SRH s and overall mortality in different ethnic groups was found in a study from the USA (McGee et al., 1999).

Another limitation is that acculturation is more complex than simply knowledge of Swedish. However, it was used previously to show a relationship between health status and use of health care services (Sundquist and Winkleby, 1999). It is an important independent predictor of mortality (Miilunpalo et al., 1997).

Discrimination is difficult to evaluate because both acculturation and discrimination are associated with multiple confounding factors, including drug and alcohol dependency, social support networks, legal and political issues, quality of local health services, income and lifestyle, working conditions and environments, family functions and support, intergenerational conflicts, ethnic support and coping, continued residence, the value of patients' life history, self-esteem, religious affliction, and life satisfaction.

Educational levels, including for basic education, are differently defined in different countries and different age groups. Nevertheless, education was a strong risk factor for poor SRH in Turkish and Iranian men and women.

One strength of the study was the use of statistics from the Swedish Population Register for a survey performed by Statistics Sweden in 1996. The sample was randomly

selected from a population register, which means that it included representative subsets of Turks, Iranians and Poles in Sweden. The same questions have been used consistently over time in the Annual Survey of Living Conditions, which increases the study's validity and reliability (Wärneryd, 1991). Questionnaires were translated and culturally adapted to enhance understanding and hopefully increase the response rate and provide more reliable responses. Face-to-face interviews were performed when answers could not be corrected directly.

## **Study II**

Since I have not found any other similar studies, I was unable to make comparisons to other countries.

The number of respondents was small and they were not equally distributed among the three selected groups. This makes it difficult to draw general conclusions about these groups in Sweden and thus significance tests were not employed. There were fewer Iranian participants and they were older and perhaps because of that may have had difficulties expressing experiences and feelings in writing. As a group, younger Iranians are better educated, do not need an interpreter's assistance to the same extent and more often visit private doctors.

It was not possible to test reliability due to the criteria for selecting respondents, the small size of the sample, and the loss of respondents who could not be included in the study sample.

The validity of the reported symptoms may be debated. Many patients do not accept that their symptoms are mentally related. The way in which each patient deals with their symptoms is influenced by their background and experiences. Validity in the analysis procedure for verifying conclusions needs a great amount of data, participants' recognition of the findings and information on how data change over time. Further studies are needed for validity testing.

The principal findings in study II based on the presented values must be interpreted with caution due to the small size of the study and also because of the large number of missing values in Table 5 for "Time from booking to consultation" for Chile (38%), Turkey (25%) and the total sample (25%) and for "Satisfaction with the PHCC" for Chile (69%), Turkey (48%) and the total sample (50%). As a consequence, there are large numbers of missing values (13, 25%) for "Time from booking to consultation", "Satisfaction with consultation" and "Consolation given by the GP" in Table 6, which shows the results of cross-tabulation analyses.

The figures for consolation must also be interpreted with caution due to differences in meaning and associations depending on cultural background and individual history. Negative reflections, for instance the feeling of being looked down on, were not mentioned or commented on in my study. However, trust, confidence and satisfaction complement each other when quality of care is evaluated. Trust and confidence are important for patient satisfaction.

### Study III

It is not possible to compare the experiences and reflections of my participants with those from international research since I have not found any similar studies in the literature. One strength of the study is my analyses of the triangular meeting from three different perspectives: patients', interpreters' and GPs' perspectives.

The clarity of the questionnaires was evaluated before the study started by two interpreters and one GP. The questionnaires were translated into the patients' native languages by authorised interpreters. However, it was not possible to test the reliability of the questionnaires because of the criteria used to select respondents and the relatively low response rate. The small number of respondents means that conclusions must be drawn with caution.

Another limitation is that the questionnaires for the three parties do not always cover the same topics. Therefore, I can only get limited insight into what really happens in the triangular meeting and interrelations between the three perspectives.

Some of the interpreters and GPs were themselves immigrants to Sweden, which might have influenced communication in the triangular meeting. It was not possible to measure these potential influences and this may be a potential limitation.

### Study IV

The strength of this study lies in the opportunity I had to gain insights into the three different perspectives of triangular meetings. A few similar studies have been published (Löfvander and Dyhr, 2002).

The study was adapted to the different stages in a qualitative research interview and I used professional interpreters, which means that the validity is good (Kapborg and Berterö, 2002). The sample in this qualitative study was "intentionally selected according to the needs of the study"; i.e. "purposeful" (Coyne, 1997).

A limitation of this study is that the number of participants from the three different countries was rather low. However, *saturation* was achieved because no new themes emerged from the last interviews when analyses were made (Kuper et al., 2008).

The findings cannot be generalised since it is a qualitative study, but they may be transferred to similar characteristics in other contexts (Patton, 2002). Participants' responses are subjectively expressed and influenced by each individual's characteristics and background. The findings in each interview have their own context and are unique.

Data analyses were performed by two authors independently, which contributes to the reliability of the results. The audio tapes from the interviews were checked against the printouts made by the researcher, and the participants were given opportunities to correct them and make comments in their own language. This means that the reliability is good.

Some of the interpreters and GPs were immigrants themselves, which might have influenced the language and the interpretation of the comments during the interviews. Moreover, one of the researchers who performed the interviews is a GP herself, with personal experiences, preconceptions and expectations. These conditions may have influenced the research process at some stages (Chew-Graham et al., 2002; Coar and Sim, 2006).

## CONCLUSIONS

The main finding of study I was the association of ethnicity with poor SRH. Based on my analysis of data from the ULF 1996 survey, I conclude that low SES, poor acculturation and discrimination are important factors for poor SRH. Differences in the risk of poor SRH between the different SES groups can be explained by poor acculturation.

I used a combination of quantitative and qualitative methods to explore triangular meetings between immigrant patients from Chile, Turkey and Iran, and their interpreters and GPs, during consultations at different PHCCs. The main finding of my questionnaire studies (studies II and III) was that patients experienced communication problems because of language and cultural differences between the GP and the patient, despite the presence of an interpreter. In addition, GPs' ability to listen was identified as an important factor by the participants (study II).

Despite communication problems, the majority of patients, interpreters and GPs in the questionnaire study (study III) reported good patient satisfaction. Feelings of having been understood and of having one's culture, personality and wishes respected were important for patient satisfaction. Demographic and migration-related factors, health status and factors related to the consultation did not seem to be important for patient satisfaction.

My conclusion from study III is that achieving a successful consultation with three satisfied participants requires the use of authorised interpreters for both linguistic and cultural interpretation, a patient-centred strategy with adaptation to patients' educational levels, and cultural competence.

In the interview study (study IV), patients, interpreters and GPs reported feelings of insecurity and frustration. Satisfactory interpretation and good relationships between all three parties are necessary for a successful consultation. Strategies for achieving a consultation that is satisfactory and successful for all three parties may therefore be needed. Among the strategies described by patients were getting to know the interpreter and the GP; using family members for support, interpretation and control of accuracy; and asking for a bilingual GP. The interpreters' strategies included adaptation of the language; mediation and supporting the patient; and cultural interpretation. According to the GPs, a strategy when the consultation time was insufficient was to limit the interpretative content. Strategies for ensuring that patients understood the information they received included repetition, extra explanation and checking questions. The use of body language was also mentioned as a strategy by interpreters and GPs.

Achieving the goal of "health care on equal terms for immigrants in Sweden" requires the transformation of triangular consultations from encounters into real meetings. This in turn depends on professional interpreters, a patient-centred approach, cultural competence and sufficient consultation time.

## POLICY IMPLICATIONS

Health care is a natural right for all persons, including immigrants. Barriers to equal care for immigrants are sometimes present at one, two or even three different levels: the patient level, provider level and system level. A review by Scheppers et al. concluded that some of the barriers at the *patient* level may be related to demographic variables, social structure, health beliefs and perceived illness (Scheppers et al., 2006). The review's authors further found relations to the provider's skills and attitudes at the *provider* level and to the organisation of the health care system at the *system level* (Scheppers et al., 2006).

In my studies I found that at the patient level there is a need for language training and language courses for immigrants in order that they can use the main language in their new country of residence. This is nowadays routine for immigrants to Sweden, who are offered an SFI ("Swedish for immigrants") course. It is important not only for acquiring language knowledge, but also for acculturation, employment and preventing discrimination. There is sometimes also a need for education at different levels in different topics, depending on immigrant patients' educational backgrounds. It is important to evaluate immigrants' foreign qualifications to help them to get work that matches their level of education.

At the provider level, access to health care must be the same for immigrant patients as it is for other patients, which means that access must be increased in areas with a large proportion of immigrants. Patients and health care staff have the right to ask for an interpreter when one is needed to improve both the quality and safety of health care. Different interpretation services may be used, with face-to-face interpretation being preferable to telephone interpretation, especially for consultations relating to mental health and when intimate examinations will be performed. A gender-concordant interpreter and GP are needed and preferable in some cases, where patients' wishes must be respected.

Family members may be used as interpreters when professional interpreters are not available or if the patient wants a relative to interpret. Knowledge of the patient's background, including cultural frameworks and beliefs about health, must be respected by the health care providers and seen as an asset. Ad hoc interpreters may only be used if a professional interpreter is not available. In such cases, patient confidentiality must be protected. Bilingual GPs are preferred by many immigrant patients and are a valuable asset, not only for the patients, but also because they can inform other GPs about cultural frameworks. Telephone interpretation has advantages in special cases and its use may be increased. Australia has the largest free telephone interpreter service in the world. There, GPs may reach an interpreter within 3 minutes, while on-site interpreters and health information resources in community languages are also provided (Phillips, 2010). Remote simultaneous interpretation (RSMI) is an alternative and was found to improve the quality of communication between physicians and patients in a study in the USA in which patients were randomised to proximate-consecutive interpretation (control) or RSMI (Hornberger et al., 1996). Patients and physicians preferred RSMI and interpreters reported that they thought patients and physicians understood each

other better using RSMI. However, the interpreters preferred proximate-consecutive interpretation (Hornberger et al., 1996).

Health care staff, including GPs and medical students, must be trained in working with an interpreter. The administrative staff at the PHCC may perceive the interpreter as a sort of parent to the patient, instead of as a consultant. Fatahi et al. found that interpreters viewed themselves as members of staff, a view shared by some of the patients – but not the staff themselves (Fatahi et al., 2005). The authors concluded that the interpreters ought to be better integrated into the health care system, for instance through employment by PHCCs.

My data also indicate that the consultations must be extended because interpretation and establishing emotional contact with the patient take time. Sometimes, cultural interpretation is needed and is performed by the interpreter. The GP must have an open attitude combining respect, flexibility and willingness to respond to patients' wishes concerning treatment, and must take into account patients' relations to different cultural frameworks (DeRosa and Kochurka, 2006). All health care staff can be empowered to make concessions concerning, for instance, different treatments as long as they do not compromise patient care (Sheridan, 2006). Cultural competence has been found to improve communication, increase trust, increase knowledge about differences between racial and ethnic groups in terms of epidemiology and treatment, and improve understanding of different cultural behaviours and environments (Brach and Fraser, 2000). To be a culturally competent physician means adopting a patient-centred approach that takes into account patients' needs, intentions, concepts, and expectations, with flexibility when planning investigations and treatment. This research project has highlighted the importance of educating health care staff about the migratory process and the risks for poor health in immigrants. Cultural training of health care staff is needed to enhance self-awareness of attitudes about minority patient groups, to increase knowledge about other populations' different cultures and to improve communication (Brach and Fraser, 2000).

Other strategies/factors for improving triangular consultations mentioned by my participants included providing written information to patients during consultations, paper prescriptions, increased use of bilingual GPs, interpreter and GP continuity, sufficient consultation time, and use of medical social workers, counsellors and psychologists.

At the system level, I conclude from my data that health education and health promotion are essential, especially for deprived and immigrant groups. Health care interventions to increase cultural competence are needed and may include the recruitment of health care personnel who reflect the cultural diversity of communities and bilingual care providers, and the use of health education materials that are linguistically and culturally appropriate (Anderson et al., 2003). Nine major cultural competency techniques were identified by Brach et al. (Brach and Fraser, 2000): interpreter services, the recruitment and retention of minority staff, cultural competency training programmes, the use of community health workers, culturally competent health promotion (including, for instance, risk reduction), including family and/or community members, "immersion into another culture", and administrative and organisational

accommodations (for instance, when producing written information) (Brach and Fraser, 2000).

# SWEDISH SUMMARY/SVENSK SAMMANFATTNING

## Bakgrund

Att vissa invandrare har en ökad risk för sämre hälsa, ökad sjuklighet och ökad dödlighet är känt i litteraturen. Men jag vill understryka att det finns invandrare som också har bättre hälsa än de infödda svenskarna. Varje invandrades bakgrund är unik, med därmed olika förutsättningar att klara den påfrestning som det innebär att migrera till ett annat land med annan kultur. Sverige är idag ett mångkulturellt land med ca 15 % utlandsfödda medborgare. När det här forskningsprojektet startade var Chile, Iran och Turkiet bland de största icke-europeiska invandrargrupperna i Sverige.

Invandrapatienters kontakter med primärvården och hur de upplever det triangulära mötet då tolk är närvarande vid läkarbesök finns inte beskrivet tidigare närmre, liksom inte heller hur tolkar och distriktsläkare upplever det.

## Syfte

Det övergripande syftet var att analysera det triangulära mötet mellan patient, tolk och distriktsläkare. I de fyra delstudierna var syftena att

- 1) ge en bakgrund ur epidemiologisk infallsvinkel hur sambanden mellan etnicitet, ackulturation/integration, diskriminering och självrapporterad hälsa ser ut,
- 2) utforska invandrapatienters erfarenheter och reflektioner av besök hos distriktsläkare, om demografiska faktorer/faktorer relaterade till invandringen, väntetiden för läkarbesök, självrapporterad hälsa/symtom och erfarenheter vid läkarbesöket påverkar patienters nöjdhet med konsultationen,
- 3) beskriva några aspekter av de tre perspektiven i det triangulära mötet mellan invandrapatient, tolk och distriktsläkare vad gäller erfarenheter, reflektioner och interaktioner, analysera patienters nöjdhet med konsultationen och om den påverkas av känslor av att ha blivit respekterad för sin kultur, personlighet och önskemål, om tolkar och distriktsläkare upplever etiska konflikter och
- 4) belysa de tre deltagarnas uppfattningar och reflektioner av det triangulära mötet genom djupintervjuer.

## Metod

Projektet innehåller både kvantitativa och kvalitativa ansatser och har en tvärvetenskaplig karaktär.

Delarbete I: Invandrare från Polen (840), Turkiet (840) och Iran (480) och svenskfödda personer (2250) deltog 1996 i Inv.-ULF (undersökning om invandrades levnadsförhållanden). Utfallsvariabel var självrapporterad hälsa.

Delarbete II och III: Ett frågeformulär distribuerades till 78 invandrapatienter från Chile (17), Iran (22) och Turkiet (39), deras tolkar och distriktsläkare på 12 vårdcentraler runt Stockholm. Deltagarna tillfrågades om bakgrund, åsikter, erfarenheter

och reflektioner kring konsultationen och om patientens nöjdhet. Statistisk analys STATA och innehållsanalys användes vid bearbetning av svaren.

Delarbete IV: Djupintervjuer av 10 invandrapatienter från Chile, Turkiet och Iran, 9 tolkar och 10 distriktsläkare utfördes av EW. Vid bearbetning av intervjumaterialet användes innehållsanalys.

## **Resultat**

Delarbete I visade att män från Iran och Turkiet hade en trefaldig ökning av risken för dålig självrapporterad hälsa, medan risken för kvinnor var femfaldig. När socioekonomiska faktorer inkluderades i den logistiska analysmodellen sjönk risken något dvs. en del av sambandet kunde förklaras av mer ogynnsamma socioekonomiska förhållanden.

Delarbete II visade att majoriteten av enkätsvaren från 52 patienter innehöll uppgifter om kommunikationsproblem beroende på språkliga och kulturella skillnader mellan doktor och patient och doktors förmåga att lyssna på patienten. Demografiska faktorer och faktorer relaterade till migrationen, hälsotillståndet och konsultationen verkade inte vara associerade till patientens nöjdhet eller känslan av att ha blivit tröstad av doktorn.

Delarbete III visade att av 182 deltagare i studien (52 patienter, 65 tolkar och 65 distriktsläkare) hade 40 stycken från varje grupp deltagit i samma konsultation. Av patienterna hade 18 upplevt språksvårigheter, 26 respekt för sin kultur, 32 respekt för sin personlighet och 32 för sina önskemål. Etiska konflikter var sällsynta. Alla tre kategorier av deltagare rapporterade att patienten varit nöjd med konsultationen.

Delarbete IV: Sex tema kunde urskiljas och arrangeras inom två ämnesområden: översättningsprocessen (sättet att tolka och sättet att informera) och själva mötet (individuellt anpassat förhållningssätt, konsultationstid, patientens känslor och familjemedlemmars roll).

## **Slutsatser**

Det finns ett samband mellan etnicitet och dålig självrapporterad hälsa som delvis förklaras av ogynnsamma socioekonomiska faktorer, diskriminering samt bristande ackulturation dvs. kulturell adaptation och integration till det svenska samhället. När tolkning och relationer vid konsultationen inte fungerar optimalt rapporterade patienter, tolkar och distriktsläkare känslor av osäkerhet och frustration, trots närvaro av tolk. För att få en framgångsrik och tillfredsställande konsultation för alla tre parter på lika villkor för invandrapatienter i Sverige indikerar våra resultat att det krävs professionella tolkar. Vidare krävs att distriktsläkare använder sig av ett individuellt förhållningssätt och kulturell kompetens och att konsultationstiden är tillräcklig i förhållande till behoven.

“Vi måste gå varandra till mötes i medvetandet om att vi alla är människor och att vi för den skull har förmågan att tillsammans känna, tänka och vilja på samma sätt...

Vi måste lära oss att värdigt ta emot livets gåva och att allt efter förmåga ge det högsta möjliga värde. Vi ställer oss i det godas tjänst när vi känner ansvar för alla andra levande varelser... ty vart enda levande väsen har ett sorts egenvärde. I vördnad för livet finns det godas grundprincip formulerad och koncentrerad.”

Albert Schweitzer: ”Vördnad för livet” (SKDB 1959 sid. 235–237)

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# APPENDICES

## Appendix I – Paper I

Wiking E, Johansson S-E, Sundquist J. **Ethnicity, acculturation, and self reported health. A population based study among immigrants from Poland, Turkey, and Iran in Sweden.** J Epidemiol Community Health 2004;58:574– 582. doi: 10.1136/jech.2003.011387.

### ERRATA

“Ethnicity, acculturation, and self reported health. A population based study among immigrants from Poland, Turkey, and Iran in Sweden” JECH 2004;58:574–582.

**Table 1B** Distribution of the explanatory variables by ethnicity (women, n=2260):

**Discrimination:** The subheadings “None” and “High” have been transposed.

### Commentary on the results

Feeling discriminated against was most common in the group of Iranian men and women. The perception of discrimination was also rather common among Turkish women. Despite the fact that about 80% of men and women from Poland had a good knowledge of Swedish, many people in the Polish group still reported that they experienced high or medium levels of discrimination. Nearly half the women perceived a high or medium level of discrimination, whereas more than half the men perceived a high or medium level of discrimination.

Eivor Wiking

Sven-Erik Johansson

Jan Sundquist

## Appendix II – Paper II

Wiking E, Saleh-Stattin N, Johansson S-E, Sundquist J. **Immigrant patients’ experiences and reflections pertaining to the consultation: a study on patients from Chile, Iran and Turkey in primary health care in Stockholm, Sweden.** doi: 10.1111/j.1471-6712.2008.00622.x Scand J Caring Sci; 2009.

## Appendix III – Paper III

III. Wiking E, Saleh-Stattin N, Johansson S-E and Sundquist J. **A description of some aspects of the triangular meeting between immigrant patients, their interpreters and GPs in primary health care in Stockholm, Sweden.** Family Practice 2009; 26: 377–383.

## **Appendix IV – Paper IV**

IV. Wiking E, Sundquist J, Saleh-Stattin N. **The consultation between the immigrant patients, their interpreters, and their general practitioners, is it just an encounter or a real meeting? A qualitative study in primary health care in Stockholm, Sweden.** (submitted)

## **Appendix V**

Questionnaires for patients, interpreters, and GPs in study II–III (Enkäter)

## **Appendix VI**

Interview guides in study IV (Intervjuguides)